Trends of participation in SUS: the emphasis on instrumentality and on interstate interface

Tendências da participação no SUS: a ênfase na instrumentalidade e na interface interestatal

Tânia Regina Kruger[1], Andreia Oliveira[2]

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ABSTRACT Given the conjuncture of fiscal austerity, regression of social rights and democratic public management, this manuscript aims to analyze the current trends of participation in the field of health. To this end, a study was carried out on documents issued by WHO/Paho/Brazil, the World Bank, and records from the international seminar on the future of universal health systems, promoted by public managers (Conass). Literature research included studies published in health journals linked to academic-scientific entities that constituted the political and organizational bases of the brazilian sanitary reform movement, as well as other national journals that dedicated special issue to the 30 years of the Unified Health System (SUS). The study found in the international documents references to an instrumental, depoliticized participation of the State-society-market partnership type, when compared with the democratic bases of political articulation of the sanitary reform movement. The emphasis of the documents lies on management and participation, based on interstate interface, in which the state is just another subject in the delivery of health services. However, there is a timid appreciation of the participatory institutionality in the Conass event, and a silence on the subject in the field's periodicals, in the commemorative publications of the 30 years of the SUS.

KEYWORDS Unified Health System. Social participation. Health councils.

RESUMO *Diante da conjuntura de austeridade fiscal, da regressividade dos direitos sociais e da gestão pública de base democrática, o presente manuscrito teve por objetivo analisar as tendências da participação na saúde. Para tanto, realizou-se estudo de documentos emitidos pela OMS/Opas/Brasil, Banco Mundial e registros do seminário internacional sobre o futuro dos sistemas universais de saúde, promovido por entidade de gestores públicos (Conass). A pesquisa bibliográfica contemplou estudos publicados em periódicos da área da saúde vinculados a entidades acadêmico-cientificas que constituíram as bases político-organizativas do movimento de reforma sanitária brasileira, além de outros periódicos nacionais que dedicaram número especial aos 30 anos do Sistema Único de Saúde (SUS). O estudo encontrou nos documentos internacionais referências a uma participação instrumental, despolitizada e do tipo parceria Estado-sociedade-mercado, quando comparada com as bases democráticas de articulação política do movimento de reforma sanitária. A ênfase dos documentos é para uma gestão e uma participação com base na interface interestatal na qual o Estado é mais um sujeito na realização dos serviços de saúde. No entanto, há uma tímida valorização da institucionalidade participativa no evento do Conass e um silenciamento quanto ao tema nos periódicos da área, nas publicações comemorativas dos 30 anos do SUS.*

PALAVRAS-CHAVE *Sistema Único de Saúde. Participação social. Conselhos de saúde.*

[1] Universidade Federal de Santa Catarina (UFSC) – Florianópolis (SC), Brasil. *tania.kruger@ufsc.br*

[2] Universidade de Brasília (UnB) – Brasília (DF), Brasil.

Introduction

This text presents an analysis of trends of the participation in the Unified Health System (SUS) after 30 years of its recognition and implementation. The SUS, despite the political and financial difficulties, presents in the course of its history real advances in terms of access to the right to health, in addition to introducing fundamental principles and guidelines for the process of democratization with social participation, comprehensive care and equality with equity. However, the tension in the public versus private relationship and the overlapping of market interests have marked the field of permanent dispute amidst complex social, political, economic, technological transformations and changes in demographic and epidemiological profile.

Participation in the SUS was the banner of the health movement that elected the slogan 'health is democracy' as its driving motto and that has brought together a set of political subjects and social forces. The political and social articulations that underpinned the sanitary movement and underlined the constitutional SUS were based on the project of building a society in which the primacy of social justice subordinated the particular interests and the determinations of the market[1].

The democratic perspective of the health movement, as the constitutive basis of the SUS, was anchored in a broader social reform proposal, that is, of the State and society, under the defense of decentralization of the decision-making process, of economic organization and of the democratization of wealth[2]. However, the context of disputes between different political, economic, social and ideological forces, sometimes moving in a more progressive direction, sometimes gaining strength in neoliberal perspectives, has forged adaptations in the understanding of SUS and subjected it to the interests of capital[3].

