NS WORLD

NATIONAL HEALTH CONFERENCES AND PARTICIPATORY PROCESSES IN THE BRAZILIAN FEDERAL PUBLIC ADMINISTRATION[1]

A CASE STUDY

Key Topics Discussed:

CO-CREATION AND EMERGENT SOLUTIONS

ENAP

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INTRODUCTION

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

Given its impact on the Brazilian legal and institutional framework, the 8th NHC is considered a watershed in health policy, a true pre-Constituent Assembly of the sector.[2] It also represented an innovation in the process of National Health Conferences: it was the first time since their creation in 1937 that the society could participate.

Brazil's Sanitary Movement of the 1980s, responsible for propelling health reform, is an example of **emergence**.[3] The movement was formed by intellectuals, professionals, trade unionists and health care users. They advocated for comprehensive health reform in Brazil and led the 8th NHC of 1986, presenting and discussing their proposals with representatives of the public sector and civil society. The conceptual and doctrinal foundations for the health sector reform were laid within this public policy community,[4] including the creation of the Unified Health System (SUS), and the planning of Conferences and Councils as mechanisms of social control.

Today, Conferences held by government are considered institutionalized spaces for social participation, in which civil society and the State mobilize and discuss and evaluate public policies. The end result produces proposals and guidelines to be incorporated into government agenda and actions. Conferences are a means to deal with complex issues of public policy. They allow governments to acquire knowledge, to anticipate emergent patterns and demands, and to dialogue and collaborate with participants. They have potential to generate **resilience**: the capacity to adapt to adversity and to anticipate change.[5]

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

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

SOCIETY, PARTICIPATION AND DEMOCRATIZATION IN THE BRAZILIAN STATE: AN OVERVIEW

In the 1980s, new players associated with various social movements, strengthened civil society and contributed to the end of military rule.[6] These new players acted upon various spheres of collective life: the struggle for democracy, civil, political and social rights; political and administrative decentralization; and the strengthening of regional and local decision-making, among other things. By the end of the decade, many civil associations had arisen, not only in the political arena, but also in the service and other more specialized fields.

The social movements and associations of the 1980s and 90s had provided guidelines for the transformation, pushing themes onto the agenda, such as the case of the health movement (predecessor to what was to become the SUS), the mobilization of Non-Governmental Organizations (NGOs) to provide care to HIV-positive people (which became the current National STD/AIDS Program), and the organization of community health workers in the state of Ceará (leading to the Federal Government's Community Health Agents Program).[7] The 1988 Federal Constitution incorporated into the

political system forms of popular participation and representation, especially the plebiscite, the referendum and the law on popular initiatives, which have so far not been frequently exercised. The majority of public participation in social policies happens through public policy councils,[8] conferences, hearings, and public consultations.

Participatory models were developed on the premise that classical representative institutions fail to address the quality issues of democracy.[9] Representative institutions are little able to respect the rights of society members who are historically excluded from public policies, nor are they able to grasp and fulfill increasingly diverse and complex demands. There is therefore a need to establish spaces for interaction, providing the public with information that represents not only the aggregate preferences of the majority, but also the interests and demands not previously contemplated by or available to public entities.[10]

> **"The government is much more likely to get it right when it listens to the people rather than when it just hires some expert to design a program. Letting the people participate is to ensure that we will do things more democratically."[11]**

In that sense, participatory spaces contribute to the creation and sharing of a more comprehensive view of society's reality and interests, as well as aspects and contexts that restrict or allow public actions. Advocates of participatory models call attention to their ability to break with the concept of immutability and institutional repetition of bureaucratic forms, assuming that better results can be obtained through **experimentation** and **innovation**, features of participatory experiences.[12]

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

In the 1990s, recognizing the inability of the State to produce effective results by acting alone and adapting to the context of autonomy and participation of new actors in public sphere, the Brazilian Federal Government began to implement changes in its institutional arrangements that culminated in new functions. It was no longer the direct and exclusive provider, but rather became the coordinator and enforcer of actions and services that could also be provided by civil society, incorporating participatory models and co-production of public policies. This process was not immune to conflicts, however, but it nonetheless revealed an important change in the State and society relationship over social policy in Brazil.[13]

WHAT THE NATIONAL HEALTH CONFERENCES ARE AND HOW THEY WERE DEVELOPED

Brazilian social policy conferences today are "democratic spaces where different sectors of society, interested in evaluating, discussing, criticizing and suggesting public policies can meet. They fulfill the important function of building agendas for social dialogue."[14] Usually, national conferences – on a range of social policy questions – are preceded by preparatory conferences at the municipal and state level.[15] All stages are conducted by the responsible federated entity (municipal, state or federal), at times with the support of the related Ministry or Special Secretariat, following a single agenda proposed by the federal government. The proposals that emerge from the previous stages are taken to the national stage for deliberation.

