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## Health Reform in Ceará: the process of decentralisation in the 1990s

### A Reforma de Saúde no Ceará: o processo de descentralização na década de 1990

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**ABSTRACT:** The objective of this article is to offer an overview of the health reform in Ceará focusing on the decentralisation process in the 1990s. The driving factor behind the Brazilian health reform movement was the necessity to reorganise the national health system and overcome inequalities. For the reformists, decentralisation, and together with it the idea of popular participation, is seen as essential to guarantee the fulfilment of the people's needs and to incorporate their voice in the decision-making processes of the health system. In the state of Ceará, after the 1986 elections, health reform movement members took control over the management of the state Health Secretariat. This is the main cause of the acceleration of the decentralisation process with the transference of responsibility over the management of health care delivery to municipalities.

**Key words:** Health Reform Ceará, Decentralisation, Policy.

## I ntroduction

The emergence of a health reform movement in Brazil during the 1970s had as an ambitious aim the radical transformation of the national health system. With roots in socialist ideology, this movement criticised the public health care system set up during the military regime, which was characterised by great inequality and inefficiency in the provision of services. It also fought a front against the dominance of the private health sector which

was contracted to provide services by the public sector and was accused of draining funds from the public sector.

One of the main proposals of the reform agenda was the implementation of decentralised health system management in keeping with international trends in reform and the need for improvements in the quality of health care delivery. The reformists argue that locally managed services make health systems more responsive to population needs, promoting a more efficient and equitable social system. Decentralisation policy can also guarantee the democratisation of the state, giving more social control through popular participation. This is especially important in a country such as Brazil undergoing political upheaval following decades of highly authoritarian government (Escorel, 1998; Carvalho, 1995; Gerschman, 1995).

In the state of Ceará, in the North-eastern Brazil, there has been a tremendous acceleration concerning the implementation of these health reform measures, especially after the 1986 elections which were won at the state level by a political group led by the businessman Tasso Jereissate. This political group - formed by industrialists who identified themselves with ideas such as 'modernization' and 'efficiency' - campaigning with slogans such as "a government of change" and "the fight for the end of *coronelismo*" contributed to bring about changes in the economic structure of the state, and also to the political and administrative level. In power, Tasso Jereissate appointed leading members of the health reform movement in Ceará to take control of the State Health Secretariat (SESA). This acquisition of power enabled them to put into practice the health policy advocated nationwide, making the state of Ceará one of the national leaders in the decentralisation process

Thus, this article focuses on the process of health reform in the state of Ceará in the 1990s, examining the complexities of this apparently contradictory political alliance between the advocate of the health reform movement, rooted in Socialist principles, and a group of capitalists.

## Health Reform in Brazil: The Health Reform Movement

The Brazilian health reform movement began in the mid 1970s comprising health professionals from academic research institutes intellectuals and political activists (especially those belonging to the Brazilian Communist Party, PCB). This coalition was the force behind the theoretical and ideological

foundations of the health reform movement with its roots in Departments of Preventive Medicine (DMPs) of some universities and with its main centre at the Brazilian Centre of Health Studies (CEBES).

The DMPs with the support of the Pan-American Health Organisation (PAHO), applied social science research and methods to the medical field, resulting in the emergence of a new approach to health that follows a Marxist theoretical tradition (Escorel, 1998). This new approach began to question and debate the political aspects of health, examining the social environment and the conditions of life within which health problems occur. The view was that the social environment is the main factor determining the health conditions of the population. In criticising the health system, the reformists argued that too much emphasis was given to expensive curative treatments, neglecting the social and economic factors contributing to ill-health. The reform agenda proposed for the national health system thus was grounded in a vision of improving the social conditions of the Brazilian population. The main proposals were: creation of one National Health System administered by the State; free medical attention and care for all; greater regulation of the private sector by the State; decentralisation; popular control over the system through participation; greater efficiency in resources management; control on the production and distribution of medicines; control on imported medical equipment (Escorel, 1998).

In the late 1970s, the members of the health reform movement would strategically occupy state positions in order to promote the reform agenda. The authoritarian government, to legitimate the system agreed to implement some social development programmes. In doing so, they made available space for members of the health reform movement in the bureaucracy. Although under the military regime the effect of this occupation had limitations, the reformists were still able to implement some alternative projects and work on the development of human resources. Among the projects, one of the most noteworthy was the programme for the development of basic health care in rural areas, PIASS (*Programa de Interiorização das Ações de Saúde e Saneamento*). PIASS was the first attempt to expand and promote health without expensive technology or specialist professionals in rural areas. Despite some claims (Silva, 1995) that the PIASS did not succeed in altering the social conditions, the programme is recognised to have brought improvements in health care to rural areas.

