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## **PANEL 2**

### **DEMOCRACY AND SOCIAL PARTICIPATION**

Participation is one of the enabling elements of public policies in a democratic Brazil. The 1988 Constitution established 14 participatory principles in the Brazilian State's structure. The most important of them is participation of the civil society in the decision-making processes regarding public policies related to social welfare, healthcare, children, and adolescents. Based on these principles, nearly 5,000 healthcare councils and 2,000 social welfare councils have been established in Brazil. In addition, special notice must be given to the participatory budget experiences which in four capitals alone – São Paulo, Belo Horizonte, Porto Alegre, and Recife – bring together about 200,000 people every year.

The purpose of all these initiatives was to bring social players into the decision-making process or into the development of mechanisms to control social policies. The principle of participation was introduced into the Brazilian health sector in order to provide social players – users of public healthcare services – with access to healthcare in the country via the so-called councils, i.e., hybrid institutions that rely on the participation of representatives from the State and from the civil society. Health councils are established by national legislation and must be in place for federal funds to be transferred to municipalities. Based on article 194 of the constitution, they are instituted by Law 8,142. Under the participatory budget, the population gains access to public goods and services in their regions. This principle of introduced in Porto Alegre in 1990, and today there are 194 examples of PB in Brazil. Once again, the assumption is the same: within PB, the social players living in the poorest areas of large cities have an opportunity to make decisions about access to infrastructure goods by the poorest segments of the urban population.

Hence, there are currently two broad participatory channels in Brazil, both with their own way of promoting participation and distribution: (1) In the health sector, participation can lead to decisions related to new public policies that broaden access specifically to public services. In this case, participation consists of decisions on the contents of a public policy or control over the healthcare service provided. (2) Under PB, the player himself/herself determines which public good he/she is in most need of. In this case, participation determines distribution of an infrastructure good, be it collective or individual, in the urban area.

In this short article, we will describe the scope and level of success of each of these policies and will discuss the problems they face in order to be broadly applied as public policies.

### 1. Participatory Budget:

The participatory budget is one of the fastest growing democratic and participatory management experiences in big cities in Brazil. First introduced in Porto Alegre in 1990, it was later implemented in Belo Horizonte, Recife and São Paulo, just to name a few large Brazilian capitals. The original format of PB, even as it underwent several changes and improvements, made it possible to develop a democratic and participatory standard that went on to become a model for subsequent experiences.

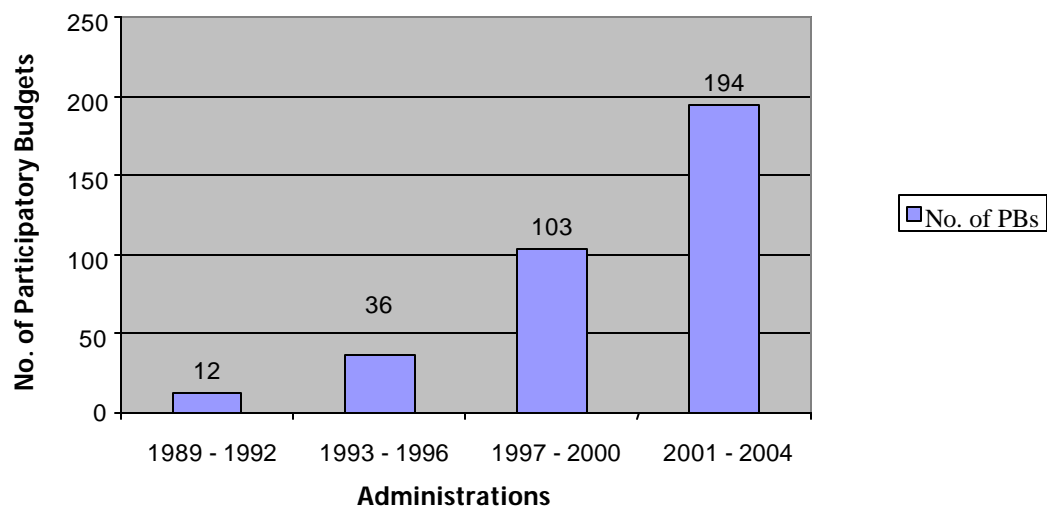
Recently, several surveys conducted by FNPP<sup>1</sup> and by the Participatory Democracy Program at UFMG collected a body of relevant data which indicate an increase in the number of participatory budget experiences during the 1997-2000 period (Grazia & Torres, 2003) and the fulfillment of the requirements for successful experiences. With regard to a quantitative analysis of PB, 103 cases of PB were identified during this period in various municipalities – capitals and medium and small cities. While these experiences revealed common aspects, they highlighted characteristics specific to each municipality involved. The purpose of the surveys was to show how PB was disseminated across Brazil, as part of the agenda not only of the Labor Party, but also of many other parties and/or party coalitions.