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

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

THE 8TH NATIONAL HEALTH CONFERENCE AND THE ROLE OF THE SANITARY MOVEMENT: A WATERSHED

The 8th NHC of 1986, the first conference after the end of military dictatorship, marked a new beginning. It became *the* primary venue to present proposals for change in healthcare. Driven by the wish to rebuild a more democratic framework for healthcare, government representatives were mobilized along with representatives of various political and social segments. The 8th NHC had more than 4,000 participants, including 1,000 delegates, of whom 50 percent were civil society representatives and 50 percent were representatives of public institutions and SUS workers.

The Sanitary Movement played a key role in organizing and conducting the preparatory stages as well as the national conference. This movement had emerged from the academic milieu of the 1970s, particularly in Preventive Medicine Departments. In the context of dictatorial repression, it was supported by students, healthcare professionals, study centers, especially the Brazilian Center for Health Studies (Cebes), the movement's representative and disseminating body—the Brazilian Association of Post-Graduation in Public Health (Abrasco), councils, trade unions, parliamentarians, and other segments of society).[16]

The movement evolved from a critique of the dominant model of health care towards the design and defense of an alternative healthcare system,[17] involving both political struggle and technical proposals. The movement proposed a radical reform of the health care system, marked "by the financial predominance of welfare institutions and by the hegemony of a technical bureaucracy that worked towards increasing the marketization of health."[18]

At that time, the healthcare system was organized under the social insurance framework, where registered workers paid insurance contributions to the National Institute of Social Security (INSS). In case of illness, they were able to access healthcare. Healthcare was "centralized, institutionally fragmented, with administrative discontinuity, vertical and exclusionary."[19] The proponents of the Sanitary Movement aimed to implement a **universal and free healthcare system** that would cover the entire population and would be based, among other pillars, on the community's institutionalized participation.

The 8th NHC pre-dates the 1988 National Constituent Assembly. The conference's final report proposed the implementation of the SUS and became the main input for drafting the Health Chapter in Brazil's 1988 Federal Constitution. The new Charter introduced social security: regardless of participation in the work market, all Brazilians became entitled to full health assistance through a model of shared responsibility among federal, state and municipal levels of government, with the municipality as the main actor. The conference also led to the incorporation of social control (the involvement of the public in management and oversight) and community participation in the new legal health framework with conferences and councils as components of the new system. It is because of the 8th NHC that the health area "was the sector that made it to the National Constituent Assembly with the most widely discussed, legitimized and complete proposal, containing the ideas of the health movement."[20]

THE 13TH NATIONAL HEALTH CONFERENCE: CHALLENGES OF MATURITY

The 13th NHC, held in 2007, illustrates the potential and limitations of the NHC forum. The comparison highlights how the process directly affects the country's **democratic governance** and the achievement of **public results**: how government agendas are altered, new stakeholders are brought on board, the role of the State is shaped, and deadlines for the fulfillment of demands are extended. The 13th National Health Conference reveals the challenges ahead, ranging from procedural issues to limitations in the incorporation of results by executive authorities.

> **"The 8th NHC was historical, but the 13th takes place when SUS has reached its maturity."[21]**

THE ORGANIZATION OF THE 13TH NHC: STAGES, THEME, OBJECTIVES AND PARTICIPATION

The 13th NHC began with high expectations. Organizers wanted to avoid the underachievement of goals that had followed the 12th NHC.[22] Promised instead as broad and democratic with methodological innovations and a distinctive theme, the Conference generated mass engagement and controversial positions by the main actors. The preparatory stages were conducted throughout 2007 in 80 percent of the 5,564 Brazilian municipalities and in all states – the most participatory in the history of healthcare (see table 1 for an overview of the process[23]).

The central theme was "Health and Quality of Life: State Policies and Development." The selection of the intersectoral theme by the National Health Council (CNS) allowed for a more preventive approach that was linked to human rights, and so was supported mainly by representatives of human rights and environmental protection movements. The idea was to overcome a corporate vision, focused on healing and self-centered, that generally permeates the processes of health conferences (healthcare services, social control in health, parmaceuticals, hospitals, etc.).

The Conference objectives were to:

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

Participants included delegates, guests and observers.[24] As delegates, public managers, health workers and SUS users discussed the proposed topics, diverging on many issues and reaching consensus on others; and finally allied to approve and reject proposals. The rules that drove the processes of discussion conferred equal rights and prerogatives to all delegates, regardless of their segment.