The condition already announced in the constitutional text of "health care being free from private initiative"[4] and the practice of the Ministry of Health of subordinating itself to the ministries of the economic area for decisions on SUS financing have facilitated the subjection of health needs to market interests. The entry of large economic groups into health, the different privatization strategies that occur through different mechanisms, such as the lack of supplementary health regulation, tax exemption, the articulation between public and private in public service and service agreements, through Social Organizations (SO), of public foundations governed by private law, legal entities of the State's counter-reform[5], amnesty to fines from health insurance companies[3], dependence on large multinational companies to purchase equipment and medicines and a series of lines of credit and loans from the National Bank for Economic and Social Development (BNDES) to philanthropic and private hospitals place the interests of the market over health as a public good. Certainly, this set of public-private relations places SUS as part of the broad and complex industrial economic health, annihilating its perspective of health as a human and collective right[6].

The global economic crisis, which has been aggravated, in Brazil, from 2014, has introduced changes in the fiscal policy of the Country, in line with the guidance of international creditors, especially from 2015 with the implementation of austerity measures and fiscal adjustment under the claim of the need to reverse the uncontrolled spending. The political and economic tension of this crisis conjuncture led, in 2016, to the impeachment of President Dilma Rousseff; and her vice Michel Temer, upon taking office, took strict fiscal adjustment measures to control expenditure, resulting in reduced funding in several areas. In this period, the so-called New Fiscal Regime was instituted, with the approval of Constitutional Amendment nº 95/2016, which established the spending ceiling for the primary

expenses of the Union, without setting a limit for financial expenses[7,8]. The spread of austerity measures has exacerbated the weakening of the financing of the Social Security System, as a whole and in health, specifically, to the detriment of SUS fundamentals, endangering the universal right to health; and reinforces the subordination of public policy to market interests[9].

The regressive reforms operated at SUS[9] occur concurrently with other ongoing structural reforms, such as the labor reform, approved in 2017. The government of Jair Bolsonaro, elected at a particular moment in Brazilian history, reinforces conservative and neoliberal measures and positions, as identified in recent normative changes of the SUS, among which the changes in mental health policy are highlighted, with the resumption of old asylum, hospital-centered practices, separated from the territorial and integral logic, with incentive to prohibitionist, criminalizing and privatizing actions[10].

In the midst of this scenario, participation in the SUS materialized itself as a kind of accommodation of institutionalized participatory democracy, through the Councils and the Health Conferences in the three spheres of government. The participatory storyline of the SUS was not enough to achieve social appropriation of the power structures of governments, but expresses a positive picture, because these collegiate organs created a public institutionality: they enable the participation of society in the elaboration and decision-making space of social policies, question the political culture of centralized decision-making and enable commitment to the construction of a public space, as opposed to exclusion[11,12]. The spaces of participation allowed the widening of State borders; similarly, they also agreed to continue the reproduction of traditional elements of the political culture of the Country and indicators of inequality. The contradictions and challenges raised by these practices of social participation in health are not only situated in the democratic improvement, but can acquire other contours when added to other struggles of the working class in the construction of a social project that guarantees the redistribution of wealth and the socialization of political power[13].

Material and methods

The study was carried out through bibliographic research and complemented by document analysis. In order to reach the objective of identifying the trends of participation in SUS after its 30 years, it was sought to know and analyze documents of international organizations and positioning of national entities, by consulting the event report and institutional documents of public access. Initially, to understand the origins and concepts on health participation, it was decided to revisit World Health Organization (WHO) documents, namely: International Conference on Primary Health Care, 1978, in the city of Alma-Ata[14]; First International Conference on Health Promotion, in 1986, in the city of Ottawa[15]; Global Conference on Primary Health Care, 2018, in the city of Astana, Kazakhstan[16]. Subsequently, references to participation contained in the Agreements of Technical Cooperation (TC) numbers 44, 68 and 88, were sought between the Pan American Health Organization (Paho) and the Ministry of Health, to support the implementation of the Strategic and Participatory Management Policy of the SUS from 2006[17-19]. As part of the analysis of current international trends in health policy, the International Seminar 'The Future of Universal Health Systems', promoted by the National Council of State Health Secretaries (Conass)[20] was chosen., for its relevance and relation to the object of study.

Following, the influence of multilateral institutions on health participation policies was studied, through two World Bank

documents, one from 2017, entitled 'A fair fit: analysis of the efficiency and equity of public spending in Brazil'[21], and another from 2019, entitled: 'Proposal for reform of the Brazilian Unified Health System'[22]. In the same direction, an analysis of the document issued by WHO/Opas/Brazil was carried out, entitled '30 years of SUS Report. What SUS for 2030?'[23], published in 2018.