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<sup>1</sup> This survey, carried out by the National Population Participation Forum, can be found in: GRAZIA, Grazia de and RIBEIRO, Ana Clara Torres (2003) *Experiências de Orçamento Participativo no Brasil – Período de 1997 a 2000*. (Participatory Budget Experiences in Brazil - 1997-2000) Ed. Vozes, Petrópolis, RJ.

These data were updated by UFMG's Participatory Democracy Program, which identified 194 experiences from 2001 to 2004, as shown in the graph below:

**Graph 1 – Evolution of PB Experiences in Brazil**



Source: Participatory Democracy Program/2004

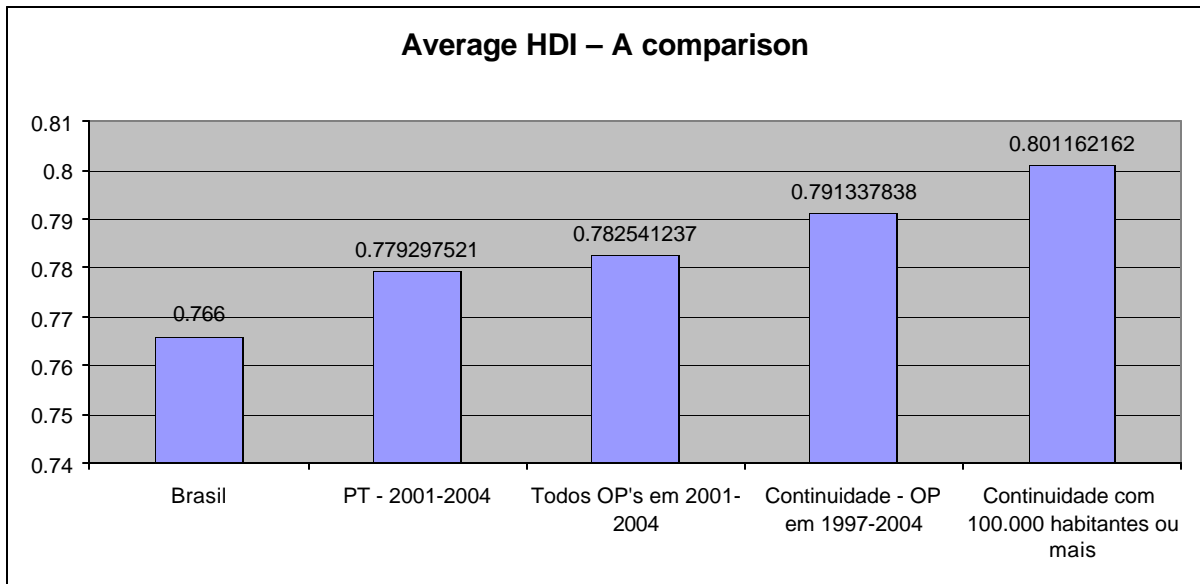
PB can be considered a successful participatory public policy based on three variables:

- First, success can be understood as effectiveness, i.e., the ability to achieve participation of the target social players. In this sense, PB can be considered as a successful initiative. Its main experiences – Porto Alegre, Belo Horizonte and São Paulo – show the participation of a poor social player whose income varies from 2 to 5 minimum wages, which is the target group of this public policy.
- Secondly, it is possible to describe success as the ability to reach participation-based consensuses that generate public policies for the sector. In the case of PB, consensuses that

generate decisions about the allocation of infrastructure goods for the public in urban areas. In this sense, PB can also be considered as a successful initiative.

