

Pedagogical dimensions for the promotion of citizenship within social control

Giovanni Gurgel Acirole

Hygienist, M.Sc. and Ph.D. in Public Health (State University of Campinas - Unicamp, Brazil)
Adjunct Professor of the Medical School at Federal University of São Carlos (Universidade Federal de São Carlos/SP – UFSCar)

ABSTRACT

This paper is about the social control practices found in the Brazilian National Health Care System (SUS) regarding its pedagogical dimensions. Social control practices have been deemed as alternatives to direct democracy and as a space for the defense of public interests in health care policies. The thought over the action of health councils recognizes the difficulties generated by conflicts and tensions brought forth by both individual and collective interests, ranging from individuality culture to citizenship relations. In addition, it encompasses the issue of power in its manifold manifestations. However, building social control in SUS means to maintain empowerment and overcome tensions and conflicts between both individual and citizen. At last, such aspects are thought to be pedagogical components to be explored for the construction of citizenship and democracy, and to improve social as well as public control in SUS.

Keywords: social control, health care systems, citizenship, health education.

INTRODUCTION

As the movement known as Sanitary Reform evolved in Brazil, one of its fundamental formulations refers to considering the possibility of strengthening civil society in regard to the

State. As far as this aspect is concerned, some statements stand for a relative consensus in public health. The first statement refers to what has become a legal principle according to which the configuration of the Brazilian National Health Care System (SUS) is intrinsically connected to social control practices, thus making the former unacceptable without the existence of the latter and vice versa. The second statement stems from the first. It points out to the fact that health councils make up an alternative to establish democracy and strengthen the defense of public interests in regard to the action taken by the government and by relevant partners in the process of managing the public health care system (CARVALHO, 1997; FLEURY, 1997). Such facts are considered to be an effective translation of Sanitary Reform's democratic conceptions.

Scrutinizing such premises implies the acknowledgment of a field of tensions found in the internal dynamics represented by a double process, which is simultaneously characterized by the search for a unique health care system and the consolidation of a model for participative management. In both cases, the councils stand for instrument and strategy at the same time. Under this double way and this double value of use lies the interaction of interests and needs existing between the counseling individual and the counseling collective, between the participant's individuality and the status of engaged citizenship, where engaged citizenship is a condition to take part in this type of council.

Such interactions acquire great importance when considered in the light of what has been dealt with as being the noblest function of a mixed council: defining what constitutes the public interests, representing collective will and point out what makes a priority for government action. This is a set of definitions that should be placed above and beyond individual interests, private needs, and the volitive dimensions hidden behind and before militant action, corporate engagement and even citizenship action crystallized in sheer formal mechanism. This discussion is going to take place in the first part of this paper.

In order to achieve the premises of building up a unique health care system and making the Status *versus* society relationship more democratic, besides accomplishing the tasks of defining public interest and directing government action for its effective fulfillment, the health councils require specific empowerment through which they legitimate themselves and enable their ability to make things feasible. In addition to being typified, such specific powers deserve to be discussed in terms of the effects they bring about and the social as well as institutional context where they take place. This is what is intended to be discussed in the second part of this paper.

At the end, it is also intended to stress out the idea that experiencing such process can be taken for a pedagogic practice and therefore contribute to the overcoming of tensions and conflicts between individual and collective interests, in addition to the diversity represented by different segments. Likewise, it is intended to consider the appropriation of power dimensions within its institutional application. This is a

pedagogical effort to strengthen the exercise of public control over the action of the State, which is typical of today's SUS. As a potential element for permanent education, it is intended for this overcoming to represent the transcendental dimension that generates the sense of a public control over the action of governments, either for the realization of SUS's effectiveness or for the construction of democratic as well as solidary relationships within the social space.

The pedagogical dimension of the tension between citizenship versus individuality for Social Control

By analyzing the relations involving democracy, citizenship and health, Fleury (1997) identified a double path of conception for sanitary reform: the former is institutionalized; the latter is "movementistic". The former is, mainly from the 80's on, recurrent to the strategy of development of sanitary conscience as a way of conjoining the singular experience of suffering with the public dimension of the individuals as citizens who bear rights and duties in regard to the State, which granted a transforming feature to citizenship. The latter was guided by communal mobilization and political socialization by experiencing the paradox of taking State as the main target of its fights and, at the same time, circumscribing such fights within the social scope. Here lies the popular, organized, and institutionalized participation that later on turned out to be sectorial, deliberative councils.

The multiplication of Health Councils throughout Brazil has required the emergence of critical issues about control mechanisms related to the realization of actions and services rendered by SUS in their whole amplitude and capacity. It also brings about the discussion on macropolitical mechanisms involved in the source of the idea of popular participation and in the management/control mechanisms over the action performed by the State, which are significantly submitted to the influence of the interest demands of world agencies that promote public policies in developing countries (CORTES, 1996; 1998).