In the bibliographic research, the option adopted included articles on the theme of participation in health, published in Brazilian journals of national and international scientific recognition, which dedicated special issue to the 30 years of SUS, highlighting the journals of the Brazilian Center for Health Studies (Cebes) and the Brazilian Collective Health Association (Abrasco).

Using elements of critical theory, which fosters the understanding of socioeconomic themes in their historicity, particularity and totality, the analysis and interpretation of data through dialogue with authors who study the theme was conducted. In the interpretation of the results, the origins and the tendencies of the participation in the SUS were observed explained in the analyzed documents, in reflexive dialogue with the conjuncture of the capitalism and its effects in the democratic process, to dialectically explore the conditions and the political articulation of different social forces, in order to build a universal, public health, state management, social justice and deliberative participation project.

Results and discussion

Origins and concepts about health participation: international organizations

Participation in the field of health is born in the context of the proposal of community medicine at the beginning of the XX Century, as a practical category, focused on adherence and assent of individuals in government education and health programs[24]. Considered at the time as a politically and technically advanced proposal, it was widely criticized by liberal medicine sectors. Subsequently, the theme of participation in health was highlighted at the International Conference on Primary Health Care in Alma-Ata, in 1978, promoted by WHO, in a very general way:

> The people have the right and duty to 'participate individually' and 'collectively' in the planning and implementation of their health care; primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development[14(1)].

In the following year, at a meeting held under the auspices of the Rockefeller Foundation, in collaboration with the World Bank and the Ford Foundation, the agenda includes the dissemination of a narrow and selective perspective of Primary Health Care (PHC), which strengthens an instrumental dimension of participation, with an emphasis on self-care[14].

In the context of disputes over different health projects, and following the guidelines of the Alma-Ata Declaration, the process of redemocratization and the health reform movement experienced by some countries made it possible to construct new national health legislation for the public service in which participation is among its foundations[25]. In the midst of this re-democratizing wave, the First International Conference on Health Promotion was held, in 1986, in the city of Ottawa/Canada. The Ottawa Charter states that Health Promotion should be

> women and men should become equal partners in each phase of planning, implementation and evaluation of health promotion activities[15(4)].

Throughout the Charter, participation still has the following meanings:

> People, in all spheres of life, should be involved in this process as individuals, families and communities. Everyone must work together, to create a health system that contributes to the attainment of a high level of health [...] the increase of the power of communities – the ownership and control of their own efforts and destiny; [...] community development [...] to intensify self-help and social support, and to develop flexible systems for enhancing popular participation in the direction of health issues[15(3)].

In October 2018, in the city of Astana/Kazakhstan, WHO and the United Nations Children's Emergency Fund (Unicef) held the Global Conference on Primary Health Care to revise the Declaration of Alma-Ata. To achieve the health and well-being of all, the text of Astana's declaration focuses on the organization of primary care and universal coverage of services[16]. The strategy to achieve these goals focuses on stakeholder cooperation, the promotion of solidarity, ethics, human rights, community empowerment, and the accountability of the public and private sectors, so that more people can live healthier lives in favorable and healthy environments. On participation, the Astana Declaration pledges that:

> Lograremos la participación de más partes interesadas en el logro de la salud para todos, a fin de no dejar a nadie atrás, a la vez que abordaremos y gestionaremos los conflictos de intereses, fomentaremos la transparencia y estableceremos una gobernanza participativa[16(6)].

On the success of primary health care:

> A través de tecnologías digitales y de otro tipo, permitiremos que las personas y las comunidades identifiquen sus necesidades de salud, participen en la planificación y prestación de servicios y desempeñen un papel activo en el mantenimiento de su propia salud y bienestar[16(09)].

The document also indicates the purpose of empowering people and communities:

> Apoyamos la implicación de las personas, las familias, las comunidades y la sociedad civil mediante su participación en la elaboración y aplicación de políticas y planes que repercutan en la salud. Promoveremos la educación sobre la salud y trabajaremos para satisfacer las expectativas de las personas y las comunidades en cuanto a la obtención de información fiable sobre la salud. Ayudaremos a las personas a adquirir los conocimientos, habilidades y recursos necesarios para mantener su salud o la salud de aquellos a quienes atienden, guiados por profesionales sanitarios[16(10)].