In the 1980s, with the acceleration of the *abertura* process, the health reform movement was occupying increasing amounts of space inside the public bureaucracy. Weyland (1995) calls this a state-centred strategy, which creates more opportunity to launch new initiatives. At first, the implementation of

measures aimed at rationalising the health system while expanding health care coverage. One of these initiatives promoted the implementation of the Integrated Health Actions - AIS (*Ações Integradas de Saúde*), constituting an important policy that helped move toward full reform of the health sector. The main principles of the AIS were:

- total responsibility of the state in promoting health care
- emphasis on basic actions
- priority to the public sector rather than the private
- decentralisation of planning and management
- training of human resources
- planning based on the epidemiological profile of the different areas
- popular participation (Escorel, 1998).

The transition to democracy and the government of the first civilian president after 21 years of dictatorship led to the appointment of some leading figures of the health reform movement to top state positions. From these positions, the members of the health movement started the process of re-structuring the health sector. Referring to this process.

A major turning point for the health reform movement was the VII National Health Conference in 1986. The outcome of this conference was to consolidate proposals of the health reform movement into an agreed strategy objectives of which were available to the public. It also involved participation not only from health professionals, but also from different social movements. The main ideas and orientations agreed at the Eighth National Conference were,

- health and sickness seen is result of the social conditions of the population
- health assistance is a fundamental right of citizenship and duty of the state (opposing the view of medical care as a reserve benefit for those who pay direct taxes to the social security system)
- the creation of the national health system is essential to promote equity and the universalisation of health care
- popular participation through the creation of community health councils

- emphasis on basic actions and preventive care
- priority to the public sector (Mendes, 1995).

These proposals resulted in the creation, in 1987, of the ‘Unified and Decentralised Health System’, SUDS (*Sistema Unificado e Descentralizado de Saúde*). Mendes (1995), an important commentator of that period and a member of the reform movement, points out, that SUDS, in an atmosphere of tension and with conflicts inside and outside the Brazilian federal government,<sup>1</sup> was unable to fulfil its objectives. For this author, it was an important administrative reform, but its failure was that it did not achieve efficiency and effectiveness in the delivery of health care,

*“The SUDS reinforced exclusion and did not succeed in altering the classical pattern of intermediation between state and society based on clientelism and corporativism”.*  
(Mendes, 1995, 46)

The private sector, defending the established health system and their privileged position, and institutional constraints imposed by clientelist politicians are important factors in explaining the limited success of the reforms (Weyland, 1995). These politicians, fearing any improvement in the right to health care, which would weaken their control over large numbers of votes and undermine their power base of favours, joined forces in the National Congress and through a complex web of traditional political relations formed an opposition force to decentralisation and to the principles of health reform in general. The opposition group gradually removed many health reform members from top state positions.

*“MPAS Minister Magalhães drew on support from the subnational governments to attempt a major reorganisation of the health care system in mid-1987. Conservative forces, however, offered fierce resistance. Above all, clientelist politicians saw health reform as a threat to their political sustenance and successfully tried to evict members and supporters of the reform movement from leading state positions. As a result, the reorganization made only halting progress and did not serve as the first step in the planned overhaul of the Brazilian health system”*(Weyland, 1995: 1705)

Despite the problems, the new constitution of 1988 contained many principles of SUDS and of the health reform movement.

<sup>1</sup>For a more in-depth discussion on the implementation of the SUDS, see Mendes 1998 and 1995; Weyland, 1995; Muller Neto, 1991.

## The health system in the 1988 Constitution

The greatest achievement of the health reform movement was to have the key principles for reform in the new constitution drawn up in 1987. Thus, when the Constitution became effective in 1988, the major proposals of the health reform movement calling for the regulation for the health system were incorporated, including a clear emphasis on decentralisation of health services. The key principles of the new Constitution are: health as a social and universal citizen right; responsibility for the provision of health care is with the State; the creation of a Single Health System; decentralisation; full medical care to all citizens; popular participation and control (Mendes, 1998). The Health Law n. 8.080, of 19/09/1990, and the Health Law n. 8.142, of 28/12/1990 (*Leis Orgânicas das Saúde*) transformed the constitutional principles into legal norms and formed the legal framework for the health sector. Article 196 of the new Constitution expresses the overall policy vision regarding health care,