Deploying health councils in most Brazilian regions has been interpreted as the result of a convergence between two macrodimensions: one that establishes councils as an institutional backbone for the Health Care System; another that sees them as one of the social control instruments that stem from the struggle for health democracy and of society as a whole within the Sanitary Reform. This project, devised as an equalitarian utopia, assumed health as an individual right and the construction of a strong local power within a democratic social management. According to this standpoint, it discloses its argumentative character as it is inserted in a polymorphic, unequal, and profoundly segmented social universe, as well as in an economy

characterized by the production of exclusion, marked up by crises and adjustments of liberal nature, which exerts significant impact on social policies. These features were especially distinguished during the last two decades (FLEURY, 1994; GERSHMANN & VIANA, 1997). Nevertheless, they are firmly and historically rooted in the development of world capitalism, in addition to the singularities of the Brazilian case – furthermore, reestablished in the current world economic globalization and productive restructuring processes.

Under this scenario, the tendency of which is to polarize and aggravate crises, the real accomplishment of a universal, equalitarian health system is made even more difficult. Such difficulty otherwise derives from the hiatus between talking about democracy as a regimen of judicial equalities and practicing democracy as a process for the construction of relationships deprived of power. This practice implies the difference that should be made between *a few* and *others*. Yet, when democracy is envisaged as synonymous with the formal warranty of individual rights, affirmation of a *jus naturale* equality that does not transcend the fetishistic mechanisms that subordinates the domain of needs (housing, transportation, education, health, social security) to the domain of freedoms (come-and-go, individual protection, property, choice, etc.).

The logic of individualism is brought forth in communion for the conception of democracy taken under a liberal focus and reinforced by social segmentation. The notion of individuality based upon the binomial of *possession* and *consumption*, which mixes us all into a mass in the kingdom of merchandise. Citizenship, on its turn, presented as a legal/political mediation for the equalization of individual differences in regard to the State, reduces the notion of social rights to a set of services to be rendered to the population in the improvement of its welfare. This is a scenario where both political and social action can be lost in perversion or absence of its public, collective sense, and/or even in its difficulty to be identified. Loss and perversion together make up fundamental stumbling-blocks for the transformations desired by the Sanitary Reform either in the way to enhancing the access on a universal basis or to improving the participation, that is, the democratization of social spaces.

This situation leads to the consideration of the following issue: faced with the advancement of the idea of accomplishment on part of the individual through the free manifestation of desire – as a presupposition of modernity –, which drags us towards the transformation of human beings into pieces of merchandise, whereas the movement that claims and fights for rights flows back, subdued by the seductive discourse of a triumphant capitalism, one is able to question: which citizenship? Which individual is interested in playing the leading role of a counseling citizen? How is it possible to participate in the fight for the defense of equality bylaws and social rights, when this very own subject is fully loaded with the affirmation of its opposites? Therefore, how is it possible to defy the contradictions of the legal equality that is granted to individuals while in the condition of citizens? If citizenship means emancipation, how is it possible to conciliate the idea of an endless

process with the positive enjoyment of rights granted by the ethical-normative condition? Likewise, why is it worth taking part of the political decision process when politics itself seems to vanish amidst the ocean of generalizations – not groundless, however – that places every member, as viewed by common sense, as accomplices of the traffic of influences and mean interests or even of corruption as an underlying practice?

Health councils stand for forums that unite the representativeness of users, workers as well as of managers and suppliers in the sector. Through such configuration, they constitute a space for mediation of divergences deriving from conflictive interests in the sector; disputes that might be overcome through constructing an agreement in which public interests openly prevail. The issue stands exactly in how this agreement can be made feasible. On the one hand, as it gathers great disparities of interests in a society used to solving conflicts and differences by employing force, conspiracy and working things out their own way; mechanisms where limits are not clear – limits that have never been quite precise between the legal and the legitimate. On the other hand, as such social contract implies overcoming contradictions and conflicts of class in a country where the gap between the ones who own almost everything and the ones who own nearly nothing is thoughtlessly unacceptable. Defeating this gap involves such a degree of difficulty that it seems to confirm the Latin American flair for the incompatibility between social development and democracy (BORON, 2001).

The configuration of councils, on its turn, seems to confirm the idea according to which social policy is simultaneously the possibility and the necessity of capitalism (FLEURY, 1994) mediated by State intervention, and it results from historical relations between capital and work which, in addition, involve three leading actors: State bureaucracy, entrepreneurial bourgeoisie, and workers – especially urban ones. Thus, a policy that expresses the contradiction between the socialization of the working process and the private appropriation of the means of production; what is in the core of discussions between what constitutes private demand and what public interest means, which denotes the search for an effective displacement of power towards the less favored socioeconomic classes.

Viewed from another angle, it is necessary to recognize the materialization of the democratic paradigm of the Sanitary Reform within the legal and institutional structure that is proper of health. A paradigm in which the increase of information access is considered, and for which the idea of democratization holds conceptions that go beyond the formal institutional format. In that respect, Fleury (1997) considers the judicial and institutional structure of health (which comprises the councils) as an overvaluation of formal democracy aspects, where the dilemma between representativeness and participation is noticed and, therefore, also a distance between representative and represented, i.e., between legality and legitimacy. Fleury states that the harsh truth of difficulties found in the deployment of a Sanitary Reform project lies in the fact that

equality cannot be created through the law, but all the same equality cannot be consolidated away from the law: then the issue of legality is likewise placed before us, almost in a tautology, as a question that is required for the existence of the institutionally collective represented by health councils.

