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# The social representations of social control in health: the advances and effect of institutionalized social participation

As representações sociais do controle social em saúde: os avanços e entraves da participação social institucionalizada<sup>1</sup>

## Helena Eri Shimizu

Universidade de Brasília. Faculdade de Ciências da Saúde.  
Departamento de Saúde Coletiva. Brasília, DF, Brazil.  
E-mail: shimizu@unb.br

## Luciana Melo de Moura

Secretaria de Saúde do Distrito Federal. Brasília, DF, Brazil.  
E-mail: melo310577@yahoo.com.br

## Abstract

The aim of this study was to analyze the social representations of the chairpersons of the regional health councils in the Federal District about the practice of social control. It is a descriptive study based on Serge Moscovici's theory of social representations. In-depth interviews were conducted with thirteen chairpersons of regional health councils about social control in health. The data were analyzed with the help of ALCESTE software. The lexical analysis resulted in the identification of three core topics: the weaknesses of the regional health councils; the quest to strengthen social control; and the issue of representation in regional health councils. The content of the representations in the first core topic demonstrated the weakness of social control in health, either because of the lack of community access to information about the purpose of the councils or because representation of social control is linked to the inspection of health services or geared towards resolving immediate demands of the population. In the second core topic, the content of the representations demonstrated that the social representation of social control coexists in the space of the councils with an emphasis on social participation in public policymaking for health. In the third core topic, the content demonstrated the incipient nature of the representations of organized social movements of health services users. The regional health councils have demonstrated their potential in formulating public policies that favor social development, especially through discussion of local needs.

**Keywords:** Social Control; Health Councils; Social Representations.

## Correspondence

Luciana Melo de Moura  
QnG, s/n, Área Especial n 18/19, Taguatinga Norte.  
Brasília, DF, Brazil. CEP 72130-005.

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## Resumo

Este estudo teve como objetivo analisar as representações sociais dos presidentes dos conselhos regionais de saúde do Distrito Federal acerca da prática do controle social. Trata-se de um estudo descritivo que utiliza o referencial teórico das representações sociais de Serge Moscovici. Foram realizadas entrevistas em profundidade com treze presidentes de conselhos regionais de saúde sobre o tema do controle social em saúde. Os dados foram analisados com auxílio do *software* ALCESTE. A análise lexical resultou na identificação de três eixos temáticos: as fragilidades dos conselhos regionais de saúde; a busca do fortalecimento do controle social; e a problemática da representação nos conselhos regionais de saúde. No primeiro eixo, o conteúdo das representações demonstra a fragilidade do controle social em saúde, ora pela falta de acesso da comunidade a informações sobre a finalidade dos conselhos, ora pela representação do controle social vincular-se à prática de fiscalização dos serviços de saúde, ora pela prática voltada à resolução de demandas imediatas da população. No segundo eixo o conteúdo das representações demonstra que convive no espaço dos conselhos a representação social do controle social com ênfase na participação social para a formulação das políticas públicas de saúde. E no terceiro eixo o conteúdo demonstra a incipiência das representações dos movimentos sociais organizados no segmento dos usuários. Os conselhos regionais de saúde demonstraram potencialidades para alcançar o papel de formuladores de políticas públicas que favoreçam o desenvolvimento social, especialmente a partir da discussão das necessidades locais.

**Palavras-chave:** Controle Social; Conselhos de Saúde; Representações Sociais.

## Introduction

In Brazil, with the incorporation of the right to health to the constitutional text, social participation in health has become a reality through the creation of formal forums with the participation of organized civil society in conferences and health councils. From there, the social control takes shape since the legal organization of the country includes health councils in the decision-making structure and inspection of the management of public resources destined to the Brazilian National Health System (*Sistema Único de Saúde* - SUS). Health councils, as spaces of power, conflict and negotiation, present considerable advances in the exercise of social control and the expansion of citizenship, however, they face difficulties because of the bureaucratization of its bodies merely to comply with legal requirements (Paiva et al., 2014).

In the Federal District (DF), the district health council was created in 1973 in order to broaden the discussion of health policy management, which showed to be complex, mainly because of the chaotic population increase resulting from migrants that came seeking better living conditions in the federal capital (Brasília, 1973). Over the years it has undergone several changes, until it was more recently modified by Law No. 4604, of July 15, 2011, which regulated the new assignments, organization and composition, incorporating to the council new social actors, making it possible, for the first time, to elect its president, a position until then occupied by the health secretary (Brasília, 2011).

