ACCOUNTABILITY PROCESSES IN THE CONSTRUCTION OF THE UNIFIED HEALTH SYSTEM IN BRAZIL

RELATÓRIO DE PESQUISA

Relatório de pesquisa do projeto "Unequal voices: the politicies of accountability for equity in health systems", produzido para o Institute of Development Studies – Brighton - Inglaterra

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2017

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Introduction

The construction of the Sistema Único de Saúde (Unified Health System - SUS) in Brazil is closely linked to the historical context of the fight against the military dictatorship and social inequality. The authoritarian regime that seized power in a military coup in 1964 led to a period of over 20 years of policies restricting civil rights, fueled by economic growth based on lowering salaries, disordered urban growth and profound inequality and social inequities.

In this context, the health field, which is sensitive to social, economic and political factors, became a joint for different social actors who shared the ideal of a fair and democratic society, where health was a fundamental human right. Democracy was, therefore, a prerequisite for social movements.

The intrinsic relation between health and democracy is the focus of this work, since it is impossible to speak of accountability and transparency in public policies without democratic conditions for the participation of social and political organizations. In 1989, with a large popular movement, It was enshrined in the Brazilian Federal Constitution that health is a right for everyone and a duty of the State. This was progress given that in the 1980s international financial institutions moving in the opposite direction, advocating, above all, the reduction of State participation in social policies.

The purpose of this work, which uses bibliographical research methods, is to discuss the construction and development of the SUS, starting from the origins of the health movement. Rather than looking at all the possible historical interpretations of this trajectory, this article takes the concept of *accountability* to be inherent in the idea of democratic freedoms, considering its interconnectedness with social participation and social control. It is based on the premise that the founding principles of SUS are only possible in environments where democratic and civil participation, capable of generating a form of *accountability,* are fully permitted.

Accountability and democracy as analytical categories

A challenging issue for any democratic regime is the development of processes that allow citizens to evaluate, hold accountable and control the exercise of public power. The term widely used for this has been *accountability*, which is difficult to translate into Portuguese due to the multiplicity of its meanings. *Accountability* covers responsibility, obligation and responsibilization "*of those who hold a position to account for the parameters of the law, possibly leading to penalties for not complying with this directive*" (Pinho & Sacramento, 2009, p. 1348). Being directly related to democracy, the degree of *accountability* increases as more democratic values (such as equality, human dignity, participation and representation) are espoused in society (A. M. Campos, 1990; Sacramento, 2005).

In this article we will use Guillermo O'Donnel classification (1998) for accountability processes: 1) Vertical *accountability*, in elections, in which citizens, through voting, can "punish" or "reward" an agent. This aspect also includes "*freedom of opinion and association, as well as access to various sources of information [which] allow articulation of claims and even denunciations of acts of public authorities*" (O´Donnel, 1998, p. 28); 2) Horizontal *accountability*. within the State itself, in which state agencies have the right and legal power to carry out actions ranging from routine supervision to legal sanctions against "*actions or issues of other agents or agencies of the State that may be classed as criminal*"(Idem, 1998, p.40).

O'Donnel approach allows us to look at the process of constitutionalizing the SUS based on the concept of *accountability* both in the wider political sphere and in the internal sphere of the State.

This article also considers the importance of the articulations of the health movement among the political-partisan apparatus so that health could be highlighted in the Constitutional progress. As well as this, from the beginning of the SUS, it could suggest the creation of several institutional mechanisms that could help to enable greater control of and transparency for resources and policies implemented.

This is what guided the direction of the bibliographic research for this article, I mean, besides the historical research on the emergence of the SUS and the health movement, it was also researched blocks of descriptors that allowed the search for information on *accountability* from the terms participation, social control, responsibilization, public administration and public management. For the intended

focus, these descriptors were cross-referenced with the terms democracy and social movements, as well as health, health sector and health area.

Soon after the promulgation of the new Constitution in 1988, which marked the end of almost three decades of dictatorial military rule, the number of studies on *accountability* as synonymous with responsibilization within the scope of the Brazilian public administration increased, focusing on efficiency and control of public management.

In the Brazilian context, where participation and social control were institutionalized, the processes of *Accountability* end up being associated to the activity and participation of the citizens in democratic public forums and in civil society (Arato, 2002). The reforms implemented in the public administration from the 1990s allowed for mechanisms of control, opening spaces for social participation through advice in different policies. The achievement of a process of full *Accountability* is only possible with public information and reliable accounts by public administration managers and with the effective participation of citizens in political decisions (social control) (Arato, 2002; Miguel, 2005; Monteiro, Pereira, & Thomaz, 2016).

The constitutional definition that health is a right is based on its social, political and economic determinants, many of them directly dependent on state action, inscribed in an expanded vision of social protection. Democracy is, therefore, a substantive value in the intrinsic relation between justice and social protection. The constitutionalization of the Unified Health System (SUS) reinforced the conceptions of democracy and participation, making the health sector in Brazil a useful area for understanding different dimensions of *Accountability*. Various instruments, mechanisms and institutional policies, equally related to the three spheres of government (Federal, State and Municipal) as to social movements, sought to build over time ideas for overcoming an exclusionary health system. Contextualizing this time historically is important for the discussion of *Accountability* in health in Brazil.

Contextualization: 1964-1990 and the Brazilian health movement

In March 1964 the military regime was installed in Brazil[1] through a coup d'état, leading to 20 years of severe restriction of civil liberties. During these years of military rule, the country experienced an economic growth known as the "economic

[1] By military regime , we mean one in which a group of officers determines who will run the country and has some influence on its political guidelines (Geddes, 2001).

miracle" (L. C. B. Pereira, 1977) , that was not felt by the large majority of the population, resulting from the heavy concentration of wealth, lowered salaries, growth of social inequalities and the repression on workers and popular movements.

In terms of social policies, during this period the National Social Security Institute (INPS) was created, which, under the auspices of the federal government, brought together different social protection initiatives linked to different professional categories, which provided healthcare and pensions for workers formally engaged in the labor market. Much of the population, therefore, had no access to health care services.

This organization created a dichotomous and exclusive model of the health sector in Brazil. On the one hand, there was the Ministry of Health (MH), responsible for the collective control of contagious diseases (vaccination, port control, etc.) and isolation sectors (psychiatry and tuberculosis) and on the other, medical and hospital care financed by the INPS. Thus, in the period 1968-1972, the MH budget was decreased from 2.21% to 1.40% in relation to the total budget of the Union (Paiva & Teixeira, 2014), while the social security budget for medical care grew (Braga & Paula, 2006). This left a model focused on curative practices, individual and taking place in hospitals, organized in a capitalist way, oriented towards the profitability of the health sector.

The international economic crisis of the 1970s, led by the oil crisis, made health a more relevant issue on the political agenda, since the increase of the costs of so-called 'scientific medicine' were extended without the system offering significant benefits to the population.

In the period from 1970 to 1974, the growth of social security resources to reform and build private hospitals (Braga & Paula, 2006) contributed to the development of a medical-industrial complex with high rates of capital accumulation, mainly monopolistic international capital in the area of medicines and hospital medical equipment (H. de A. Cordeiro, 1984; Oliveira & Teixeira, 1989).

From 1974 to 1979, the economic miracle a distant memory, the country saw inflation, a decrease in purchasing power and productive activity with strong financial speculation. These facts forced the government to adopt a proposal for social and political openness, albeit slow and gradual. This allowed the emergence of popular movements under social banners. The critique of the health care model had great power to mobilize, since the model in force excluded large portions of the population.

The mobilization of resident physicians claiming the regulations of the Medical Residency and the growing medical academic debate around alternatives to the current health model, allied with the popular movement, were precursors of what would be called the Sanitary Reform movement.

In 1976, the creation of the Brazilian Centre for Health Studies (CEBES) and its *Saúde em Debate* (Health in debate) magazine deepened criticism of the health model, while consolidated the close relationship between democracy and health, defending the principle that health is everyone's right and acknowledging the relationship between the organization of the health system and the health conditions of the population (Paim, 2007, 2012). This political and ideological conception of health has aligned itself with the social movements in the struggle for the democratization of the country.

This pressure forced the government to seek alternatives, among which was the so-called Extension of Coverage Programs. A notable program was the Program for the Internalization of Health and Sanitation Actions (PIASS) (Brasil, 1976) which had as its objective the organization of a basic health structure in municipalities with up to 20,000 inhabitants (most Brazilian municipalities), using auxiliary staff and the community itself, providing for the integration, at a local level, of the different health services under the responsibility of the State Health Secretaries. The PIASS presented a space for progressive groups to recommend collegial management between the spheres of government (Paim, 2007).

In 1979, the first Symposium on National Health Policy was held in the Chamber of Deputies in Brasília, whose final document established central principles defended by the health reform movement, such as: the universal right to health; The intersectoral character of health determinants; the regulatory role of the State in relation to the health market; decentralization, regionalization and hierarchy of the system; popular participation; democratic control and, fundamentally, the need for integration between social security and public health (Paiva & Teixeira, 2014).

In the process of political distension, there was a widespread campaign throughout the country for the holding of direct elections for president of the republic of which the health movement was a significant part. Although the demand for direct elections was defeated in parliament in 1985, an indirectly elected civilian government was set up to make the transition that would shape the new constitution and bring direct election back to all levels of the executive branch. In this transition, the organized and

vocal health movement held key positions in the Ministry of Health, the Ministry of Social Security and in Parliament. In 1987, the Unified and Decentralized Health Systems (SUDS), a precursor of SUS institutional design, were instituted. The Health Councils, previously established in some municipalities, continued in the SUDS. Through these forums, the health movement was able to intervene in institutional fragmentation and to bring the new social movements closer to the patterns and demands of health, especially with neighborhood associationism in this period (Côrtes, 2009).

The favorable conjuncture made possible the holding, in March 1986, of the 8th National Health Conference (8ªCNS), which included the participation of users of the health system. The final report of the Conference promoted the strengthening of the public sector, the unification of the health system, the expanded concept of health, the citizen's right to healthcare and the creation of institutional examples of social participation (Comissão Nacional da Reforma Sanitária, 1986) .

In 1988, the National Constitutional Assembly took over the guiding principles of health reform and added a specific chapter to the Federal Constitution about health around the proposal for a new National Health System, called the unified health system (SUS), and the principles of universality, equality, administrative decentralization and social control. The article 196 defined health as: "*everyone's right and a duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other health problems, and the universal and equal access to actions and services for its promotion, protection and recovery*."(Brasil, 1988) With the enactment of CF1988, the right to health was inscribed as a fundamental aspect of the democratic period that began. Since then, the challenge is no longer to justify the right, but to guarantee it in fact in people's lives.

The historical process that gave rise to the SUS is part of the so-called *Constitutionalization of social rights*[2]. It means that the guarantee of these rights is a necessary condition for the existence of the Brazilian State. Therefore, the central issue when it comes to human rights, "is not so to *justify them*, but to *protect them* " (Bobbio, 2004, p. 43), which makes it a political issue. Since then, the challenge has no longer been to justify the right to health, but to guarantee it in people's lives. It is on this 'political problem' that the idea of *accountability* is presented and draws attention to the

[2] It was the constitutionalization of social rights that allowed the emergence of the phenomenon of judicialization of health policy in Brazil, as we will see in the following section.

need for the clash between society and government over the interpretation of social rights.

