DEMOCRATIC AGENDA SETTING ON PRIMARY HEALTH CARE: THE SUSCOM+ PROGRAM

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Abstract: The paper presents a case study about the SUSCOM+ Program, which was developed and has been conducted by the Public Prosecution Service of the State of Paraná in Cities of this federative unit, having as its main objective to strengthen community participation in the construction of Primary Health Care public policy in the field of the Unified Health Care System. The work has empirical-theoretical nature and analyzes that Program parting from references and concepts given by Legal Science, Public Administration Science, and Political Science, notably the ideas of fundamental social rights, public policy cycle, democracy, and popular or community participation, concluding that it is capable of providing a democratic openness at the beginning of the constitutive cycle of Primary Health Care public policy, that is, the agenda setting, in order to enable the concrete aspirations of the community to be effectively received and

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answered by the competent governmental sphere.

Keywords: Primary Health Care public policy; agenda setting; community participation; Public Prosecution Service of The State of Paraná; SUSCOM+ Program.

Resumo: O artigo apresenta um estudo de caso sobre o Programa SUSCOM+, o qual foi desenvolvido e tem sido conduzido pelo Ministério Público do Estado do Paraná em municípios desta unidade federativa, cujo objetivo principal é fortalecer a participação comunitária na construção da política pública de Atenção Básica à Saúde no âmbito do Sistema Único de Saúde. O trabalho tem natureza empírico-teórica e analisa aquele Programa a partir de referenciais e conceitos fornecidos pela Ciência Jurídica, pela Ciência da Administração Pública e pela Ciência Política, notadamente as ideias de direitos fundamentais sociais, de ciclo de políticas públicas, de democracia e de participação popular ou comunitária, concluindo que ele é capaz de proporcionar uma abertura democrática no momento inicial do ciclo constitutivo da política pública de Atenção Básica à Saúde, qual seja, a definição de agenda, de modo a possibilitar que as concretas aspirações da comunidade sejam efetivamente recepcionadas e respondidas pela esfera governamental competente.

Palavras-Chave: Política pública de Atenção Básica à Saúde; definição de agenda; participação comunitária; Ministério Público do Estado do Paraná; Programa SUSCOM+.

INTRODUCTION

We might say that the study of public policies usually embraces a transdisciplinary character, calling contributions from various branches of knowledge to compose a – as much as possible – holistic picture of

this phenomenon, which is present, to a greater or lesser extent, in all societies organized in the form of States.

Indeed, the confluence of multiple looks allows us to identify and understand since the collective needs that determine the adoption of public policies to the transformations that they are capable of provoking in social reality, without forgetting, of course, the whole process that mediates these poles and involves the formulation and implementation of such public policies.

In the case of Brazil, among the public policies imposed as governmental duties, the public health care policy, operated through the Unified Health Care System, deserves permanent attention, given its importance for the configuration of a minimum level of decent living for people – which, in the legal field, is usually called *the existential minimum*. And, within the Unified Health Care System, Primary Health Care public policy, considered as its "gateway", must be illuminated.

This paper presents a case study about the SUSCOM+ Program, which was developed and has been conducted by the Public Prosecution Service of the State of Paraná in Cities of this federative unit, having as its main objective to strengthen community participation in the construction of Primary Health Care public policy in the field of the Unified Health Care System.

The work has empirical-theoretical nature and analyzes that Program parting from references and concepts given by Legal Science, Public Administration Science, and Political Science, notably the ideas of fundamental social rights, public policy cycle, democracy, and popular or community participation, seeking to demonstrate that it is capable of providing a democratic openness at the beginning of the constitutive cycle of Primary Health Care public policy, that is, the agenda setting, in order to enable the concrete aspirations of the community to be effectively received and answered by the competent governmental sphere.

First, however, it brings the premises of all the reasoning

developed: the constitutional provision and the crisis of effectiveness of fundamental social rights, the role of the Brazilian Public Prosecution Service as an inducer of public policies aimed at the satisfaction of such rights, and the structuring lines of the Unified Health Care System and Primary Health Care.

1. THE LONG QUEST FOR THE ENFORCEMENT OF FUNDAMENTAL SOCIAL RIGHTS IN BRAZIL

The granting of fundamental character to social rights occurred notably from the current Brazilian Constitution (1988), which, as pointed out by Piovesan (2015), not only brought these rights in its article 6, but also contemplated several measures responsible for their implementation, including guidelines and programs. In this sense, the fundamental social rights represented a paradigmatic turn regarding an "abstentionist" State model for a State action based on an active and prestational logic of rights. This has entailed a process of epistemological inscription of public policies[1] in the field of Legal Science, as they represent the forms of fulfillment of constitutionally provided social rights (BUCCI, 2006).

Thus, the fundamental social rights presented in the Brazilian Constitution are related to a conceptual enlargement of the dignity of human person, in which these rights are added to the set of fundamental individual rights in a logic of "rights-means" (since they enable the enjoyment of individual rights) (BUCCI, 2006), and are inscribed in the dynamics of the Democratic Rule of Law in its dimension of "social transformation", which privileges the substance of rights and guarantees means of materializing the Constitutional Text (STRECK; MORAIS, 2006).

This increment of the dignity of human person's legal

[1] In this sense, public policies can be considered a design of governmental action, in which there is an organized combination of various mechanisms and actions for the achievement of the State's ends and/or the realization of the underlying rights (BUCCI, 2006).

content has brought the complexity of the realization of human and fundamental rights. The constitutional construction of a repertoire of mechanisms for the concretization of these rights through governmental action is essential and inserts the latter in the process of institutionalization of social dynamics, in order to amortize "the disintegrating force of the capitalist economy" and "promote the development of human person" (BUCCI, 2006). However, it's not possible to transpose these theoretical formulations on alleged governmental activities directly to countries occupying peripheral international positions, such as Brazil, as they experience the absence of a Social State in the path of the accomplishment of those rights (BUCCI, 2006).

It's necessary to consider, in the contradictory experience of governmental prestational performance in the Brazilian reality, that the ineffectiveness of fundamental social rights cannot be accepted peacefully, because the Brazilian Constitution was drafted emphasizing the strength of these rights in the course of political redemocratization and in the efforts to overcome historically consolidated inequalities. The effectiveness of fundamental social rights crosses the desired substantial sense of Democracy, and this democratic panorama depends on material equalization and social opportunities in the quest for overcoming situations of subhumanity and inequalities that permeate and structure Brazilian society (BUCCI, 2006).