It is noteworthy that, with the exponential population growth of the so-called satellites cities, it was observed that the district health council could no longer meet the demands of the population of these cities, that was when the regional health councils of the Federal District (*conselhos regionais de saúde do Distrito Federal*, CRS-DF) started to appear, aiming to create a decentralized structure to assist in the management of the health system. However, the CRS-DF does not have administrative and financial autonomy because they are not formally inserted in the organizational chart of the Health Secretariat of the DF.

Many of the CRS-DF were created by pressure from civil society, living in a precarious situation

in so-called settlements without sewage, water, electricity, health services, among other infrastructure conditions. Although the CRS-DF are the main *locus* for formulation of the health care needs of the region, namely the channels for expression of several community health needs, it is known that they present consolidation difficulties due to several factors, such as lack of community habit for health participation, highly hierarchical health services, which do not include the participation of users, their transformation into bureaucratic spaces that do not allow transparency in health care, among others (Pereira, 2010).

It is observed, however, that the CRS-DF have strategic contribution to the health care restructuring process in the Federal District, as it indicates the real needs that must be considered in the formulation of public health policies. Another important fact is that the social control exercised by CRS-DF is decentralized, that is, with greater potential for interconnections because they are located close to residents, allowing their actions to take place *in situ*. It is therefore the exercise of citizen participation, which can be understood as the ability of individuals and the community to intervene in decision-making within the management of public policies, with the purpose of improving the quality of life, especially in the region where they live (Cotta et al., 2011; Müller Neto; Artmann, 2012). In this context, it is essential to understand how the CRS-DF participate in the formulation and organization of health actions. Based on this perspective, this study aims to identify and analyze the social representations of the presidents of the regional health councils of the Federal District about the practice of social control.

## Methodological theoretical framework

The social representations (RS) are the result of human interactions that originate from people meetings in different spaces where they transit daily. Thus, the collective thought is individualized from the moment that the RS influences the behavior of the individual that takes part in a collective medium, guiding human practices (Moscovici, 2010). Therefore, it is important to know the social repre-

sentation (RS) of the presidents of the CRS-DF about social control, especially if they are positive and able to enhance social participation in health. In this logic, RS has the function of standardizing objects, people or events that are found giving them definitive form and allocating them in a certain category, in such a way that all that is not fully known by the group becomes appropriate for their environment (Moscovici, 2010).

The RS are generated by two cognitive processes, anchoring and objectification, translated as ways of dealing with memory. The first relates to the anchoring of foreign ideas into existing memory categories (classification), or to put them in a familiar context and give them a name (nomination). In the second, objectification means the materialization of an abstraction, it is the reproduction of concepts and images in the outside world (Moscovici, 2010). That done, we start off from the assumption that, by knowing the CRS-DF presidents RS content about social control, it is possible to understand the behaviors and practices that guide such councils, as well as identify their strengths and weaknesses, in addition to proposing strategies to strengthen it.

## Methodology

The present is a descriptive study, which aims to describe the RS of the CRS-DF presidents about social control, in other words, to recover its process of structuring and its contents. The study was conducted in the Federal District (DF), characterized as a city-state, consisting of 31 administrative regions (RA) (Codeplan, 2014), which are prohibited from being divided into cities, and is, therefore, assigned the legislative powers reserved to the states and cities (Brazil, 1988). As a consequence, it is organized in RAs, according to the Organic Law of the Federal District (Brasilia, 1993).

The DF has an estimated population of 2.9 million inhabitants (Brazil, 2014). It is a region with great social, economic and cultural inequalities. Considering its population in 2011, from the 2.6 million inhabitants, the gross domestic product (GDP) *per capita* was estimated at R\$ 63,020.02—nearly three times the national GDP (R\$ 21,535.65), and nearly double the one observed in São Paulo (R\$

32,449.06)—the second largest in the country, which contrasts with the worst Gini coefficient (0.584) in the same year, nationwide (Codeplan, 2013). In this context, the health system, which has already been a historical model of organization of hierarchical and regionalized services of reference and counter reference, has a wide network of its own, offering all healthcare levels: primary, secondary and tertiary. However, with regard to primary care, there is low coverage of family health strategy (*estratégia de saúde da família*, ESF), 24.1%, which leads people to seek other access points, especially hospitals and more recently in the emergency care units (*unidades de pronto atendimento*, UPA), which are often crowded (Göttems et al., 2009). So that the CRS-DF are faced with the need to improve the services and the health system, especially through the identification of local needs. However they face difficulties, especially the lack of coordination and support from the district health council, which still stands as appendix of the management, with small role in decision-making of public health policies (Pereira, 2010).