Over the decades, there is a change in social movements in Brazil with increasing diversification of actors and demands to be included in the government agenda. SUS gradually incorporated new social actors with specific interests, which is reflected today in the composition of delegates participating in the NHC.[25] A member of the National Organizing Commission (NOC) believes that the 13th NHC gave visibility to actors who were already organized around health issues, such as the lesbian, gay, bisexual, transsexual and transgender (LGBTT) movement, black communities, and riverside communities, among others.[26] This heightened visibility was evident with the approval of proposals relating directly to these actors. Their participation, however, did not minimize the involvement of traditional actors.

> **"We in the National Health Council feel a profound pride when we see that this Conference is the result of discussions carried out in all states, which involved more than 4,000 municipalities. Altogether, 1.3 million people participated in the debate."[27]**

The NOC had been responsible for organizing the 13th NHC, following the deliberations of the CNS and the

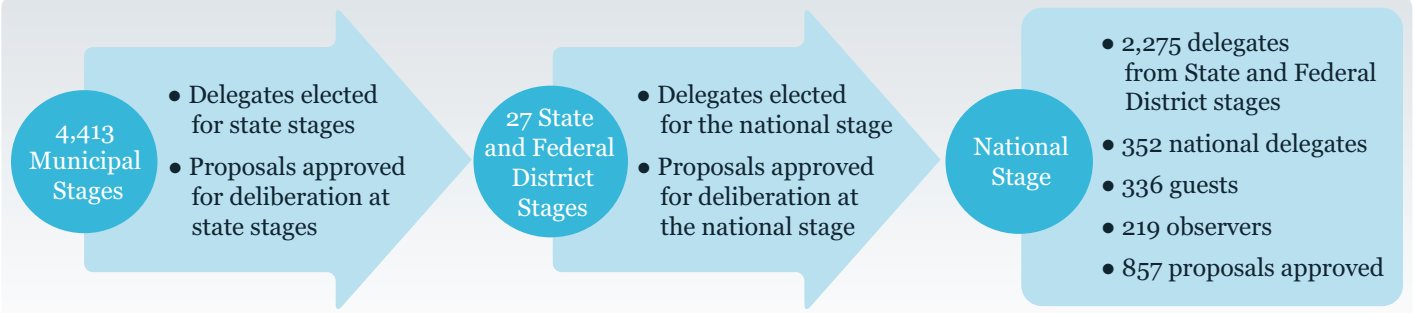

TABLE 1: Proposal and delegate selection process

Ministry of Health.[28] The Commission, in addition to their regimental duties, had a role in mobilizing and selecting representatives, which affected the content discussed, positions taken, and actors involved.[29] Apart from the General Coordinator of the 13th NHC (by Statute, the Chair of the CNS), other NOC members were defined by the Commission itself.

Conferences are built upon the consolidation and summarization of the debates of previous stages. The Consolidated Report for the 13th NHC consisted of more than 5,000 proposals. The reporting coordination function played a key role in the discussions by representing those proposals succinctly in table format, and by facilitating group work at thematic plenary sessions.

That complexity led to another innovation in the 13th NHC: instead of the Reference Text that was usually prepared for debate, this time, organizers prepared a Roadmap for Discussion and Presentation of Proposals. According to the General Coordinator of the 13th NHC,[30] that change was motivated by the need to present the complexity of the SUS adequately and embrace the reality of each local context. Thus, there would be an incentive for actors to build creative understandings according to their needs and realities, without limiting the discussion.

INNOVATIONS IN DELIBERATION

The NOC tried to innovate also in the *ways* that debate was to be organized – in part, to avoid problems that occurred at the conclusion of the 12th NHC. Their plan was to work with fewer themes and to introduce new discussion methods that were considered controversial by some actors.

Unlike previous health conferences, in which delegates chose which thematic group they would follow throughout, the methodology of the 13th NHC allowed all delegates to discuss the three themes in thematic plenary sessions.[31] The National Stage was structured into ten Thematic Plenary Sessions for discussion and for voting on the proposals that emanated from state and Federal District stages. To warm up the debate prior to voting, the thematic plenary sessions were preceded by Roundtables with presentations on each thematic area. Afterwards, the voting on proposals took place — collectively built statements with the aim of intervening in the government agenda.

At each thematic plenary session, the delegates could *only* discuss the proposals contained in the Consolidated Report and the new proposals also presented there (which had not been discussed at any other stage). Proposals could not be amended, only *withdrawn entirely* from the process, a rule criticized by some participants, especially those accustomed to the more flexible rules adopted in other conferences. Another area of controversy was the ability to present new proposals – this practice was not supported by the General Coordinator of the 13th NHC, who considered them a means to bypass debate at previous stages.(See table 2 for overview of process).