In this context, fundamental social rights operate inside the objective of achieving material equality and demand, therefore, a chain of concrete governmental actions – legislative and administrative –, impacting greatly on the public budget dynamics. The satisfaction of these rights spontaneously by the Government is expressed through public policies, which are mainly elaborated by the Legislative and the Executive Branches (CANELA JÚNIOR, 2011) and can be based on different normative substrates, from constitutional norms to infralegal instruments (BUCCI, 2006).

However, as can be taken from the Brazilian reality mentioned above, governmental actions are not necessarily fully aligned with the complete realization of those rights and, in this ineffectiveness, they are expressed in a commissive or a omissive dimension. The commissive behaviors that violate the fundamental social rights and the primary purposes of the Government are those that need a control that denies them validity, since they establish public policies in a defective manner. The omissive behaviors are those that demand the filling of a void of public policies that have not been implemented. Both situations share the same core: the divergence between what is legally provided as a right and what is concretely done (CANELA JÚNIOR, 2011).

The correction of these "deviations from the route" in the formulation and implementation of public policies and the fulfillment of fundamental social rights began to rely on the efforts of the Public Prosecution Service and the Judiciary Branch. As mentioned, the constitutional provisions brought an institutional and legal, substantial and procedural repertoire (COSTA, 2016), which contemplates forms of enforceability of those rights, in Courts or in the extra-judiciary sphere. The Public Prosecution Service and the Judiciary Branch have gained space as actors in the political scenario, with constitutionally delineated potential for "counter-majority" action (SADEK, 2013; COSTA, 2016).

There has been a process of "juridification" of social relations, in which spaces previously destined for political action began to incorporate the intervention of the Public Prosecution Service and the Judiciary Branch (OLIVEIRA, 2019), leading to the phenomenon of judicialization or judicial review of public policies, resulting from the inertia or the negligence of the Legislative and the Executive Branches (especially the latter) in their implementation (SANTIN, 2005, 2013; MACHADO; DAIN, 2012; GRINOVER, 2017). Thus, the Judiciary Branch is summoned to intervene in cases in which there's violation of the so-

called *existential minimum*, composed of fundamental social rights such as the rights to education, to the full protection of children and adolescents, to social assistance, to housing, to health care, to food, and to public security (SANTIN, 2005, 2013; GRINOVER, 2010). It's worth mentioning, however, that the existential minimum is characterized by dynamism and conceptual organicity and malleability, adapting, in historical and geographical terms, to the socioeconomic conjuncture, and having as its guiding line the *principle of prohibition of regression* (WATANABE, 2013), according to which the achievements in the realization of fundamental social rights cannot be simply revoked.

The quest for the enforcement of fundamental social rights can be considered long, because they are historical victories that have taken shape over time. As pointed out by Piovesan (2015), social rights began to be provided from the Brazilian Constitution of 1934, however dispersed throughout its text and without the connotation of fundamental character. As we have explained, it was the Brazilian Constitution of 1988 that gave these rights the position of fundamental rights and their immediate applicability. In this sense, it's not possible to take them from a current reference only, without considering an entire History that permeates them.

Moreover, the course of the realization of fundamental social rights through the implementation of public policies is a path to their affirmation in the face of many obstacles, being associated with a perspective that takes into account social cleavages and that reflects on forms of inter-institutional dialogues (OLIVEIRA, 2019).

It's precisely as an agency that promotes and facilitates these inter-institutional dialogues aiming at the implementation of public policies and the enforcement of fundamental social rights that the Public Prosecution Service must behave, given its current constitutional configuration.

2. THE BRAZILIAN PUBLIC PROSECUTION SERVICE'S ROLE ON FORMULATION AND IMPLEMENTATION OF PUBLIC POLICIES

The Public Prosecution Service is generally seen as the agency responsible for criminal prosecution, and the prosecutor as the public agent that has the power (and in Brazil also the obligation) to present and sustain criminal cases before Courts of Justice.

Since Brazil's a Federation, composed of States and a Federal District[2] endowed with broad political and administrative autonomy and the Union (Federal Government), plus the Cities, it has several Public Prosecution Services. Each State, the Federal District, and the Union have their own independent Public Prosecution Services. And each Public Prosecution Service is headed by an Attorney General and composed of a great number of members. However, the identity of structure, principles and purposes allows us to recognize its national and unitary character.

The Brazilian Public Prosecution Service, as a whole, is granted by the Brazilian Constitution with lots more tasks other than criminal prosecution. Article 127, *caput*, of the Constitution bestows the nature of permanent institution, essential to the Judiciary Branch, and the responsibility for defending the legal order, the democratic regime and the social and the individual unavailable interests. To do so, the Brazilian Public Prosecution Service has a broad standing for class actions and other legal instruments aimed at seeking the enforcement of rights, the implementation of public policies, and the accountability of negligent authorities, for example, according to article 129 of the

[2] In the Brazilian federative structure, the Federal District emerges as a kind of "hybrid entity" that brings together State's and City's competences. There is located the City of Brasília, capital of the Federative Republic of Brazil.

Constitution.

The Brazilian Constitution of 1988 truly represented the milestone of the consolidation of a new identity for the national Public Prosecution Service, having broadly reflected the aspirations contained in the so-called "Curitiba's Charter", a proposal prepared by its various segments and approved at the First National Meeting of Attorneys General and Presidents of Associations, held in the State of Paraná's capital from June 20th to 22nd, 1986 (GARCIA, 2008).

Jatahy (2010) states that article 127 of the Constitution has redefined the Public Prosecution Service and altered its essence, in a conceptual and paradigmatic modification never seen before, and asserts that two changes are clear in the reading of the provision: its new institutional function, as an agency for social transformation, and its differentiated constitutional position before the other Branches of Government, implying that it's not formally integrated with the Executive, the Legislative or the Judiciary Branches, but maintains with them institutional relations that allow the necessary checks and balances for the harmonious functioning of the system.

Almeida (2010), in turn, argues that the best conception to explain the current position of the Public Prosecution Service is the one that sees it moved from political society, as a governmental repressive agency, to civil society, as a legitimate and authentic defender of society.