In the study period (2008), there were nineteen CRS-DF, from which thirteen were selected for research because they met the following inclusion criteria: being in operation for more than three months, having full party composition (managers and service providers 25%, workers 25% and users 50%), and with at least one monthly meeting. Participants were the Brasília CRS, Ceilândia CRS, Cruzeiro CRS, Gama CRS, Paranoá CRS, Planaltina CRS, Recanto das Emas CRS, Riacho Fundo CRS, Santa Maria CRS, São Sebastião CRS, Sobradinho CRS, Taguatinga CRS and Varjão CRS. In-depth interviews were conducted with thirteen presidents of CRS-DF, which spoke about the following questions: a) how do you perceive the practice of social control in your District? and b) talk about your experience regarding the practice of social control. Respondents were allowed to speak freely without the interference of the researcher, whose role was limited to keeping the narrative focused on the central issue. No time limitation was established for the answer. The interviewer was the same for all the presidents, and the interviews were recorded and integrally transcribed. The research project was approved by

the State Health Secretariat of the Federal District Research Ethics Committee, in Opinion No.158/7.

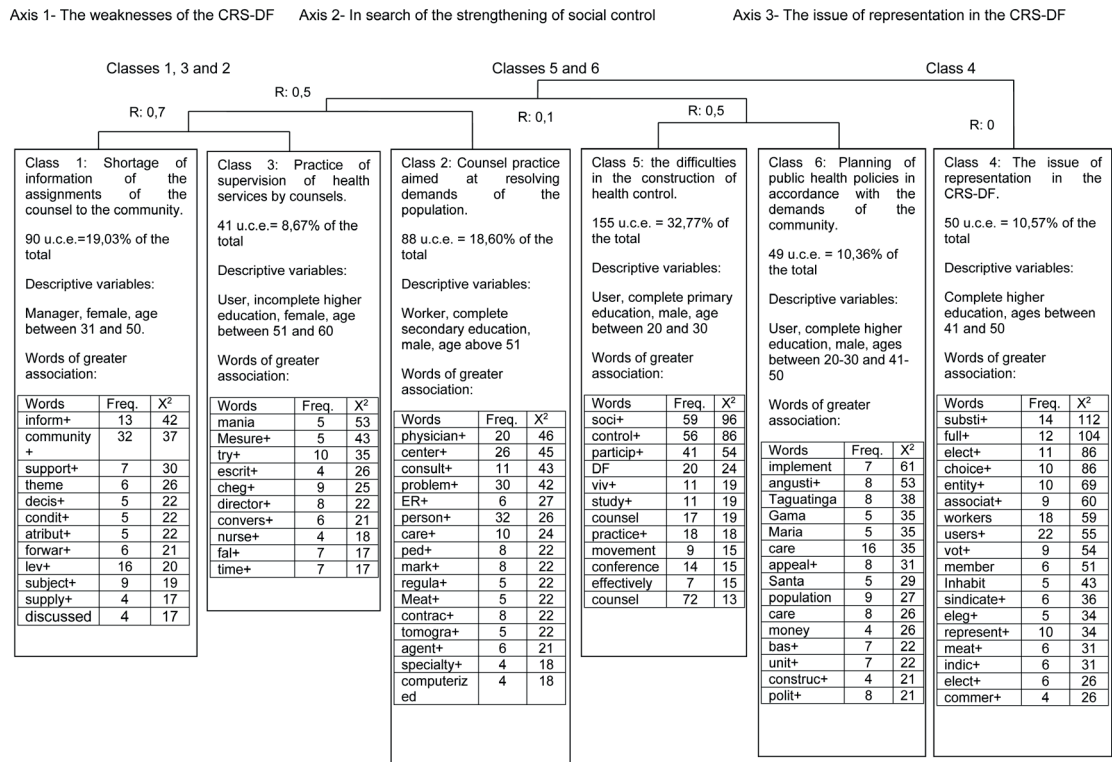
To capture the RS, it is important to verify the degree of sharing of the main ideas mentioned by the subjects involved in the process. The software *Análise Lexical par Contexte d'un Ensemble de Segments de Texte* (ALCESTE) is widely used in RS studies because it allows us to highlight the main meanings and sense contained in the texts. This software uses the analysis of co-occurrences of words in the statements that compose the text, to organize and summarize information regarded as most important, and it has as a reference the “lexical worlds” (Reinert, 1990), which are groups of words meaningful for a particular social group, but that require the interpretation of the researcher, who must draw from the full text produced by the subjects, as much as from the context in which it was produced.

