Coordinating Care
State Politics and Intergovernmental Relations in the Brazilian Healthcare Sector

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I am forever in debt to my wife, Lisa, for picking up and coming with me as we moved from Salvador, Providence, Campinas and New York. And I hope our newborn son, Danilo, will one day get around to reading his father’s work.

Finally, I dedicate this to the countless SUS workers and managers, who took time to explain it all to me.

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1: A Theory of State-Level Healthcare Institutions

Despite a modern history of segregated and highly centralized provision of healthcare services, the introduction of Brazil’s universal-access public healthcare system (the Sistema Único de Saúde, SUS) in the 1988 Constitution broke with tradition and increased access to healthcare services to a large, previously excluded population. Though underfunded and highly scrutinized, the SUS’s emphasis on primary care strategies had significant impact on Brazilians’ basic health conditions, lowering childhood mortality and extending life expectancy. Decentralization of healthcare responsibilities, one of the main pillars of healthcare reform, provided ample space for policy experimentation by subnational governments, particularly municipalities, but also created opportunities for policy confusion and inefficiency. After an initial period of ostracism and bewilderment, state-level governments reclaimed an active role in the public healthcare arena, but despite the existence of a single, nationally-deliberated

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1 Primary care is “that level of a health service that provides entry into the system for all new need and problems, provides person-focused (not-disease oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere or by others” (Starfield 1998, p.8-9). While primary care is generally associated with lower technological density, it does preclude specific activities or services—i.e., prevention, diagnostic, curative and rehabilitative services. In contrast, secondary care deals specifically with short-term consultations, and tertiary care with long-term management of chronic conditions. Concurrently, medical services are also designated in levels of technological complexity: medium complexity services include ambulatory and diagnostic services such as radiology, ultrasound, or requiring medical specialization, while high complexity services include technologically dense (and therefore expensive) specialties such as oncology, intensive care or neurosurgery. In Brazil, primary care (atenção básica) is the responsibility of municipalities, while states should guarantee hierarchical access to secondary and tertiary care. The federal government also provides secondary and tertiary care indirectly through public university hospitals.

2 Brazil is a three-tiered federal system with 26 states, a Federal District (which functions as a state), and 5,564 municipalities. Though federal terminology varies across countries, I use the Brazilian federal vocabulary; the national level is referred to as the Federal Government or the Union, States are the intermediate level of the federal system, and Municipalities are the local level of government. All have directly elected executive and legislative positions.

3 Health offices are a part of the executive branch, and follow broadly analogous designs across levels of government. The institutional actors are the Ministry of Health (Ministério da Saúde, MS) at the federal level, and state and municipal health offices (Secretarias Estaduais de Saúde, SES; and Secretarias Municipais de Saúde, SMS). Healthcare managers at the state and municipal levels are referred to as
institutional blueprint, formed quite differing healthcare sub-systems. Though the Constitution calls for integration\(^4\) of municipal and state systems with state-level offices as coordinators, the vast majority of states failed to take on this role. Why did state-level governments build such different subnational healthcare systems, and why is subnational coordination so unlikely? To answer this question, this study links the institutional choices in the healthcare sector to the patterns of political competition facing incumbents and opposition forces in three Brazilian states—Bahia, Minas Gerais and São Paulo.

State-level healthcare institutions in turn greatly affect the access to quality health services experienced by local populations. Imagine for example the life of a chronically-ill patient residing in a small municipality. If she lives in the state of São Paulo (SP), she will probably have access to primary healthcare facilities locally, but which would likely be disconnected from the state’s highly advanced secondary and tertiary care network. If she lived in Bahia (BA), she would be in a far worse situation: healthcare service availability is not only scarce, but more blatantly related to whether her mayor is politically aligned with the state governor. If not, her only hope for care is to travel to the capital, Salvador, and wait for the overwhelmed state hospitals to treat her. In contrast, even if she lived in the poorest town in northern Minas Gerais (MG), she would likely have access to coordinated care, which would maximize her chance of timely and quality care even where healthcare capacity is low. Even within a municipal-based system such as the SUS, the quality of care she receives locally is a product of choices made at the state level.

\(^4\) Hierarchical integration of health systems refers to the distribution of healthcare infrastructure from the broadly disseminated lower technology and low cost primary care facilities at the local level, and the pooling of population and resources as technological density and costs increase.