*“Health is the right of everyone and the duty of the State, which should guarantee via social and economic policies the reduction of risk of disease and other injuries and universal and equal access to activities and services for health promotion, protection and recovery”.* (Constituição Federal, article 196)

In order to break the stratified, unequal provision of health services, the Constitution calls for one, single system of health care. The implications of this are that all publicly provided care should be under the control of one management, the Ministry of Health. The organisation of the SUS is according to the following principles,

- 1) decentralisation, with single management in each sphere of government
- 2) integrated provision, with priority to preventive activities, without compromising medical services
- 3) community participation (Federal Constitution, article 198)

Related to the private sector, the Constitution regulates,

*“health care is open to private initiative*

*1) private institutions can participate in a complementary form to the single health system, following its principles,*

*through contract of public law or convention, with preference for those entities which are without aims of profit*

*2) it is forbidden for public resources to end up, through aid or subsidies, going to private institutions with profit making aims*

*3) the direct or indirect participation of businesses or foreign funds is forbidden in health care in the country apart from those agreed by law*

*4) the law will regulate conditions and needs for the removal of organs, tissues and other human substances for transplant, research and treatment, as well as the collection, treatment and transfusion of blood and its derivatives, forbidding any type of commercialisation” (Federal Constitution, article 199).*

Decentralisation, however, means local control of health provision within a defined geographical area. Thus, the third tier in the Brazilian political administrative structure, the municipality can enter into a contract with the Federal (Ministry of Health) to receive resources and authority to manage the facilities and health care within the municipality. The municipality has to demonstrate capacity to manage its own local health system and allocation of resources is according to set of criteria made by size and existing services. The contract is formally made with the Single Health System (SUS) through which the Federal resources and programmes are channelled.

Thus, in summary,

*“Four main strategies were laid down by which reform of the existing health sector would come about: integrating the different public providers into one single system, greater emphasis on preventive rather than curative care, decentralised management of health care provision to the district level and popular participation in the management of health care system at all levels”.* (Atkinson *et al*, 2000: 623)

## The Health System Reform in the State of Ceará

There has been a tremendous acceleration concerning the implementation of health reform in the state of Ceará, making it one of the national leaders in the decentralisation process. Two factors put the state in the forefront of this reform

process (Abu-El-Haj, 2000). First, there has been political continuity in the state government Tasso Jereissate's political group winning elections from 1987 to 2006. Second, all those with leadership appointments in the State Health Secretariat (*Secretaria de Saúde do Estado - SESA*) since 1987 are and have been members of the health reform movement. These two factors are congruous because the victory of Tasso's political group was responsible for the local reformists' acquisition of power enabling them to put into practice the health policy advocated nationwide. However, even before this period, Ceará had been experiencing some reformist projects such as the PIASS and the AIS.

The official implementation of the PIASS in the state of Ceará in 1997 had as its aims to,

*“implement basic structure for health in communities under 20,000 inhabitants, contribute to improvements in the health conditions of the population and promote participation of the community in health and sanitation issues”.* (Ceará/CEPLAN, 1979: 12. In: Noronha Brasil, 1997)

Another important step towards reform was the implementation of the Integrated Health Actions (AIS) programme in 1983, when the state of Ceará made contracts for allocation of resources from INAMPS in order to pay for its health services at the state and municipality levels. The creation in March 1984 of the Inter-institutional Health Commission (*Comissão Interinstitucional de Saúde - CIS*) was to administer the AIS. This was an advisory committee set up to support the execution of programmes (Noronha Brasil, 1997). The main principles of health reform for the state of Ceará proposed by the CIS were: the state health system should have a management team (rather than one director); single management at all levels; integration into a regional and hierarchal network; redefinition of the relation among the different providers; human resource training; social control and popular participation (IPLANCE, 1998). Thus, the CIS sought to initiate at the state level, some of the national reform movement strategies, turning into a transition programme between the previous centralised health system, and the new system represented by SUS.

Carlile de Lavor, a key member of the reform movement in Ceará comments in an interview cited in Abu-El-Haj (2000), that the health reform movement found its initial expression in the state through the social movements of the health professionals. In 1984 and 1986, the I and II Health Meetings in Ceará brought together health professionals and the representatives of the population to discuss the projects of the national health reform movement.