The statements of the three Conferences, although covering a historical period of 40 years, do not treat health and participation as a right of citizenship. Participation does not appear as a political action that involves democratic relations between State and society nor a process of articulation of social forces for the construction and/or strengthening of a public health service project. Alma-Ata is the only statement that speaks of the right to participate, but in the context of primary care. It indicates that full participation will come with practical technology methods at a cost that the country can maintain. In the Ottawa Charter, participation is presented as a duty of involvement, working together to intensify self-help and social support to raise standards and health. Astana's document highlights participatory governance and

conflict management to achieve health for all. It proposes participation through digital technologies to identify health needs and for people to receive guidance on maintaining their well-being.

Paho/WHO as an international body has offered technical cooperation in health to its member countries through TC. In the Brazilian case, the TC is signed with the Ministry of Health and/or other subnational governmental bodies; and the resource to be passed on is from the Ministry of Health itself, which acts as a direct counterpart in the implementation of the actions established in the Term[26]. Our research has identified that Paho/WHO maintains 58 TC with Brazil that are available online, but linearly they are numbered to 104, of which three explicitly refer to participation. We consider that the concept of participation of World Conferences of the WHO, presented above, is disseminated in the TC of this international organization with Brazil, through negotiations with representatives of the Ministry of Health. Therefore, it is possible that its objectives and actions may reflect the intentions and interests of the two bodies.

Chart 1. Agreements of Technical Cooperation (TC) negotiated between Brazil and Opas dealing with the theme of participation in SUS

Number of TC	Theme	Period of Validity	Objectives	Resources R$
TC 44 Process 25000.157569/2005-90	Strategic and Participatory Management Policy of SUS	Jan. 31, 2006, to Jan. 30, 2016	Support the implementation Strategic and Participatory Management Policy of the SUS	85.950.000,00
TC 68 Process 25000.111098/2011-11	Institutional Strengthening of the National Health Council	Dec. 1st, 2011, to Nov. 30, 2016 Extended until Nov., 2021	Improve and strengthen the technical capacity of the Federal Manager, seeking to strengthen public policy implementation actions in the SUS.	33.263.150,00
TC 88 Process 25000049564/2015-66	Strategic and Participatory Management of SUS	Dec.31, 2015, to Dec. 30, 2020	Strengthening the strategic and participatory Management of SUS	46.000.000,00

Source: Own elaboration from TC and technical reports[17-19,27-29].

The content of the TC is not available in the presentation, and only its objectives are accessed. With the imprecision of the analysis put aside, given the limit on access to content, all terms refer to SUS, but their objectives describe in general terms the intention to strengthen the participatory management of SUS, without, however, demarcating the fundamentals of the perspective of participation and social control adopted. Here is the indication that these TC and their reports are better studied in their actions, concept of participation, financing and articulating subjects. It is strange that, in TC 68, the title and its purpose seem to refer to different objects.

The International Seminar 'The Future of Universal Health Systems' was promoted by Conass in April 2018, in Brasilia, the year SUS turned 30, to seek solutions in the face of a scenario of serious political and economic crisis that threatens the world system. With this intention, Conass invited experts from

different countries to make explanations, such as: Canada, Costa Rica, Portugal, United Kingdom and Brazil[20].

The representative of the United Kingdom stated the National Health Service (NHS) is recognized as part of national identity, has considerable political and popular support despite negative media ratings and declining levels of patient satisfaction. The 'Future of Universal Health Coverage', in the United Kingdom, according to the speaker, is challenged by rising costs due to chronic conditions and expensive technologies, difficulties in managing long-term multiple morbidities. Therefore, the goal is to improve efficiency, introduce new care models and emphasize actions to protect public health.

The Canadian expert highlighted in his lecture the vision of a health ecosystem capable of learning from itself, focused on value creation as one of the foundations of the modernization of universal systems. Applied to health policy, the notion of value provides an objective framework and a type of compass to support a decision based on what is right, fair and reasonable. Governance and management strategies, aligned with achieving the best results at the lowest cost, should support better integration of individual and population dimensions, whether preventive and curative, intersectoral and societal actions to create value for individuals and the collectives they serve.