Meanwhile, this has been a space which a significant amount of social organizations have leaned to, especially the ones directly involved with the condition of service users such as, for example, housewives through local neighborhood associations; people with special needs through their countless means of representativeness; urban trade unions concerned with various economic activities; people bearing pathologies, etc., perhaps even because they represent the most expressive group to endure the insufficient resolute capacity of a system under permanent construction. This range of associations and organizations in civil society expresses the recognition of health as a right for all and a duty for the State, and of the institutional space of health councils as well as of the conferences and sectorial plenary sessions as a field for explicitness and legitimacy of guidelines and demands. The groups flocking around this field can be the ones that more keenly experience the issue of specific health necessities.

In this *locus*, it is expected from them to act through the pressure to redefine the role to be played by the State and through the need to reformulate its practices in fulfilling and obtaining political as well as public recognition for every fight and demand. In this sense, when providing these groups with the possibility of fighting for the realization of rights that qualify them as citizens, the arena of councils grants them the commitment to get organized to increase and make their demands heard. At the same time, by considering their own legitimacy in the arena, the group of people gathered together in that place is supposed to surpass the limit as it proposes a control that has not only the inspecting, but also the deliberative and pluralist features, whose functions go far beyond the sheer forum of claims or the qualified channel for the processing of demands.

Therefore, a practice that universalizes the discourse of demands is desired and primarily necessary as a propulsion and stimulation of the chains of participation, although not sufficient to cope with the surpassing that has been pointed out. It is not our intent to exclude the fact that the existence of claims and demands to satisfy health needs can produce pedagogical and educational effects for another political and sanitary conscience. And we take it for feasible owing to two reasons: the former, inasmuch as an internal antagonism can be noticed, many times even conflictive, between the different motions or projects that are systematically drawn into dispute, which incites a compelling process of argumentative discussion and negotiation towards a *communicative action* (HABERMAS, 1987); the latter, albeit this participation and business process mean involvement and appropriation, or even contamination through other discourses, mainly the technical discourse.

Likewise, the sanitary movement defends every citizen's need to get appropriation of

knowledge and technology for the full exercise of the right to health; this includes from the dialogic and pedagogical relation in the physician-patient care to the socialization of knowledge that explain the determiners of health status and of the organization of services as well as of the health policy. For the group of citizens involved in social control practice, on the other hand, this means an appropriation that distinguishes them individually in relation to the institutional collective that they represent. The amount of specific information and knowledge ends up producing another level of participation and experience, which includes the interested uses of such appropriation when obtaining direct and indirect gains: either in the specific purpose of health system knowledge for oneself or for the ones who are near – or in the engagement and cooptation of which they can be victims and agents. In spite of such facts and distortions, it is important to highlight the relevance of such appropriation as a way for the spread of a sanitary culture, as a participative element in the culture of citizenship that one intends to improve, up to the point where it constitutes a counter-hegemonic movement in relation to the passiveness that is expected from individual service consumers.

Moreover, the health councils seem to represent a reinforcement element within the policy of disentanglement between the public civil space and the State. A disentanglement that refers either to bureaucratic spaces of power or to institutional legitimacy spaces such as parliaments and respective political bonds, presupposing the existence of a field of interests, logics, strategies and actions that do not coincide with the action of parliamentary and governmental spaces without, however, denying their legal as well as institutional importance for the democratic game. Such an effort that seems to drive us towards Spinoza, for whom a city and corresponding political model draw more interest rather for being free than fair. So it is not a question that being fair or not is not important at all, but the aspect of freedom is essential for the survival of the desire of life in the city; and the power that stems from that is not captured within private groups identified with its exercise, but, when it is the most possible among them all, so it does not belong to anyone (CHAUI, 2000). That is, however, freedom that overlaps the equality issue, when we all can be entirely free to exercise certain kinds of choice, though we certainly have unequal possibilities of participation and engagement in the social dynamics of the city where we live.

Costa (2002), for example, ponders that the civil society envisaged by such acting perspective faces greater difficulties, which distinguishes it in comparison to the political and economic organization, either in regard to parties or trade unions. These difficulties emerge from the dependence on public attention that their claims require to obtain power and influence resources; on the *ad hoc* feature held by the formation of groups that occur within the context of their own actions (they do not have an *a priori* existence); on the voluntary nature that is freely arbitrated in the recruiting of members; and on the complexity of the world of life from which they extract their complete guidelines, agendas, and demands.