In the final plenary, proposals were approved by a simple majority (50 percent plus one) of accredited delegates. The plenary decided if it was necessary to debate a specific proposal before voting (an option questioned by participants who wanted to present their positions in front of all delegates, arguing that important issues were

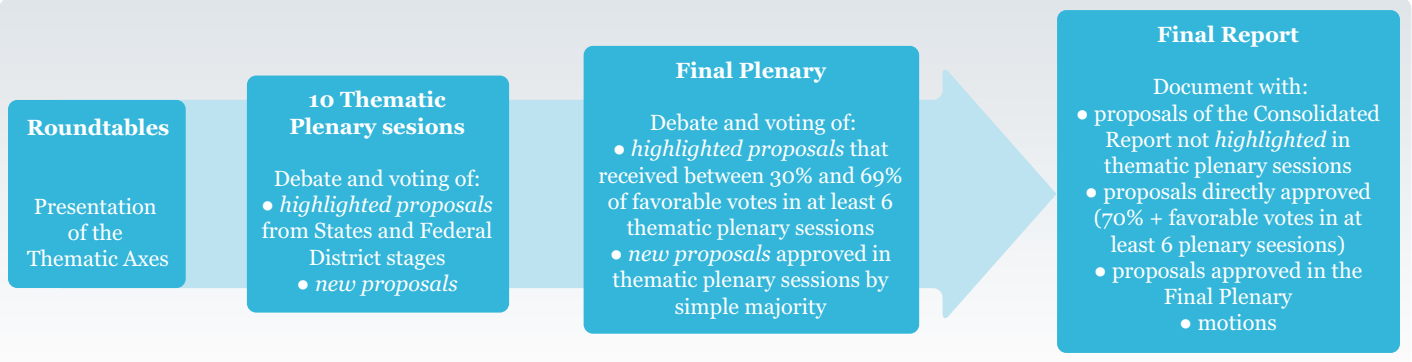

TABLE 2: Deliberative process of the 13th NHC

not thoroughly discussed in some groups).

For the General Coordinator, this change in methodology was a major improvement, since in previous conferences the final plenary session became "*real stages for personal and corporate manifestations*; (...) *an attempt to approve defeated proposals*."[32] For him, the methodology allowed a more productive conference and discussion of all issues by all delegates, preventing an environment free from rules that would be harmful to the process. The intention was to overcome the usual frustration felt by participants at the end of the process. In his opinion, the methodological filters (rigid editing of proposals, possibility of the plenary to veto the defense of proposals) allowed a much more successful governance of the 13th NHC.

> **"We received a fine legacy from the 8th NHC. What legacy will we leave to the participants of the 18th?"[33]**

FINAL REPORT

After the end of the 13th NHC, a Final Report was prepared, documenting the 857 approved proposals and 157 motions.[34] Table 3 compares the states' proposals with the national proposals; noteworthy was the very low rejection rate for existing proposals (12.4 percent) and the high proportion of proposals that had never been debated in earlier stages (40 percent).

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

The content of the proposals is wide-ranging: there are demands focused on the principles of the SUS and on the need to ensure quality healthcare for all, and proposals aimed at specific groups and interests. Some entail the holding of specialized conferences, as, for example, national conferences on mental health and on occupational health, to name a few.

There is also a noteworthy tendency for the number of final proposals to grow in successive conferences. The 13th NHC produced 857 proposals, while the 8th NHC had approved only 49. The increased diversity of actors and interests is increasingly evident. The National Council of Health Secretariats (Conass) analyzes: "*While these numbers reflect, on one hand, the increasing complexity of society and interests present at the conferences, they can reveal, on the other hand, the possible loss of substance of approved proposals and the* ***unfeasibility*** *of so many resolutions. It is interesting to compare the number of resolutions of the last two conferences with the 8th NHC, whose historical importance is undoubtedly greater and whose resolutions had a profound impact on the national health policy. This increasing fragmentation of deliberations, which virtually covers the entire spectrum of actions implemented by the system, makes it difficult to identify the guidelines that should conduct health policy and* ***do not allow identification of priorities.***"[35]

The Brazilian Association of Post-Graduates in Public Health (Abrasco) also did an extensive analysis of the final report: "*The profusion of proposals, often reiterating resolutions from other conferences, indicates, on one hand, the huge* ***gaps in implementation*** *of health policies and actions, and on the other hand, strongly expresses fragmented and partial aspects*

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

TABLE 3: Comparison of approval rates

Source: Table extracted from Ragio et al, 2009:18

regarding the regulation of health professions, the defense of labor markets, and health protection of population's segments, which are defined by individual and socio-occupational attributes. In spite of all the positive dimensions of this scenario, a considerable part of these proposals are not directly focused on tackling critical bottlenecks in our system and the complex factors that hinder the effectiveness of social policies for Brazilians' health and quality of life."[36]

The final report showed that times have changed. The **expansion of participation** had in the end made it difficult to achieve consensus and define priorities.