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“Health Secretaries” *(Secretários de Saúde, or simply Secretários)*, and are one of the more visible first-tier cabinet nominations made directly by governors and mayors.
While under constant scrutiny by domestic media and the more affluent portion of the population that has access to private services, the SUS’s effect on basic health indicators is nothing short of impressive. The percentage of population with access to free basic care reached 59.5 in 2008, and unattended deaths were virtually extinguished, falling from 14.5% of all deaths in 1990 to 2.7% in 2007 (DATASUS 2010). Infant mortality rates dropped precipitously from 46 per 1,000 live births in 1990, to 28 in 2000, and 18 in 2008 (61%) (WHO 2010), a feat made more notable by the fact that income per capita was stationary through most of this period (McGuire 2010). Overall life expectancy has also risen quite dramatically, from 66.6 in 1990 to 72.8 in 2008 (a 9.3% climb) (Paim et al. 2011). As primary healthcare strategies were disseminated, avoidable hospitalizations have fallen by 17% between 1999 and 2007 (Macinko et al. 2011), even while the overall number of hospitalizations continued to rise. The burden of infectious diseases has fallen to 4% of deaths (Barreto et al. 2011); non-communicable chronic diseases and external causes (e.g. violence, accidents) are now the main causes of death, approaching developed-country experiences (72% versus 84%) (Schmidt et al. 2011). Furthermore, the emphasis on primary care strategies such as the family health teams

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5 Around 26% of the population is covered by health insurance (public and private employees), with 74.1% of the population either paying out-of-pocket, or being considered “SUS-dependent” (Indicadores e Dados Básicos 2009 (DATASUS 2010), available at http://www.datasus.gov.br/idb/). Insurance clients commonly use the public system for expensive services.

6 In comparison, global figures fell 27.4%, from 62 per 1,000 in 1990, to 54 in 2000, and 45 in 2008, with upper-middle income figures of 37, 26, and 19 respectively (a 48.4% decline) (WHO 2010).

7 In comparison, global figures rose from 64 years in 1990 to 68 2009 (6.3%), and upper-middle income figures of 68 and 71 (4.4%) in the same period (WHO 2010). Overall life expectancy is correlated with infant mortality. Nonetheless, life expectancy at 60 years of age (a better indicator to late life care and conditions) also rose, from 17.6 years in 1990 to 20.6 in 2009 (3.9%) versus a global growth from 17.8 to 19.4 (2%) and upper-middle income figures growing from 78 to 79.3 (1.6%) (WHO 2011, available at http://www.who.int/whosis/database/life_tables/life_tables.cfm).

8 Avoidable hospitalizations, also known as Ambulatory Care Sensitive (ACS) conditions, are conditions that are responsive to preventive services (such as diarrheal diseases), early diagnosis and treatment (e.g. pneumonia), or management of chronic conditions (e.g. high blood pressure, diabetes). For more on ACS concepts and operationalization, see Billings et al. (1996), Alfradique et al. (2009), and Macinko et al. (2011).
(Programa de Saúde da Família, PSF) has disseminated the gains of basic care to the less-developed areas, such as the poverty-stricken Northeast region and the remote North (Figure 1).

Figure 1: Life Expectancy in Brazilian Municipalities

![Map showing life expectancy in Brazilian municipalities from 1991 to 2000.](image)

Source: UNDP (2000)

And yet, a focus on aggregate national-level advances clouds significant variation in subnational experiences. Despite major institutional and equity-enhancing reforms, significant inequalities in health conditions and the capacity to address them remain. Infant mortality in the Northeastern states is still over twice as high as in the well-developed South. More alarmingly, the great inequalities in supply linger, with the concentration of physicians (2.4 per 1,000 in the Southeast versus 0.9 in the North) and hospital beds (2.9 per 1,000 in the state of Rio de Janeiro versus 1.3 in the northern state of Amapá) continuing to reproduce the historical inequities in service availability across the territory. Managerial and technical capacities are also quite

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9 The Life Expectancy component of the United Nations Development Program’s (UNDP) Human Development Index (HDI) is the Life Expectancy at Birth in years divided by 100. It is updated yearly at the national level (Brazil’s composite score is 0.66 for 1990, 0.70 for 2000, and 0.73 for 2010 respectively). Disaggregated municipal figures have not yet been released beyond 2000.

10 All data cited in this paragraph from the aforementioned IDB 2009 (DATASUS 2010).
discrepant; a telling example is the proportion of deaths reported as “ill-defined” causes: though this number has fallen by 68% since the foundation of the SUS (18.2% of reported deaths in 1990 versus 7.7% in 2007) (DATASUS 2010), it still accounts for 13% of reported deaths in the North region, almost three times higher than in the Center-West region surrounding Brasília. Due to lingering legacies from previous systems, the federal government continues to use an unbalanced financing system: despite recent reforms in distribution rules, the federal government spends resources disproportionately in a few states (including a network of directly-owned hospitals in the former national capital of Rio de Janeiro) at the expense of the rest (Figure 2), un-evening the playing field for subnational governments who already cope with regional and local heterogeneities.