In the proposal of sectorial health councils (as seen from the optics of structures of the civil society), however, it is possible to see other merits in addition to the ones deriving from institutional formality, once they can be sources to foment a democratic culture that is full of subjectivity; an arena that presupposes complexity, though it can aggregate diversity, which produces a feeling of collective belonging (CARVALHO, 1997). Surely because the social condition of modernity has given rise to increasing connections – shaped as political innovation – between citizenship and individuality as well as between citizen and individuality plus democracy (BOBBIO, 1997; SANTOS, 1997). These connections make it even more difficult to dissociate where the beginning of one and where the end of the other are to be found, i.e., the citizen and the individual dwell with each other, although the capitalistic production mechanisms of modern society will want each one in a fully detached manner: the individual for the market and the citizen for the State.

As Santos (1997) puts it, this detachment places citizenship and individuality under permanent tension. The former, which consists of rights and duties, enriches the latter and opens new accomplishment horizons to it; on the other hand, when doing so, it reduces individuality to its universal extent and transforms the *subjects* into equal, interchangeable units within the space of bureaucratic administrations, either public or private, while playing the role of passive recipients of production strategies as workforce; of consumption as consumers; and of domination strategies as formal democracy citizens. That is to say that it emphatically places the conflict between the equality expressed by citizenship and the difference expressed by individuality. This conflict allows us to disclose the issue of *subjects* in their formation process, this time wrapped up in a double dimension: as the result of their bio-psycho-social existence and as an essential political element for the production of democracy. This formation is based upon the production of citizenship, though founded in the subjective matrix of individuals, which is the greatest philosophical as well as ideological contribution to modernity (HABERMAS, 2000).

How to understand these subjects then? Testa (1997) provides elements for the understanding of such contradiction. According to him, the subject undergoes a double constitutional process: on the one hand, through inner individual transformations that gradually form the psychic adult apparatus with ultimate features, even when it is difficult to accept something as being ultimate in this field; on the other hand, from the changes considered in the incorporation to collective organizations, which will regulate the subject's life from then on: the family, a job, and several other social institutions. This double character in subject's constitution is the source and the justification for the tension between individual and collective, which is never going to disappear and, exactly because of that, must never be neglected. As the subjects are progressively inserted in this process, under a perspective of preservation of its utopistic feature, of resistance and counter-hegemony, they preserve individuality but they recognize *alterity*, i.e., they

establish the recognition of the complexity required for the intervention in reality, and pass through the way that leads to the solution of these conflicts and underlying tensions.

As though confronting the experience of participation in health councils and this underlying tension was not enough, the council accomplishes its institutional task by approaching *subjects* in different times in history. *Subjects* immersed at a time in different moments and forms of subjectiveness (TESTA, 1997) and, collectively, constituent and constructor of another subject, the so-called *collective subject* (SADER, 1995). *Subjects* possessing diverse knowledge and competences with different competence degrees for the practice of their discourses and different degrees of power to imprint different praxes, with a single resulting one, the decisions being taken by the board of counselors. *Subjects* possessing a diversity of values and projects gathered and grouped for the construction of a unique time in history that subsumes the different institutional times – either from the view of an institution that is built (the council itself), or the view of the insertion in an institution that is preserved (the health government). These are other stumbling-blocks that configure the grounds of the problem and claim for the challenge of overcoming them.

From the multiplication of health councils within a significant universe of Brazilian localities, and practically in every capital city of each federative state, two outstanding effects can be seen in the opposite direction. In the micro working daily life of these councils, such action has resulted in the contact of manifold pieces of knowledge – technical, political, administrative, unionist, social, popular, economic, sanitary, etc. – a reciprocal contamination process. When doing so, we are able to understand that the concept of discursive competence is called into question, i.e., the construction of legitimacy channels for other discursive contents and of *porosities* for places where these discourses can then be pronounced (CHAUÍ, 2000).

It is over this chain of tensions and difficulties, which belongs either to subjects or institutions, that the health councils are supposed to form a new competent *subject*. That means to say that they can be transformed into an organic instance of the production of democratic relations in the space of micro-daily-life owing to the overcoming of politically engaged and atavistically demanding corporate issues on part of the members; where the appropriation of discourse contents, of the manifold represented sectors, turns the instituted legitimacy into a capillary structure, the ideas of democracy and participative citizenship into a substantive notion, and end up increasing the subsumption of the individual within the citizenship dimension (SILVA, 1999). It is neither an easy nor a feasible task within a foreseeable time! However, we can devote ourselves to this task in a process of permanent pedagogical production by incessantly reconsidering the critical reflection about the track that has been followed, about the process and the results!

The Power Issue and its pedagogical dimension for the social control

As a constitutive element of social control – an institutional pillar of the Brazilian National Health Care System – the health councils act as a multiple, institutional, diversified space of permanent tension between individuals and collectives, where corporate interests interact as well as the politically engaged discourses and the atavistically demanding movements. The transcending task is the construction of agreements concerned with the display of common, public, and priority interests. Meanwhile, there is also the possibility of using the councils as consolidation or even legitimacy strategies for a political project formed by the action of local Health Departments.