The representative of Costa Rica explained that, despite its many limitations, his country has the most consolidated democracy on the continent. Social security is unitary, universal, solidary and compulsory, which implies a model of attention for the entire population and contributes to the redistribution of income in society. Due to the characteristics of tripartite funding – the State, employers and workers – risks to the sustainability of the system are observed, as unemployment and underemployment increase, in addition to changing the epidemiological profile and the low efficiency of institutional management.

The National Health Service (NHS) of Portugal, according to its representative, has made significant progress in reducing mortality and increasing life expectancy at birth with financial resources that come from the pooling of public and private funds, but the private sector represents a small proportion's part of the funding. Among the challenges of the Portuguese system, the following stand out: increase the healthy life expectancy from the age of 65; achieve a balance between financial sustainability and NHS expansion; improve needy areas such as dental care, mental health and palliative care; improve the salaries of health workers in the public sector; reorganize the public hospital network and integrate it with other levels of care; improve regulatory intervention in health. The last challenge is participation in the design and evaluation of health policies and in empowering citizens.

For the World Bank, its representatives considered the advances of the universal systems and the SUS, but among the challenges to consolidate these achievements and to respond to existing and growing pressures, results with the current level of spending must be improved. According to them, Brazil's health system needs strategic reforms, such as: consolidating hospital care to maximize scale, quality and efficiency; improve health workforce performance, introducing incentives to increase productivity; integrate the various levels of health care. Finally, they point out that the consolidation of SUS depends on the ability to adopt advanced measures for its modernization.

There were several representatives from Brazil, including intellectuals and managers. Their speeches, generally, presented the struggle of social movements that led to the construction of the SUS. Since the 1990s, neoliberal counter-reforms have been disrupting their democratic and popular tradition, hiding the number of services that the SUS produces and tirelessly questioning the condition of the public power to ensure transparent, effective

and efficient management. The speakers considered the contradictions of SUS constitutional, and the expansion of the private sector, but the consolidation of SUS as a universal health system of public nature, depends on the possibility of political action of social institutions and subjects as a counterpoint to economic determinism.

The theme regarding participation in public health systems was not highlighted by the speakers, but expressions of the need for social support were recognized as fundamental to the implementation and sustainability of these systems. Among international systems, the portuguese one, objectively indicated that participation remains a challenge for civil society involvement in the design and evaluation of health policies and in the empowerment of citizens. Brazilian exhibitors highlighted SUS as a system of universal law, constituted through democratic bases, driven by the health reform movement. One of the common points in the speech of Brazilians was the understanding that, over the last 30 years, the implementation of SUS, despite the neoliberal policies, the weakening of social movements and the disarticulation of the sanitary movement, has depended and still depends on the support of social and political forces defending the right to health and universal and public systems[24].

The analysis of the content expressed in the records of the Seminar on 'The Future of Universal Health Systems'[20] suggests that the dimension of participation is secondary to such a debate, where, among the exhibitors, only Brazilians emphasized the theme, emphasizing the need to revitalize participation in health, on the grounds that only with social support will it be possible to uphold the founding principles of universal systems.

Austerity, health and participation: World Bank and WHO recommendations for SUS

The complexification of capitalist society has taken on new shapes with the 2008 world economic crisis, which introduced a set of austerity policies, to reduce public spending and government intervention and restrict itself to focusing. In general, this economic crisis stems from the *modus operandi* of neoliberal capitalism, which has been occupying space in the field of social policy since the 1980s, with emphasis on three central axes: a) privatization of social policy sectors previously assumed by the State, based on the superiority of the market in the efficient allocation of resources; b) reinforcement of individualism, configuring a new proposal for the organization of individual-society relations; c) equality and social solidarity give way to the differentiation of individuals and the prioritization of freedom of choice of goods and services to be consumed[30,31].

The renewed crises of recent decades only deepen neoliberal responses; and, in health systems, they are expressed in the worsening of living conditions of huge portions of the population, as they impact on increased demand for health services. In this context, multilateral institutions such as the World Bank and WHO, the first directly and the second permeated by contradictions and disputes in the democratic field, drive the expanded reproduction of the industrial economic complex of health, especially in the countries of peripheral capitalism, and induce governments to implement measures and adjustments to respond to such interests[6].