Indeed, the current Brazilian Public Prosecution Service is part of the positive model of Democratic Rule of Law, structured by the Brazilian Constitution in an institutional form and with independence from the other Branches and agencies of Government, being directly linked to the Brazilian Constitution, the legal order compatible with it, and with civil society and its best interests (CAMBI; LIMA, 2011; ZUFELATO; LIMA, 2015).

Regarding its new role, the view that the Public

Prosecution Service should act as an agency for social transformation (JATAHY, 2010) or as a political agency, social producer and promoter-enforcer of public policies (CAMBI, 2009) has already become established.

That is, in addition to seeking the enforcement of public policies, the Public Prosecution Service must also act in their own formulation (CAMBI, 2009). In this very important mission, it's summoned to intervene effectively, both in the legislative sphere of fundamental social rights and in the level of the institutions that must ensure the democratic political process and the realization of prestational governmental activities (CHOUKR, 2010).

Thus, the Public Prosecution Service should be contemplated as a mediating agency in conflicts of social interests (JATAHY, 2010), and as a true communication channel for society, especially with the Judiciary Branch (CAMBI, 2009).

3. THE BRAZILIAN UNIFIED HEALTH CARE SYSTEM AND PRIMARY HEALTH CARE AS ITS "GATEWAY"

Public health care began to gain political prominence from the moment the major epidemics have indelibly marked countries, giving birth to the concept of social hazard and demanding control over people and hygiene practices, in order to avoid those epidemics and the devastation of villages, towns and regions (SANTOS, 2005).

This awareness of the collective – disease as a contagious social risk that could spread without distinction, regardless of social classes – led the authorities to worry about health care public policy. The Government's participation in health care derives precisely from the awareness of social danger and the need for collective intervention (SANTOS, 2005).

Throughout Brazilian History, health care has acquired several features. In the Empire (1822-1889) and in the First or

Old Republic (1889-1930) it was regarded as a Government's favor to the people, since there was no legal framework that could guarantee the right to health care for all. The Government, thus, acted at its discretion. From the President Vargas' Era (1930-1945) until the period of redemocratization, in the 1980s, there were two ways in which citizens could enjoy health care: a) being a worker with a formal contract and a social security contributor; and b) being able to pay for a private health insurance (OLIVEIRA, 2015).

Beginning in the 1970s, in a context in which various segments of Brazilian society were fighting for democratic freedoms against the Military Regime, the health care reform movement raised its banner in defense of health care as a right of all people and the conception that health actions and services should be formulated not only by the Government, but in conjunction with society, which closely knows health institutions (OLIVEIRA, 2015).

Coming to light in 1988 the current Brazilian Constitution, the right to health care was elevated to the category of public subjective right endowed with fundamental social nature, with the recognition that each person owns it and that the State (*lato sensu*, understood as Government) is its debtor (SANTOS, 2005). Article 196 of the Brazilian Constitution textually states that health care "is everyone's right and duty of the State, guaranteed by social and economic policies that aim at reducing the risk of disease and other harms and universal and equal access to actions and services for health's promotion, protection and recovery".

On this trail, a new national public health care system was created, the Unified Health Care System[3], with public responsibilities and a definition of health that does not only take into account purely biological phenomena, also comprising

[3] In Brazilian Portuguese it is called "Sistema Único de Saúde", from which derives the acronym SUS.

social, economic and environmental conditions (SANTOS, 2005).

According to express constitutional provisions (articles 197 and 199), the existence of the Unified Health Care System doesn't exclude the possibility of private health care actions and services provided by private persons or companies, with or without profit intent, and autonomously or complementary to public actions and services.

The guidelines of the Unified Health Care System are drawn in article 198, *caput*, of the Brazilian Constitution. The provision establishes that public health care actions and services are part of a regionalized and hierarchical network and constitute an Unified System, organized according to the following directives: a) decentralization, with single direction in each sphere of Government (n. I); b) integral care, with priority for preventive activities, without prejudice to assistance services (n. II); and c) community participation (n. III).

Decentralization of the Unified Health Care System means that public health care actions and services are distributed as duties of all entities of the Federation, that is, among the Federal Government, the States, the Cities and the Federal District, what is compatible with the constitutional division of material and legislative competences of these entities.

The Federal Government, the States, the Cities and the Federal District have material competence to organize and execute public health care actions and services, under the terms of articles 23, n. II, and 30, n. VII, of the Constitution. Also the legislative competence is divided among the Federal Government, the States, the Cities and the Federal District, as provided in articles 24, n. XII, and 32, paragraph 1, being attributed to the Cities the power to supplement the federal and state legislations, where applicable, by virtue of article 30, n. II (SANTOS, 2005).

The distribution of competences in public health care can be summarized as follows: a) the Federal Government, the

States, the Cities and the Federal District have competence to take care of the population's health, that is, competence to organize and execute public health care actions and services; b) the Federal Government, the States, the Cities and the Federal District have concurrent competence to legislate on public health care; c) when legislative competence is concurrent, the Federal Government legislates on general rules and the States and the Federal District supplement Federal laws by legislating exhaustively to take account of their peculiarities; States, such as the Federal District, in their supplementary competence, may issue specific, more detailed rules; d) regarding the City, its legislative competence in the field of public health care will always refer to local interests: the City legislates in local interest, in addition to being able to supplement Federal and State public health care legislations, whenever the local interest requires so (SANTOS, 2005).

In each sphere, however, there must be an office or agency responsible for the direction of the Unified Health Care System. In the case of the Federal Government, the office is the Ministry of Health, while, in the case of a State, a City or the Federal District, the office is its Secretary of Health.

On the other hand, the directive of integral care refers to quantitative and qualitative aspects of public health care actions and services, which should cover all the person's needs related to one's well-being. Therefore, not only everyone has the right to health care, but it must be provided completely, without exclusion of diseases or pathologies, due to technical or financial difficulties of the Government (TAVARES, 2014). Integral care must focus on preventive activities, that is, those aimed at preventing diseases and health problems and/or reducing their possible consequences in advance, without forgetting assistance services. As we will see ahead, Primary Health Care public policy is the main instrument to achieve integral health care.