Decentralization of the Unified Health System (SUS): the challenge of bringing health management closer to local health problems

Like democracy, decentralization was an idea that gained much strength in the process of setting up the SUS in Brazil. The combination of democracy and decentralization seemed to be the key strategy to ensure the provision of health services to the entire population and the arrangements to ensure *accountability*. Approaching management of local health problems based on participation and social control in local councils represented a significant step towards the implementation of the model of health care advocated by the health reform movement.

Analysis of some characteristics of the political-institutional process

The SUS is shaped by the Federal Constitution (CF88) and the Organic Health Law (acts 8080/90 and 8142/90), representing the social pact that legally recognizes health as a right and establishes the universality, integrality and equality principles of the health system. Through these, the institutional and management models of the system, based on political-administrative decentralization and community participation, were defined, establishing that health financing would be tripartite (federal, state and municipal) with budgetary responsibility through fiscal resources and social contributions.

CF88 defined the municipality as an autonomous federative entity, alongside the Union and the states[3]. The establishment of a threefold federation, with the emergence of the municipality as a federal entity, is an important feature of decentralization in post-1988 Brazil and has had repercussions for the organization and management of the health sector, pointing out the relevance of negotiated and cooperative management (A. M. M. Pereira, Lima, Machado, & Freire, 2015; A. M. M. Pereira, 2014).

The SUS decentralization process was regulated throughout the years 1990 and 2000. The Basic Operational Norms (NOBs) issued in 1991, 1992, 1993 and 1996, the Health Care Operational Standard (NOAS) of 2001 and 2002, the Health Pact of 2006

[3] According to the Constitution: "The political-administrative organization of the Federative Republic of Brazil comprises the Union: the States, the Federal District and the Municipalities, all autonomous under the terms of this Constitution" (Brazil, 1988, article 18). The federal structure of Brazil is formed by the Indissoluble union (Brazil, 1988, art. 1) of the Central Government (Union); 26 states and the Federal District; And 5,565 municipalities.

and Decree 7.508 of 2011 can be considered important milestones in the Process of decentralization of health (Levcovitz, Lima, & Machado, 2001).

For Pereira (2014) , the analysis of the decentralization process for the SUS is defined by four moments: 1) the promulgation of the Organic Law on Health (1990) as a framework for the transfer of the health authority and the management of services to States and municipalities (Brasil - Presidência da República, 1990a) ; 2) NOB 93 and 96, which promoted the extension of management abilities of municipalities, considering the significant increase in direct transfers ("fund to fund") of the financial resources of the National Health Fund for municipal entities (Brasil. Ministério da Saúde, 1993b, 1996) ; 3) the NOAS (2001 and 2002) and enabling all provided full management with greater power for the management of (Brasil. Ministério da Saúde, 2001, 2002) resources; 4) the Health Pact (2006) and the Decree 7,508/2011, promoting a new Federal Pact on health and increasing responsibilities (Brasil - Presidência da República, 2011a; Brasil. Ministério da Saúde, 2006) .

The Organic Law, despite being economically unfavorable in a political context[4], encouraged planning (Municipal Health Plans), the establishment of Community Participation Boards and the establishment of funds to receive financial transfers on a regular and automatic basis ("fund to fund" mechanism), although through a slow and asymmetrical process (Brasil - Presidência da República, 1990a). NOBs 91 and 92, although they contributed to the development of institutional capacity at the local level, were criticized for having limited the decision-making power of the states and municipalities and inducing the formation of isolated municipal systems, without the articulation and integration deeded for the creation of regional reference flows. (G. Carvalho, 2001; Levcovitz et al., 2001).

The criteria for financing NOBs ended up impacting on the model of health care adopted, favoring health care actions to the detriment of those of a collective nature and favoring the states and municipalities that had the largest installed infrastructure (A. I. Carvalho, Gawryszewski, Mendonça, & Moisés, 1993).

In August 1992, the 9th National Health Conference was held, based on the theme of "SUS: municipalization is the way forward". There was widespread participation of municipal leaders debating the difficulties and limits to the achievement of decentralization, in terms of both finance and of the powers of municipal leaders(G.

[4] Political context marked by the Collor government crisis at the federal level, followed by his impeachment in 1992. Economically, the scenario was marked by recession and uncontrolled inflation.

Carvalho, 2001; Levcovitz et al., 2001). Within the Ministry of Health, a tripartite group (Special Decentralization Group - GED) was created to draw up a proposal for health decentralization consistent with the discussions of the ninth Conference, which generated the document "decentralization of health actions: the audacity to uphold and enforce the law," from which was built NOB 93 (Brasil. Ministério da Saúde, 1993a, 1993b) .

NOB 93 was a milestone in the process of decentralization of health. The methods municipal management progressively extended their functions and responsibilities regarding the execution of actions and services; programming, control and evaluation; contracting and registration of providers; function of the Council and the Municipal Health Fund. At the end of 1994, 48.3% of municipalities were qualified under some management condition; at the end of 1995, it was 55.5% of them and 62% at the end of 1996 (Levcovitz, 1997; A. M. M. Pereira, 2014).

As for the states, the management conditions defined gradual functions and responsibilities regarding the programming, control and evaluation of services; coordination of specific actions and networks; formulation, control and execution of actions in the surveillance area; functioning of the State Health Council (CES), the State Health Fund (FES) and the Bipartite Interagency Commission (CIB). Pereira (2014) (2014) emphasizes that the evolution of state qualifications occurred more slowly. By the end of 1996, nine states were qualified in partial management and seven in semi-total, totaling 16, of the 26 states of the federation. The "bottom-up" transfers to the states have not materialized (Levcovitz et al., 2001; Lucchese, 1995)

The abilities of states and municipalities, according to the conditions set forth in NOB 93, were not fully implemented because they did not carry out the proposed financial transfers. On the other hand, NOB 93 formalized the Tripartite Interagency Committees (CIT), which had been in operation since 1991, and established the Bipartite Interagency Committees (CIB) as forums for articulation and intergovernmental agreements. These forums represented spaces for negotiation and resolution of conflicts between the entities of the Federation. By the end of 1995, all states had already established their IBCs, and they were fully operational in 23 of the 26 states (Lima, 1999; Lucchese, 1995).

The NOB 96 building process lasted a year and involved several actors from the macro-regional meetings of the Ministry of Health to form CIBs (Levcovitz et al., 2001) (77). One of the main contributions of NOB 96 was the proposal of a care model based

on primary health care (APS). The proposal to establish an assistance model based on primary health care (called basic care by the Ministry of Health) was made through NOB 96. To establish financial incentives (*per capita* transfers which conformed to the Basic Care Limit - PAB) to implement the Community Health Agent programs (PACS) and Family Health (PSF), the NOB 96 made it possible to expand the offer of basic attention in the country and changed the logic of production financing (A. M. M. Pereira, 2014) . The PACS and the FHP strategies to expand coverage accounted for health care, especially for those sections of the population with greater difficulties in accessing the health care system, while at the same time giving an incentive for municipalities to assume responsibility in the process of decentralization of the system.

The publication of the NOAS (2001 and 2002) represents the moment when the territorial organization of health services was further advanced (regionalization), with emphasis on the role of states in coordinating this process (Brasil. Ministério da Saúde, 2001, 2002; A. M. M. Pereira, 2009; Souza, 2001). The NOAS for the municipalities aimed at the progressive expansion of responsibilities regarding: 1) management of the units; 2) regional planning of service provision; 3) organization of the system and development of the SUS users' national registry (called SUS Card); 4) strengthening of the model of care foreseen by NOB 96, with maintenance of "fund to fund" transfers.

NOAS strengthened the role of the state leader in the coordination of the health system, and it was responsible for conducting regionalization (through instruments such as PPI and RDP) and contributed to a strong systemic rationality[5], with an emphasis on regionalization, guaranteeing access and creating instruments (PDR and IDP) to support this process (A. L. D. Viana, Heimann, Lima, Oliveira, & Rodrigues, 2002).

In 2006, the Ministry created the Health Pact made up of three components (Pact for Life, Pact in Defense of the SUS and Management Pact), with the objective of strengthening the decentralized management of the SUS, maintaining regionalization as an important strategy for this. Under the logic of a cooperative federalism, the Health Pact defined responsibilities for each SUS manager aiming at cooperative management (through a Regional Management Collegiate - CGR) and reducing the "push game" of more competitive contexts. The Management Pact of the SUS established the sanitary

[5] According to Viana *Et al* (2002), the strong systemic rationality is "linked to the definitions of the set of actions and services to be covered in the assistance modules by the federal sphere and to the initiatives and discussions between municipalities under the coordination of the state body (PPI, PDR and PDI)."

responsibility[6] of municipalities, states, Federal Union and Federal District in seven axes of responsibility: 1) SUS management; 2) regionalization; 3) planning and programming; 4) regulation, control, evaluation and audit; 5) work management; 6) health education; and 7) participation and social control (Brasil. Ministério da Saúde, 2006). By 2008, 24 of the 26 states had joined. The adhesion of municipalities to the Pact for Health was also significant, 82.5% in 2012, although with significant variations among states (Lima et al., 2012; A. M. M. Pereira, 2014).

In June 2011, the process of decentralization of health received a new direction with the publication of Decree 7.508 / 11, which regulated Law 8.080 / 90, with emphasis on planning, health care and interfederative articulation functions, seeking to guarantee access to and completeness of the SUS by legal and contractual means, as the most appropriate strategy to achieve these objectives when proposing the Public Action Organizational Contract (COAP), an "*agreement to collaboration [...] necessary for the integrated implementation of health actions and services* ", Aiming to consolidate the responsibilities of each sphere of government in SUS management (Brasil - Presidência da República, 2011a, p. 1). Each COAP must be signed by the representatives of the Union, state and municipalities that make up the region in a single contract. This Decree reaffirmed the role of the CGR, already defined by the Pact for Health, which became known as the Regional Interagency Committee (CIR). By the end of 2016, few states and municipalities had signed the COAP.

Challenges of decentralization in a federal context

The administrative and managerial structure of the Brazilian federation is based on a threefold arrangement (federal, state and municipal) and its political configuration is multiparty (35 political parties). This means a high degree of complexity within intergovernmental relations, characterized by significant political, economic and institutional differences between each federal entity. The strengthening of integration

[6] Regarding sanitary responsibility, the Pact for Health states that: "Some responsibilities assigned to municipalities must be assumed by all municipalities. The other responsibilities will be allocated according to the agreement and / or the complexity of the service network located in the municipal territory. With regard to the responsibilities assigned to the states, they must be assumed by all of them. Regarding the management of the service providers, the standardization established in NOAS SUS 01/2002 is maintained. The references in the NOAS SUS 01/2002 management conditions of States and municipalities are replaced by situations agreed in their Term of engagement management "(Brazil, 2006, p. 16).

processes (vertical and horizontal) and the establishment of cooperative relations between the spheres of Government, as well as a clear definition of the role of each one of them is important to avoid the ungovernability of common projects and overlapping of actions or the lack thereof in specific areas (A. M. M. Pereira, 2014) .