At first, the software performs the downward hierarchical classification (*classificação hierárquica descendente*, CHD), which highlights the words, how often they appear and their associations in words classes (calculation of the  $X^2$ ), allowing the highlighting of the common fields of the RS, whose graphical representation is a dendrogram (Gutz; Camargo, 2013). Secondly, it performs the factorial analysis of correspondence, aiming to identify the individual and group variations on the common field of representations, which generates a Cartesian plane indicating the approach between words, resulting in variables and classes of the CHR (Saraiva; Coutinho, 2012). This way of understanding is based on Doise's (2011) proposal, in which the consensus concept is understood as sharing of reference points. Thus, one might think that the representational system constitutes a common reference point, and therefore, is an organizer of a consensus that allows different positions.

## Results

The contents of the thirteen interviews processed by the ALCESTE software resulted in the identification of three thematic axes shown in the dendrogram (Figure 1): the weaknesses of the CRS-DF; the search for the strengthening of social control; and the issue of representation in the CRS-DF.

**Figure 1 - Dendrogram resulting from CHD on RS of the presidents of the CRS-DF regarding the practice of social control in health, 2008, Brasília, DF**



In the first thematic axis, **the weaknesses of the CRS-DF** is composed of Class 1, which deals with **the lack of information of the assignments of the council to the community**, of the Class 3, which addresses **the practice of supervision of health services by councils**, and the Class 2, which deals with **the council practice aimed at resolving demands of the population**.

Class 1 (**lack of information of the assignments of the council to the community**) presented 90 elementary context units (*unidades de contexto elementar*, u.c.e.), which corresponds to 19.03% of total u.c.e. of the corpus, and significant descriptive variables were the presidents belonging to the manager segment, being female and having age between 31 and 50 years. It addresses the importance of information and dissemination of health councils to the community. It highlights the need for meetings to be open to the community, in addition to its important support in decision-making and discussion of issues relating to management of health services.

[meetings] *open to the community to inform precisely in this idea that the more information, less hostility, less misunderstanding, because you're saving yourself from something. Mainly to discuss the community's health problems and propose alternatives to solve these problems, what kind of solution to forward, what kind of proposal to be implemented* (Subject 13).

In this Class, it is also revealed that the CRS-DF is unable to meet its formulation assignments, monitoring the implementation of public health policies by not having autonomy, neither human and material resource, nor financial incentive.

*but it [the council] has no independence no and has no autonomy what so ever in regards to finance, and so we have important assignments to follow, to develop and implement, but we do not have physical, material condition* (Subject 11).

This Class talks about, due to the CRS-DF's lack of autonomy for decision-making, it has only the role of forwarder of incoming community problems, especially issues relating to the resolution of more immediate problems, such as the poor's access to health services.

*the user makes the complaint directly to the counselor, who takes this complaint to an ordinary meeting, to the council, for us to discuss. And through reports, we hear and make a report of that, debate over that subject and make a report and send it to the segment that asked for it (Subject 6).*

**Class 3 (the practice of supervision of health services by councils)** was structured with 41 u.c.e., representing 8.67% of the total. Taking into account the descriptive variables, one can characterize it as a class that was composed mostly of presidents of user segments with incomplete higher education, female and aged between 51 and 60 years. It describes as RS content the role of the CRS-DF as supervisor of health services, which is reinforced in trainings as shown in the following statement:

*we try to follow, we took classes for this, we were trained for this, to prevent this disorder. I used to say it's educational, it is not complicated, for me when the staff says like what is the counsel for? It is to supervise (Subject 7).*

In this class, it is reinforced, several times, that the practice of supervision is mainly focused on control of the daily operation of health services by the counselors, in other words, to verify that the services are up and running, if there are staff on duty, among other aspects. This restricted role has led to the need to rethink their practices, mainly, through community involvement in the CRS-DF.