Despite the Ministry of Health’s prominence in determining national standards and funding capacity on the one hand, and the municipalization of healthcare services on the other, I find important variation in healthcare institutions at the state level of government. Choices made by state-level governments (political incumbents and bureaucrats) when building healthcare institutions determine the overall cohesion of state healthcare systems—both in terms of the distribution of healthcare infrastructure, and subsequently its operation. Furthermore, state-level governments determine the level of support for the complex web of institutions that the SUS rests upon—and by doing so, they shape subnational intergovernmental relations both vertically (between states and municipalities) and horizontally.

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11 Ill-defined or unknown causes of mortality are classification codes in the WHO’s International Classification of Diseases (ICD) for instances where no cause of death could be determined, including cases of unattended death.
12 Decentralization to the municipal level of government.
13 The SUS has an intricate network of support institutions that reach across levels of government. There are three main types: Health councils (Conselhos de Saúde) provide opportunities for civil-society inclusion and oversight. Joint management commissions (Comissões Intergestores) are technical chambers in which policies are negotiated vertically, and manager associations (Conselhos de Secretários) are bodies
Figure 2: Healthcare Spending *per capita* in Brazil


(among municipalities). Paradoxically, the importance of state-level institutional choices is magnified by the national healthcare system’s emphasis on municipalization. In many instances, such as in Bahia, the state-level government held tightly to its discretionary use of health resources, excluded municipal governments from decision-making and exploited inequalities in access to healthcare services. In states that delegated a large share of healthcare responsibilities to municipalities, such as the case of São Paulo, mayors responded to local political incentives and built local overcapacity, resulting in a fragmented state system. In the few instances where state-level offices stepped in as coordinators, such as in Minas Gerais, fragmentation was reduced.

To explain this state-level variation in healthcare systems, I point to the political determinants of these institutional choices. State-level governments built healthcare institutions for horizontal consensus-building. A more detailed review of the SUS support institutions will be the subject of Chapter 02.
responding to two main features of subnational political competition: the *competitiveness* of political contests,\(^{14}\) and the *degree of pluralism* (number of relevant actors). Subnational political systems that approached two-party systems (with two main competitors or one dominant party versus a fringe) yielded incentives that resulted in fragmented systems (either overly centralized or overly decentralized). Instances that approached a competitive multiparty democracy (with multiple relevant political actors) yielded incentives for rules-based institutions, and for state-level offices to pick up the ornery and complex tasks of system coordination.

Academic and professional accounts have linked the success of healthcare reforms in Brazil to the mobilization of a public healthcare movement (*Movimento Sanitário, or Sanitaristas*),\(^{15}\) and local advances in healthcare services to municipalization reforms, and to grassroots mobilization in participatory health councils (e.g. Avritzer 2009). Of particular note, they point to the importance of an intricate web of support institutions meant ground the public system in a participatory framework which includes a wide range of interests. Yet, these accounts generally ignore the political environments which made structurally identical institutions behave so differently across state settings. Therefore, focusing on this “missing middle” (the state level as an arena, as well as the effects of state-level action) allows us to understand the electoral and institutional environments which foster or dampen the efforts of

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\(^{14}\) Sartori (1976) differentiates between competition—a structural characteristic of the political game—and competitiveness, as a state of the game. Competition hinders on the possibility of competitiveness. “…competition is competitive when two or more parties obtain close return or win on thin margins.” (p. 218).

\(^{15}\) The *Movimento Sanitário* or *Sanitaristas* are a generally Leftist group of public-health activists, thinkers and practitioners who have in large part shaped the face of public healthcare in Brazil. Though varied, their views centered on universal access, a broader definition of health that included socioeconomic conditions, a large role for the state in providing preventive rather than curative (hospital-centered) care, and decentralization of decision-making and resources to the municipal level. For more on the *Sanitarista* movement see Gerschman (1995), Escorel (1998), Campos (2007), Paim (2007), Pimenta (2007), Falleti (2010), and CONASS (2011a).
municipal, bureaucratic and civil-society actors in healthcare. This is particularly relevant in the Brazilian setting, considering that scholars have long established that the state level has historically been the source of political power in Brazil (Abrúcio 1998, Hagopian 1996, Samuels 2003, Souza and Dantas Neto 2006).16

In studying the subnational variation in the development of the SUS, my work makes significant contributions to the study of the Brazilian public healthcare system and to important and broader research agendas in comparative politics. First, I challenge the assumption made by much of the early public health literature on decentralization that increased decentralization leads to more efficient provision of social services.17 São Paulo, the state with the highest level of decentralization in my sample, is not the most efficient in healthcare. Furthermore, state and municipal managers there have had the most difficulty emphasizing primary care. Therefore, in addition to the well known perils of decentralization such as potentially enabling subnational authoritarianism (e.g. Gibson 2005), we must also add the possibility of uncoordinated (and wasteful) development of capacity. Additionally, I argue that the decision regarding how much to decentralize is only one of a menu of institutional choices state-level officials make. To properly understand the contrasting subnational institutional realities we must consider a broader multidimensional space that also includes other features, which I identify as discretion—and most importantly—coordination.