Finally, the directive of community participation is

mainly implemented, according to article 1 of Law n. 8,142 (1990), through two collegiate bodies, existing in each sphere of the Federation: the Health Conference and the Health Council (PICORELLI, 2019).

According to article 1, paragraph 1, the Health Conference should meet every four years, with the representation of the various social segments, to assess the public health care situation and propose directives for the formulation of public health care policy. It will be convened by the Executive Branch or, extraordinarily, by the Conference itself or by the Health Council (PICORELLI, 2019).

Under the terms of article 1, paragraph 2, the Health Council is a permanent and deliberative collegiate body composed of Government's representatives, service providers, health professionals and users. It acts in the formulation of strategies and in the control of the execution of public health care policy in the corresponding instance, including the economic and financial aspects (PICORELLI, 2019).

In addition to the constitutional rules that outline the Unified Health Care System, came Law n. 8,080 (1990), which basically provides for the organization, direction and management of the System, the competences and attributions of the spheres of Government, the operation and complementary participation of private health care services and the human resources policy, as well as the financial resources, the financial management, the planning and the budgeting of public health care actions and services.

Among the various specific public policies that make up the larger picture of the Brazilian public health care policy – for example, pregnant women's health care policy, elderly health care policy, children's health care policy etc. – stands out, for its enormous importance and its immediate articulation with the guidelines stamped in article 198, *caput*, of the Brazilian Constitution, the so-called Primary Health Care National Policy.

Primary Health Care is often referred to as the "gateway" for users in the public health care system, being responsible for the initial care of citizens seeking its services. The objectives of Primary Health Care are essentially to advise on disease prevention, to take actions aimed at solving cases of harms and pathologies within its level of complexity and to direct the severe cases to more complex levels of care. Primary Health Care, thus, functions as a "filter" able to organize the flow of cases that enter the Unified Health Care System.

The Primary Health Care National Policy has evolved notably from the experience of the Family Health Program, launched by the Ministry of Health in 1994, and was the subject of the Ministry of Health's Ordinances numbers 648 (2006) and 2,488 (2011). It is currently disciplined by the Ministry of Health's Ordinance n. 2,436 (2017).

Article 2, *caput*, of the Ministry of Health's Ordinance n. 2,436 (2017) defines Primary Health Care as the set of individual, family and collective health care actions that involve promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance, developed through integrated care practices and qualified management, carried out with multiprofessional teams and directed to the population in a delimited territory, over which the teams assume sanitary responsibility.

Paragraph 1 of article 2 expressly states that Primary Health Care will be the main gateway and the communication center of the Health Care Network, care coordinator and organizer of actions and services available on the Network, while paragraph 2 advocates that Primary Health Care will be offered fully and for free to all people, according to their needs and the demands of the territory, considering the health determinants and conditions.

In line with its genealogy, article 4 establishes that the Primary Health Care National Policy has in Family Health its

priority strategy for the expansion and consolidation of Primary Health Care.

Article 3 highlights the principles and directives of the Unified Health Care System and the Health Care Network to be operationalized in Primary Health Care. The principles (n. I) are universality, equity and integrality and the directives (n. II) are regionalization and hierarchization, territorialization, assignment of population, person-centered care, resolutivity, longitudinality and coordination of care, Network's ordination and community participation. These principles and directives mean, in short, that Primary Health Care must focus on the population located in a given territorial space and provide a welcoming, humanized, articulated, quality and effective health care service, as well as open to community longings, which should find channels of expression and be taken into account in the formulation and implementation of the public policy.

The responsibilities of political entities in Primary Health Care are made explicit in articles 7 to 10.

The Federal Government, the States, the Cities and the Federal District are equally responsible for regulating, promoting, financing, providing infrastructure and logistics, planning, monitoring, supervising, evaluating, giving professional qualification, managing information, encouraging popular participation and social control, and guaranteeing effective and integral health care.

Also, as can be seen from article 10, in line with the directives of regionalization and hierarchization, territorialization and assignment of population brought in article 3, n. II, it is essentially the responsibility of the Cities and the Federal District, in the exercise of its City competences, to organize, execute and manage the actions and services of Primary Health Care, universally, within their territories, in order to allow it to act as the preferential and ordering gateway to the Health Care Network. Such political entities must, for example, program the actions of

Primary Health Care from their territorial bases, according to the health needs identified in their populations, using the operative national programming instrument; organize the flow of people, inserting them into care lines, establishing and guaranteeing the flows defined in the Health Care Network among the various points of attention with different technological configurations, integrated by logistic, technical and management support services, to ensure integral health care; establish and adopt mechanisms of responsible referral for the teams that work in Primary Health Care, according to the people's health needs, maintaining the attachment and the coordination of health care; and to organize the flow of people, aiming at guaranteeing references to health care actions and services outside the level of Primary Health Care, and according to the health needs of those people.

We can conclude that the tasks, the popular participation and the social accountability in Primary Health Care must take place primarily at the local level and take as criteria the characteristics, the needs and the interests of the members of a concrete community. As a consequence, it's in the respective public space of debate and with the eyes and ears open for such characteristics, needs and interests of the people that the public policy must be formulated and implemented, that is, they must form the basis for a democratic agenda setting regarding Primary Health Care, an effort proposed by the SUSCOM+ Program of the Public Prosecution Service of the State of Paraná.

4. THE PUBLIC PROSECUTION SERVICE OF THE STATE OF PARANÁ'S SUSCOM+ PROGRAM: STRENGTHENING THE DEMOCRATIC AGENDA SETTING CONCERNING TO PRIMARY HEALTH CARE

The expression *policy cycle* is used to refer to the set of steps – not necessarily linear – in the process of designing, implementing and evaluating a public policy, although there is no

uniformity among theorists about what these steps are and how they follow each other (SECCHI, 2012; RUA, 2014; BAPTISTA; REZENDE, 2015).

Notwithstanding these divergences, it's certain that there's significant attention to the great importance of a stage which lies at the beginning of the cycle of any public policy and serves as its starting point: the agenda setting (KINGDOM, 2003; JOHN, 2006, 2013; CAPELLA, 2007; SECCHI, 2012; RUA, 2014; BAPTISTA; REZENDE, 2015; SANTOS, 2016).