*not only involve the hospital, the manager, truly involve the community. Hey community, come on here because the situation here is bad. And one helping the others. Through letters, through meetings, our meeting is open to both the management council, and the community, then one notifies the other, usually nurses take the subject to patients, patients got there, commented, spoke (Subject 7).*

**Class 2 (the council practice aimed at resolving demands of the population)** was structured with 88 u.c.e., corresponding to 18.60% of the total. The prevalent descriptive variables in this class are presidents representatives of workers, with secondary education, male and over 51 years of age. It unveils the contents of the RS that the practices of the CRS-DF focus on solving more immediate demands of the population due to insufficient health services, which is attributed to recent urban unorganized growth, mainly due to migrants' pursuit of better living conditions, since job offer is more expressive in Brasilia than in other cities in the surrounding states.

*[they] come from other cities, get a job there in Cruzeiro Novo, Cruzeiro Velho or Southwest and go to the health care center No. 9 from Cruzeiro Novo, then exactly this problem is what causes some difficulty in the organization of the service in this health care center and that today, with more focus, he registers at the health care center No. 9 because, as I said, is closer to the Structural (Subject 12).*

A national strategy to improve the coverage of primary health care has been the implementation of the ESF, which is still incipient in the DF. Health care centers located in RA are few and present difficulties to work integrated with the remaining services of the health care network. The inefficiency of primary care, as a gateway to the system, has led to a common problem, which is the search for care in the emergency room. Thus, the user learns to value this type of care for resolution of all kinds of health problems. Besides the difficulty of users' access to health services, it is shown that there is a lack of humanization in the service, for several reasons: lack of attention/of listening to the user, lack of access to services, mainly specialized ones, lack of medicines, among others. It is observed that completeness of the attention, understood as the access to the various levels of care and satisfaction of the various needs presented by users, is greatly compromised.

*for this seed also to improve humanization is necessary, the doctor has to be aware that his patient, he has to call him, know him by name. That's a big problem also that the doctor continues to treat*

*people, looking at his face, when he looks, sometimes he doesn't even look, and when he looks, he look from a higher place, with superiority, and the doctor is an agent of the state (Subject 12).*

The **second thematic axis (in search of the strengthening of social control)** is composed of **Class 5 (the difficulties in the construction of social control)** and **Class 6 (planning of public health policies in accordance with the demands of the community)**.

**Class 5 (the difficulties in the construction of social control)** is structured with 155 u.c.e., which corresponds to 32.77% of the total. There was a predominance of the following descriptive variables: president of the segment of users with complete primary education, male and with age between 20 and 30. The discourse again shows that the daily practices of the counselors are focused on supervision of health services.

The statement below shows that the CRS-DF lacks visibility as it has lower status compared to the district health council. Moreover, it is pointed out that there is no link between the CRS-DF and the district health council.

*you have the district health council, you have the CRS-DF and the truth is that there is no link so far between the councils, in the case of Paranoá here, you have this outbreak, for example (Subject 11).*

However, in this class, social control is represented as the ability of society to interfere in public management, guiding the actions of the State and the state spending toward the community's interests. However, as it is a relatively recent practice, it has not been fully absorbed by society.

Some more intense social participation experiences have been carried out in the DF, which allowed some advances on the notion of social control, especially linked to improving the management of services. From this perspective, in this Class is described, there are some local management experiences that have advanced the possibility of increasing social participation, especially by allowing the negotiation of demands and needs.

*in a government, participatory budgeting helped us a lot with the issue we are discussing and tak-*

*ing proposals for improving the quality of life and when we put forward the question of humanization of services as a control (Subject 8).*

And the respondents' concern with training are in the sense of improving the understanding regarding social control, community participation in planning, monitoring the implementation of public health policies, as well as on the management of health.

*in the understanding of what this social control would be and the difficulty that is the participation of the population, democratic participation in the management and planning of public policies and in our case the public health policy (Subject 1).*

In this logic, given the complexity of the assignments of health councils, which are part of the management and have the legal requirement to formulate strategies and control the implementation of health policies, including in economic and financial aspects, this class reinforces that training should be carried out in the perspective of permanent education, in other words, based on problematization of concrete reality.