The World Bank, in its document entitled 'A fair fit: analysis of the efficiency and equity of public spending in Brazil'[21], gives centrality to a diagnosis of a country with low governance and inefficiency in public spending and proposes reducing spending as a strategy to restore the fiscal balance and the governance of the Country. Natural assets, concentration of income, land and wealth, the situation of exporting country of mineral commodities (iron, aluminum, oil, gold, nickel, silver) and of agroindustry, the subordination technology are not even indicators considered among the strategies. The recommendation, based on

austerity measures, focuses on reducing public spending, especially social spending.

With regard to SUS, the report presents an inefficient scale of service delivery, and with this justification determines the need for cuts in public funding. The diagnosis indicates strategic reforms to boost efficiency, equity and fiscal economy: rationalize the service network, especially the hospital; encourage increased productivity of professionals; integrate diagnostic, specialized and hospital services, expand primary care coverage and reduce health tax expenditures[21]. However, the document completely silences the considerable services of the SUS, resulting from the policies of disease and health prevention, promotion and assistance and primary care, with the creation of the Family Health Strategy, among the services that are widely recognized by Opas[23]. The neoliberal policy to implement its programmatic approach uses unilateral diagnoses and rhetoric that has legitimacy in itself, as evidenced.

These proposals were detailed in an own document, presented in Public Hearing at the House of Representatives, in 2019, entitled: 'Proposals for reforms of the Brazilian Unified Health System'[23]. The diagnosis of SUS is full of expressions such as ineffectiveness, inefficiency, lack of agility, autonomy and rigid system. The Bank understands that, in Brazil, universal health coverage was implemented three decades ago[23]. Given this unilateral diagnosis, the reflection of Cebes (2019)[32] reaffirms that the Brazilian health system is based on universality, comprehensiveness, equality, principles that are contrary to the focused strategy proposed by the World Bank, masked as universal coverage, reduced to offering a basic package.

The proposals for the health sector of the World Bank[21,22] focus on reforms to change the current incentive structure through the introduction of competition between health service providers and cost-sharing mechanisms; changes in financing flows and intergovernmental onlendings; reform of the legal framework for the management of health services and the workforce; improved cooperation between the public and private systems; rationalization of service provision through PHC; broadening the scope of practice of nurses and other auxiliary professionals; rationalization of the hospital and outpatient network based on volume, access and outcome parameters; and variable incentives, such as reductions in co-participation or direct charging to patients who resort to specialized care without referral to a general practitioner.

In this set of reform and rationalization proposals, recommended (some appear to be threats to managers and users) by the World Bank in both documents, there was no room for society to participate in SUS decisions, moreover, all the principles that bind health as a human right and obligation of provision by the public authorities have disappeared. User management, financing, working relationships and customer service are commodities or merely products wrapped in a streamlining process to ensure effectiveness, efficiency and agility. In this proposal, any link between the organization of the system and health needs, territorial inequalities and access, as well as the democratic foundations that structure the Brazilian system, have disappeared.

This diagnosis and these World Bank proposals are consistent with the analysis of Osorio[33], in which changes in globalization lead to weakening and disintegration of the state, a growing loss of sovereignty, while other subjects came to occupy the place of power and determine social relations, such as financial capital, multinationals, Non-Governmental Organizations (NGO), civil society and new social movements. The State seems doomed to assume a secondary role in neoliberal social and political organization, as capitalism needs an interstate system to reproduce itself. Such a system, to shape a society without interests, without strategies and without power relations, obscures the frontier of capital and

labor relations, fragments and depoliticizes economics and politics. Liberal democracy, consecrated by the political equality of citizens, plays a central role in the fetishization of capital over the imaginary of society, in which the prevailing inequality in the economic sphere is presented as non-political. Therefore, the author emphasizes, politics as the "ability of subjects to decide the meaning of life in common"[33(153)] is subsumed under the formal conditions of political equality.

Thus, the rhetoric of World Bank documents corresponds with the idea of a powerless, inefficient State, with the emergence of other centers of power in civil society, broadening the interstate face of public services. Thus, health services are now offered by this broad set that makes up the state interface; and the State is one more among the subjects. The public relevance of the performance of State functions in guaranteeing the right to health with a public and collective good is annihilated.

In turn, the '30 Years of SUS Report – What SUS for 2030?', published by Paho/WHO in Brazil[23], highlights some achievements of the SUS and makes recommendations for system managers to achieve the goals of the Sustainable Development Goals (SDG) in 2030. In the presentation of the report, the SUS is a mandatory reference for a nation committed to universality in health, participatory public management, and its structure and results in Brazil are internationally known and positively valued.