Agenda is a schedule of issues or themes that are recognized as publicly relevant (SECCHI, 2012; BAPTISTA; REZENDE, 2015), or, in other words, a list of initially established priorities to which a governmental sphere should devote its efforts, and among which social actors struggle hard to include the topics of their interest (RUA, 2014).

The public policy agenda setting is the result of a non-systematic and extremely competitive flow, from which are extracted, within the universe of questions that could occupy the attention of the Government, those that will effectively receive treatment (RUA, 2014).

It's noticed that the identification of a social problem as worthy of public concern and its insertion in the Government's agenda, from a systemic perspective, means the openness of the public policies system for a given *input*, which, from then on, will enter the system and be processed, although without the guarantee of an *output* that fully corresponds to the aspirations of the people or groups that achieved such inclusion.

The agenda setting, of course, gains even more importance in the wide theme of public health care policy, as it implies the choice of a way of acting and the allocation of limited material and human governmental resources to meet the needs elected as priorities in a given spatiotemporal reality.

In the context of Primary Health Care, by virtue of constitutional, legal and ordinatory commandments, as we saw

earlier, the formulation and implementation of the public policy must necessarily rely on community participation. Ensuring this participation from the beginning of the policy cycle, that is to say, since the agenda setting, in addition, gives the resulting public policy greater democratic validation.

In order to promote a more intense community participation in the construction of Primary Health Care in the Cities of the State of Paraná, the Public Prosecution Service of the State of Paraná (PPSSPR) (2018), through its Operational Support Center for the Public Health Care Protection Prosecution Offices (OSCPHCPPO), developed and has been conducting an innovative experience: the SUSCOM+ Program.[4]

The Program was introduced in 2017 and, since its implementation, has reached eight Cities of the State of Paraná – Cerro Azul, Medianeira, Rio Negro, Capanema, Maringá, Tijucas do Sul, Xambrê and Terra Roxa. It can be noted, therefore, that the initiative is relatively recent – and is temporarily suspended since 2020 due to the Covid-19 pandemic –, but, as we will see below, it has already revealed interesting and promising results.

The general objective of the Program, in the field of Primary Health Care public policy, is to recognize, in the places where it develops, the population's predominant perceptions of health care, combining them with the investigation of the major health indicators and the detection of eventual care gaps, thus extracting majority consensus, registered in a proper document, that will motivate the possible interventions. The Public Prosecution Service of the State of Paraná intends, through it, to collaboratively stimulate the governmental and non-governmental sectors to elaborate strategies and responses that can guarantee, as much as possible, the consensus obtained, without prejudice

[4] The acronym visibly derives from "Sistema Único de Saúde" (SUS = Unified Health Care System) with more (+) community participation (COM). Official webpage of the SUSCOM+ Program: http://www.saude.mppr.mp.br/pagina-1053.html.

to the legal interventions, thus inspiring a new inter-institutional framework for dialogue and transformation – characterized by the spirit of cooperation among all participants – which includes the most effective community participation in interlocution with the Unified Health Care System (PPSSPR, 2018).

Among the specific objectives expected from the Program are the following: a) the situational survey and the visibility of sanitary conditions of the selected Cities; b) the identification of local priorities, valuing community manifestation as an element for expanding and improving access to public health care; c) inducing good sanitary practices by the Government, as well as the improvement of its social control; d) inducing the construction of a collective discourse on the right to health care at the local level; e) increasing social cohesion around the Unified Health Care System (development of the notion of "belonging"); f) encouraging participatory construction of local solutions; g) reducing the information gap between the public health care manager and the user; h) reducing community frustrations by participating in Primary Health Care public policy; i) identification and consolidation of strategic alliances, including regional ones, for the purpose of the Program; j) honoring the constitutional guidelines of the Unified Health Care System, through their practical applicability; k) the deepening of interfederative integration; l) the strengthening of the reception and the resolutivity of Primary Health Care in the user's perception; m) greater effectiveness of inter-regional references; n) the creation or adequacy of the functioning of the ombudsman's offices of the Unified Health Care System; and o) promoting the replication of the Program in other territories (PPSSPR, 2018).

The Program initially selected five Pilot Cities, located in different regions of Paraná, with different demographics and socioeconomic and health aspects and occupying different strata in the latest available version of the Municipal Human Development Index (MHDI), in order to explore different realities and

stabilize concepts, initiatives, experiences, and deadlines. These Pilot Cities were Cerro Azul, Medianeira, Rio Negro, Capanema, and Maringá. In this initial phase, it was intended to obtain volume of sanitary practices, results and experiences that constituted a heterogeneous set of realities and that could favor, simplified, modulated and with greater autonomy, the later expansion of the Program to other territories (PPSSPR, 2018).

The MHDI, which follows the same pattern as the Global HDI, was the criterion used to select the first Cities of the Program because, through it, it's possible to portray, in greater depth, the reality and difficulties common to the populations and identify the general challenges for the human development (including those related to health). The HDI analyzes human development studied from three dimensions: longevity, education and income. It tends, therefore, to show wider and deeper regional weaknesses than health markers alone might suggest (PPSSPR, 2018).

Regarding the methodology of the Program, its implementation begins with the agreement of the OSCPHCPPO with the local Public Prosecution Office, aimed at syntonizing efforts and deadlines (PPSSPR, 2018).

The OSCPHCPPO then begins the preliminary survey of health information and indicators on the territory. This investigation is carried out in official databases (Ministry of Health, City and State Secretaries of Health, among others) and originates a document called City Situation Sheet (CSS). The CSS includes, among others, general data about the City (development indexes, population and income data, supply and sanitation, expenses), own budget investment in public health care, social participation (existence of the City Health Council and respect for the parity of composition between society and governmental sphere), configuration of the local network and references, health facilities, coverage of Primary Health Care, vaccination and immunization, health of children and women,

general morbidity and mortality, and mental health (PPSSPR, 2018).

The CSS must be supplemented with information gathered locally and then delivered to the interlocutors and partners in the Program (notably the City Health Council and State and City agencies and offices) and publicized for access to all interested parties (PPSSPR, 2018).

Subsequently, working meetings are held with representatives of the Legislative, Executive and Judiciary Branches and the organized civil society, with the purpose of presenting the Program and discussing the public health situation of the City and the referrals to hold a public hearing (PPSSPR, 2018).