**Class 6 (the planning of public health policies in accordance with the demands of the community)** is composed of 49 u.c.e., equivalent to 10.36% of the total. As for the descriptive variables, the president was predominantly from the users segment, had a university degree, was male and aged between 20-30 and 41-50. In this class, it is demonstrated that the content of the RS indicates the primary function of advice to contribute to the planning of public health policies of the RA, in line with the guidelines and principles of SUS, for them to be at the service of the community. In this sense, presidents interviewed recognize that the practice of social control is linked to the observance of the principles and guidelines of SUS in health units, to quality health care.

*along with the management of health in the region seeking to implement health policies for the entire region of Taguatinga, perhaps running all units to satisfaction, seeking exactly the precepts of the SUS, which is quality health care (Subject 9)*

It is recognized that the articulation of the CRS-DF with other public policy councils is critical to the



resolution of the health needs of the population. This intersectorial articulation has been one of the major investments of current public policies aimed at improving the population's quality of life as well as the development of cities. In this class, it is revealed that, with regard to improving health services, there is a great concern of the counselors to increase the number of hospitals to meet the population's needs. In this view, the provision of hospitals contributes to guarantee the right to health.

*with the security council, with the environmental council then it has had a greater involvement with the society, and I prioritized in my term as president. Today we have the construction of the hospital especially because the Article 6 of the constitution says that health is everyone's right and a duty of the State; I have no doubt that with this hospital work, especially because the hospital with 384 beds for the community (Subject 4).*

**Class 4 corresponds to the third thematic axis (the issue of representation in the CRS-DF)** and is structured with 50 u.c.e. (10.57% of total). Descriptive variables most characteristic of this class were the presidents having completed higher education and aged between 41 and 50. It describes the content of the RS that deals with the problem of representation in the CRS-DF, above all, the difficult process of choosing representatives of the users segment to compose the CRS-DF and insertion of people who are actually involved with organized social movements. It is revealed in this class, that the CRS-DF are formally structured, in other words, conform to guidelines set out in Resolution No. 453 of the National Health Council for the composition of council members (Brazil, 2012), but there is great difficulty to attract subjects that are, in fact, engaged in any social movement originated in the territories where they live. It must be noted that the increase in the number of users representatives on the CRS-DF means, undoubtedly, opportunity to expand social participation. However, the content of the RS that composes this class shows that the process of choosing user representatives occurs in a bureaucratic way: once public the election of councils, the entities run for a member seat on the CRS-DF and some representatives of the entities are indicated.

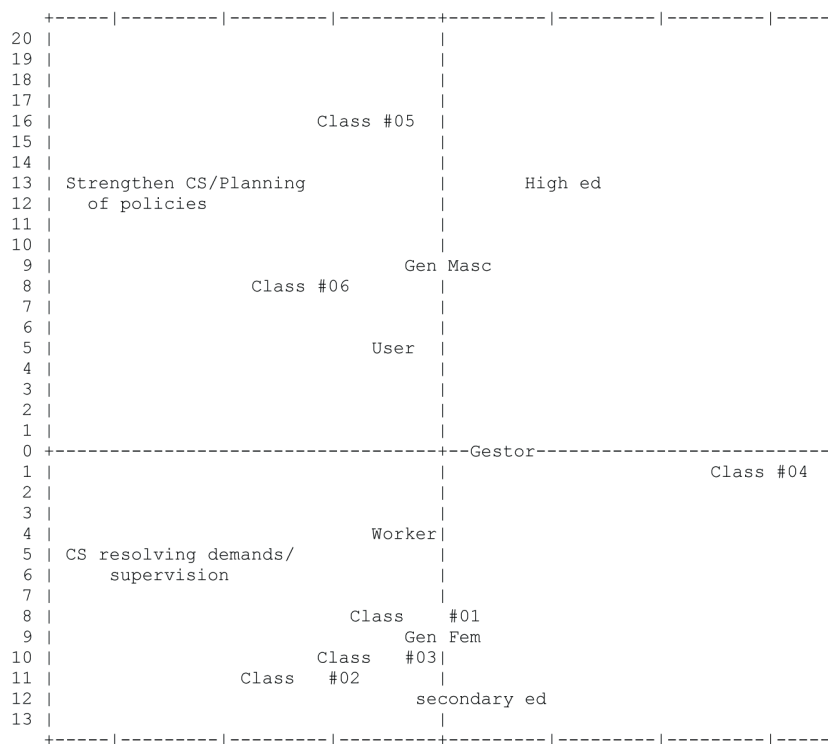
*And users, they are chosen through associations of the entities, then they gather each one in their entity, in their association and make an election among them and then they send us a letter with a copy of the minutes in which they were elected (Subject 5).*