## Health reform movement in Ceará and the “*governo das mudanças*”

The 1986 election for the state governor was an important moment for the health reform movement in Ceará. In an apparently contradictory alliance, the reformists, rooted in Socialist principles, formed a political alliance with a group of capitalists led by the businessman Tasso Jereissate who won the election. Abu-El-Haj (2000) notes that some main factors explain this apparently bizarre alliance. The first factor contributing to this alliance derives due to the difficulties of the health reform movement to implement their policies at the Federal level. Because of this, the reformists began to focus attention on the state and municipality levels believing that they might provide the best conditions for the implementation of reform. Later, more responsibility for health reform at the state level came from the implementation of the SUDS in 1987 by the federal government. The health reform movement saw in this an opportunity to reinforce their agenda and began to search for allies in the states and municipalities. Consequently, state and municipal governments became important allies in the efforts of health reform movement. This illustrates that it was becoming increasingly clear that the implementation of the health reform agenda was going to be dependent on political conditions at the state and the local levels.

The second factor draws from the strategy taken by the health reform movement for occupying institutional spaces inside the state bureaucracy. The health reform movement at first tried but failed in mobilising support in society, especially among the poor, for their progressive project. In this way, they saw the civil society as fragile and unable to help them to execute the reforms. Therefore, the achievement of social change could only happen through effective actions taken by the State. They began to believe that the implementation of the reforms had to be driven by the health system itself. Following the path of the national movement, the emphasis of action by the state reformists was to gradually take over important bureaucratic positions as an essential pre-condition to implement the reforms. The strategy of occupying leading positions inside the state favours an alliance between the health reform movement with roots in socialist principles and the capitalist group.

The third dynamic to understand the alliance between these two groups, according to Abu-El-Haj (2000), is the crisis of socialism as an alternative social system throughout the 1980s culminating in the fall of the Berlin wall and the disintegration of the Soviet Union. The Marxist crisis generates dilemmas and taints the achievement of the ideological utopia present in the social movements, including the health reform movement. As a result, the health reform members assumed a more pragmatic discourse initiating

political alliances with different reformist groups. In the state of Ceará, the group led by Tasso Jereissate, although capitalistic, had as its political campaign platform ideas such as rationalisation of the state, modernisation, rejection of clientelism and *coronelismo*, and the necessity of reforms to promote social change and improvement in the life condition of the population (Abu-El-Haj, 2000). In this regard, the health reform members saw in Tasso's victory the chance they had been waiting for, especially in a state traditionally characterised by vertical power relations and corruption.

In 1987, leading members of the health reform movement in Ceará took control of the State Health Secretariat (SESA) and consequently the power to formulate and implement health policy. Abu-El-Haj believes that these two apparently contradictory groups “in practice had convergence of interests, political objectives and personal affinity” (2000: 152). Thus, Abu-El-Haj argues that relations based on mutual trust and political interests contribute to improve the state health institutions, which subsequently places Ceará as a leading state in the health reform process.

The health reform members adopt the principles of preventive care in the elaboration of health policy for the state. This made it possible for the state of Ceará to improve the coverage of health care and be the first state in Latin America to win the UNICEF Maurice Pate prize in 1993. Child support programmes won the award for their reduction of the infant mortality rate in Ceará by 36% - from 102 per 1,000 to 65 per 1,000 in 1992 (Tendler and Freedheim, 1994). Through the Community Health Worker programme, the state improved the coverage of vaccination where the majority of the children in the state are included in this programme.

Following this, even the critics of the state government recognise that there has been a substantial improvement in health care delivery in the state. Gondim, for example, says,

*“Although the programmes of the governors Tasso and Ciro have not been enough to alter the sanitation condition in which people live, it should be recognised that a reduction in the mortality rate is a notable result in itself”.* (Gondim, 1988, 56)

## The organisation of the health system in Ceará

The first stage in the process of decentralisation came with the implementation of SUDS in 1997. SUDS brought with it the transference of the health facilities belonging to INAMPS to the state of Ceará. This also brought the integration

of different public health institutions into one system under the management of the State Health Secretariat -SESA.

The reformists, now in command of the SESA, had the conviction that only the municipality, as the closest political administrative unit to the population, could guarantee a higher standard of responsiveness in the delivery of health care. The publication of *Cartilha No 1 - Construindo a Municipalização*, by SESA in 1989 explains on the benefit claims of the decentralisation process,

*“... it is in the municipality that people live, work and get sick, so they are the ones who better know their necessities and problems and can decide what is more important to their health. With decentralisation medical attention is closer to you”* (1989: 14).