My study also highlights a key shortcoming in the participatory governance literature, namely, the overemphasis on civil society inclusion, which in the case of Brazilian healthcare specifically has focused on grassroots inclusion in local health councils (e.g. Avritzer 2009, 16 The relevance of state-level institutions and political environments has also been established for other large federal systems such as India (Kohli 1987, 1990; Corbridge and Harriss 2000; Heller 2000) and Mexico (Snyder 2001b, Ward and Rodriguez 1999, Birn 1999).
17 I am certainly not the first to do so in comparative politics. Influential accounts that make this argument include Prud’homme (1995), Treisman (2002) and Samuels (2003).
Coelho 2006, Gerschman 2004). While the functioning of local health councils can be linked to citizen empowerment and even local allocation of healthcare services, I find that the Conselhos (health councils both at the municipal and state levels) are not the relevant venue of participation for institutional and policy formulation outcomes. By mapping the complex associational space previously ignored by political scientists and sociologists, I highlight that it is the participation and deliberation of Secretários (public managers) in joint committees and manager associations that is most directly linked to policy negotiation, formulation, and the ultimate shape of state institutions. In doing so, I reinforce the continued importance of the Sanitaristas—both as representatives of the healthcare movement and also as politically active technocrats—but also qualify how their effectiveness is mediated by the behavior of political elites who care foremost about electoral incentives. By doing so, I supplemented these explanations for healthcare outcomes in Brazil by highlighting the political actors behind healthcare successes in some Brazilian states. I build on the insights developed in the literature on the effects of political competition on state building (e.g. Bueno de Mesquita 1974, Bueno de Mesquita et al. 2003, 2005, Grzymala-Busse 2007) to explain the conditions in which these institutions are fostered or dampened.

Finally, I contribute to the long tradition of studies on federalism by focusing on the previously ignored intergovernmental relations between subnational tiers (states and municipalities). Much has been written about national-level and state-level intergovernmental relations (Abrúcio 1998, Hagopian 1996, Samuels 2003, Gonzalez 2008), particularly regarding national-level decisions to decentralize (Willis, Garman and Haggard 1999, O’Neill 2003, Eaton 2004, Montero and Samuels 2004, Falleti 2005). However, these studies ignore an additional layer of intergovernmental relations—between the state and municipal levels—at the cost of
our understanding how these alter state-level institutional decisions about key issues such as healthcare.  

In the remainder of this introductory chapter, I first map out the differences in state healthcare systems. Next, I develop the mechanisms through which elite electoral incentives affect the institutional design choices of healthcare frameworks. I then survey existing scholarly approaches to the study of healthcare institutions, and discuss how my work connects and fills an important void in the literature. Finally, I discuss my choices of research design, methodology and data, and conclude with an overview of the dissertation.

**Classifying State-Level Healthcare Systems**

The crux of my argument is that the SUS support institutions do indeed shape the fate of state healthcare systems and their ability to address the healthcare needs of their populations. But, unforeseen by their original designers, these institutions take widely divergent paths in each of the states I studied. Where they function properly, the “triumvirate” of SUS support institutions (councils, manager associations, and state-municipal joint-commissions) supply the venue in which important tasks are accomplished—the least of which are “baseline” responsibilities they were designed to fulfill, such as civil-society inclusion in the determination of policy priorities and permanent oversight in the councils, and the negotiation of the distribution rules for federal transfers in the case of the joint commissions (Figure 3). In practice, except when most they are most feeble, these institutions serve as venues for ongoing negotiation, the deliberation of policies and the achievement of political consensus first among municipal actors, and then provides them an opportunity to face state-level actors as a unified

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body. Furthermore, they allow actors to get to know one another over repeated interaction, potentially building networks—and in the best cases trust and cooperation—increasing potentialities for technical problem-solving, long-term planning, and bridging of the political gap between levels of government (which are in many ways inherently conflicting positions) and representatives of opposing political forces.

Figure 3: Reaching Intergovernmental Coordination

Informed by extensive field research over a two-year period in Brazil, I first inductively develop a classification of state-level healthcare frameworks\(^\text{19}\) based on three main pillars—all of which involve decisions made by state-level health officials: First, is the level of *decentralization*; since healthcare is by default highly decentralized to the municipal level, I focus on *additional* decentralization—in practice, how many municipalities were certified to assume secondary and tertiary care responsibilities. Certification granted municipal governments access to the municipality's per capita allocations for higher-complexity procedures, otherwise under state control. Second, is the degree of state-level *discretion*, or

\(^{19}\) I define state healthcare frameworks as the set of institutions that govern the formulation, negotiation, and implementation of healthcare policies in a state. As an *institutional outcome*, state healthcare frameworks are the main dependent variable of this study.
whether state-level officers established and followed clearly defined distributional rules or maintained the discretionary control over state funds and federal transfers. Finally, I draw attention to the level of coordination states pursued by developing planning and management tools with which to guide municipal action (as opposed to allowing municipalities free-reign).