CONTROVERSIAL PROPOSALS

Among all the debates, emphasis should be given to two issues that polarized the National Stage, in particular: decriminalization of abortion and state-owned foundations under private law. Both issues are important topics for government.

In Brazil, abortion is a crime. It is allowed in only two cases: if there is no other way to save the mother's life or if the pregnancy resulted from rape. By contrast, the Ministry of Health had long considered abortion a public health issue, and in his keynote speech, the Minister asked the delegates of the 13th NHC to take a stand "*without fear of discussing the termination of pregnancy.*" In favour were organizations supporting women's rights; those against including religious organizations, particularly those linked to the Catholic Church.

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

Discussions during the vote in the thematic plenary sessions were heated as conservatives sought to convince the undecided delegates. Despite intense conflict, the proposal was approved at the thematic plenary level.

Before the final plenary, the conservative group lobbied intensely. It had successfully joined forces with the indigenous movement and other groups and movements in defense of life. During the vote, despite pressure from the feminist movement, the final plenary decided that there was no need for defense. Without a final debate, Proposal 37 was abolished from the final report, under shouts of "Yes to life! Life won!" While the Executive Secretary of the NHC celebrated with civil society organizations who sought to defeat the proposal, the representatives of the Ministry of Health suffered their defeat. The final plenary also approved a related motion opposing the decriminalization of abortion, a backsliding of a proposal *in favour* of decriminalization that had been approved at the 11th Conference.[38]

For the Executive Secretary of the Feminist Health Network, a movement to defend the health, sexual and reproductive rights of women, the position taken by delegates illustrated the invisibility of the problems caused by abortion. The network's leader also argued that catholic and protestant groups imposed a religious idea based on the denial of rights despite the secular nature of the conference,[39] and asserted that "*the Conference postponed the debate, but it will return.*"[40]

According to the National Council of Health Secretariats (Conass): "*The rejection of this resolution (proposal) is a sign of the distance between managers and social movements and represents a clear setback in addressing an issue that generated, in 2005, almost 250,000 hospital admissions to treat the complications of unsafe abortion. It is a major cause of maternal mortality.*"[41] The rejection of the proposal is contrary to the previous deliberation of the 11th NHC, when the decriminalization of abortion was proposed.

The decriminalization debate, a topic debated in several other participatory processes without consensus,[42] highlights a deep clash within civil society itself around moral values and understandings of public health.
Another divisive proposal was the creation of a new type of governmental entity under private rather than public law. Public officials and some scholars supported

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

the proposal as a possible solution to bureaucratic and management weaknesses in the existing system. These new foundations would be more autonomous than enti-

ties under public law and follow a rationale of result-based performance through management contracts. However, since the beginning of the Conference, the proposal was opposed by workers' organizations and social movements that saw it as a veiled move towards outsourcing healthcare, a move which could in turn cause difficulties in labour relations between SUS and its workers, and could lead to the privatization of hospital management.

Lack of dialogue and a paucity of information shaped the discussions on the subject. For the General Coordinator of the 13th NHC, the Ministry of Health had been building the proposal "*in an excluding and veiled way*", without debating it at the National Health Council. The National Council was against the proposal of state-owned foundations under private law and opposed it at all stages. At the National Stage, delegates of users' and workers' groups were advised to not accept the proposal.

At the roundtable of Axis 3, the chair of Cebes, speaking to an audience that opposed the proposal, said that the discussions on that matter should first be deepened.[43] Despite her pleading, the topic was suppressed in the thematic plenary sessions. Those who tried to argue in favor of it, generally public managers who dealt with the day-to-day difficulties of the system, were even booed. At the final plenary, no proposal endorsing the government's project on the state-owned foundations under private law was approved and several counter proposals were accepted.[44]

The General Coordinator of the 13th NHC celebrated the result: "*all proposals for public partnerships with private companies were rejected. (...) Some people told me they found it an exaggeration, but I believe that the delegates realized that the system is privatized and needs to be restructured.*"[45] For Abrasco, "*the confusing recommendations of the Ministry of Health regarding the presentation of the project on state-owned foundations under private law to the CNS and the eminently plebiscitary nature that sealed its immediate rejection by this forum undermined the essence of formulation of alternatives and construction of new hegemonies and consensus about social control in healthcare.*"[46]

The Minister of Health, one day after the end of the 13th NHC, said to the press that the result was a "*mistake,*" even more so because the delegates did not present alternatives. He said that the government respected the Conference's position, but would continue to advocate at the National Congress for "*a law that allows SUS to operate its hospitals with some efficiency.*"[47] Because the government continued to advocate in favour of the proposal, some actors held demonstrations and other forms of protest, distributing to congressmen a document containing the records of the discussions, decisions of the 13th NHC, and the SUS guidelines.