In spite of which has been the preponderant conception, whether of a “movementistic” or institutionalist nature, the fight for popular participation is and should be essentially a political fight for the construction of *subjects*. A construction inserted in a double perspective: the first is disclosed by the conception of citizenship as a historical process of popular achievement in which society acquires conscience and organization to make its own projects real (DEMO, 1992); the second is disclosed by the challenge of promoting the distribution of an effective power and not only due to onus, and which requires a resource-decentralization action to bear the expenses and the investments of such projects, democratizing the system’s financial management in every governmental instance; however, an aspect that has not been fully accomplished. The achievement of such double dimension depends on the effective distribution of power and not only on deliberative or decision onus. Effective power, for instance, from the decentralization of resources to bear expenses and investment of projects, their effective prioritization, i.e., system financial management democratization in every government instance; an aspect, however, not fully accomplished so far.

The topic of power, beyond the tension of disputes – as possibilities of use for power can be admitted in terms of consolidation or legitimacy –, clearly presupposes the action of correlative forces within a given arena. On the one hand, the sectorial institution that conducts the health policy, taking its organization as a starting point as well as its knowledge and technical competence, in an attempt to implement and deploy an essentially political “project” – though immersed in technical issues –, dealing with a social, multiple, not well organized structure of extremely diverse fields of knowledge. On the other hand, comprising a diversity that conjoins militant discourses and practices on a corporate basis, which are ideologically fortified, atavistic, ingenuous or alienated, Manichean or biased. Although they never admit themselves as being wrong! Configuring a web of complex interfaces as pointed out before. Another angle, not at all less interested nor an inferior possessor of “projects” by means of which interests, tensions, conflicts and consensus are sought after in addition to the pursue of the obtainment of attention on part of government policies.

In order to rise up against these features, the arena represented by the council is formed of paired elements and has a deliberative character. Moreover, it is formally an agent and co-conductor of health policies. At the same time, it plays the role of inspection and control over the institutional agent – the health manager. Owing to its diverse and multiple nature to cope with its legal and constitutional role, it only endures to constitute itself as a social and political actor as it gains power and gets consolidated, gathering its participants around a feeling of mutual participation. This scenario displays a dispute about power: an institutional power – the health managers – before a power that gets institutionalized – the health councils.

As the theme of power is clearly presented, the categorization proposed by Mário Testa (1992) should be considered, especially as it reflects over the uses assumed by power in societies and organizations. Regarding power in the organizations, Testa conceptualizes them by considering two aspects: one is institutional, related to the bureaucratic consolidation of a general organization; another refers to a group of people around common interests, i.e., the primary social actors. In relation to power, a double axis is presented: the one corresponding to the results of its exercise and the one differentiating specific types. The first axis considers the existence of a daily power that refers to what and how to do things. It is the generator of a dispute inside the manifold organizations, where natural allies are the ones who share the same social division of labor, generating conjunctive alliances. It considers that the daily power implies social power as the dispute over what and over how to do daily life – a sphere where personal domination mechanisms are located – reproduces the domination of a class over another on an individual basis. It refers, therefore, to the type of society to be constructed (produce or reproduce), in which the natural ally is the class ally.

The second axis, which corresponds to the types of power concerned with each branch of activity, three types are identified: technical power, administrative or organizational power, and political power. About the first type it is said that it deals with diverse aspects concerned with the pieces of information involved in this type of power. For instance: medical, sanitary, administrative, theoretical information, etc. Such knowledge is found in different fields susceptible to be subdivided into different categories, such as the fields of teaching, investigation, services, higher administration, and population. For the technical power, two important issues should still be mentioned. One refers to generation procedures and instances, processing and use of information in relation to social groups that deal with each of such instances, which leads to a heterogeneous distribution, implying the possibility of a greater accumulation of this power in a given social group. Another peculiar feature of this power is its style, in which languages either conceal or reveal the basis of the process about which information is generated.

Since information is synonymous with power, the space that Chauí (2000) called *competent discourse* is configured. Therefore, this cryptographic aspect assumed by language (in the core of

the information process, appropriated by a certain segment or class) has – or might have –, especially for most populational strata, the main function of retaining, along with information, the power generated by such information. As pointed out by Chauí, this particular aspect is the key to the establishment of interdicts or for the fact that nobody is allowed to say whatever they wish to whomever they choose, wherever they like, unless when protected by the competent discourse. On its turn, the establishment of interdicts is understood as a generator of certain requisites for the constitution of interlocutors.

It is important to highlight the fact that health councils have a whole lot of technical knowledge holders, namely in the health field, so it is essential to break the monolithic treatment of such knowledge which, on its turn, is a power keeper: the competent discourse power, a power that holds the hegemony of technical over political and social, for example, as it prevails over most discussions on this field, where one is able to notice a certain tendency to cover the health issue with an aura of "technical" isolation: a kind of protective shield that is, if not invincible, at least aseptic in relation to the impureness of the "political".

The administrative or organizational power, on its turn, synthesized in the manifold financing forms, is a core element for the organization of several sectors within the health sector. Similarly to the technical power, in relation to the homogeneity variable, it is fundamental in regard to power displacements. In addition, it identifies three subsectors: the public, the private and the semi-public or intermediate, each of them holding their own peculiarities within the service rendering modality, and in the way that the financing received is managed for that purpose.