The definition of roles assumes the establishment of limits on the activities of each entity. This issue becomes complex at the federal level, where autonomy is a constitutional principle. Coexistence of autonomy and interdependence requires the establishment of mechanisms of *checks and balances* (forms of mutual supervision) and negotiation processes between the levels of Government that respect the autonomy and the pluralism which is characteristic of the federal model(Almeida, 2001) . The institutional model, therefore, must be based on the interrelationship between the different administrative spheres and strengthening of community participation.

This is the case of the SUS, whose decision-making organization is made through democratic spaces and instruments and sharing of management, based on a broad conception of the right to health and the role of the State in guaranteeing this right, since it depends on the articulation between several governmental actors and civil society at the national, state and municipal levels. The agreement of responsibilities for each sphere of government involves two dimensions: the political dimension, necessary for dialogue between the managers themselves and other social actors, and the dimension of the technical actions necessary for the accomplishment of managerial functions (Noronha & Soares, 2001; A. M. M. Pereira, 2014). The managers are organized through Councils (representing the different interests of States and municipalities) and interact in bipartite and tripartite regional committees.

Decentralization of health in Brazil redistributed functions and responsibilities between levels of Government and has opted for the municipalities, which have been given decision-making capacity, skills and resources for the provision of basic health services. However, the decentralized systems that have been formed are heterogeneous, as they reflect historical inequalities between municipalities with different administrative and financial capacities (Arretche, 2004; A. M. M. Pereira, 2014). The majority of Brazilian municipalities (44.0%) had, in 2015, less than 10,000 inhabitants (IBGE, 2015) , with large budgetary difficulties and were therefore dependent on the federal Government to maintain social policies in their territories. Despite the expansion of the autonomy of the States and municipalities over the 27 years of implementation of the SUS, there are still challenges to be overcome in the field of decentralization and

democratization of management and access to healthcare in Brazil. In addition, new forms of administrative management have been brought about by states and municipalities and, for some, are challenging the founding principles of SUS.

The Private Sector in SUS Management

When the SUS was created, given the political tension between the those in favor of privatizing health and those in favor of nationalizing health, it was decided not to nationalize private, philanthropic or non-governmental public services that would provide assistance to the old social security system. However, in order for these services to be integrated into a single network, the function of making contracts and agreements with these autonomous providers was delegated to the municipalities and states, following up their performance.

The context of the crisis of the State during the 1990s gave rise to the idea that countries should carry out a reform of the State, diminishing its role (minimum state) and assuming the market as the main model for reform. In Brazil, state reform was carried out on the basis of the 1995 State Reform Master Plan (Brasil, 1995). In this paper, it was emphasized that reform would be essential for the efficient implementation of public policies. Melo & Tanaka (2001) emphasize that the government's proposal would be based on two aspects. The first would be the transfer to the private sector of those activities that can be controlled by the market, in other words the privatization of certain sectors that were under the responsibility of the State. The second aspect would be the decentralization to the non-state public sector of the execution of services that do not involve the exercise of state power. For the authors, the measures proposed by the government in 1995 reveal a clear direction towards the State's lack of accountability to public policies and, particularly in health, the reinforcement of the image of an SUS directed only at the poorest population (Idem, 2004).

The proposed strategy for the reform of the Brazilian state had as one of the objectives to provide the conditions for the implementation of the managerial administration model in the state services (Brasil, 1995). The administrative reform of the Brazilian State was defined by Constitutional Amendment No. 19, dated June 4, 1998, after a long process of negotiation and political dispute in the National Congress.

In order to respond to the decentralization and deconcentration guideline recommended in the master plan, activities of the non-state services sector are carried out by non-profit institutions. In the managerial management model, the management contract becomes an important tool insofar as it enables a rearrangement of the functions of the State in which the control mechanisms are considered key elements for the efficiency of public administration (Hortale & Duprat, 1999).

In the context of reform in the 1990s, the model of management contract with social organizations was widely defended with arguments ranging from the inefficiency of the public administration, through corporatism of the professional categories to political manipulation by the governments (Carneiro Júnior & Elias, 2003).

Social Organizations (OS), regulated by Provisional Measure No. 1591/97, later transformed into Law (No. 9.637 / 98) and Civil Society Public Interest Organizations (OSCIP), regulated by Law No. 9,790/99, assume a central role in Strategy of delivery of services provided by social policies, among which are health and private initiative (Menezes & Leite, 2016).

It is incumbent upon the Executive Branch to qualify, as social organizations, private non-profit legal entities whose activities are directed to different areas, such as health (Brasil - Presidência da República, 1998). According to the terms of the Law, OS qualification is not a bidding procedure but a discretionary one, which carries the risk of the OS being co-opted either by private interests - with the potential of diverting it from the mission for which it was created - or by the bureaucracy of State crossed by interests other than those inherent in the common good. It seems that this risk was foreseen in the formulation of Law 9.637/98, which provides for participation in the collegiate of superior deliberation "*of representatives of the Public Power and of members of the community, of known professional capacity and moral suitability*"(Idem, 1998).

The State of São Paulo was a pioneer when passing on the administration of the hospitals under its responsibility to the Social Health Organizations (OSS). In 1995, there were 14 hospitals with unfinished works, almost all located in the metropolitan region of Sao Paulo, which had your construction financed by World Bank loans throughout the 80s. To resume the construction of those hospitals where the works were more advanced, and where there was smaller judicial backlog in contracts with contractors, the São Paulo State Government handed over the management to the OSS. The qualification of OSS was given through specific legislation in 1998 (Governo do Estado de São Paulo, 1998). By 2017, there were 42 entities qualified as OSS, of which

around half (22 entities) were qualified in the first decade of the 2000s (Governo do Esatdo de São Paulo, 2017).

Due to legal restrictions on staff costs, state and municipal governments have begun to transfer management of health services to outsourced entities such as cooperatives, associations, nonprofit (or for-profit) charities, civil service entities , etc., qualified as social organizations (OS). This movement occurred despite an apparently contradictory message issued by the National Health Council (CNS) in 2005. For the CNS, the qualification of different entities such as OS for the management of health services would be "underhanded ways of transferring state responsibility for health to the Private Sector, which are not in line with the SUS management model, as constitutionally defined "(BRASIL. Ministério da Saúde. Conselho Nacional de Saúde, 2004). The last three National Health Conferences also carried out specific deliberations contrary to the process of outsourcing the management and management of health services and actions by OS and Oscip.

In 1998, two national political parties, then the opposition, filed a Direct Action of Unconstitutionality in the Federal Supreme Court challenging Law 9.637/1998 and XXIV of article 24 of Law 8.666/1993 (Law on Bids). Only in April 2015 did the Court partially adjudicate the Direct Action in the understanding of the validity of non-exclusive public service provision by social organizations in partnership with the public power provided that the conclusion of an agreement with such entities is conducted in a public, objective and impersonal manner, with observance of the constitutional principles that govern the Public Administration (Supremo Tribunal Federal, 2017).

The Brazilian Institute of Social Organizations (Ibross) was created in the same month that the Federal Supreme Court issued its opinion on the Direct Action of Unconstitutionality. Based in the city of Brasília, Ibross intends to disseminate "the health equipment management model - such as hospitals, outpatient clinics, health centers, emergency care units, specialty clinics and emergency mobile service - among others, carried out through partnerships established between social organizations and public power " (Instituto Brasileiro das Organizações Sociais de Saúde, 2017).

The increasing adherence of state and municipal governments to management contracts with OSS shows that, despite all the resistance to this type of management within the public health system, manifested mainly by representatives of the health movement, it represents a further challenge for councils to guarantee the process of *accountability* In these new institutional arrangements. The strengthening of the

activities of entities such as the Health Council, Legislative Assembly, Court of Auditors and the Public Prosecutor's Office in the supervision of contracts and results obtained is one of the central strategies for access and quality to be effectively evaluated.

The challenge of *accountability* In the Unified Health System

The historical process that gave rise to the SUS is inserted in the so-called constitutionalization of social rights. It means that the guarantee of these rights is a necessary condition for the existence of the Brazilian State. Therefore, the central issue when it comes to human rights is "not so much to justify them as to protect them" (Bobbio, 2004: 43), which makes it A political issue. It is on this 'political problem' that the idea of accountability is presented and draws attention to the necessity of the clash between society and government on the interpretation of social rights.

The health reform movement has been able to institutionalize spaces and spheres of participation and negotiation between governmental leaders and civil society, with a view to enabling citizen control of the exercise of the power granted to its representatives (Rocha, 2011). Article 198 of the Federal Constitution presents **Community participation** as a fundamental value for the organization of the health sector (Brasil, 1988). This guideline is reaffirmed as a principle in the so-called Law 8142/1990 which, after intense social mobilization and political dialogue surrounding the health movement, defines participation in the scope of the SUS through health councils and conferences (Guizardi et al., 2004).

Health Councils

The Health Councils were regulated as permanent and deliberative collegiate bodies "*In the formulation of strategies and in the control of the execution of the health policy in the corresponding instance, including in economic and financial aspects* [...] " (Brasil - Presidência da República, 1990b, p. 1). The councils would allow, in principle, the vocalization of interests and the intervention of groups and sectors usually segregated from the plane of political deliberation. The commitments to transparency and democratization become explicit in the equal mode of representation of users and other segments.

Throughout the 1990s, health councils were rapidly established throughout the country: between 1991 and 1993, more than 2,000 Health Councils were organized, and in 1996 it covered 65% of Brazilian municipalities (Tatagiba, 2002). The rapid dissemination and capillarity of health councils are directly related to Law 8142/90, which conditioned the transfer of a series of budgetary resources to the existence of councils. This factor, which functioned as an important factor of induction in the organization of an institutional architecture of social participation, ended up bumping into historical social relations characterized by an unusual coexistence between the archaic and the modern that perpetuate patrimonialistic and clientelistic characteristics of the relation of the elites with the State .

The linking of the transfer of resources to the existence of councils was an important inducement factor in the organization of an institutional architecture of social participation.

Although the constitution of the councils represents an undeniable democratic achievement, the historical experience of more than 26 years of operation of these mechanisms allows us to identify a set of contradictions that need to be overcome so that there is an effective progress and consolidation of the democratization process of the Brazilian State, Therefore, there is a strengthening of a culture of *accountability* and citizenship.

There is no doubt that the councils have broadened the political process of SUS management, but experience has shown that this occurred in a way that is separate from the daily life of health services, with little visibility for the society as a whole that is unaware of its performance and prerogatives (Santos & Bastos, 2009). This finding is reinforced by the recorded difficulties of their political representation, identified by the relationship between the organization of society, decentralization, government transparency and new democratic values (A. M. Campos, 1990).