Participatory processes can leverage opposition to government initiatives – a risk inherent in the collective construction of agendas. These processes are governance mechanisms that highlight the emerging needs of specific groups that may no longer organize themselves in blocks and consensual positions, and can halt the progress of agendas where consensus was not achieved among stakeholders. Democratic governance involves laying a lot of groundwork before the public policy agenda can be changed.

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

CONCLUDING REFLECTIONS

National conferences stimulate the emergence of new ideas, new relationship patterns between State and society, and the management of participatory mechanisms inside the state apparatus.
There was also **resilience** in evidence. Brazilian social movements and civil society organizations worked to boost the democratization process through political mobilization and the transformation of public spaces to defend rights and expand autonomous social action. This process moreover generated new roles for society (co-production of policies, collaboration, and mutual

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

commitment). The question, however, is whether society's capacity for resilience, adaptation and innovation will continue in an environment of greater complexity, as actors with unequal power engage on an ever-growing policy field.

The rising number of actors and social movements in conferences indicates the success of the participatory model in expanding the range of active public policy stakeholders. There is a **democratizing potential** in these spaces because they add information, diagnosis and collective knowledge. They also enable the development of respect for diversity, interaction, expression of ideas and interests, engagement with public affairs, and learning through dialogue. This dynamic produces social and governmental learning, contributing to better governmental *and* civic results.

Conferences can also foster the **emergence and legitimacy** of new actors; enable recognition of the multiplicity of issues and interests not previously accessible to or considered by the state; and generate mutual commitments.

Yet at the same time, the increasing complexity of the process raises challenges. The 8th conference led to a deeper consensus about diagnoses, themes and alternatives and so led to clearer public results and allowed the creation of the SUS. With the expansion and diversification of participants and interests at the 13th NHC, the plethora of resolutions and conflicting positions made it more difficult for the government to process the conference's decisions. The risk may be frustrated expectations because comparatively few resolutions – disparate, fragmented and non-consensual – can be taken on board.

Moreover, the possibility of presenting new proposals at the national stage brought an unpredictable component that contradicts the essence of participatory processes, built on dialogue and negotitation. Would this be an attempt to directly capture the emerging issues that come from the social base without passing through the rules and approval filters? Are new proposals inputs that help the government to capture collective intelligence? Or was this a concession to social local bases?

Resilience in government involves experimentation, continuous review of management tools and legal and political frameworks, dialogue, and the involvement of outside actors. Because bureaucratic systems are slower and less adaptable than the unpredictable context in which they work, these processes are necessary for knowledge to be turned into results. In the story of the NHCs, it was thus crucial to adapt the participatory mechanism to the new social context (increasingly complex, diverse, reflective and participatory), by learning from mistakes and reviewing the ways in which proposals thus entered the decision agenda.

Yet at the same time, the inclusive process made it much more difficult to weigh alternatives. Simplification necessarily had to become part of the dynamic. There was complex information to process and a broad variety of actors to consult in order to build consensus. There were problems in coordinating actors, organizations, interests, alternatives, projects and political decisions. The alternatives were limited by political priorities, technical feasibility, legal constraints and law interpretations that reduce the set of the solutions.[48] Given these characteristics, and the profusion of diluted, generic alternatives generated on the Conference floor, the government was in the end "liberated" to define what went into the final public policy agenda.

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

Would the Conferences be seen by government leaders only as consultation mechanisms or as effective models for developing public policy in a particular sector? Given the challenge of transforming proposals into workable policy input, do the Conferences really allow civil society to influence decision-making? How can governments cope with multiple, growing and distinct demands of powerful actors? How should they address the problem of "representativity" in the public interest? To what extent can and should government yield policy-making to civil society actors, since the government remains the steward of public interest?

In spite of the efforts already undertaken, governments worldwide have not fully adjusted to the innovations and changes in civic expectation in recent decades. Rather than creating new structures, governing today is more about managing in complex environments: enabling flexible and coordinated responses among networks in order

to achieve results, connecting organizations to create collective intelligence, and reshaping existing spaces for civic engagement. The challenge now for governments is to create, restructure and manage democratic forms of governance aimed at achieving still better public results.