In 1989 the process of reform and reorganisation of the health sector was intensified in the state. In the period between July 1989 and July 1990, SESA transferred health care management to 42 of 184 municipalities, the highest rate at that time in Brazil (Abu-El-Haj, 2000). In the early stages, the state was carrying out the decentralisation process without the participation of the Federal Union. In 1994, the state of Ceará became the national leader as regards the proportion of its municipalities that had achieved the status of decentralised system, and by 1996, 92% of the overall number of municipalities (170 municipalities) were decentralised.

According to Almeida *at al* (2000), the decentralisation process at the national level only began in 1991 through the administrative instruments known as *Normas Operacionais Básicas* - NOB/91, NOB/93, NOB/96 (Basic Operational Norms).

In the process of decentralisation, the guarantee of popular participation supposedly was through the creation of municipal health councils and the state health council. The creation of the first municipal health councils in the state of Ceará was in 1989. Again, this happened before the Health Laws 8.080 and 80.142 (*Leis Orgânicas da Saúde*) that define the legal framework of the health system. The establishment of the State Health Council (*Conselho Estadual de Saúde* - CESAU) occurs in 1989 as a deliberative body to accompany and evaluate the health policy in the state (*Resolução* 07/80 de 01/03/89). CESAU is responsible for the approval of the municipal health councils in Ceará, and gives support to the municipalities in the regulation of these councils. The municipal health councils follow the organisation model

of the CESAU, thus they are responsible for planning, monitoring and controlling the provision of health services. All councils at whatever level need to have a 50% of its representative from government and health institutions and 50% from the population.

According to recommendations from the CESAU, selection of the members of the municipal health councils should take place in meetings held with the general community where the population could have the opportunity to choose their representatives.

In line with the health reform principles, the municipal health councils should be the main power in decision making regarding local health system management and the major instrument used to bring the health sector close to the local population. In complement to the municipal health councils are the municipal health conferences. The main objectives of these conferences, held every two years, is to evaluate the provision of health care at the local level and to define priority needs for the next two years.

In 1993, the state government built the *Escola de Saúde Pública do Ceará - ESP* (Public School of Health). The objectives of the ESP are to provide training and research in public health and offer courses both on clinical and preventive care and in other aspects of health planning and management, in order to make viable the local health system and the improvement of the health sector within the state.

Another two important programmes initiated and implemented by SESA are the Community Health Worker programme (*Programa de Agentes de Saúde*) and the Family Health Programme (*Programa Saúde da Família*).

The Community Health Worker (CHW) programme in the state of Ceará was first implemented in the municipality of Jucás<sup>2</sup> by the reformist physician Carlile de Lavor. In 1987, Carlile de Lavor takes over state secretary of health, implementing the CHW programme at a state level. The programme initially appeared as part of the Permanent Actions Against Droughts Programme (*Programa de Ações Permanentes de Combate às Secas*). This was an emergency programme aimed at creating employment to assist the population during one of the periodic droughts that afflicts the states in Northeast Brazil. At that time, temporary disaster relief funds from the federal and state government financed the CHW programme. The success of the CHW programme made the state government decided to finance it permanently in 1989, even after the emergency funding had ended (Tendler, 1998). The CHW had as its objective,

<sup>2</sup>As Silva (1995) points out, the basic principles and ideas of the programme were not new, since many other countries had already experienced the use of community workers to promote basic actions in health. Freedheim (1995) cited in Godim (1998), says that even in the state of Ceará other programmes with the same principles had been developed. However, none of them achieved the success of the programme implemented by the state governor.

*“to reach the communities, offering mainly basic actions in health, and promote a better coverage of these actions, contributing to reduce the mortality rate, especially among the children”.* (IPLANCE, 1998: 16)

The CHW programme has been significant in redressing the focus of health care provision, with an increase in the coverage of preventive care. Through the efforts of community health workers, Ceará saw a reduction in the infant mortality rate and a successful extension of the vaccine coverage.

The success of the CHW programme brought national and international<sup>3</sup> attention to the state and the Federal government decided to implement it as a national programme, which started in 1991 as the *Programa de Agentes Comunitários de Saúde - PACS* (Community Health Workers Programme).