The parity in the councils, formally assured, has not been sufficient to guarantee a voice and intervention of the popular sectors in the management of health policy due, on the one hand, to the difficulties encountered by the counselors in the socialization of the information of the health policy with the entity represented And, on the other hand, the difficulty of sharing this representation with the community in general. The composition of the councils has also been analyzed as one of its weaknesses, since in many contexts parity was not observed and "*the criteria for choosing representatives are often obscure and strongly influenced by political interference, especially in the determination*

of those who represent the interests of users" (Cotta et al., 2011, p. 1130). The historical patrimonialistic relations of the elite with the State are only overcome only with the letter of the law.

Complaints from counseling boards have been frequent. Some of these instances only exist formally and are controlled by local leaders who configure the agendas and the indication of their components. This led to so many discussions that the National Health Council established Resolution 333 with guidelines for the creation, reformulation, structuring and functioning of health councils (Conselho Nacional de Saúde, 2003).

However, the structural decision-making aspect of the councils and the issue of financing have not been defined in a normative way and the councils, to this day, depend on resources distributed at the discretion of the executive branch, which interferes with their autonomy and capacity for action.

In 2005, the only census of municipal and state health councils was carried out, at the initiative of the federal executive. The census revealed that: 1) the councils had limited resources and infrastructure; 2) State health councils had computer and internet access, but six of them were without an exclusive telephone line; 3) 37% of the municipal councils had no phone line, 59% had a shared line, and only 2% had an exclusive telephone line; 4) almost 70% of municipal councils had no computer and more than half had no access to the internet; 5) 25 of 27 State health councils had the Secretary of Health as president, or a representative of the managerial sector; 6) in 67% of the municipal councils the Presidents were the managers, 68% of which had held (Moreira et al., 2006) an election.

The councils were set up to bring civil society closer to the management of health policy, but it is observed that they ended up concentrating the political power of the managerial sector. There was also a lack of knowledge of a significant part of the councilors on their duties and functions and that the councils reproduce the asymmetries of access to information and organization of civil society groups (Cotta, Cazal, & Rodrigues, 2009).

The asymmetry of information between governors and governed in the management of the SUS is aggravated by the technical-scientific language, resulting in the difficulty of intervention of the popular groups and in the prevalence of a bureaucratic-administrative functioning of the councils, to the detriment of the debate and the political mobilization around processes, priorities and definitions of the SUS.

Cotta, Cazal & Rodrigues (2009) analyzed the experience of a municipal health council and found that, in practice, counselors do not interfere in the decisions about allocation of health resources. This case seems to represent the reality of most health councils.

It is observed that the dynamics and effectiveness of the health councils are dependent on the local political culture, so that these instances express the relations of strength and the organizational capacity of the community, but interfere little as an isolated device of democratization and transformation of values and political practices. A perspective of improving this experience would be the strengthening of internal and/or external networks with other collegiate and participatory bodies of society and even with other public bodies responsible for overseeing the actions of executive power, such as the Ministry Public, the Courts of Accounts and the Legislative branch.

Health Conferences

Although regulated by law 8142/1990, Health Conferences already existed in Brazil. Between 1941 and 1980, seven national consultative health conferences were held. The Ministry of Health had the authority to convene a conference at its convenience. The guests, usually technical experts and specialists in Public Health, played a mostly technical advisory role to the rulers. In 1986, the 8th National Health Conference (8th CNS) marked a difference, both for its wide-ranging call for popular participation and for the debate on the bases and values that would later form the SUS.

The experience of the 8th CNS served as a reference for the institutionalization of Conferences in Brazil, based on Law 8142/1990, which regulated its implementation. These conferences have upward dynamics, that is, every four years each Brazilian municipality holds its municipal health conference that convenes with the respective state health conferences. Finally, such conferences serve as the basis for the four-yearly national conference on health. After the Federal Constitution of 1988, seven national health conferences were held.

Since the birth of the SUS, the conferences have become a stage of great participation of civil society, becoming the mobilization of the public debate around the issues affecting the materialization of the right to health in Brazil. The rules of composition and development of the work are defined in each edition by the National Health Council. The upward characteristic is necessary for the survey, selection and legitimation of the analyzes and proposals that will be debated at the national stage, which involves thousands of participants throughout the national territory.

Although the guarantee of parity composition does not ensure, per se, that user representatives become protagonists in public policy, conferences have become an important space for social participation, producing visibility of local social demands and enabling relevant analyses of the health situation and of the problems experienced in the daily life of the SUS (Côrtes, 2009). On the other hand, the conferences reveal a restricted capacity to interfere in the definition of priorities and to influence the health policy unfolding, since public managers do not have sanctions or damages for disregarding their recommendations and deliberations in the formulation of projects and programs and in the conduct of the Decision-making process of health policy (Müller, 2015). The resolutions of the conferences end up having little guidance in the planning and management of the SUS and, therefore, with little symbolic space in the society as a whole (G. W. de S. Campos, 2016). This does not mean the conferences do not have significant effects, but these effects need to be better studied and understood, because analyses restricted to normative aspects do not make it possible to elucidate the role that CNS plays in the health area of the country (Côrtes, 2009).

In 1992, in a neoliberal context, the 9th CNS had a prominent role in dialogue and social mobilization and guaranteed the constitutional project of the SUS in an adverse situation to the right to health (Gadelha, 2015). The 10th CNS, in turn, played an important role in legitimizing, from a municipal perspective, of decentralization, resulting in the increased empowerment of municipal managers (Idem, 2015). This influence on the decision-making process of health policy can be explained by the social recognition of conferences as a legitimate space of diversity and heterogeneity of the different interests represented (Stotz, 2005).

Providing a potential space of social agreement between actors and social groups with diverse interests, the conferences end up allowing the diversification of themes and political positions with greater inclusion in the participatory process. However, despite the increased mobilization and participation of in the conference process, one of the components of the SUS crisis is due to the low social legitimacy among the larger portions of the population, who know little about and are little represented in the participating participatory bodies.

The last CNS, in 2016, occurred in the context of a parliamentary coup to the fragile Brazilian democracy. Its organization expanded the previous stages with less formalized events and with popular plenaries throughout Brazil in a strategy articulated with formative intent, aiming to qualify the discussion and engage it in other spaces and

scenarios. With plenary sessions open to the participation of the population, in an autonomous way and different modes of organization and themes, it was an attempt to socialize the debate around health policy and to provide the expression and inclusion of new actors, signaling that "*The strength of participatory management depends on the connection with social movements and public opinion*" (G. W. de S. Campos, 2016, p. 5).

An important aspect of NHAs is the creation of flexible areas of accountability directly to the population. From the 10th CNS, in 1996, emphasis was put on the creation, in the health area, of new mechanisms of participation such as ombudsmen and *Hotline Services at all levels of the SUS, linked to Health Councils.* In In 2003, the Ministry of Health created the SUS General Ombudsman's Office for receiving suggestions from citizens throughout Brazil with an obligation to respond in the short term. Because it is a direct channel between the citizen and the management, the ombudsman's office is an important instrument for *accountability*.

The Ombudsman's Office as an Accountability Strategy

Serapioni (2014) highlights the growth and diversity of civil participation experiences, coupled with the more demanding democratic context of State responses in the area of social rights and the direction of public policies, have enabled the strengthening of two important and strategic examples of *accountability*: the public prosecutor's office[7] And the ombudsmen (Lyra, 2011a).

The public ombudsman's office is a form of exercise of societal control of republican institutions (Idem, 2011). Ombudsmen listen to citizens' complaints about the services provided, especially in social areas, and by principles governing public administration (legality, impersonality, morality, publicity and efficiency) in the defense of human rights and the promotion of justice and social inclusion (Lyra, 2011a; L. H. Pereira, 2002). The ombudsman brings the public power of citizens closer together, consolidating existing rights as well as offering answers to concrete problems, opening institutions up to society.

ParticipaSUS inaugurates participatory management as a national policy, although incipient in terms of implementation and operational proposals. According to this document, "it is the Ombudsman's role to carry out the referral, guidance, follow-up

[7] On the role of the public prosecution service see section on judicialization.

of the demand and the return to the user, in order to provide an adequate solution to the problems presented, in accordance with SUS principles and guidelines" (Brazil (Ministry of Health, 2009, page 23) (41). The first experience that comes close to what we call the Ombudsman's Office of the SUS dates back to 2002, since it added all contact services with MS citizens (Tele Service Center, Disque Saúde and Citizen Assistance Service User SUS or SAC-SUS) (Brazil, Ministry of Health, 2010) (52). In 2003, the General Ombudsman Department of the SUS (DOGES) was created with responsibilities to propose, coordinate and implement the SUS National Ombudsman Policy.

The implementation of the SUS Ombudsman's Office, through the creation of the General Ombudsman Department of the SUS (DOGES) in the Ministry of Health, was conceived as an instrument for visibility of the State, for the configuration of democratic spaces of popular participation and also as a management tool (Brasil. Ministério da Saúde, 2010). The promotion of the implementation of health ombudsmen in the states and municipalities, in turn, would have the objective of assisting and complementing the actions of health councils, inter-agency bodies, regulatory agencies and auditing systems (Brasil. Ministério da Saúde, 2013, p. 8).

The ombudsman may be the only organ able to monitor the day-to-day functioning of the Brazilian public administration and to ensure *accountability*, although its association with health councils, proposed at the last CNS, will still be a challenge (Lyra, 2011b).

The Judicialization of Health as an Accountability Strategy

Since the 1990s, the growing participation of legal institutions in the direction of public policies has been highlighted, guided by the notion of *complex citizenship*[8], according to which "*the activities of agents of the legal system, as well as of social agents, are interpreted as political action that seeks, in terms of the application of law, solutions and resolutions for dilemmas arising from social conflicts*" (Eisenberg, 2002, p.46). It is a form of access to public services by an indirect means, a kind of triangulation.

[8] "complex citizenship" would expand citizenship in addition to the issue of political representation, since it would find in other instances, such as the Judiciary, new forms of political action, i.e. the judiciary will set off to access the Executive. This occurs, for example, with the proposal of direct action of Unconstitutionality and security and warrants and issuance of Subpoena.

The pursuit of the guarantee of rights by judicial means is also associated with the idea of *accountability*. Insofar as a series of social rights are constitutionalized, the judicial apparatus becomes a way of making leaders responsible for the realization of these rights. This process of judicialization essentially means taking public policies in the form of legal process (Tate & Vallinder, 1995) .

In Brazil, this phenomenon has two central actors: the Judiciary Branch and the Public Prosecutor's Office (MP), with distinct methods. The direct connection between the citizen and the Judiciary (most common phenomenon in Brazil) is aimed at guaranteeing their individual right of citizenship, since the Public Prosecutor's Office aims, in most cases, to guarantee collective rights.