The political perspective of the report produced by Paho in Brazil[23], regarding the right to health, reveals some ambiguity, when compared with the World Bank documents (2017[21] and 2019[22]). The Paho document expresses, in part, the tensions that Brazil experiences in relation to the SUS. There is a relative emphasis that preserving health is a right for all people, but this right remains a challenge for health systems in many countries. However, it does not mention the decisive role of national States in the realization and financing of services for the realization of this right. However, regarding SUS funding, it indicates that CA 95/2016[7] will inhibit the real growth of federal spending, weaken sustainability and make it impossible to expand PHC, which was instrumental in reducing health inequalities. It warns that such a policy will result in increased child mortality, reduced immunization coverage and increased hospitalizations.

> Financially limited, SUS will run the risk of becoming a system focused on serving the poor, with low quality and resolution, increasing, rather than decreasing, health inequalities[23(20)].

However, as the trend of Paho/WHO policies has not been the effective advocacy of universal health systems regulated and funded by States, for this reason, it recommends, contradictorily, that, in order to achieve the SDG, it is "essential to open a broad dialogue with Brazilian society about SUS financing"[23(21)]. For policy based on dialogue, it recommends the combination of creativity between governmental actors and representatives of civil society, disappearing the directing and regulating role of the State.

Participation is among the recommendations presented in the report for achieving the 2030 Agenda, requiring improvement. The synthesis of the conclusions of a study on SUS sustainability, applied, by Paho in Brazil, to SUS and private sector managers, academics, parliamentarians and experts, is emblematic: "Social participation in SUS is important, but needs to be revised in order to be effective"[23(15)]. There was a consensus that this is an essential attribute and should be strengthened, but that, over the 30 years, the excessive bureaucratization of councils predominated, focusing on corporate interests and distancing from the interests of the population. The recommendation of the Paho/WHO for the SUS to advance is to carry out

> an open debate and a broad dialogue between government actors, academia and representatives of civil society, as it represents an important strategy towards a strengthened SUS, key to the development strategy[23(17)].

Initially, the Paho document was not as radical in the analysis of proposals for SUS as those of the World Bank, in its administrative rationality to generate efficiency. The proposals of the World Bank do not even address health and social needs and indicators of brutal social and regional inequality, as these do not fit the efficiency and logic of universal coverage.

The World Bank text and '30 Year of SUS Report' of Paho follow an alignment with neoliberal adjustment policies, exalting the market and minimizing the social policies of the State. Paho's recommendation for participation is characterized by a discourse of collaboration with society, aligned with the idea of efficiency, cost reduction and governmental interests, separated, therefore, from the political and critical component of participation in the democratization of health. Such proposals, as Cohn and Bujdoso[34], transform the State/society relationship into a triad – State, market, society – in which participation in health seems to be independent of political direction.

It has become very clear, on the World Bank documents, the inexistence of any mention of society's participation in SUS decisions and any indication of the government's obligation to guarantee the right to health. The interpretation of this finding denotes the understanding that such recommendations induce subaltern governmental policies and regulations to the interests of the health industrial economic complex, without compromising the preservation of the legal and political-democratic bases that constitute the SUS. It is understood, therefore, that recent federal government measures, such as Decree nº 9.759 of April 11, 2019[35], are in disarray and breaking with the foundations of the Democratic State of Law. This decree extinguishes countless collegiate bodies of the federal public administration and eliminates the participation of society in the instances of formulation and management of important social policies. Even if the institutionalized participation instances of SUS were not initially reached, the democratization process and the constitutional principle of community participation and other spaces related to citizenship rights are in the annihilation phase.

Theoretical-political trends: academic-scientific references

The 30 years of SUS did not go blank, as the main academic-scientific journals in the area dedicated a special issue to the theme. In a quick search for these journals, we sought to identify in their summary publications that address the issue of health participation, with reference to the guideline of community participation in art. 198 of FC and the principle of SUS indicated in art. 7 of Law nº 8.080/1990[36].

The journal 'Ciência & Saúde Coletiva', issue 23.6 (June 2018), with the theme 30 Years of SUS: context, performance and challenges; published 35 articles, none of them dedicated to participation. We have identified some similar expressions, such as 'struggles' and 'popular struggles', however, the titles focus on other themes[37].