The next step is to listen to the community in a public hearing open to the broad participation of its members, organized or not, when the work will be carried out with the democratic logic of freedom of expression aimed at the election of community priorities in Primary Health Care public policy. The idea is to listen to the yearnings of the population concerned, which is intended to become a perennial practice and to provide local arrangements for the desired solutions in Primary Health Care (PPSSPR, 2018).

The problems identified and the proposals and timelines for overcoming them will be the subject of the file of the public hearing and the commitment document signed by the authorities. It will also be sought that the obligations assumed in this commitment document are included in the City Health Care Plan, so that there is one more formal recognition of the City regarding the commitment to perform the actions and services that the population identified as priorities (PPSSPR, 2018).

In addition, the contents of the file and the commitment document will also serve as a basis for the Public Prosecution Service's legal initiatives in relation to the problems found (PPSSPR, 2018).

After the deadlines set for governmental activities aimed

at solving the problems identified by the population, a second and devolutive public hearing will take place, with the scope of reporting to the community on the actions and services actually performed and their results and evaluating them. With the information exposed and gathered at this public hearing, a final report will be prepared (PPSSPR, 2018).

It's important to highlight that the Program does not aim to replace any of the management or control instances of the Unified Health Care System, but to value them and add greater legitimacy, and that the legal initiatives of the Public Prosecution Service don't exempt the legal responsibility of public managers and other authorities, in the event of wrongdoing that may eventually be discovered (PPSSPR, 2018).

As stated earlier, eight Cities of the State of Paraná received the SUSCOM+ Program and seven out of them completed all its phases. Let us look briefly at the main characteristics of these seven Cities that completed the Program and the results obtained, according to the information extracted from the respective CSS and the documents referring to the public hearings, and then move to the general conclusion of this paper.[5]

The City of Cerro Azul is located in the southeastern region of the State of Paraná. At the time of preparations for the first public hearing, its estimated population was 16,938 people and its MHDI was 0.573, below the State's average of 0.749.

The first public hearing of the SUSCOM+ Program was held on August 18th, 2017, and was attended by representatives of governmental spheres and civil society entities and 325 community members. Among the topics raised in the participants' statements, the three major local problems of Primary Health Care were identified: lack of medicines, oral health, and health of women and children. The subjects were submitted to the voting of participants for the election of the priority that would be

[5] Available on the official webpage of the SUSCOM+ Program: http://www.saude.mppr.mp.br/pagina-1053.html.

faced by the Government, and the majority chose health of women and children. The City and State authorities then signed the commitment document whereby they were obliged to draw up a plan and a schedule of actions aimed at solving the deficiencies and to present them to the local Public Prosecution Office.

The second public hearing was held on May 28th, 2019, again with the presence of representatives of governmental spheres and civil society entities and members of the community. It was found that the plan and the schedule of actions – especially dealing with professional training, user awareness and provision of health care services – were presented and satisfactorily fulfilled, considering that the SUSCOM+ Program was successfully concluded in the City of Cerro Azul.

The City of Medianeira is located in the western region of the State of Paraná. At the time of preparations for the first public hearing, its estimated population was 41,817 people and its MHDI was 0.763, above the State's average of 0.749.

The first public hearing of the SUSCOM+ Program was held on October 5th, 2017, and was attended by representatives of governmental spheres and civil society entities and 127 community members. Among the topics raised in the participants' statements, the two major local problems of Primary Health Care were identified: deficiency of the information process in the Health Care Network, and child mortality. The subjects were submitted to the voting of participants for the election of the priority that would be faced by the Government and the majority chose improvement of the information process in the Health Care Network. The City and State authorities then signed the commitment document whereby they were obliged to adopt measures aimed at improving users' access to information and guidance in the Primary Health Care Network.

The second public hearing was held on May 8th, 2018, again with the presence of representatives of governmental

spheres and civil society entities and members of the community. It was found that the measures assumed were satisfactorily fulfilled, considering that the SUSCOM+ Program was successfully concluded in the City of Medianeira.

The City of Rio Negro is located in the southeastern region of the State of Paraná. At the time of preparations for the first public hearing, its estimated population was 31,274 people and its MHDI was 0.760, above the State's average of 0.749.

The first public hearing of the SUSCOM+ Program was held on February 24th, 2018, and was attended by representatives of governmental spheres and civil society entities and 206 community members. Among the topics raised in the participants' statements, the three major local problems of Primary Health Care were identified: lack of community health care agents, lack of medical doctor, and poor quality of care provided. The subjects were submitted to the voting of participants for the election of the priority that would be faced by the Government and the majority chose the increase of the number of community health care agents and the improvement of the care they provide. The City and State authorities then signed the commitment document whereby they were obliged to draw up a plan of actions aimed at solving the deficiencies and to present it to the local Public Prosecution Office.

The second public hearing was held on July 11th, 2019, again with the presence of representatives of governmental spheres and civil society entities and members of the community. It was found that the plan of actions – especially dealing with the proceedings and the schedule for the admission of community health care agents – was presented and partially fulfilled, as four community health care agents were still missing to complete the staff of the City. Thus, it was established that the local Public Prosecution Office should continue to follow up the issue until the actual admission of the missing professionals and the SUSCOM+ Program was considered concluded in the City of

Rio Negro.

The City of Capanema is located in the southwestern region of the State of Paraná. At the time of preparations for the first public hearing, its estimated population was 18,526 people and its MHDI was 0.709, a little below the State's average of 0.749.

The first public hearing of the SUSCOM+ Program was held on March 28th, 2018, and was attended by representatives of the governmental spheres and civil society entities and 82 community members. Among the topics raised in the participants' statements, the three major local problems of Primary Health Care were identified: quality of care, in the aspects of lack of training of professionals, staff deficiencies and inadequate territorialization, plan for jobs, careers and wages of health care workers, and mental health care. The subjects were submitted to the voting of participants for the election of the priority that would be faced by the Government and the majority chose mental health care. The City and State authorities then signed the commitment document whereby they were obliged to redeploy the Psychosocial Care Center in the City by August 2018.

The second public hearing was held on September 11th, 2018, again with the presence of representatives of governmental spheres and civil society entities and members of the community. It was found that the measure assumed was integrally fulfilled, considering that the SUSCOM+ Program was successfully concluded in the City of Capanema.