The judiciary does not propose actions, only receives them and judges them, maintaining a passive attitude until it is called to the resolution of the litigation. The Public Prosecutor's Office is a permanent institution responsible for defending: a) the legal order; B) the democratic regime; C) unavailable individual interests (immanent to human personality and belonging to a collectivity) and; D) collective and diffuse rights (characterized as encompassing those who have something in common)[9]. Therefore, it is autonomous and is not subject to any of the Powers of the Republic, being an unelected institution whose main function is to watch over the promotion of constitutional rights, among them the right to health, according to the art. 197 of the Constitution.

Case law has shown that the "*Public Prosecutor's Office has its raison d'être in the need to activate the Judiciary, at points where it would remain inert because the attacked interest does not concern specific people, but the whole community*" (Bastos, 1998, p.123). In the field of health, its performance as an excellent fighting partner is linked to the organized groups of society (Dallari, 1988; F. R. de S. Machado, 2006; Torres-Fernandes, 1999). The dialogue between the Public Prosecutor and health councils constituted an important strategy to combat the accentuated process of clearing examples of participation, since both the PP was qualified in its work, and it "empowered" the councils in their demands.

The receptivity of the Judiciary to actions, demanding individual rights or collective rights, has shown itself to be diverse. In general, more results are obtained in

[9] More specifically, the collective rights and interests that transcend the scope of individual benefit, reaching the area of benefit of a group of people, and that undeniably have a preponderant public nature.

individual cases than in cases directed by the Public Ministry in the health area, possibly because such actions directly affect the conduct of public policies for the sector.

The current framework of health judicial demands is marked by difficult situations and diverse opinions. The construction of the Federal Constitution of 1988 was written by a National Constituent Assembly (ANC) formed by strong tension between opposed groups. For a consensus to be possible at that time, the creation of broad laws and, at times, vacancies was needed, leaving "*for the future the realization of the values and principles enshrined in the Charter, depending on the new arrangement of forces following the democratic process that the Constitution itself should inaugurate*" (Vianna, Melo, Burgos, & Carvalho, 1999, p.141). For the authors, the Magna Carta had a paradox: the more indeterminate, the greater the possibility of conflicts in its interpretation between the managers of the three federal spheres, and, on the other hand, the greater the discretion of the Judiciary. This new role attributed to the Judiciary meant an unavoidable expansion of its action.

For many health managers, judicialization is a problem to be tackled. At the other extreme, for many patients and users, the Judiciary is the last alternative to access to the maintenance of their rights. It is possible to identify in Brazil at least four fundamental factors in the generation of judicial demands in health: 1) insufficiency of the system; 2) care gaps (diseases without clinical protocols in the SUS); 3) conflicts between scientific evidence and medical opinion; and, 4) commercialization of health (induction of technological incorporation and of drugs to SUS stimulated by business groups).

Health management should not, in principle, be limited to service scheduling by lawsuits, but should plan service to which all people have access. In this sense, lawsuits can serve as indicators of access and point out failures in the system, indicating neglected sectors. However, analysis of lawsuits has called attention to the fact that the "right to health" means only the idea of access to services and the consumption of medicines. As Vieira points out (Vieira, 2008, p. 2), "*Completeness for the courts is more closely associated with the notion of consumption*" and the right to health" *with the supply of medicines, reduced to curative and palliative actions, without considering the fundamental character of promotion and prevention of diseases and injuries*".

In general, actions in the courts plead for medicines, many of them outside the list of the SUS and/or without the authorization of the National Health Surveillance Agency (Anvisa) to be marketed in Brazil. The approval by the public power of a drug or

any unregulated health input in Brazil transforms the Judiciary into a vocalizer of two citizenships in Brazilian society: the one that has access and the one that does not have access to the judiciary. In addition, some demands are stimulated by commercial interests that aim at the incorporation of certain inputs to the SUS supply list.

According to the Ministry of Health, from 2010 to 2014, R$2.1 billion (About US$650 million) was spent on lawsuits for the acquisition of medicines, equipment, supplies, surgery and judicial deposits (Brasil. Ministério da Saúde, 2015). That is, to the extent that Judges grant injunctions for the acquisition of health goods or services, they must be acquired by the Executive Branch (under the risk of imprisonment for the manager), generally without bidding. In this sense, the judiciary intervenes directly in the budget allocation determined by the Legislative Branch and in the conduct of the public health policy established by the Executive Branch. According to Borges (2007, p. 23), "*the exercise of the subjective right against the State by an individual may affect the exercise of the subjective right of other citizens, constituting in these cases an exclusive and rival consumer good*". That is, health ceases to be a right of citizenship guaranteed to the entire population to become a private consumer exclusive, now disputed by citizens, reinforcing the historical idea of several citizenships in Brazil.

However, the process of judicialization is an effect of democracy itself and only possible in a context of universal policies. Thinking about the judicialization requires a broad public debate about the state's constitution and its bill of rights and, in the case of health, about the quality and breadth of public services. Judicialization is not the cause of the current situation in which Brazilian public health finds itself, but a result of these conditions (F. R. de S. Machado, 2010). From the perspective of the patient and of the user judicialization is part of the logic of *accountability,* either by individual or collective action. For the Manager, judicialization can be an undue interference in matters of technical definition of priorities. Therefore, the insertion of health councils, as an important actor in the dialogue between the judicial and executive branches, has the potential to make the judicialization of health more a strategy of exercising accountability.

Decentralization, Participation and Equity: the case for health among native Brazilians

The processes of decentralization and popular participation were based on the search for equity that is, prioritizing the provision of health care for the most vulnerable

sections of the population. Despite a proportionately small contingent in relation to the total Brazilian population, taking health care to the natives represented a huge challenge. Generally living in hard-to-reach reserves, but with national leaders who demanded differentiated treatment for their demands, the construction of a participative model that was coherent with the cultural traditions of this segment of the population was carried out from the promulgation of the CF88.

Brief contextualization

Information on indigenous populations in Brazil is disparate since there is no integrated system that allows greater knowledge about the sociodemographic characteristics of this population segment. In the Demographic Census of 2010, a little more 817 thousand people declared themselves indigenous, of which 502,783 lived in rural areas and 315,180 inhabited Brazilian urban areas. Of this contingent, 305 different ethnic groups and 274 indigenous languages were registered (IBGE, 2012).

The National Indian Foundation (Fundi)10, in turn, has estimated the indigenous population living in indigenous lands at about four hundred thousand people. Indigenous Peoples are present in the five regions of Brazil, and the Northern region has the largest number of individuals, 305,873 thousand, 37.4% of the total (Funai, 2010).

It is worth noting that native Brazilians are Brazilian citizens who can vote and stand for election. In 2000, for example, eighty native Brazilians were elected as council members, deputy mayors and one mayor. In the 2008 elections, as Ferreira notes (2012, p. 40), more than three hundred and fifty indigenous candidates were counted in one hundred and fifty Brazilian municipalities, spread over 21 federal states.

National Policy on Health Care for Indigenous Peoples

The current model for the organization of health services for indigenous areas began in the framework of the 8th CNS, when the 1st National Conference on Health for Indigenous Peoples (CNSPI) was held. But it was in the wake of the discussions of the 2nd CNSPI in 1993 that the current model was endorsed by the indigenous movement and health professionals working in the area (Athias & Machado, 2001). Already in 1991, responsibility for the health care of the indigenous population had been transferred from Funai to the Ministry of Health and the text pointed to the creation of a differentiated model (Brasil - Presidência da República, 1991). In the same year of 1991, the National Health Foundation (FUNASA) was created within the

[10] Funai was created by law No. 5,371, of 5 December 1967, under the Ministry of Justice, and is the Coordinator and main executor of indigenous policy of the Federal Government.

Ministry of Health. The 2nd CNSPI reaffirmed federal responsibility for indigenous health care and defended the model based on the Special Indigenous Sanitary District (DSEI). Social control was also the object of this Conference and the creation of the District Indigenous Health Councils was proposed, with parity composition and deliberative character in relation to health actions in its area of coverage (Ferreira, 2012; Ferreira, Portillo, & Nascimento, 2013). The decision to establish a health subsystem for the indigenous population based on sanitary districts was a measure to avoid that the health care of this part of the population would be at the mercy of the local political oscillations in the case of the process of radical municipalization of health defended to the During the 9th CNS. Resistance to decentralization of indigenous health care comes from historical differences around disputes over land and ethnic conflicts in which the municipalities were involved. In 1999 a Federal law was approved that created the Distinctive Subsystem for indigenous health (Brasil - Presidência da República, 1999).

The Dseis are organized independently of the State and municipal divisions, and vary significantly in relation to size and ethnic composition. Each district has a staff of FUNASA that manages and transfers financial resources to government agencies (municipalities) and partner with non-governmental organizations to formulate and administer the primary care programs in indigenous areas, as well as establish a network of reference with the municipalities, hospitals and other institutions for the provision of specific services in and out of the areas.

The National Policy of health care for indigenous peoples (PNASPI) was discussed throughout the 3rd CNSPI held in May 2001. In that same year, the National Health Council approved the proposal of the Policy and the Ministry of Health assumed the PNASPI through the publication of Ministerial Ordinance No. 254 of January 31, 2002 (Brasil. Fundação Nacional de Saúde - Funasa, 2002). For its implementation, PNASPI is based on the "adoption of a complementary and differentiated model of service organization - aimed at the protection, promotion and recovery of health - that guarantees the Indians the exercise of their citizenship in this field" (2002, p. 6).

In addition to the Indigenous Health District Councils, the participation of indigenous people is also carried out by the Local Indigenous Health Councils, consultative bodies made up of indigenous people who organize themselves by village, set of villages or by river channels. According to Ferreira (2012), In 2012 there were 337 local councils of indigenous health, with their own rules of operation and respecting the form of community organization.

The District Indigenous Health Councils suffer the same contradictions and difficulties as Municipal and State Health Councils noted throughout this work. There is evidence of lack of commitment on the part of managers with the questions asked by the indigenous population. The Councils are configured as a space of intercultural conflicts and, because of their structural weaknesses and difficulties in effective functioning, such conflicts end up not having resolute outcomes (Ferreira, 2012). However, the author emphasizes the importance of the Councils for having "great potential for inclusion of indigenous peoples, traditionally excluded from the debates about governmental actions" (Ferreira, 2012, p. 118).

During the period, five National Health Conferences for Indigenous Peoples were held, the last one being held in December 2013 in the city of Brasília. After this, no other conferences on the subject of indigenous health have been held.

Brazilian legislation affects accountability

The Brazilian legislation highlights six laws or decrees whose approval had a strong relationship with practices associated with *accountability* of health in Brazil: 1) Constitutional Amendment 29 (EC29), of 2000; 2) Law 12.438, of 2011; 3) Decree 7.508, of 2011; 4) Law 12.466, of 2011; 5) Law 12.527, of 2011; 6) Law 141. of 2012.

EC 29, one of the greatest achievements of the health sector, ensured a minimum application of resources by each federal health entity, establishing a percentage of expenses based on the income of the entities[11]. This law was fundamental for the existence of a public health system, as it ensured continuity of public funding. On the other hand, this law has brought about a need for transparency in the application of resources, increasing the possibility of social control in the collection of managers, although the question of how to spend the resource remains open.