Observed in conjunction, these decisions form three main types of state healthcare frameworks (see Table 1 below):

<table>
<thead>
<tr>
<th>Type of Framework</th>
<th>Exclusionary</th>
<th>Fragmented</th>
<th>Coordinated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decentralization</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Discretion</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Coordination</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
</tr>
</tbody>
</table>

**Implication for Care:**
- Patient access to treatment depends on political alliances of the mayor.
- Patients are treated by disconnected municipal and state-level systems.
- Patients are treated by municipalities organized within a state-level system.

**Practical Example:**
- Large hospital in small but politically-connected town
- “Referral by ambulance”
- Electronic medical referral

<table>
<thead>
<tr>
<th>Case</th>
<th>Bahia</th>
<th>São Paulo</th>
<th>Minas Gerais</th>
</tr>
</thead>
</table>

In the highly centralized and exclusionary system in the state of Bahia, state elites held a tight grip on all facets the decision-making process (the underlying logic of which will become clearer in the following section). The state-level health office kept virtually full discretion over the allocation of healthcare funding, particularly when it came to investment in new installed capacity. State leaders channeled a large portion of this funding into the state’s own hospital network, which the state government kept geographically focused around the capital. Seen by incumbents as a potential drain of power, participatory institutions were stunted: the state

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20 “Referral by ambulance” points to the fact that for many small and remote municipalities that have no way to coordinate patient referral with larger healthcare facilities their only option is to have the municipal ambulance drive the patient without knowing whether the destination facility can accept the patient.
health council was at first delayed and later isolated, and state elites interfered directly to ensure that only municipal representatives from the incumbent group occupied voting seats in the state’s joint commission (CIB). Even with restricted participation, municipalities were excluded from actual policy formulation. The state health office used its control over the joint commission to rubber stamp its allocation choices, and then to discourage (when not outright blocking) applications for certification, keeping additional decentralization at a minimum (see Table 2 below). As a result, municipalities were in large part excluded from the policy-making process. Therefore, healthcare institutions in Bahia did not create the vertical and horizontal ties and negotiation, nor did they alter the makeup of those making healthcare allocation decisions.

If we were to think in terms of identifying the main “bottleneck” to citizen access to public health services, in Bahia we would classify it as a political one.

Table 2: Decentralization: Municipalities with “Full-Management” Certification

<table>
<thead>
<tr>
<th></th>
<th>1998</th>
<th>2002</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mun</td>
<td>Pop</td>
<td>Mun</td>
</tr>
<tr>
<td>BA</td>
<td>1%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>MG</td>
<td>5%</td>
<td>21%</td>
<td>6%</td>
</tr>
<tr>
<td>SP</td>
<td>24%</td>
<td>43%</td>
<td>25%</td>
</tr>
<tr>
<td>Brazil</td>
<td>6%</td>
<td>25%</td>
<td>9%</td>
</tr>
</tbody>
</table>


As Tolstoy so eloquently put it, happy families are alike, but each unhappy family is unhappy in its own way; health institutions in São Paulo also fall short of the ideal functioning of the SUS, yet their shortcomings are the opposite of the baiano experience. As the previous table shows, health actors in São Paulo maximized the decentralization auspices of the SUS—

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21 Though I use it as a measure of decentralization, it is important to recognize that certification potential is dependent on the size profile of a state’s municipalities. The likelihood of attaining “full management” increases with municipal size, and is outright unfeasible for the lion’s share of Brazilian municipalities. For instance, while small municipalities (populations under 10,000) account for almost half of all municipalities in Brazil, only 1% of them had full management certification by 2006, compared to 78% of cities larger than 500,000 (0.7% of total).
both due to a greater demand from municipalities but also from a very willing state health office.\(^2\) Healthcare service capacity in São Paulo is second to none in Brazil; both municipal and state governments provide better coverage than their counterparts throughout the country. And yet, state and municipal systems are disconnected, generating inefficiencies, duplication of services, and frustrating patients that need to be referred to services outside their home towns. The state health office owns an extensive direct-provision network of hospitals and other health facilities. It channels a large portion of its budget to supporting it, financial and policy decisions that are decided unilaterally. At the same time, the state of São Paulo is the home of many of the early health-movement practitioners; therefore the SUS participatory institutions are well established, including civil-society groups and municipal managers, at least when it comes to dividing federal monies. In pursuing such extensive decentralization, the state office has allowed municipal governments to build capacity unchecked, resulting in the proliferation and maintenance of small and inefficient local facilities. Despite the highest healthcare capacity in Brazil, São Paulo nonetheless presents an *operational* bottleneck to citizen access to healthcare services.