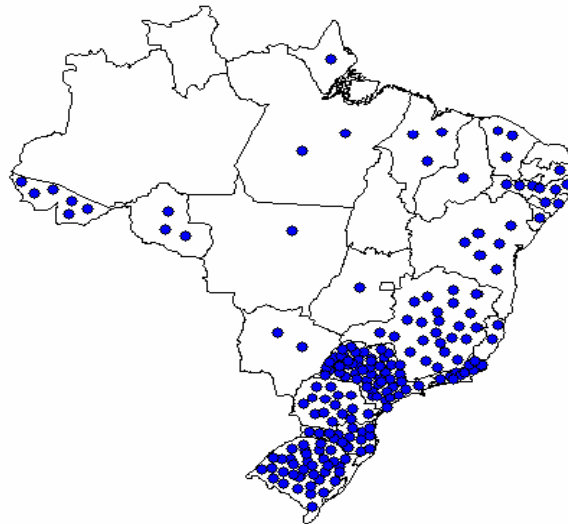
- Thirdly, ability to link participation to distribution. In this case, the main indicator is the ability of PB to provide distributional results. Marquetti (2003) and Pires (2003) show the achievements obtained through PB in this sense in major capitals, such as Porto Alegre and Belo Horizonte. According to the authors, PB favors areas in these cities where poverty is more concentrated, through mechanisms such as IQVU (Urban Quality of Life Index) and poverty tables.

PB-related survey data available show that PB seems to be a successful participatory policy in the cities with the following characteristics: more than 100,000 inhabitants, concentrated in regions South and Southeast, with poverty levels below the national average and HDI above the national average. Graph 2 below shows the relationship between the cities where PB exists and their HDI.



Source: Participatory Democracy Program – 2004

The data shown in Graph 2 indicate a problem associated to the widespread use or extension of PB as a public policy for all regions in Brazil. Cases of PB are concentrated in cities with over 100,000 inhabitants, which have characteristics that make it difficult to implement the concept at the country level, such as fiscal capabilities and relatively low levels of poverty concentration. With 194 cases in Brazil at the present time, regional concentration and city profile of PB points to its limits, especially when it comes to implementation in medium-sized cities in the regions North and Northeast.



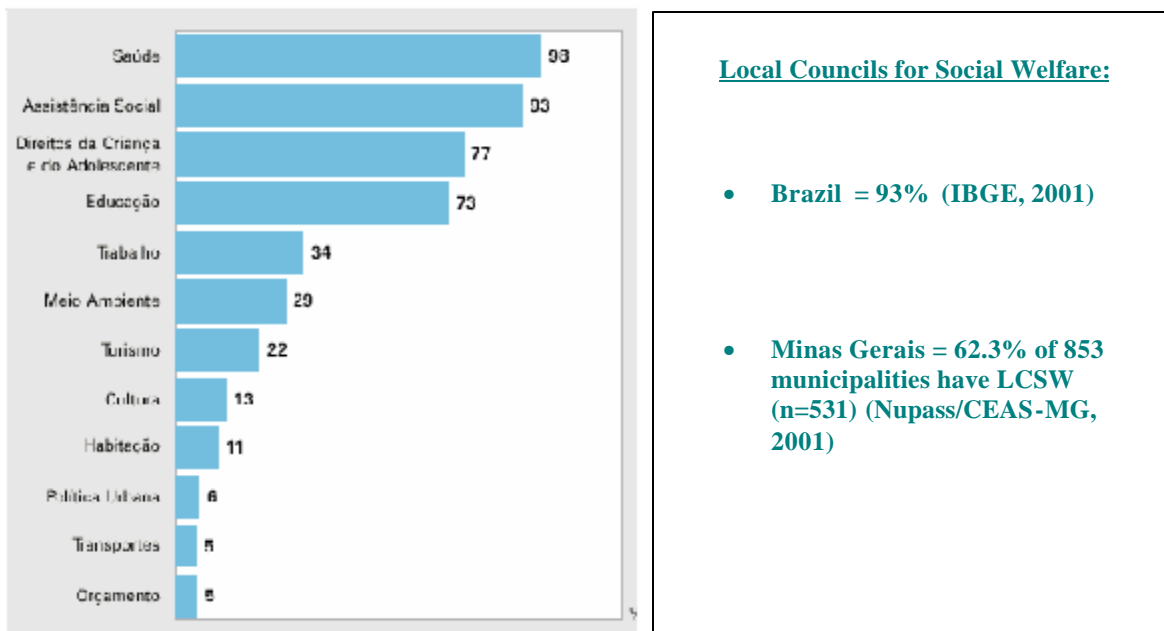
Then we will look at another case of more generalized participation in Brazil: the case of councils, with an emphasis on health councils.