ENDNOTES

1. The authors thank Paula Montagner and Sonia Amorim for discussions on the research themes, reflections and contributions to the text; and Amarílis Tavares who helped translate the text. Special thanks go to Clarice G. Oliveira, who helped to put this text into final form. Elisabete Ferrarezi is PhD in Sociology at the University of Brasília and holds a MA in Public Administration at the FGV/SP. She belongs to the career of specialist in public poicy and government management of the Brazilian Federal Government since 1996 and serves as General Coordinator of Research of the Brazilian National School of Public administration (ENAP). Mariana S. de Carvalho Oliveira holds a LL.B. of Laws and a MA in Law, State and Constiution at the University of Brasilia. She belongs to the career of specialist in public policy and government management of the Brazilian Federal Government since 2006 and serves as advisor of the General Coordination of Research of tte Brazilian National School of Public Administration (ENAP).

2. The 1988 Constituent Assembly approved Brazil's new National Constitution.

3. Walle and Vogelar, 2010

4. Kingdon, 2003 and Ferrarezi, 2007

5. NS6, 2009

6. Sader, 1991

7. Ferrarezi, 2007

8. Councils at the national level are "Sectoral or thematic institutional organizations, with an advisory and/or deliberative and supervisory nature, aimed at producing and monitoring public policies within the federal government." (Definition used in official presentations of the National Secretariat for Social Interaction of the General Secretariat of the Presidency). Presentation can be found on the official website: http://www.secretariageral.gov.br/art_social

9. Santos and Avritzer, 2002, 42

10. Avritzer, 2000, 25-26

11. Brazil Agency, "For Lula, conferences strengthen democracy" (notice, March 15 2010)

12. Avritzer, 2000, 27

13. Ferrarezi, 2007

14. National Secretariat for Social Interaction of the General Secretariat of the Presidency (SNAS/SG-PR). Official website: http://www.secretariageral.gov.br/art_social

15. There are recent cases of secretariats and ministries innovating within this structure, proposing virtual conferences, free conferences, regional conferences, etc. Free Conferences were first held during the 2007 National Youth Conference and were replicated at the first National Conference on Public Security (1st CONSEG 2008/2009) and at the Conference on Culture and Communication in 2009/2010. They are mechanisms intended to enhance, simplify and diversify participation to include anyone interested in the theme of the

Conference: any social group can organize a space for discussion. At the 1st CONSEG, for example, free conferences were held inside prisons, battalions, universities, NGOs, and councils.

16. Oliveira, 2005, 47

17. Carvalho, 1995, 48

18. Escorel et al, 2005, 60

19. Brazil, 2009, 15

20. Rodriguez Neto, 2003, 51

21. Radis, n. 65, 2008:22

22. At the 12th NHC held in 2002, the voting on the priority proposals was not completed. Four thousand proposals and hundreds of motions were then sent by mail to the delegates for voting, a process that delayed the final report by one year (Radis, 2008, 10) and undermined the deliberative principle that required physical presence at the conferences.

23. At the National Stage, the Statute of the 13th NHC forecasted 3,068 delegates (1.534 healthcare users, 767 health workers and 767 public managers and service providers); however, only 2,627 delegates had their attendance registered.

24. The participants of the 13th NHC were divided into delegates, guests and observers. Delegates were participants with voice and vote (the general rule was 50 percent were to be representatives of SUS users, 25 percent were to be workers in the health system, and 25 percent were to be public managers and providers of health services). Guests had voice in discussions and were representatives of agencies, organizations, institutions or national and international personalities with key roles in health and related sectors. Observers were people interested in attending the Conference.

25. Raggio et al, 2009, 24-28

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

27. Radis, n.65, 2008:29

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

29. The NOC was supported by an Executive Committee, appointed by the Ministry and comprised by representatives from its departments to provide administrative, financial and technical support and infrastructure

for its activities. Each level of government's health councils were responsible for conducting and funding the stages.

30. The Coordinator of the 13th NHC, also Chair of the CNS, was interviewed by Mariana Oliveira and Elisabete Ferrarezi in May 2010. His words highlighted along this narrative were extracted from that interview, except when another source is mentioned. He was the first elected chair in the history of the Council, a workers representative (from the National Confederation of Social Security Workers). Until 2004, the Chair of CNS had always been the Minister of Health; the move to elect the chair was an achievement of council members.

31. For more information on the composition of the program of hte 13th NHC, see Annex A.

32. The Coordinator of the 13th NHC, see endnote 30.

33. Radis n. 65, 2008:22

34. Motions are documents approved by consensus, and are related to issues other than the themes proposed. They have a political nature, often presenting a position of "applause" or "rejection." After approval, the motions are forwarded to the appropriate group.

35. Raggio et al, 2009, 23. Translation by the authors.

36. Abrasco newsletter, Editorial, December 2007, 2. Translation by the authors.

37. Brazil. Ministry of Health. *The Consolidated Report of the 13th NHC*. 2007. p 13. Translation by the authors.

38. Motion 106 was "Repudiation to Bill (PL n. 1.135/91) that legalizes (sic) abortion until the ninth month of pregnancy."