Law 12.438, of 2011, sought to ensure the power of health councils on the accountability of managers: "*the manager of the SUS, in each sphere of government, shall submit quarterly to the corresponding health council and, respectively, in a public hearing, to the city councils, legislative assemblies and to the two Houses of the National Congress, a detailed report regarding their performance in that period [...] highlighting, among others, information on the amount and source of funds invested, audits completed or initiated in the*

[11] Municipalities should spend 15% on health. States should invest 12%. Union has guaranteed a minimum and increasing contribution according to the variation of GDP.

period, and supply and production of services in the own, contracted or contracted assistance network (Brasil - Presidência da República, 2011b).

Decree 7,508 of 2011 regulated Law 8080 regarding health planning; health care and interfederal dialogue and incorporated, under the terms of the previous laws, agreements that generated disputes through judicialization both between the federal entities and between society and leaders. The Decree gave legal status to the SUS drug list, recognizing the National Rationale for Health Actions and Services (RENASES) and the National List of Essential Medicines (RENAME) as legal and transparent mechanisms of health management (Brasil - Presidência da República, 2011a). In this sense, both managers can protect themselves from misplaced lawsuits, as users may require more secure access to their rights of citizenship.

Law 12.466, of 2011, regulated management bodies that, although fully functioning, did not have legal protection. Thus, bipartite[12] and tripartite[13] intermanagement, The National Council of State Secretaries of Health (Conass) and the National Council of Municipal Health Secretaries (Conasems) had institutional recognition and part of their activities could have government funding (Brasil - Presidência da República, 2011c).

Law 12,527 enacted in 2011 solved historical questions of the performance of the public sector and its relationship with civil society. Known as the Access to Information Law, its text can be considered an expression closer to what the literature has recognized as *accountability,* because it guarantees access to all the decisions and acts of the powers of the republic (Brasil - Presidência da República, 2011d).

Finally, Complementary Law No. 141, of 2012, defined 12 areas of action in which the State can apply the funds from the health fund[14] and clarified which areas, even related to health, are not considered as health actions (Brasil - Presidência da República, 2012). One of the articles of the Complementary Law unites perspectives on *accountability*, since it presents both the need for accountability of managers and popular participation. Under the law, public access to the "*Information on the public budgets of the Union, the States, the Federal District and the Municipalities*" was assured, and

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[12]State spaces of articulation and political agreement that aim to guide, regulate and evaluate the operational aspects of the decentralization process of health actions. This committee includes municipal managers and the state manager. (http://bvsms.saude.gov.br/bvs/publicacoes/manual_sus_screen.pdf)
[13]Instance of articulation and agreement at the federal level that brings together managers from the three governmental spheres.
[14] It does not mean that other sectors can not receive funding, but that this should come from another source.

also reinforced the role of health councils, both as tax inspectors and judges of accountability, as legitimate instances of political proposals (2012).

Conclusion: democracy and decentralization, conditions for *accountability* in Brazil

Even in the face of such progressive legislation, much of the health advice in Brazil remains mechanical and part of uncritical approval of accounts managers. However, despite acknowledging the limits of dynamics of health boards in Brazil it is very important to reaffirm its importance to the consolidation and advancement of the SUS in the country. The work of the National Health Council has sought to consolidate and expand its political role in the health field, but both its work and health councils depend on a democratic openness of leaders. During her tenure, President Dilma Rousseff made great strides in respecting and strengthening the participatory bodies in the country, in 2014 by publishing Decree 8.243, which created the National Policy on Social Participation to work in various social policies (Brasil - Presidência da República, 2014). However, a few months later the Brazilian parliament overturned this decree as well as the President herself. The Parliament's repudiation of this law gives a clear dimension of the impasses to the advancement of *accountability* in Brazil. Accountability to Brazilian society, although present at the time of its constitution, does not seem to have established itself as an ideal in the conduct of public affairs in Brazil. Many of the difficulties of implementing the SUS since its origin are related to this issue.

Thus, several studies have pointed to both structural difficulties (Draibe, 1998), As well as economic, political, and institutional aspects in the construction of the SUS (H. Cordeiro, 2001; Levcovitz et al., 2001; Lima et al., 2012; C. V. Machado, 2012; Noronha & Soares, 2001; Ribeiro, 2009). These include the country's socioeconomic inequalities, governed by the imperative of inflation control, macroeconomic adjustment, political crises, and the neoliberal priorities of national executives in the 1990s. In addition, the vulnerability of the health sector and the challenges faced by institutions (Ministry of Health, State Secretaries of Health and Municipal Health Secretariats, as well as by the National, State and Municipal Health Councils) to carry out the management of a new organizational model in health (A. M. M. Pereira, 2014) Characterized the conjuncture conditioning the trajectory of SUS decentralization in the process of redemocratization and state reform.

The redemocratization of the country brought the reorganization of the territorial power and the institutionalization of new actors from the Government and society in the political arena as opposed to restriction of autonomy suffered by States and municipalities in the dictatorial period. In the process of decentralization of the SUS, several actors and institutions are permanently involved in the construction of the system (Central Government and Ministry of Health, State Government, State Health Secretariat (SES) and CONASS, Municipal Governments, SMS), CONASEMS and COSEMS, CIT, CIB and CIR, in addition to the National (CNS), State (CES) and Municipal (CMS) Health Councils). However, as reality has shown, the relationships constituted (made and periodically remade) between these actors do not always seek the same objective. In fact, these are conflicting and often fragile arrangements. Throughout this text, we have discussed some of these weaknesses, but it is important to emphasize that the lack of SUS social support is one of the main issues of this process.

The SUS trajectory emphasized the decentralization to the municipalities, concomitant with the development of institutional capacity for SUS management, valuing the role of the state manager in the conduct of this process. In addition, this trajectory was characterized by the progressive transfer of responsibilities, attributions and resources from the federal level to the municipal and state levels, and by the institution of the Tripartite (CIT), Bipartite (CIB) and Regional Interagency Committees (CIR) Aiming to effect the federative articulation in health and promoting shared and cooperative management

The construction and consolidation of a single, decentralized health system involves: 1) articulation and commitment of managers at all three levels of government to shared management and funding; 2) structuring a network of health services capable of meeting the needs of the population, from primary to tertiary care, including actions to promote health and prevent the risk of becoming ill; 3) organization of these services in the territory, through self-sufficient health regions up to the defined level of care, with national coverage and guarantee of sufficient financial resources; Participation of society in the management of these systems (A. M. M. Pereira, 2014).

The model of cooperative federalism among the three bodies of the federation, proposed constitutionally, still faces challenges in its consolidation. In the context of a shortage of financial resources, the practice of predatory competition between federative entities ends up overlapping with negotiation and cooperation, negatively affecting the

realization of universality, equality and integrality of health care throughout the national territory.

Lastly, it is important to mention the recent Amendment to the Constitution (PEC55), which aims to limit the expansion of social spending for 20 years. If health spending was already in deficit, now it will be even worse. It is not yet possible to evaluate the impact of this law on the material life of the Brazilian population, but it can be said that it was the biggest legal setback since the creation of the SUS under the 8080/90 law. We do not know what lies ahead, the only certainty is that without social participation and without accountability on the part of the rulers, the progress we are experiencing today will be eliminated.

Bibliographic References

Almeida, M. H. T. de. (2001). Federalismo , Democracia e Governo no Brasil: Idéias, Hipóteses e Evidências. *Bib – Revista Brasileira de Informação Bibliográfica*, *51*, 13–34. Retrieved from http://www.anpocs.com/index.php/universo/acervo/biblioteca/periodicos/bib/bib-51/518-federalismo-democracia-e-governo-no-brasil-ideias-hipoteses-e-evidencias/file

Arato, A. (2002). Representação, soberania popular, e accountability. *Lua Nova: Revista de Cultura E Política*, *n. 55/56*(55-56), 85–103. http://doi.org/10.1590/S0102-64452002000100004

Arretche, M. (2004). Federalismo e políticas sociais no Brasil: problemas de coordenação e autonomia. *São Paulo Em Perspectiva*, *18*(2), 17–26. http://doi.org/10.1590/S0102-88392004000200003

Bastos, C. R. (1998). *Curso de Direito Constitucional* (18ª ed.). São Paulo: Saraiva.

Bobbio, N. (2004). *A Era dos Direitos*. (Nova Editora, Ed.) (7ª ed). Rio de Janeiro: Elsevier Editora Ltda. Retrieved from https://direitoufma2010.files.wordpress.com/2010/05/norberto-bobbio-a-era-dos-direitos.pdf

Borges, D. da C. L. (2007). *Uma Análise das Ações Judiciais para o Fornecimento de Medicamentos no Âmbito do Sus : o caso do Estado do Rio de Janeiro no ano de 2005*. Fundação Oswaldo Cruz. Retrieved from https://www.arca.fiocruz.br/bitstream/icict/4609/2/968.pdf

Braga, J. C. de S., & Paula, S. G. (2006). *Saúde e Previdência: estudos de política social*. (Hucitec, Ed.). São Paulo: Hucitec.

Brasil. Decreto nº 78.307, de 24 de Agosto de 1976: Aprova o Programa de Interiorização das Ações de Saúde e Saneamento no Nordeste e dá outras providências (1976). Brasil: Diário Oficial da União - Seção 1 - 25/8/1976. Retrieved from http://www2.camara.leg.br/legin/fed/decret/1970-1979/decreto-78307-24-agosto-1976-427254-publicacaooriginal-1-pe.html

Brasil. Constituição da República Federativa do Brasil de 1988, Imprensa Nacional 1–139 (1988). Retrieved from http://www.planalto.gov.br/ccivil_03/constituicao/ConstituicaoCompilado.htm

Brasil. (1995). Plano Diretor da Reforma do Aparelho do Estado. Brasília: Documentos da Presidência da República. Retrieved from http://www.bresserpereira.org.br/Documents/MARE/PlanoDiretor/planodiretor.pdf

Brasil - Presidência da República. Lei 8080 de 19 de setembro de 1990: Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências (1990). Brasil: Diário Oficial da União.

Brasil - Presidência da República. Lei Nº 8.142 de 28 de dezembro de 1990: Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS} e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências (1990). Diário Oficial da União. Retrieved from http://www.planalto.gov.br/ccivil_03/leis/L8142.htm

Brasil - Presidência da República. Lei Nº 9.637 de 15 de Maio de 1998 (1998). Diário Oficial da União.