Meanwhile, these sectors are not easily distinguished as they may seem to be at a first glance due to the confusion between distinguishing what is state-owned, taken as entirely public, or as state-owned and non-public; or the private in a strict sense, being a service render to the state-owned, or for SUS; the philanthropic, private or public; the private supplemental; the supplemental sector (ACIOLE, 2006). Such examples might show that it is not easy to identify the several modalities presented in the council arena due to the shrewdness of decision that is found, many times, in its discussion agenda. Furthermore, when the destination of resources to a given branch of activity results or depends on such decision.

As Testa (1992) reminds us, this is so because, under such analytical category, the notion of power is usually disguised so that the examination of resources and corresponding productivity is put as the main focus, assuming efficacy and efficiency as main features in this type of analysis. Moreover, between the notions of administrative efficacy and efficiency, each use of the administrative power – the administrative decision – leads to consequences over the social groups affected by the decision, bringing forth the increase or decrease of support that is rendered by each of these groups to the ones who took the decision. These variations either allow other decision-making or not. Another essential consideration refers to the start of two other times at the moment

of making an administrative decision: the political, or the time required to produce the support/repulsion reaction on part of the affected/interested social groups; and the technical, i.e., the time spent by decision to be implemented until its operative efficacy is attained. From the technical stems a new political time that corresponds to the answer given to facts produced – or the political efficacy from both administrative efficacy and efficiency.

For Testa, the political power is the ability to trigger a mobilization, which basically depends on a given form of knowledge – a view of reality. This one appears as knowledge generated by several means: as the experience stemming from concrete situations and, still, as feelings derived therefrom; as a reflection about such situation and, in particular, as scientific knowledge. At the same time, such mobilizing capacity can be considered as a practice that clearly impacts on its social actors either in their *mobilized* or *mobilizer* conditions. So the political power emerges as a result of its consideration in the two axes: knowledge and practice – knowledge as a view of the world and practice as a constructor of subjects. This is also defined as ideology. The political power, especially in the health case, manifests itself in ways such as the practice of domination – in intersection with the powers of technical and administrative types, in scientific knowledge; and as a hegemonic practice resulting from the intersection with empirical knowledge. At last, the way it would have to pass through to constitute a class political power is pointed out, recognizing the possibility of combination between the types of power and the forms assumed by the transformation of some types into others as well as of some forms into others. It is also made clear that the power of political type belongs to a different level in relation to the two previous ones: a different quality that establishes a hierarchy above those types, which is manifest in the fact that, at some instance of the power dynamics, both administrative and technical powers are subsumed by the political power.

In the face of this scenario of forms and intersections of power pointed out by Testa, Rivera (1995) focuses on a few difficulties imposed by such taxonomy by questioning, among other issues: what is the relationship among such power forms and organizational types? How to consider democracy as a regimen that is not a strict class power, in a hegemonic sense? Why not to consider the mobilization around technological, organizational, and economic resources as a starting point of the political project devised by a group? In response, he states that such difficulties are given by recognizing the structural heterogeneity of other power forms rather than bureaucracy, which generates difficulties of understanding and for the definition of adequate behaviors before such issue. He emphasizes, at last, certain camouflage around the specificity of each power resource and the variation of its specific importance due to the dynamic variation of situations. At the same time, he recognizes the limits brought forth by that categorization when it produces a given uncertainty in relation to the instrumental or strategic treatment that the action taken by the agent or by the political actor may assume.

Therefore, is it possible for health governmental instances to take effort to deploy and regulate health councils in their respective scopes of action as an instrument of legitimacy and strength, in a process of institutional overture; even though it occurs as a response to a demand made by civil society to conquer such space of citizenship (CASTRO, 1992), searching to monitor the process so that it does not transcend the limits of instrumental reason? Even deriving from a process of favorable political circumstances, is there a field of tensions between the democratic culture that is intended to be built and an individualistic scenario that is made hegemonic as a social practice? Where does this scenario stem from? Does it result from an institutional political culture of a discontinuous administrative practice, from governments that alternate power at each election, in a space for the exercise of incipient citizenship, where immediate interests are overlapped by the most transcendent collective values? All the same, does it result from a regimen guided by the overthrow and defeat of social movements, which was valid until the appearance of new actors, especially in regard to social and unionist movements from the 70-80's on (SADER, 1995)? Movements that will meet the consolidation of a movement to recover institutional normality and democratic affirmation?

As we mention a historical period of time referring to the crystallization of politics in its conservative and formal aspects, we are certainly supposed to admit that the simple existence of councils is not uniquely able to banish this type of despicable practice. Only when they gradually constitute themselves as even more effective actors, actually accumulating power, the practices followed by the councils may be favorable for the construction of a true democratic culture, which is understood here as the process of politically experiencing the search for an equalitarian distribution of power. However, more than presenting potential evidences of the powers required for the full control over the action of the State to defend the public character, we are bound to recognize the immanence of the pedagogical dimension that leads the institution of a council of that nature during the accomplishment of its legal and legitimate objectives. And such immanence is consistently made evident according to Testa's formulation (1992), in the incongruence between historical time and institutional time, and also as a possible answer to the question raised by Rivera (1995) – which proposes the consideration of a fight for the accumulation of organizational as well as technical powers as parts of a political project of a given actor.