Finally, a select few states were able to build up a cooperative—though far from seamless—relationship between state and municipalities using the SUS support structure as a cornerstone from which to coordinate intergovernmental action. The state health office in Minas Gerais shed the direct provision of healthcare services, freeing its financial and human resources to focus on system coordination. Municipalities are the main providers of healthcare services, which the state office supports by distributing portions of its own budget to municipalities. Furthermore, the state office makes use of dynamic planning and management tools, using clearly established rules to govern the distribution of resources and capacity

\(^2\) A more detailed discussion of the process will follow in the São Paulo case study chapter.
throughout the territory, and coordinating municipal projects, which allows for the pooling of resources. The Minas state government also developed real-time tools to manage patient flows through the system, such as easily updatable financial commitments between municipalities (so that a municipality can divert funding in case of a commitment not being met by a neighbor), and more importantly an integrated electronic medical referral system which matches capacity to patients throughout large portions of the state. Municipalities take part in the determination of the distribution rules by taking part in highly active participatory institutions.

The Political Determinants of Healthcare Institutions

In the second part of my argument, I explain this cross-state variation in design of subnational healthcare frameworks by arguing that institutional decisions were shaped primarily by the patterns of subnational political competition. State-level political elites made some very basic decisions in response to their electoral environments that would later be critical to the final outcome of their healthcare systems. Two characteristics of subnational electoral competition were of particular relevance: First, the competitiveness of political contests made incumbents (governors and their political group\textsuperscript{23}) more or less certain of remaining in office. Next, the level of pluralism, or the number of relevant political opponents\textsuperscript{24}, also shaped institutional decisions. The combination of these characteristics of the political environment make subnational systems approach either competitive two-party systems or multiparty systems. And the nature of political competition between state groups in turn determined

\textsuperscript{23} The use of “political groups” as a term is common among Brazilianists, if imprecise (see for example: Melo 1993, Kinzo 1997, Borges 2007, and Souza 2009). The common feature in all these uses is the idea that they include a multiple and fluid number of political parties centered around key individuals.

\textsuperscript{24} Sartori’s (1976) seminal account states that though the number of parties is indeed an important factor in analyzing political systems, its relevance, or strength is as important. Sartori then suggests “intelligent counting” in which numbers are weighed by their importance. Following in the spirit of this approach, I refer not to the universe of candidates on the ballot, but a candidate that was identifiable as the clear viable alternative to the incumbent.
whether political elites were receptive to, or actively sought the transformational changes in healthcare institutions promoted by public healthcare specialists and/or civil society actors, or whether they chose to maintain the pre-existing status quo.

I argue that two characteristics of state-level political environments are of particular relevance with regards to shaping institutional outcomes: the level of political competitiveness and the degree of pluralism. First, the overall level of political competitiveness, simply interpreted as whether political turnover at the state executive has existed in the recent past, the difference of total vote outcomes, and the plurality in the division of legislative and mayoral seats.25 The level of political competitiveness—and the uncertainty it generates—has an initial effect of generating centralizing or decentralizing tendencies. Where competitiveness was low, such as in the state of São Paulo, political incumbents felt relatively safe in their control over the state executive.26 As such, they had less to fear from decentralization. When subsequent federal decrees allowed municipalities to apply for additional responsibilities and resources beyond primary care—a mandate that increased municipal independence but was more complex and costly than many municipalities originally understood—the São Paulo state-level health office encouraged municipalities to apply.27 In a low-competitiveness environment, state political elites preferred to focus on their pre-existing health capacity (secondary and tertiary care) than

25 I am defining as relevant loci of political competition the state executive in conjunction with the division of seats in the state’s representation in the federal legislature (Senate and Câmara dos Deputados), state legislatures, and the proportion of mayoral seats in the state. While the intra-municipal competition for mayor and city-council seats is by no means irrelevant, it plays a minor role in the development of state healthcare frameworks. (Empirically as well, it is impossible to study all municipalities even within the three-state sample.)
26 Though the conventional wisdom portraits São Paulo as a highly competitive political system, the same political party (PSDB) has won the governor position for the past 5 terms (20 years). Therefore, while municipal political competition is indeed plural, I argue that the competition for state executive is actually low.
27 There is also an issue of higher demand, since the state of São Paulo is also the home of the leftist Worker’s Party (PT), who had their public healthcare activists in control of many municipal systems. PT municipal health secretaries were big pushers for decentralization.
facing the potential costs of building a coordinated state system. Conversely, in heatedly contested political environments such as Minas Gerais or Bahia\(^{28}\), where control over the state executive was not secure, incumbents were far less willing to decentralize. Needing to at least maintain but also to expand political power, state incumbents discouraged or prevented municipalities from assuming additional responsibilities, maintaining centralization of healthcare decisions and resources at the state-level health office.