The journal 'Saúde em Debate' dedicated a special issue to the '30 Years of PHC in SUS: strategies for consolidation'[38]. In the 31 articles that make up the edition, none is exclusively dedicated to the theme or presents in its title the word participation or any expression that comes close to it.

Likewise, we did not find emphasis on the debate of participation in any article, or allusive text, at 30 Years of SUS, in 2018 editions, in the following journals: 'Revista de Saúde Pública', of the Public Health School of the University of São Paulo (USP); 'Revista Interface – Communication, Health,

Education', of the Department of Public Health, of the São Paulo State University (Unesp) – Botucatu; 'Gestão & Saúde' Journal, of the Center of Multidisciplinary Advanced Studies (Ceam), of the University of Brasilia (UnB); 'Ciência & Saúde' Journal, School of Health Science, of the Pontifical Catholic University of Rio Grande do Sul (PUC-RS). In these journals, we have found only one thematic article on popular participation in health care policy for people with disabilities, published in 'Interface'.

Another search for references to participation in SUS was in the journal 'Domingueira da Saúde', which is a weekly publication of the Health Law Institute (Idisa), in honor of Gilson Carvalho, the creator and its editor for over 15 years. In 2018, Idisa published 34 editions; and they only dealt with the 30 Years of SUS: copies 1, 11, 20, and 21. None of the texts had centrality in the theme of participation or related expressions[39].

The institutions that are publishing companies of the consulted journals are important political subjects and mobilizers of health reform, indispensable in the historical process of the social struggle for the guarantee of the right to health in Brazil. Throughout the SUS construction process, the political-scientific position of these institutions has been moving towards defending the organization and realization of spaces for popular participation, in the different clashes in the construction of this public policy.

The gaps observed in the results of the survey of scientific production on the theme of participation in health in journals that dedicated a special issue to the 30 Years of SUS denote contradictions present in the process of building political, theoretical and academic-scientific strategies. If, on the one hand, it is common point for journals to highlight studies and research that demonstrate the right to health as a public good and the duty of the State, on the other hand, by putting in second place the theme of social participation, they can contribute to weaken and weaken social bases and democratic that constituted the system in the three decades.

End notes

Participation, critically conceived as a dialectical movement of transformation, and not as a participatory discourse or symbolic representation, acquires relevance especially in the regressive conjuncture that has been potentiated in the Country since 2016. There is a corrosion of public responsibility towards the needs in defense of big capital in health. In this scenario, institutionalized participatory spaces, such as the National Health Council, are being hit by repeated attempts by the Executive Branch to end the deliberative role of these collegiate, making them marginal in decision-making processes, ignoring their manifestations and resolutions.

Under the auspices of neoliberalism and neoconservative ascension, added to the alliance postures of cooperation, agreement and consensus, measures to annihilate spaces related to citizenship rights and the founding bases of the Democratic State of Law in Brazil are strengthened. However, in order to counter the proposals of the World Bank, it is necessary to take the place of politics as long as the ability of subjects to decide the meaning of life in common and to understand the unity between economy and politics in society. In the same way, it is intended to face the contradictions, concepts and proposals of WHO and Paho, in order to guarantee and understand the principle of community participation in the SUS as a socialization of the power of political decision. We refute the idea of participation in health as a liability of civil society for services and funding or reduced to external social support.

The concepts found in the documents studied are quite generic and broad, encompassing different forms of participation, but only shyly indicate that it is a way to exercise

rights and mature democracy; however, they do not refer to health as a universal right and should not be guaranteed by the public system, with the primacy of the State. However, from a democratic point of view and without departing from the liberal scope, the interpretation of the conception of participation adopted by Paho denotes a perspective of valuing the protagonism of users, defends participation in the SUS via the Councils and Conferences and other participatory mechanisms, but it also expresses a kind of self-service compared to World Bank references that do not even recognize this dimension.

In this understanding of the perspectives on participation in health, the references that we have emphasized of Brazilians in the debate and in international organizations oscillate between the rhetoric of the defense of constitutional SUS, the defense of the principles of participation, and its link with social bases, while defending the democracy of efficiency and the modernization of institutional management.

Collaborators

Kruger TR (0000-0002-7122-6088)* and Oliveira A (0000-0001-8759-059X)* also contributed to the conception, planning, analysis of documentary data, and the theoretical-critical review of content. Finally, they reviewed and approved the final version of the manuscript. ■

*Orcid (Open Researcher and Contributor ID).

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