This occurs as we notice that the council's agenda can be guided by the collective specific, peculiar situations. Not always corresponding to a syntonization with the universe where it is found; passing through and sometimes lingering on a few more local, particular issues – as the accumulation of organizational power, more important for a start – and in a more incipient way on the other types and forms of power. This initial situation may seem somehow inertial or even constitute a bureaucratic or discouraging practice to those who are immersed in a certain unruléd militancy that places political fight in dissociation with its context, at a *being-in-itself*, or even

claim for a dive into restless voluntarism or into instrumental action (SILVA, 1999).

The health council will play a prominent role within the power accumulation perspective as it organizes and structures itself internally, building its own Internal Bylaws, for example; yet, getting organized in permanent work committees, which generates organizational power, related to the accumulation required by the political projects under dispute inside it, either hegemonic or not. Similarly, when searching for technical power accumulation, elaborating information agendas about what they are and how the technical sectors of health governments work, closely questioning and scrutinizing the universe of technologies and tools in use at work (SILVA; *idem*). It similarly accumulates this type of power, either when it schedules itself to know and discuss the ordinary projects and programs executed by the governmental instance that it should inspect and control or, yet, when it searches for external technical advisory to appropriate, get familiar to, or even enable itself to face the most difficult issues, as the apparent greater difficulty to understand an accounting issue or a budget allocation: an accumulation that is best evidenced as an accounting advisory service, for instance, is obtained from the society so that the public discussion on accounting issues can be dealt with.

At another time, it may show reluctance to approve or even reject the accounting provided by the public management, for instance: if this is so, an emblematic moment of political power accumulation can be envisaged, again remembering its categorization as mobilization power, as it sounds evident that making such decision means accumulating this type of power to generate tensions of such nature. Here, despite the exceptions made to the circumstances around the formal matter at issue, when divergences and conflicts of interests are made evident within society, it seems that the council will adopt such attitude based on pertinent questionings or consistent doubts: this may sound as an indication to public interest defense or a manifestation of second-rate interests; which can only be disclosed by the forthcoming events.

Nevertheless, none of these power accumulations take place in dissociation with the other ones. When accumulating knowledge and information (power) about the technical and administrative dimensions of the organism which it is supposed to inspect, the health council operates under a political perspective, constituting itself as the health managers' *alter*, though as an interlocutor, not necessarily an opponent. The element that leads such accumulations towards a substantive direction is the production process of the accumulations themselves, which occurs silently through the learning derived from practice.

Otherwise we are not supposed to neglect the role played by health managers, which is institutionally better structured, and whose government agenda feeds the necessity of a sectorial council. In this case, it is worth considering that managers are not inserted actors. They compete in the macro-political agenda of a given government with other actors for resources, priorities and autonomy to govern, keeping this conjuncture in direct ratio with the complexity and the web of

interests that overlap in sequence. For any government instance, the health manager plays an essential role within the process of constituting such *collective* interlocutor: not only as it adopts a positive position in terms of its permeability and receptivity to the penetration of external control, in both formal and informal aspects, but rather within the *modus operandi* with which it produces, reproduces, transmits, processes, and reprocesses the entire range of information and counter-information at stake in a game of competent discourses; and using councils for the sake of transformations, as mentioned before – information democratization, power decentralization, construction of a citizenship culture.

Testifying so keeps a strict relationship with its internal construction process in the form of a *collective subject* as it accumulates powers – technical, organizational, and political – according to the meanings built for these terms, in an attempt to bring them increasingly closer to the ideal situation, which is constitutionally appointed. Similarly, for a demonstration of the feasibility to make health councils real, it is necessary to consider the possibility of such type of council being autonomously constituted, in spite of its institutional origins, breaking through the limits and stumbling-blocks placed before its plenitude of action. And, in addition, alluding to the field of structural and conjunctural, over and/or infra-determining relations, acquiring a transversal feature that is able to expose its entire transforming potentials.

Doing so requires, besides identifying the whole context and structure where its constitutional and active process starts, examining and recognizing the process itself, since it is connected to the perspective of power. Technical, organizational and political powers accumulated by the Council to get legitimated before the society as well as the public and, in order to allow the complete consecution of its inspecting role and verify what happens in the political agenda concerned with health within a given time and place. When doing so, it does not only get legitimated but rather it ends up legitimating the managers, who thus borrow the official seal of the directions that the public interest is supposed to follow. Avoiding, however, what only happens through the learning that arises from experiencing the process, then constituting a parallel power that is able to immobilize or rigidly thicken the daily life in terms of political exercise and health management.