![Figure 4: The Political Determinants of Healthcare Frameworks](image)

Not all centralized systems are made the same, thus a focus on the level of competitiveness alone misses an important part of the story. How political forces were distributed—the degree of \textit{pluralism} of state-level political competition—also affected institutional choices. The number of relevant political forces in the state—as viable alternatives for state office and control over municipalities—impacted what strategies were viable in dealing with municipal players. Despite the presence of multiple political parties, politics in Bahia was

\(^{28}\)Likewise, the state of Bahia has generally been classified as a “dominant party” or “old-style machine” political system. Yet, as Souza (1997, 2009) argues, the overall stock of votes that the dominant group historically commanded was fairly stable, and low enough (around 1/3) that opposing forces could (and did) surmount it if they coalesced. Additionally, opposition forces were able to maintain important legislative positions at the federal level, and therefore survived as relevant political forces.
polarized between a conservative group led by Antônio Carlos Magalhães (ACM) and a series of smaller challengers that ranged from other conservative elites displaced by Magalhães to the political Left. The opposition parties never competed against each other, commonly reaching tacit agreements to back each other in possible runoff scenarios. But when they came together, it was enough to defeat the Carlisa group (see Table 3), as they did in 1986 under the centrist PMDB’s Waldir Pires, and later with the PT victory in 2006. Programmatic politics is particularly underdeveloped in Bahia’s many small and poor municipalities—leading to pragmatic “incumbent politics” (governismo) where mayors swing support (and switch parties) for the party in power (Souza 2009, Borges 2010). Notice in table 3 that therefore political victories in Bahia tend to be winner-take-all affairs: with the exception of the PT’s 2006 victory, every other election saw the group taking the state executive “sweeping” all the other major positions as well.29 Magalhães was humbled by the loss to Pires in 1986 and, and despite being appointed to national-level cabinet positions, was nonetheless practically excluded from power in Bahia for a term. This reinforced his governing preferences, and he harnessed the centralizing incentives (the incentive to control) with a binary distributional strategy in which members of the political group (“us”) were rewarded with state resources, and all opposition (“them”) was starved off. As a part of this strategy, the state-level health office under the Carlisa group held on tightly to power, stunting the growth of participatory and rules-based distribution institutions. In order to prevent the opposition from uniting, the state-level offices kept the power of discretion in order to co-opt mayors and municipal health secretaries. The clear message was that to benefit from state healthcare investments, municipalities must align with the state government. A state

29 Though the 2010 election falls beyond the scope of this study, I included the information to show the effects of policy choices (of which healthcare institutions are one example) on electoral outcomes. Note that after the initial “shock” and pluralization of politics in Bahia in 2006, the 2010 election brought a return of the pattern, with the PT taking overwhelming control of the state as did previous winners.
system that excluded at the same time as it could discretionarily include was the tool seen as most effective for increasing the likelihood of continued political victory.

In plural environments, such as in São Paulo and Minas Gerais, opposing forces were sufficiently strong to make such discretionary distributional strategies unattractive or unfeasible (Table 4, above). Powerful municipal actors from different political groups pressured for inclusion in the policy process (through participatory institutions) and for the creation of clear rules for resource distribution. Facing multiple viable political forces, state elites could not successfully pursue a “divide and conquer” strategy with municipalities, who were strong enough to resist them either from within healthcare institutions or through normal legislative political channels. Furthermore, the dynamics of pluralized politics generated quite different incentives: The presence of multiple political players translates into the greater availability of potential allies for future contests. These can more likely be brought closer through the inclusive and equitable distribution strategies. This was true both in São Paulo and in Minas Gerais. However, since the incumbents in São Paulo were more secure, they maintained a certain degree of discretion over their own network decisions, which were kept outside of joint commissions. Likewise, a policy of outsourced management of public hospitals was pursued despite strong resistance from the state health council.

Limiting state-level discretion over health resource transfers is not a sufficient condition for increased citizen access to healthcare services. Rather, it is a necessary condition that permits the critical factor in differing state healthcare frameworks: state-level coordination. This is the main difference between the case of Minas Gerais and the other two cases in this study. The difference in approach to state-municipality coordination is particularly interesting when
### Table 3: Political Control in Bahia, Minas Gerais and São Paulo

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</table>

¹ Each state has 3 senators, elected for 8-year terms. Elections are staggered (2-1). ¹ Party with the largest share of the seats, and percentage share. ³ Party with largest share of mayors, and percentage of municipalities. Mayoral elections are held midterm (year+2).  n.a. = not available.  * Negative margins indicate candidate who lost in the first round, but won in runoff. Source: Tribunal Superior Eleitoral (TSE), and Tribunais Regionais Eleitorais (TREs). For 1982 - 1990 data, information compiled by Jairo Nicolau (http://jaironicolau.iesp.uerj.br/banco2004.html).