Brasil - Presidência da República. Decreto Nº 7.508 de 28 de Junho de 2011: Regulamenta a Lei no 8.080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde (SUS), o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras pr (2011). Brasil: Diário Oficial da União. Retrieved from http://www.tjdft.jus.br/institucional/comite-

executivo-distrital-da-saude/legislacao/decreto-no-7.508-de-28-de-junho-de-2011/view
Brasil - Presidência da República. Lei N° 12.438 de 6 de Julho de 2011 (2011). Brasil: Diário Oficial da União. Retrieved from http://www.planalto.gov.br/ccivil_03/_Ato2011-2014/2011/Lei/L12438.htm
Brasil - Presidência da República. Lei N° 12.466 de 24 de Agosto de 2011 (2011). Diário Oficial da União. Retrieved from http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2011/lei/L12466.htm
Brasil - Presidência da República. Lei N° 12.527 de 18 de Novembro de 2011 (2011). Diário Oficial da União. Retrieved from http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2011/lei/l12527.htm
Brasil - Presidência da República. Lei Complementar N° 141 de 13 de Janeiro de 2012 (2012). Diário Oficial da União. Retrieved from http://www.planalto.gov.br/ccivil_03/leis/LCP/Lcp141.htm
Brasil - Presidência da República. Decreto N° 8.243 de 23 de Maio de 2014: Institui a Política Nacional de Participação Social - PNPS e o Sistema Nacional de Participação Social - SNPS, e dá outras providências (2014). Brasil: Diário Oficial da União. Retrieved from http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2014/decreto/d8243.htm
Brasil. Ministério da Saúde. (1993a). *Descentralização das Ações e Serviços de Saúde: a ousadia de cumprir e fazer cumprir a Lei*. (Ministério da Saúde. Sistema Único de Saúde, Ed.). Brasilia: Ministério da Saúde. Retrieved from http://bvsms.saude.gov.br/bvs/publicacoes/cd09_02.PDF
Brasil. Ministério da Saúde. Portaria N° 545 de 20 de Maio de 1993: Estabelece normas e procedimentos reguladores do processo de descentralização da gestão das ações e serviços de saúde, através da Norma Operacional Básica-SUS 01/93, Diário Oficial da União 1–9 (1993). Brasil: Diário Oficial da União. Retrieved from https://dre.pt/application/dir/pdf2sdip/2013/07/140000000/2316423164.pdf
Brasil. Ministério da Saúde. Portaria N° 2.203 de 5 de Novembro de 1996 (1996). Brasil: Diário Oficial da União. Retrieved from http://www.saude.mppr.mp.br/arquivos/File/kit_atencao_perinatal/legis/portaria_4279_2010_diretrizes_rede_as.pdf
Brasil. Ministério da Saúde. Portaria N° 95 de 26 de Janeiro de 2001 (2001). Brasil: Diário Oficial da União. Retrieved from http://bvsms.saude.gov.br/bvs/saudelegis/gm/2001/prt0095_26_01_2001.html
Brasil. Ministério da Saúde. Portaria N° 373 de 27 de Fevereiro de 2002 (2002). Brasil: Diário Oficial da União. Retrieved from http://www.saude.mppr.mp.br/arquivos/File/kit_atencao_perinatal/legis/portaria_4279_2010_diretrizes_rede_as.pdf
Brasil. Ministério da Saúde. Portaria N° 399 de 22 De Fevereiro de 2006: Divulga o Pacto pela Saúde 2006 –Consolidação do SUS e aprova as Diretrizes Operacionais do Referido Pacto (2006). Brasil: Diário Oficial da União. Retrieved from http://bvsms.saude.gov.br/bvs/publicacoes/prtGM399_20060222.pdf
Brasil. Ministério da Saúde. (2010). *Falando de Ouvidoria: Experiências e Reflexões*. (D. de O. G. do S. Ministério da Saúde, Secretaria de Gestão Estratégica e Participativa, Ed.). Brasília: Ministério da Saúde.
Brasil. Ministério da Saúde. (2013). *Guia de orientações básicas para implantação de ouvidorias do SUS*. (Ministério da Saúde, Ed.) (1ª ed.). Brasilia. Retrieved from http://bvsms.saude.gov.br/bvs/publicacoes/guia_orientacoes_implantacao_ouvidorias_sus.pdf
Brasil. Ministério da Saúde. (2015). Em cinco anos, mais de R$ 2,1 bilhões foram gastos com ações judiciais. Retrieved March 14, 2017, from http://portalsaude.saude.gov.br/index.php/cidadao/principal/agencia-saude/20195-em-cinco-anos-mais-de-r-2-1-bilhoes-foram-gastos-com-acoes-judiciais
BRASIL. Ministério da Saúde. Conselho Nacional de Saúde. (2004). *As Organizações da Sociedade Civil de Interesse Público – Oscips omo instrumento de gestão pública na área de saúde*. Brasília. Retrieved from http://conselho.saude.gov.br/ultimas_noticias/2010/12_abr_oscips.htm
Campos, A. M. (1990). Accountability: Quando Poderemos Traduzí-la para o Português? *Revista de Administração Pública*, *24*(2), 30–50. Retrieved from http://bibliotecadigital.fgv.br/ojs/index.php/rap/article/view/9049
Campos, G. W. de S. (2016). XV Conferência Nacional de Saúde: o que comemorar e o que criticar? *Trabalho, Educação E Saúde*, *14*, 5–6. Retrieved from http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1981-77462016000100005&lang=pt
Carneiro Júnior, N., & Elias, P. E. (2003). A reforma do Estado no Brasil : as organizações sociais de saúde. *Revista de Administração Pública*, *37*(2), 201–227. Retrieved from http://bibliotecadigital.fgv.br/ojs/index.php/rap/article/view/6484
Carvalho, A. I., Gawryszewski, V., Mendonça, M. H. M., & Moisés, N. (1993). Os caminhos da descentralização no setor saúde brasileiro. *Saúde Em Debate*, *38*, 49–54.

Carvalho, G. (2001). A inconstitucional administração pós-constitucional do SUS através de normas operacionais. *Ciência & Saúde Coletiva*, *6*(2), 435–444. http://doi.org/10.1590/S1413-81232001000200012

Comissão Nacional da Reforma Sanitária. (1986). COMISSÃO NACIONAL DA REFORMA SANITÁRIA - Documentos I. Rio de Janeiro: Assessoria de Imprensa da CNRS.

Conselho Nacional de Saúde. Resolução N° 333, de 04 de Novembro de 2003 (2003). Conselho Nacional de Saúde. Retrieved from http://conselho.saude.gov.br/ultimas_noticias/2005/resolucao333.htm

Cordeiro, H. (2001). Descentralização, universalidade e eqüidade nas reformas da saúde. *Ciência & Saúde Coletiva*, *6*(2), 319–328. http://doi.org/10.1590/S1413-81232001000200004

Cordeiro, H. de A. (1984). *A Indústria da Saúde no Brasil* (1ª ed.). Rio de Janeiro: Graal.

Côrtes, S. M. V. (2009). Conselhos e conferências de saúde: papel institucional e mudança nas relações entre Estado e sociedade. In S. Fleury & L. C. de V. Lobato (Eds.), *Participação, Democracia e Saúde* (pp. 102–128). Rio de Janeiro: CEBES. Retrieved from http://cebes.org.br/site/wp-content/uploads/2013/10/livro_particioacao.pdf#page=101

Cotta, R. M. M., Cazal, M. de M., & Rodrigues, J. F. de C. (2009). Participação, Controle Social e Exercício da Cidadania: a (des)informação como obstáculo à atuação dos conselheiros de saúde. *Physis*, *19*(2), 419–438. http://doi.org/10.1590/S0103-73312009000200010

Cotta, R. M. M., Martins, P. C., Batista, R. S., Franceschinni, S. do C. C., Priore, S. E., & Mendes, F. F. (2011). O controle social em cena: refletindo sobre a participação popular no contexto dos Conselhos de Saúde. *Physis: Revista de Saúde Coletiva*, *21*(3), 1121–1138. http://doi.org/10.1590/S0103-73312011000300019

Dallari, S. G. (1988). Uma nova disciplina: o direito sanitário. *Revista de Saude Publica*, *22*(4), 327–334. Retrieved from http://www.scielo.br/pdf/rsp/v22n4/08.pdf

Draibe, S. M. (1998). *Avaliação da descentralização das políticas sociais no Brasil- saúde e educação fundamental*. Santiago. Retrieved from http://repositorio.cepal.org/bitstream/handle/11362/7421/S9800519_pt.pdf?sequence=1&isAllowed=y

Eisenberg, J. (2002). Pragmatismo, direito reflexivo e judicialização da política. In L. W. (Org) Viana (Ed.), *A democracia e os três poderes no Brasil* (p. 569). Belo Horizonte: UFMG.

Gadelha, P. (2015). [The Brazilian National Health Conference: challenges for the country]. *Cadernos de Saúde Pública*, *31*(10), 2047–58. http://doi.org/10.1590/0102-311XDE011015

Geddes, B. (2001). O quê sabemos sobre democratização depois de vinte anos? *Opinião Pública*, *7*, 221–252. http://doi.org/10.1590/S0104-62762001000200005

Governo do Esatdo de São Paulo. (2017). Entenda o que são Organizações Sociais de Saúde: pesquisa por unidades contratualizadas e OSS. Retrieved May 31, 2017, from http://www.portaldatransparencia.saude.sp.gov.br/

Governo do Estado de São Paulo. Lei Complementar n° 846, de 04 de Junho de 1998: Dispõe sobre a qualificação de entidades como organizações sociais e dá outras providências (1998). Brasil: Diário Oficial do Estado de São Paulo, V.108; n.106 de 05 de Junho de 1998. Retrieved from https://www.al.sp.gov.br/norma/?id=6680

Guizardi, F. L., Pinheiro, R., Mattos, R. A. D. E., Santana, A. D., Matta, G. da, & Gomes, M. C. P. A. (2004). Participação da Comunidade em Espaços Públicos de Saúde : uma análise das Conferências. *Physis: Revista de Saúde Coletiva*, *14*(1), 15–39. http://doi.org/10.1590/S0103-73312004000100003

Hortale, V. A., & Duprat, P. (1999). O contrato de gestão na reforma do subsistema hospitalar francês : contribuição à discussão sobre a descentralização dos serviços de saúde no Brasil. *Revista de Administração Pública*, *33*(2), 7–22. Retrieved from http://bibliotecadigital.fgv.br/ojs/index.php/rap/article/view/7648/6193

IBGE. (2015). IBGE divulga as estimativas populacionais dos municípios em 2015. Retrieved from http://saladeimprensa.ibge.gov.br/noticias?view=noticia&id=1&busca=1&idnoticia=2704

Instituto Brasileiro das Organizações Sociais de Saúde. (2017). Instituto Brasileiro das Organizações Sociais de Saúde: Nossa História. Retrieved May 31, 2017, from http://www.ibross.org.br/

Levcovitz, E. (1997). *Transiçäo X consolidaçäo: o dilema estratégico da construçäo do SUS: um estudo sobre as reformas da política nacional de saúde-1974/1996*. Universidade do Estado do Rio de Janeiro. Retrieved from http://bases.bireme.br/cgi-bin/wxislind.exe/iah/online/?IsisScript=iah/iah.xis&src=google&base=LILACS&lang=p&nextAction=lnk&exprSearch=229506&indexSearch=ID