This class makes evident that in the DF counselors seem very distant from social movements, mainly due to difficulties of organization and maintenance of today's social apparatus, which favor the most individualistic practices.

The factorial correspondence analysis (Figure 2) allows us to visualize the differences of group positioning in the factorial plane. It enables, above all, the complementation of information typicality obtained from the CHD (Saraiva; Coutinho, 2012). In this study, we sought to, in the factorial plane, verify the differences in the position taken by counselors with different profiles about social control in DF. In the factorial plane, one can observe the projection of the words analyzed (classes) with a combination of additional variables: higher education (High Ed) and secondary education (Medium ed), Gender (Male and Female) and represented segment (User, Worker, Manager), which are distributed in the different quadrants as well as the six classes discussed above. In the factorial analysis shown in Figure 2, it is possible to perceive that in the upper quadrant are classes 5 and 6, in which it is also highlighted the following variables: subjects belonging to the segment of users, with higher education and male. In this group, the prevailing RS of social control is linked to the strengthening of social control, with community participation in planning and making public policies. On the other hand, the lower quadrant represents classes 2, 3 and 1, and the variables that stand out are the subjects belonging to the segment of workers, female, and with secondary education. In this group, the RS of social control is linked to the practice of supervision and resolution of the health needs of local population.

In summary, two dimensions emerged from the factorial analysis. The first dimension is related to the educational level. On the one hand, the discourse of the CRS-DF presidents, that have higher education, address the relevance of building the strengthening of social control. On the other hand, the subjects who have secondary education relate

**Figure 2. Factorial Plane with the projection of variables and words in factorial correspondence analysis on the practice of social control in health, 2008, Brasília, DF**



the social control to the act of supervising and responding to the demands of health services coming from the community. The second dimension relates to gender. Male subjects highlight the importance of emphasizing the issue of formulate public policies for the health sector under the CRS-DF, while the female subjects highlight as a primary responsibility of the CRS-DF the technical expertise of doing the daily tasks, through the resolution of demands for health services and supervision of the work of the professionals and services.

## Discussion

It was observed that the content of the RS demonstrates the fragility of the social control in health by CRS-DF. Axis 1 depicts the contents of the RS that deals with the lack of access to information on the purpose of the CRS-DF as a determinant. In this way, it would be necessary to expand access to daily dynamics of these forums, in order to increase the

reasoning capacity of individuals in the decision-making processes, since the use of information in health would provide elements for the analysis of the health situation, supporting the search for possible routing alternatives, in order to define priorities, by the counselors and health managers (Paiva et al., 2014).

The first thematic area, also reveals that there is a strong RS social control centered on supervision of health services, which is anchored in the notion of social control as a control of the society by the State, in other words, the opposite of what was envisioned by the health reform movement. The supervision as an instrument of control of the implementation of health policy by the counselors reflect a degree of immaturity, because their role as deliberators is not clear (Martins et al., 2013) or even because they lack the autonomy to decide. In the factorial plane, it was shown that these demands have been voiced on the councils, especially by women, who have historically been responsible for health care (Pires et al., 2010).

It is evident, in fact that the emphasis of social control exercised by the CRS-DF on the SUS has shifted from formulation to supervising of policies. This finding demonstrates the risk of the notion of social control of the SUS, with the sense of a society's control over the state, be emptied in daily practices. The form of organization and functioning of health councils, hierarchical and bureaucratic, and the absence of social movements in the councils are important factors that contribute to distancing of the counselors from the discussion regarding on formulating policies that address the real health needs of the population (Shimizu et al., 2013). It is, therefore, a process that should involve several actors with different interests, where are noted, at the same time, complementarities and conflicts.