39. Proposal 157 of Axe 1 of the Final Report of the 13th NHC states: "To ensure a secular State, so that health issues and public policies are not guided by religious precepts."

40. Interview in Radis, n. 65 2008, p 14-15.

41. Raggio et al, 2009, 44

42. The decriminalization theme also emerged in other national conferences such as the National Conference on Human Rights and National Conference on Policies for Women.

43. Radis, 2008, 21

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

45. Radis, 2008, 14

46. Abrasco, December 2007, 5

47. Radis, 2008, 10

48. Ferrarezi, 2007, 268

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ANNEXES

ANNEX A - PROGRAM AND DEVELOPMENT OF THE 13TH NATIONAL HEALTH CONFERENCE

<table>
<tr><th>DAY 1</th><th>DAY 2</th><th>DAY 3</th><th>DAY 4</th><th>DAY 5</th></tr>
<tr><td>REGISTRATION</td><td colspan="3">VOTING OF STATUTE

The moment was tense because the statute brought methodological changes to the deliberations, as compared to previous Conferences. Several highlights were requested – 12 out of 28 articles were highlighted for amendment, but only minor changes were approved.</td><td rowspan="4">FINAL PLENARY
Last deliberative instance of the 13th NHC.

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

In addition to approving proposals to compose the final report, the final plenary had the task of approving motions at national level.</td></tr>
<tr><td rowspan="2">OPENING CEREMONY

With the participation of the President of Brazil, the Minister of Health, the Chair of the Council, other Ministers of State and authorities, besides the participants.</td><td colspan="3">ROUNDTABLES
Presentation and discussion on each Theme</td></tr>
<tr><td>ROUNDTABLE - AXIS 1

The speakers were the General Secretary of the Presidency of the Republic, a representative of the Brazilian Forum of NGOs and Social Movements, the Feminist Health, Sexual and Reproductive Rights Network, and the Technical Committee of Black Population Health. It addressed issues such as marketization of health, abortion, national development and capitalism.</td><td>ROUNDTABLE - AXIS 2

The speakers were a representative of the National Movement for Fighting Against AIDS, a researcher from the University of Brasilia, a former congressman of the Workers Party responsible for a bill on financing of public health and the chairman of Cebes.

The themes discussed were intersectoriality, social security and state-owned foundations under private law.</td><td>ROUNDTABLE - AXIS 3

The speakers were the vice-chair of the National Association of Health Defense Public Prosecutions Offices (Associação Nacional do Ministério Público de Defesa da Saúde), a public health doctor, the chair of Conasems and the chair of the National Confederation of Agricultural Workers.

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

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

AXIS 1
Discussion and voting on proposals under Axis 1.

AXIS 2
Discussion and voting on proposals under Axis 2.

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

ANNEX B - COMPOSITION OF PARTICIPATION IN THE NATIONAL STAGE OF THE 13TH NHC

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

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

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

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

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

FROM NS6 TO NS WORLD

THE NEW SYNTHESIS PROJECT

The New Synthesis Project is an international partnership of institutions and individuals who are dedicated to advancing the study and practice of public administration. While they hail from different countries, different political systems and different historical, economic and cultural contexts, all share the view that public administration as a practice and discipline is not yet aligned with the challenges of serving in the 21st century.

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In 2009, Madame Jocelyne Bourgon invited six countries to join the New Synthesis Network (NS6), composed of officials, scholars and experts from Australia, Brazil, Canada, the Netherlands, Singapore and the United Kingdom. Committed to supporting practitioners whose work is becoming increasingly difficult, this network has engaged close to 200 people from more than 24 organizations. Their efforts have resulted in five international roundtables, five post-roundtable reports, and 17 case studies. Collectively, this work has generated significant insights into preparing governments to serve in the 21st century.

The Network's findings have been captured in the publication of a new book entitled *A New Synthesis of Public Administration: Serving in the 21st Century*, and is available in print and electronic formats from McGill-Queen's University Press. Its signature contribution is the presentation of an enabling governance framework that brings together the role of government, society and people to address some of the most complex and intractable problems of our time.

TOWARDS NS WORLD

So where to from here? Reconfiguring and building the capacities of government for the future cannot be accomplished through the publication of a single book. It is a continuous journey which requires the ongoing sharing and synthesis of ideas, as well as the feedback, learning and course adjustments that can only be derived by testing ideas in action.

And so the journey continues and the conversation expands. Our goal is to build upon the rich partnership of the original six participating countries by opening up this exchange with others—wherever they may be located. We seek to create an international community that connects all leaders—from government, the private sector and civil society—committed to helping prepare governments for the challenges ahead.

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