Levcovitz, E., Lima, L. D. de, & Machado, C. V. (2001). Política de saúde nos anos 90: relações intergovernamentais e o papel das Normas Operacionais Básicas. *Ciênc. Saúde Coletiva*, *6*(2), 269–29. http://doi.org/10.1590/S1413-81232001000200002

Lima, L. D. De. (1999). *O Processo de Implementação de Novas Estruturas Gestoras no Sistema Único de Saúde : Um Estudo das Relações Intergovernamentais na CIB do RJ*. Universidade do Estado do Rio de Janeiro. Retrieved from http://www6.ensp.fiocruz.br/repositorio/sites/default/files/arquivos/Processo.pdf

Lima, L. D. De, Viana, A. L. D., Machado, C. V., Albuquerque, M. V. De, Oliveira, R. G. De, Iozzi, F. L., … Coelho, A. P. S. (2012). Regionalização e acesso à saúde nos estados brasileiros: condicionantes históricos e político-institucionais. *Ciência & Saúde Coletiva*, *17*(11), 2881–2892. http://doi.org/10.1590/S1413-81232012001100005

Lucchese, T. R. (1995). Descentralização Do Financiamento E Gestão Da Assistência À Saúde No Brasil : a Implementação Do Sistema Único De Saúde — Retrospectiva. *Rev. Planejamento E Políticas Públicas*, *14*, 75–156. Retrieved from http://www6.ensp.fiocruz.br/repositorio/sites/default/files/arquivos/DescentralizaçãoFinanciamento.pdf

Lyra, R. P. (2011a). Ouvidorias e Ministério Público: as duas faces do ombudsman no Brasil. In A. S. R. Cardoso & R. P. (Org) Lyra (Eds.), *Novas modalidades de ouvidoria pública no Brasil* (pp. 41–73). João Pessoa: Editora Universitária da UFPB.

Lyra, R. P. (2011b). Ouvidorias públicas e privadas: análise comparativa. In R. P. (Org) Cardoso, Antônio S.R.; Lyra (Ed.), *Novas modalidades de ouvidoria pública no Brasil* (pp. 19–39). João Pessoa: Editora Universitária da UFPB.

Machado, C. V. (2012). O modelo de intervenção do Estado na saúde: notas sobre a atuação federal. In C. V. Machado, T. W. de F. Baptista, & L. D. de Lima (Eds.), *Políticas de saúde no Brasil: continuidades e mudanças* (1ª ed., pp. 117–147). Rio de Janeiro: Editora FIOCRUZ.

Machado, F. R. de S. (2006). *Direito à Saúde, Integralidade e Participação: um estudo sobre as relações entre Sociedade e Ministério Público na experiência de Porto Alegre.* Universidade do Estado do Rio de Janeiro. Retrieved from http://www.bdtd.uerj.br/tde_busca/arquivo.php?codArquivo=7018

Machado, F. R. de S. (2010). *A judicialização da saúde no Brasil: cidadanias e assimetrias*. Universidade do Estado do Rio de Janeiro. Retrieved from http://www.bdtd.uerj.br/tde_busca/arquivo.php?codArquivo=1578

Melo, C., & Tanaka, O. (2001). As organizações sociais no setor saúde: inovando as formas de gestão? *Organizações & Sociedade*, *8*(22), 1–12. http://doi.org/10.1590/S1984-92302001000300007

Menezes, D. H. L., & Leite, J. L. (2016). A Nova Configuração da Política de Saúde no Brasil: o Rio de Janeiro como laboratório. *Revista Políticas Públicas*, *20*(1), 121–136.

Miguel, L. F. (2005). Impasses da accountability: dilemas e alternativas da representação política. *Revista de Sociologia E Política*, (25), 25–38. http://doi.org/10.1590/S0104-44782005000200004

Monteiro, R. P., Pereira, C. A., & Thomaz, J. L. P. (2016). Accountability e Controle Social: uma reflexão sobre sua importância e relação para a democracia. *Revista UNEMAT de Contabilidade*, *5*(9), 62–82. Retrieved from http://periodicos.unemat.br/index.php/ruc/article/view/1162/1359

Moreira, R., Fernandes, B., Manuel, F., Sucena, M., Fernando, L., & Oliveira, N. De. (2006). A Democratização nos Conselhos de Saúde. *Saúde Em Debate*, *30*(73-74), 205–218. Retrieved from http://www.redalyc.org/pdf/4063/406345309007.pdf

Müller, N. P. (2015). *Guia de Políticas, Programas e Projetos do Governo Federal para a População Idosa: compromisso nacional para o Envelhecimento Ativo*. *Secretaria de Direitos Humanos da Presidência da República*. Brasília: Secretaria de Direitos Humanos da Presidência da República. Retrieved from http://sbgg.org.br/wp-content/uploads/2014/10/1436207288_Guia_de_poli_ticas_pu_blicas_2015.pdf

Noronha, J. C. de, & Soares, L. T. (2001). A política de saúde no Brasil nos anos 90. *Ciência & Saúde Coletiva*, *6*(2), 445–450. http://doi.org/10.1590/S1413-81232001000200013

O´Donnel, G. (1998). Accountability Horizontal e Novas Poliarquias. *Lua Nova*, (44), 27–54. http://doi.org/10.1590/S0102-64451998000200003

Oliveira, J. A. de A., & Teixeira, S. M. F. (1989). *(IM) Previdência social: 60 anos de história da previdência no Brasil* (1ª ed.). São Paulo: Editora Vozes. Retrieved from http://cebes.org.br/site/wp-content/uploads/2013/10/Im-previdencia-social-60-anos-história.pdf

Paim, J. S. (2007). *Reforma Sanitária Brasileira: contribuição para a compreensão e crítica*. Universidade Federal da Bahia. Retrieved from https://repositorio.ufba.br/ri/bitstream/ri/10376/1/5555555555.pdf

Paim, J. S. (2012). *A Reforma Sanitária Brasileira e o CEBES*. (CEBES, Ed.). Rio de Janeiro. Retrieved from http://cebes.org.br/site/wp-content/uploads/2014/11/E-Book-1-A-Reforma-Sanitária-Brasileira-e-o-CEBES.pdf

Paiva, C. H. A., & Teixeira, L. A. (2014). Reforma sanitária e a criação do Sistema Único de Saúde: notas sobre contextos e autores. *História, Ciências, Saúde-Manguinhos*, *21*(1), 15–35.

http://doi.org/10.1590/S0104-59702014000100002
Pereira, A. M. M. (2009). *Dilemas federativos e regionalização na saúde: o papel do gestor estadual do SUS em Minas Gerais*. Fundação Oswaldo Cruz. Retrieved from http://bvssp.icict.fiocruz.br/lildbi/docsonline/get.php?id=1942
Pereira, A. M. M. (2014). *Descentralização e Regionalização em Saúde no Brasil e na Espanha: trajetórias, características e condicionantes*. Fundação Oswaldo Cruz. Retrieved from https://www.arca.fiocruz.br/handle/icict/13072
Pereira, A. M. M., Lima, L. D. de, Machado, C. V., & Freire, J. M. (2015). Descentralização e Regionalização em Saúde na Espanha: trajetórias, características e condicionantes. *Saude Debate*, *39*(N.Especial), 11–27. http://doi.org/10.5935/0103-1104.2015S005410
Pereira, L. C. B. (1977). A estratégia brasileira de desenvolvimento entre 1967 e 1973. *Revista de Administração de Empresas*, *17*(4), 17–26. http://doi.org/10.1590/S0034-75901977000400002
Pereira, L. H. (2002). A voz do usuário no sistema hospitalar: ouvidorias *. *Sociologias*, *7*, 82–121. Retrieved from http://www.scielo.br/pdf/soc/n7/a04n7
Pinho, J., & Sacramento, A. (2009). Accountability: já podemos traduzi-la para o português? *Revista de Administração Públicaública*, *43*(6), 1343–1368. http://doi.org/10.1590/S0034-76122009000600006
Ribeiro, P. T. (2009). A descentralização da ação governamental no Brasil dos anos noventa: desafios do ambiente político-institucional. *Ciência & Saúde Coletiva*, *14*(3), 819–828. http://doi.org/10.1590/S1413-81232009000300017
Rocha, A. C. (2011). Accountability na Administração Pública: Modelos Teóricos e Abordagens. *Contabilidade Gestão E Governança*, *14*(2), 82–97.
Sacramento, A. R. S. (2005). Contribuições da Lei de Responsabilidade Fiscal para o avanço da Accountability no Brasil. *Cadernos Gestão Pública E Cidadania*, *10*, 20–47. Retrieved from http://bibliotecadigital.fgv.br/ojs/index.php/cgpc/article/view/44042
Santos, C. C. da S., & Bastos, R. L. (2009). Participação Social : a construção da democracia na saúde brasileira. *Revista Brasileira de Promoção Da Saúde*, *24*(3), 266–273. Retrieved from http://www.unifor.br/images/pdfs/rbps/artigo11_2011.3.pdf
Souza, R. R. De. (2001). A regionalização no contexto atual das políticas de saúde. *Ciência & Saúde Coletiva*, *6*(2), 451–455. http://doi.org/10.1590/S1413-81232001000200014
Stotz, E. N. (2005). A educação popular nos movimentos sociais da saúde: uma análise de experiências nas décadas de 1970 e 1980. *Trabalho, Educação E Saúde*, *3*(1), 9–30. http://doi.org/10.1590/S1981-77462005000100002
Supremo Tribunal Federal. (2017). Convênio do poder público com organizações sociais deve seguir critérios objetivos. Retrieved May 31, 2017, from http://www.stf.jus.br/portal/cms/verNoticiaDetalhe.asp?idConteudo=289678
Tatagiba, L. T. (2002). Os conselhos gestores e a democratização das políticas públicas no Brasil. In E. (Org) Dagnino (Ed.), *Sociedade civil e espaços públicos no Brasil* (p. 364). São Paulo: Paz e Terra.
Tate, C. N., & Vallinder, T. (1995). *The Global Expansion of Judicial Power*. New York and London: New York University Press.
Torres-Fernandes, M. de C. (1999). *Ministério Público em São Paulo: eficácia da função institucional de zelar pelo direito à saúde*. Universidade de São Paulo. Retrieved from http://www.teses.usp.br/teses/disponiveis/2/2139/tde-16052005-144603/pt-br.php
Viana, A. L. D., Heimann, L. S., Lima, L. D. de, Oliveira, R. G. De, & Rodrigues, S. da H. (2002). Mudanças significativas no processo de descentralização do sistema de saúde no Brasil. *Cadernos de Saúde Pública*, *18*, S139–S151. http://doi.org/10.1590/S0102-311X2002000700014
Vianna, L. W., Melo, M. P. C., Burgos, M. B., & Carvalho, M. A. R. (1999). *A judicialização da política e das relações sociais no Brasil*. Rio de Janeiro: Revan.
Vieira, F. S. (2008). Ações judiciais e direito à saúde: Reflexão sobre a observância aos princípios do SUS. *Revista de Saude Publica*, *42*(2), 365–369. http://doi.org/10.1590/S0034-89102008000200025