The City of Maringá is located in the northern region of the State of Paraná. At the time of preparations for the first public hearing, its estimated population was 357,077 people and its MHDI was 0.808, above the State's average of 0.749.

The first public hearing of the SUSCOM+ Program was held on April 12th, 2018, and was attended by representatives of governmental spheres and civil society entities and 118 community members. Among the topics raised in the participants'

statements, the four major local problems of Primary Health Care were identified: lack of medical doctors, quality of care, physical structure, and dengue cases. The subjects were submitted to the voting of participants for the election of the priority that would be faced by the Government and the majority chose to address the lack of medical doctors. The City and State authorities then signed the commitment document whereby they were obliged to remedy the lack of medical doctors and other professionals in Family Health Strategy teams.

The second public hearing was held on April 15th, 2019, again with the presence of representatives of governmental spheres and civil society entities and members of the community. It was found that the measure assumed was integrally fulfilled, considering that the SUSCOM+ Program was successfully concluded in the City of Maringá.

The City of Tijucas do Sul is located in the southeastern region of the State of Paraná. At the time of preparations for the first public hearing, its estimated population was 14,526 people and its MHDI was 0.716, a little below the State's average of 0.749.

The first public hearing of the SUSCOM+ Program was held on March 14th, 2019, and was attended by representatives of governmental spheres and civil society entities and 98 community members. Among the topics raised in the participants' statements, the three major local problems of Primary Health Care were identified: lack of medical doctors, quality of care, and lack of medicines. The subjects were submitted to the voting of participants for the election of the priority that would be faced by the Government and the majority chose to address the lack of medical doctors. The City and State authorities then signed the commitment document whereby they were obliged to remedy the lack of a gynecologist and medical doctors in Family Health Strategy teams.

The second public hearing was held on August 15th,

2019, again with the presence of representatives of governmental spheres and civil society entities and members of the community. It was found that the measure assumed was integrally fulfilled, considering that the SUSCOM+ Program was successfully concluded in the City of Tijucas do Sul.

The City of Terra Roxa is located in the western region of the State of Paraná. At the time of preparations for the first public hearing, its estimated population was 17,439 people and its MHDI was 0.764, above the State's average of 0.749.

The first public hearing of the SUSCOM+ Program was held on June 5th, 2019, and was attended by representatives of governmental spheres and civil society entities and 72 community members. Among the topics raised in the participants' statements, the three major local problems of Primary Health Care were identified: quality of care, need to operate the public pharmacy at extended hours or 24 hours, and lack of specialized medical care. The subjects were submitted to the voting of participants for the election of the priority that would be faced by the Government and the majority chose to operate the public pharmacy at extended hours or 24 hours. The City and State authorities then signed the commitment document whereby they were obliged to enable the operation of the public pharmacy at extended hours.

The second public hearing was held on August 29th, 2019, again with the presence of representatives of governmental spheres and civil society entities and members of the community. It was found that the measure assumed was integrally fulfilled, considering that the SUSCOM+ Program was successfully concluded in the City of Terra Roxa.

CONCLUSION

As we could see, the SUSCOM+ Program was really able to provide a democratic openness in the agenda setting of

Primary Health Care public policy in the Cities where it took place, allowing the concrete aspirations of the community to be effectively received and answered by the competent governmental sphere.

Admittedly, the number of community members who attended the public hearings was still rather shy compared to the number of inhabitants in each City. This must necessarily lead to think about increasing the Program's publicity and better encouraging community participation, but it doesn't eliminate its positive results, especially if we consider it to be a relatively recent initiative and a work still in progress.

Indeed, out of the seven Cities that completed the Program, it's noted that in six of them the priority identified by the participating community members was satisfactorily addressed and resolved, and that in the City of Rio Negro, the only one in which there was no full compliance with the agreement of the commitment document, little was missing for that.

Thus, it can be concluded that the SUSCOM+ Program's strategy is a valid and worthy experience to replicate, not only in public health care policy, but also in other public policies that implement fundamental social rights, in order to ensure greater democratic openness and popular participation in the initial moments of their constitutive cycles, without prejudice to the reinforcement of social control of their results.

REFERENCES

ALMEIDA, Gregório Assagra de. O Ministério Público no neoconstitucionalismo: perfil constitucional e alguns fatores de ampliação de sua legitimação social. In C. Chaves, L. B. M. Alves & N. Rosenvald (Coords.). *Temas atuais do*

Ministério Público: a atuação do "Parquet" nos 20 anos da Constituição Federal. 2. ed. Rio de Janeiro, RJ: Lumen Juris, 2010.

BUCCI, Maria Paula Dallari. O conceito de política pública em direito. In M. P. D. Bucci. *Políticas públicas:* reflexões sobre o conceito jurídico. São Paulo, SP: Saraiva, 2006.

CAMBI, Eduardo. *Neoconstitucionalismo e neoprocessualismo:* direitos fundamentais, políticas públicas e protagonismo judiciário. São Paulo, SP: Revista dos Tribunais, 2009.

CAMBI, Eduardo; LIMA, Thadeu Augimeri de Goes. Compromisso de ajustamento de conduta: um eficaz instrumento à disposição do Ministério Público para a implementação de políticas públicas e à efetivação de direitos fundamentais sociais. *Revista dos Tribunais*, São Paulo, SP, v. 908, p. 113-141, 2011.

CANELA JÚNIOR, Osvaldo. *Controle judicial de políticas públicas*. São Paulo, SP: Saraiva, 2011.

CAPELLA, Ana Cláudia Niedhardt. Perspectivas teóricas sobre o processo de formulação de políticas públicas. In G. Hochman, M. Arretche & E. Marques (Orgs.). *Políticas públicas no Brasil*. Rio de Janeiro, RJ: Fiocruz, 2007.

CHOUKR, Fauzi Hassan. Ministério Público e políticas públicas. In C. Chaves, L. B. M. Alves & N. Rosenvald (Coords.). *Temas atuais do Ministério Público:* a atuação do "Parquet" nos 20 anos da Constituição Federal. 2. ed. Rio de Janeiro, RJ: Lumen Juris, 2010.

Constitution of the Federative Republic of Brazil, October 5th, 1988. (1988). Brasília, FD. Recovered from http://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm.