In the second axis, the content demonstrates that coexist in the space of the counsels RS social control with an emphasis on social participation, hence with greater capability to cater to its main function, the formulation of public health policy consistent with the health needs of the population. This RS, as shown in the factorial plane, has been more vocalized by men with higher education, and is anchored in the SUS social control concept in the sense of a control of society over the State. Through the councils, civil society exercises the right to participate in the management of various public policies, taking the opportunity to exercise greater control over the State. In this sense, it is clear that, despite the weaknesses of the councils that have been restricted only to an advisory characteristic, limiting their decision-making and deliberation power (Gohn, 2011), the CRS-DF have advanced primarily as room to negotiate the demands and health needs of the population living in the regions, and stand out as spaces for citizen reflection and exercise of democracy, therefore require constant evaluation and improvement (Bispo Junior; Gerschman, 2013). It is a form of participation that reduces the distance between society and politics, through the pact among social actors with multiple interests (Coelho, 2012).

This process can help to build the planning of public health policies in accordance with the demands of the community, as was also noted in axis 2. Moreover, it is an opportunity to plan what has

been called "local development" which comprises the living area that encompasses multiple interactions (social, cultural, political, economic, etc.), steeped in conflicts and different interests, but in which one can get past the traditional hegemonic model of monitoring and supervision of the health system to collectively draw up a common goal: to define social problems and jointly develop a local health plan (Ponte et al, 2012.). In this context, the region should be valued as a possible locus of construction of the care model proposed for the SUS, configured as potentiating space of networks of high capillarity social participation. According to Ponte et al. (2012), these spaces can be considered as community interaction spaces not exclusively linked to the practice of health unities, but that includes many aspects of everyday human life, correlated with the determinants and social conditions, economic, cultural and political, that does not make obvious the construction of intersectorial policies, therefore, more likely to become tools for realization of participatory democracy.

In axis 3, one can observe RS content that demonstrate that contribute to the fragility of social control such as a field of power the incipient representations of social movements organized in the segment of users. The data suggest that there are great difficulties in the dialogue of the councils with social movements in the region, which stimulates the permanence of the same subjects in the CRS-DF for long periods of time. This difficulty in composition and representativeness of the councils has been demonstrated in other studies, according to which the principle of equality was not respected in the council composition, since all responding counselors have been appointed by the local manager (Cotta et al., 2011; Zambon; Ogata, 2013). The centralization of the participation can reproduce political relations in which the notion of citizenship and democratization of political and public resources is little known. This time, it is necessary to enlarge the spaces that allow the inclusion of new actors through plural composition in decision-making processes (Bispo Júnior; Gerschman, 2013).

Therefore, is reiterated the importance of social movements in the proposal and construction of a new health paradigm, because their distance from

the institutionalized social participation forums is harmful and makes them fragile and unable to fully exercise social control (Gohn, 2011). It is necessary to understand the social movements as a democratization matrix and political solidarity, which helps in improving the civic quality of social participation in health, since the articulation of social movements in public policy management councils is critical to create an agenda for decision-making processes and the implementation of public policies (Kauchakje, 2008). Moreover, when there are links between councils and social movements with advocacy character, it is possible that this expanded public space may favor the formation of social subjects with adherence to civic action based in the democratic values and sense of political solidarity.

## Final remarks

It was found that there are several weaknesses to the CRS-DF function as instances of social control in health, mainly resulting from the RS social control as an instrument and enforcement strategy of health services, anchored in the concept of social control as only control. However, the CRS-DF demonstrated potential to achieve the role of policy makers that favor social development, especially from the discussion of local needs. It stood out also the distancing of social movements in these arenas, which once represented the segment of users, can contribute to the councils becoming more organic forums. The strengthening of social participation through the permeability of the CRS-DF in social movements of the regions, may increase the voice of citizens in the policy-making process and contribute to the formation of positive RS on social control.

It is also clear that an educational function—of participation in community and political affairs—should be included in participatory democracy, which can contribute to creating citizens able to sustain democracy. With the possibility of active participation, citizens can become more informed about the political system, change their representations and expand their horizons beyond their personal interests, or in defense of a greater public good, the defense of SUS.

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#### **Authors' contribution**

Shimizu took part in the conception, design, analysis, data interpretation, article writing and approval of the version to be published. Moura participated in the design, collection, analysis and interpretation of data, article writing and approving the version to be published.

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