## 2. Sector-specific health councils

Sector-specific councils are public decision-making mechanisms established within the Executive Power to enable participation of the civil society, with representatives from private service providers, in the case of national systems of social welfare and health. The role of council members is to make decisions, in conjunction with the public power, about health policies; to provide direct control; and to oversee government actions. Sector-specific councils were also created in several areas, and they became a component of the institutional structure of important sector-specific policies in Brazil — such as those regarding education, assistance, children and adolescents, and health — when the 1988 Constitution was put in place. In regulating such policies, this constitution brought about countless provisions regarding community participation (article 194, VII; article 198, III; article 204, II; and article 206, VI). For this reason, councils are vital for the effectiveness of social rights insofar as they make decisions about the abovementioned public policies, i.e., they translate

a budget into tangible actions, tools and services for the community. The following graph contains the number of councils in Brazil, according to data provided by IBGE:

Graph 3: local councils in Brazil



Source: Survey of Basic Municipal Information – IBGE, 2001;

Among the various areas of social policies for which a council exists, special notice should be made of health, a required area for transfers of federal funds. The main characteristics of health councils are: they are the participatory public policy making sector with the best institutional structure in Brazil – currently in place in 98% of Brazilian municipalities; they are established through national level legislation throughout the three levels of the federation (Federal, State and Local levels), which enhances its institutional formality in the context of the abovementioned participatory experiences; they hold decision-making competencies, not only advisory competencies; they are a participatory instrument that works on a regular and ongoing basis (and not simply when convened); and they are usually comprised of members of the civil society (entailing therefore a type of participation that is more complex than individual participation).

Nevertheless, while we have all of these elements associated to a relative level of success of institutional participation in the health sector, we also have different reasons to raise questions as to a potential generalization of this distributional mechanism.

First of all, there is a significant discrepancy regarding the level of institutionalization of councils in regions South and Southeast on the one hand and, on the other hand, in regions North and

Northeast, as shown in Table 1 below. In this sense, even in the case of health, where the level of institutionalization is higher, a significant discrepancy still exists:

Table 1

**Municipal Councils in Brazil (2001) – geographical distribution and discrepancy in the level of institutionalization**

Area of coverage of the council	Region where it appears		Discrepancy among regions Higher/lower frequency
	more frequently	less frequently	
Healthcare	South (99%)	Northeast (97%)	2%
Social Welfare	South (96%)	Northeast (92%)	4%
Children and Adolescents' Rights	South (91%)	Northeast (66%)	25%
Education	South (79%)	North (63%)	16%
The Environment	South (40%)	Northeast (14%)	26%

Source: IBGE – Survey of Basic Municipal Information, 2001

Secondly, the fact that health councils have a higher degree of institutionalization is no indication of other criteria of achievement mentioned above. So, the question is: have these councils been effective in increasing access to healthcare services and democratizing access to these policies for low income social players? Is there a discrepancy between the levels of democratization in terms of the management of the various councils in the different regions? Do we have the same level of democratization of access to services across the different regions?

The analysis above shows that participatory social policies in Brazil are faced with three major challenges today:

The first challenge is to generalize and integrate participatory approaches. Participation in the health sector is more intense than participation in the area of social welfare, which in turn is more intense than participation in the field of education. On the other hand, participation is more intense in regions South and Southeast since they have lower poverty levels. A need exists to encourage new ways of disseminating participation in the poorest regions of the country.

Secondly, there is the problem of correlation among sectors for participation. Participation is as discontinuous as the organization of the Brazilian state. This holds true for both PBs and participation in Councils. Neither of them is integrated to other public policies so as to enable a discussion on participatory public policies.

Thirdly, there is the problem of the different types of organization of civil society and its impact. Civil society in Brazil is extremely heterogeneous. It is more organized in regions South and Southeast than it is in all other regions. It is more organized in large cities than it is in small towns. Although conclusive data on how councils and PBs work in small towns are not available, case studies show that they do not work so well (Silva,2003; Teixeira,2003). It is important to design a policy to consolidate participatory approaches in small municipalities.