COSTA, Susana Henriques da. Acesso à justiça: promessa ou realidade? Uma análise do litígio sobre creche e pré-escola no município de São Paulo. *Civil Procedure Review*,

São Paulo, SP, v. 7, n. 2, p. 36-58, 2016.

GARCIA, Emerson. *Ministério Público:* organização, atribuições e regime jurídico. 3. ed. Rio de Janeiro, RJ: Lumen Juris, 2008.

GRINOVER, Ada Pellegrini. O controle das políticas públicas pelo Poder Judiciário. *Revista do Curso de Direito da Faculdade de Humanidades e Direito*, São Paulo, SP, v. 7, n. 7, p. 9-37.

GRINOVER, Ada Pellegrini. Caminhos e descaminhos do controle jurisdicional de políticas públicas no Brasil. In A. P. Grinover, K. Watanabe & S. H. Costa (Coords.). *O processo para a solução de conflitos de interesse público*. Salvador, BA: Juspodivm, 2017.

JATAHY, Carlos Roberto de Castro. 20 anos de Constituição: o novo Ministério Público e suas perspectivas no estado democrático de direito. In C. Chaves, L. B. M. Alves & N. Rosenvald (Coords.). *Temas atuais do Ministério Público:* a atuação do "Parquet" nos 20 anos da Constituição Federal. 2. ed. Rio de Janeiro, RJ: Lumen Juris, 2010.

JOHN, Peter. The Policy Agendas Project: a review. *Journal of European Public Policy*, London, England, v. 13, n. 7, p. 975-986.

JOHN, Peter. Agendas and instability in American Politics. In S. Balla, M. Lodge & E. Page (Ed.). *Oxford handbook of the classics of public policy and administration*. Oxford, England: Oxford University Press, 2013.

KINGDOM, John. *Agendas, alternatives, and public policies*. 2. ed. New York, NY: Longman, 2003.

Law n. 8,080, September 19th, 1990. (1990). Provides for the conditions for promotion, protection and recovery of health, the organization and operation of the corresponding services and other measures. Brasília, FD. Recovered from http://www.planalto.gov.br/ccivil_03/leis/l8080.htm.

Law n. 8,142, December 28th, 1990. (1990). Provides for community participation in the management of the Unified Health Care System and intergovernmental transfers of financial resources in the health care area and other measures. Brasília, FD. Recovered from http://www.planalto.gov.br/ccivil_03/leis/L8142.htm.

MACHADO, Felipe Rangel de Souza; DAIN, Sulamis. A Audiência Pública da Saúde: questões para a judicialização e para a gestão de saúde no Brasil. *Revista de Administração Pública*, Rio de Janeiro, RJ, v. 46, n. 4, 1017-1036, 2012.

MINISTRY OF HEALTH. *Ordinance n. 648, March 28th, 2006*. Brasília, FD: Author, 2006.

MINISTRY OF HEALTH. *Ordinance n. 2,488, October 21st, 2011*. Brasília, FD: Author, 2011.

MINISTRY OF HEALTH. *Ordinance n. 2,436, September 21st, 2017*. Brasília, FD: Author, 2017.

OLIVEIRA, Solange de. O direito à saúde na Constituição da República de 1988 e o Sistema Único de Saúde. *Revista de Direito Constitucional e Internacional*, São Paulo, SP, v. 93, p. 119-134, 2015.

OLIVEIRA, Vanessa Elias de. Apresentação. In V. E. Oliveira (Org.). *Judicialização de políticas públicas no Brasil*. Rio de Janeiro, RJ: Fiocruz, 2019.

PICORELLI, Luiz Fernando. O papel da participação comunitária no SUS. *Revista de Direito e Medicina*, São Paulo, SP, v. 1, digital, 2019.

PIOVESAN, Flávia. Justiciabilidade dos direitos sociais e econômicos: desafios e perspectivas. In J. J. G. Canotilho, M. O. G. Correia & E. P. B. Correia. *Direitos fundamentais sociais*. 2. ed. São Paulo, SP: Saraiva, 2015.

PUBLIC PROSECUTION SERVICE OF THE STATE OF PARANÁ. *Programa SUSCOM+:* participação da comunidade na construção da Atenção Básica. Curitiba, PR:

Author, 2018.

SADEK, Maria Teresa. Judiciário e arena pública: um olhar a partir da ciência política. In A. P. Grinover & K. Watanabe (Coords.). *O controle jurisdicional de políticas públicas*. 2. ed. Rio de Janeiro, RJ: Gen-Forense, 2013.

SANTIN, Valter Foleto. Característica de direito ou interesse difuso da segurança pública. *Argumenta,* Jacarezinho, PR, v. 5, p. 208-216, 2005.

SANTIN, Valter Foleto. *Controle judicial da segurança pública:* eficiência do serviço na prevenção e repressão ao crime. 2. ed. São Paulo, SP: Verbatim, 2013.

SANTOS, Lenir. Saúde e meio ambiente. Competências. Intersetorialidade. *Revista de Direito do Trabalho*, São Paulo, SP, v. 120, p. 135-158, 2005.

SANTOS, Priscila Ribeiro dos. Inovações participativas, diálogo social e construção de consensos. *Revista de Administração Pública*, Rio de Janeiro, RJ, v. 50, n. 3, p. 501-511, 2016.

STRECK, Lenio Luiz; MORAIS, José Luís Bolzan de. *Ciência política e teoria do estado*. 5. ed. Porto Alegre, RS: Livraria do Advogado, 2006.

TAVARES, André Ramos. *Curso de direito constitucional*. 11. ed. São Paulo, SP: Saraiva, 2014.

WATANABE, Kazuo. Controle jurisdicional das políticas públicas – "mínimo existencial" e demais direitos fundamentais imediatamente judicializáveis. In A. P. Grinover & K. Watanabe (Coords.). *O controle jurisdicional de políticas públicas*. 2. ed. Rio de Janeiro, RJ: Gen-Forense, 2013.

ZUFELATO, Camilo; LIMA, Thadeu Augimeri de Goes. O Ministério Público no novo Código de Processo Civil: breve análise sistemática. *Revista Forense*, Rio de Janeiro, RJ, v. 421, p. 23-49, 2015.