The Family Health Programme (*Programa Saúde da Família - PSF*), first came into existence in the state of Ceará as well, in the Municipality of Quixadá, as a programme implemented by the local Secretary of Health in 1993 (Viana e Poz, 1998). In 1994 the MoH implemented the PSF in Brazil. A multi-professional team constitutes the Family Health Programme: a doctor, a nurse, a technician in basic health services and some community health workers; since October 2000, a dentist became part of the team. The team's base is a health facility – usually a health post or a health centre - where they can be responsible for a certain number of families in a specific area of the municipality. The MoH recommends that each team should accompany a maximum of 4,500 people. The Family Health Programme gives priority to the promotion of preventive health care,

*“The objective of the PSF is to reorganise the practice of care on a new basis and criteria, and in substitution of the traditional model of care, oriented to cure and established at the hospital. The provision is centred on the family, viewed in its physical and social environment which enables the Family Health teams to extend the understanding of health/sickness (saúde/doença) process and the necessity for interventions that go beyond curative practices”.* (Ministério da Saúde. Programa Saúde da Família, 2001: 05)

The Family Health team has the responsibility for development of activities including the identification of local health problems, education to tackle problems, complete health care for the population, household visits and

<sup>3</sup>For the international coverage of the programmes developed in the state of Ceará see the references cited in Tendler and Freedheim (1994).

meetings with the community to discuss health related issues. The Family Health Programme, according to the MoH adopts the principle of integration. Although it gives priority to preventive measures, it integrates the team to other levels of the system ensuring a comprehensive service for the population.

*“The Family Health team is part of the primary level of actions and services of the local health system, denominated basic care. [the PSF] needs to be linked to the services network to guarantee integral attention to individuals and families and assure the referral and back-referral between the different levels of the system, when a more advanced facility is required to address the problem identified at the basic care level”.* (Ministério da Saúde. Programa Saúde da Família, 2001: 06)

The Family Health Programme is a health strategy included in what the MoH calls basic health care (*atenção básica da saúde*) which is defined as a series of actions based at the primary care level of the health system concerned with preventive care and the promotion of health actions. This includes medical consultations in basic specialities, basic dental treatment, ambulatory care through the PSF teams, vaccination, educational activities, ante-natal care, family planning, simple surgery, community health worker activities, nutritional orientation (Ministério da Saúde, Programa Atenção Básica - PAB, 2001).

By March 2000 the PSF programme had been implemented in 2,101 municipalities in Brazil (of a total number of 5,507), covering 20.6 million inhabitants (38% of the municipalities). Figures from the MoH shows that the state of Ceará has moved fast in the implementation of the Family Health Programme. By March 2000, 179 (of 184) municipalities had at least one PSF team in operation with a total of 856 PSF teams in charge of 2,953,200 million people across the state (Ministério da Saúde, Programa Saúde da Família, 2001).

## Conclusion

The objective of this article is to offer an overview of the health reform process in Ceará. The driving factor behind the Brazilian health reform movement was the necessity to reorganise the national health system and overcome inequalities. This reform was born during the military government with a democratic ideology that enhances the concept of citizenship where social needs are fundamental rights and the responsibility of the State. By occupying leading positions inside the national level bureaucracy, the reformists were

advocating key principles that became part of the new Brazilian Constitution. Among these principles, the decentralisation of health care management and the emphasis on preventive care are important. Decentralisation, and together with it the idea of popular participation, is seen as essential to guarantee the fulfilment of the people's needs and to incorporate their voice in the decision-making processes of the health system. In the state of Ceará, health reform movement members have control over the management of the state Health Secretariat. This is the main cause of the acceleration of the decentralisation process with the transference of responsibility over the management of health care delivery to municipalities.

**RESUMO:** O objetivo deste artigo é oferecer uma visão geral do processo da reforma de saúde no Ceará, focando no processo de descentralização na década de 1990. O fator principal atrás do movimento da reforma sanitária brasileira foi a necessidade de reorganizar o sistema nacional de saúde e superar desigualdades. Para os sanitaristas, descentralização, junto com a participação popular, é vista como essencial para garantir a satisfação das necessidades de saúde da população, além de possibilitar incorporar sua voz processo de decisão do sistema de saúde. No estado do Ceará, depois das eleições de 1996, membros do movimento da reforma sanitária local assumiram controle sobre a administração e gerenciamento da Secretaria Estadual de Saúde. Esta é a causa principal da aceleração do processo de descentralização no Estado, com a transferência de responsabilidade sobre o gerenciamento do fornecimento de assistência a saúde para os municípios.

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