It will be able to play such role, though not always doing the right deliberations; it can act in compliance with somehow momentary interests or on behalf of readings that follow a more progressive, advanced or reforming, or even conservative profile. The result of its action will mainly reflect upon the result of the confluence of manifold actors and segments that coexist within a real structure of society. More real and more adjoining in terms of representativeness, lawfulness, and legitimacy.

It is important to remind that the point of discussion at this point is the perspective of councils as spaces for the construction of democracy and under the standpoint of power

distribution. Power is neither delegated nor distributed only to suit the majesty of the prince! Hence, power must be conquered! We shall not consider the existence of councils as a form of majestic decision made by the governor on duty; its effectiveness results more probably from at least two conditions: the demand, on part of the governed party, and sensitiveness to respond to it, on part of the governor. The greater the observance of legality and legitimacy aspects, the better it will be! These two aspects deserve a distinction in terms that legality can be easily resolved by following the norms and constitutional, lawful standards in effect. As stressed by Fleury (1997), the painful truth of the difficulties found in deploying the Sanitary Reform project lies in the fact that passing laws does not create equality, but equality cannot be consolidated without law; thus legality arises, almost specularly, as a necessary issue for the existence of such institutional collective: legality is created by law, though legality is not only consolidated through law! Legality calls for legitimacy! And the latter is conquered and built during the process itself: from the choice and composition of its members, for example, and in the direct dependence on respecting legality. Legitimacy is thus a rather complex issue! As understanding it in its entirety escapes the scope of this paper, let us think of it as something constructible.

Because of its participative and democratizing conception, the establishment of councils can similarly build an inclusion aesthetics in which, in a fragmentary and polymorphic way, diverse segments of civil society form a paired and deliberative council, whose conjoining element is the constitutional judicial framework. Unlike a militant institution or the exercise of structured, stratified knowledge, the chance does not join them in a project in common, which is executed either before or afterwards, but replaced on a continuous and daily basis. Rather, its combination starts from obeying the constitutional norm. It equally depends on the democratizing winds blowing in the interior of the state apparatus of the health sector to imprint a greater or smaller amount of legality to its deployment. An external factor that will also play a prominent role in the ability of the council to take into action as the assembling process of this collective – made according to the democratic spirit that is supposed to lead the choice and the election of its members – is understood as the direct possibility to reach immanence for the role to which it was devised. External and internal factors are, therefore, interacting and complementary.

This construction touches the issue of power very closely and deeply. That is, to anyone – individual subject or collective – the conquest of the former passes through the accumulation of the latter within a quantitative as well as qualitative dimension. These two conditions presuppose the idea that the consolidation of this project passes through the accumulation of political power, organizational power, and technical power. Starting from the practice of social, institutionalized control in the form of paired, tripartite, and deliberative councils, and according to conception and legalization presuppositions for SUS. Achieving the functions of citizenship partition space and democratic construction space is dependable on knowing how to positively explore the pedagogical

dimensions found in their own accomplishment, breaking through possible tendencies towards the crystallization of formal principles or towards the idealized as well as ingenuous view according to which such effects will take place “naturally”; or yet, they are subdued to the capture of the organizational power, thus being institutionalized as bureaucracy.

CONCLUSION

Though it may seem utopistic, reforming the state as a simultaneous process with the democratization and the consolidation of a citizen culture and a citizen practice might become an even more feasible reality as the process of establishing SUS advances; along with the deployment and functioning of health councils in an even larger number of Brazilian localities. This silent reform mobilizes a meaningful army that is formed in the space of transformation of the relationships established among powers. It can lead to the construction of a culture in which there is the coexistence of a strong feeling of responsibility, responsibility, and social solidarity; at the same time, it means a quick approximation to the objectives set up towards the construction of another relation between State and society.

The power constitution process accomplished by the councils becomes real when it means, as it seems to be the case, the breakthrough, the rupture, the transformation of its members into a *collective subject*, where pieces of knowledge have experienced a fusion, from whose transversal axis another practice and another understanding can be elaborated. As to allow the substantive dialogue between opposites, within the dialectical intent by means of which they become something new, keeping their original features and preserving their origins, which are otherwise necessary.

Through a process that is at first aimed at institutional improvement, this movement can imprint a remarkable feature of democratic space to the health sector – full of subjectivity, and as a generator of citizenship. These are fundamental conditions for the vital stabilization of reasons of State, market interests, public needs, either collective or individual, which pass through the warranty of rights and the fulfillment of necessities: elements that generate interests, which go through health care production, both individual and collectively, within a social web marked up by the existence of exclusion, inequality, and overlapping of structural as well as conjunctural problems, whose signals of crisis seem to become eternal. They should therefore constitute elements whose pedagogical possibilities are expected to be better explored and developed, forming key parts for the construction of a critical learning to overcome structural as well as conditioning limits found in the scenario of social policies under deployment in Brazil, and which make the shortening of distances an indispensable asset between intentions and gestures.

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Address:

Universidade Federal de São Carlos – Departamento de Medicina

Rodovia Washington Luiz, SP 310 - KM 235

São Carlos/SP - CEP 13565-905

E-mail: giovanni@power.ufscar.br

Translated by Evanir Brunelli

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