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### Table 4: Pluralism in Bahia, Minas Gerais and São Paulo

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<td>State Assembly</td>
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<tr>
<td>Chamber of Deputies</td>
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<td>Parties &gt;10%</td>
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<td>Effective Parties</td>
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Source: Tribunal Superior Eleitoral (TSE) and Tribunais Regionais Eleitorais (TREs). For 1990 data, information compiled by Jairo Nicolau (http://jaironicolau.iesp.uerj.br/banco2004.html)
one compares Minas and São Paulo—where incumbents belonged to the same political party (PSDB). In São Paulo, municipalities were granted independence to determine their own healthcare investments without any regional or scale constraints. In Minas Gerais, a series of rationalizing guidelines made it increasingly difficult to build more advanced health capacity if it did not fit within the state’s regionalization plan (which in turn was negotiated between state and municipal leadership in the joint-commission, CIB).

To understand why this is so, one must look at the two aforementioned sets of incentives in conjunction—especially in light of the multiple costs of coordination. Coordination is costly operationally in that it requires complex planning tools, properly trained personnel to execute them, and a great deal of intra and inter-bureaucratic cooperation and communication. It is financially costly in developing and maintaining these capacities, and also in providing financial incentives to induce behavior. For example, the Minas Gerais electronic medical referral system (SUSFácil) cost in the vicinity of R$ 40 million ($25 million), about the same amount the state spends on medications in a year.\(^3^0\) Finally, it is politically costly in that it requires “saying no” to many powerful actors, including mayors, regionally-based legislators, and private healthcare providers. Facing local constituencies, mayors of smaller municipalities have the incentive to build and maintain small facilities, generally inefficient and ineffective, which might also duplicate existing capacities in neighboring municipalities. Coordinating technical complexity hierarchically involves picking where new capacity will be installed, upsetting local elites whose municipalities are foregone, and even closing underperforming facilities. Likewise, governing the flow of patients through this system requires removing

\(^{30}\) The SUSFácil cost about 2% of the total health budget for 2008 (though it was not paid fully during the first year). This represents about a fifth of the state’s healthcare personnel expenditures, and 80% of the state health office’s management and planning budget.
freedoms from the existing healthcare providers, who are accustomed to picking which patients to serve (through economic, political or other logics).

With this understanding, let us revisit why state elites in Minas and São Paulo made such different choices in the coordination of their healthcare systems. In the closely competitive Minas Gerais, state officials not only had incentives to eschew decentralization, but also faced pressures from the many relevant political players to distribute resources through clear institutional rules. In this environment, the overarching need to control outcomes (to ensure policy outcomes as envisioned by state officials but also being able to claim political ownership in upcoming elections) translated into an impetus to coordinate. The costs of coordinating care were outweighed by the potential benefits of controlling a working state healthcare system. Municipalities and providers were naturally resistant to state direction; however, the state-level office had created significant financial incentives both for municipalities and private providers—financed in large part from the state’s own budget—that were available through equitable and clear rules. Municipalities accepted state coordination in return for the state’s commitment to follow rule-based distribution, and guaranteeing municipalities a seat at the table to determine these rules. Once within the system, the state’s financial incentives and the foregone costs of individual action were enough to make exiting the state system undesirable for the majority of municipal and private provider actors.

In contrast, São Paulo elites faced no such constraints or incentives. Opposing political forces were plural and powerful enough that they succeeded in curtailing state discretion and making health participatory institutions relevant and contested. Yet, facing a relatively certain outcome at the state-level contest, elites saw no need to face the complex (and expensive) tasks required for coordinating care. The state-level office therefore focused on maintaining the status-quo: investing heavily on its existing secondary and tertiary care network, and delegated
the construction of municipal and regional systems for municipalities to figure out, with minimal oversight from state-level regional offices. And though participatory and distributional institutions were strong, municipal and healthcare movement actors are nonetheless frustrated by the state’s unwillingness to add state resources to the negotiating table, and distributing only federal transfers through joint healthcare institutions.

**Bringing Politics into the Healthcare and Institution-Building Discussion**

This study starts from an apparently simple, though encompassing question, namely, how do you achieve intergovernmental coordination in order to ensure good policy implementation? The studies of the causes behind good policy implementation are anything but new. Weber’s answer to effective state action was in the isolation of the techno-bureaucracy from political interference (Weber 1978).31 Yet, practitioners and academics quickly identified the practical shortcomings of the Weberian approach’s emphasis rules and hierarchy. The US literature on bureaucratic politics has studied extensively how either the decision-making within them is fundamentally different than the ideal type of rationality or how the interplay between personal, organizational and situational incentives ultimately shapes bureaucratic behavior (e.g. Allison 1969, March 1981, Pressman and Wildavsky 1974, Wilson 1989) to the detriment of good policy implementation. One potential solution to these problems was to reform state institutions to break this iron cage mentality and introduce private-sector-like managerial reforms (the New Public Management school, such as the work of Hood (1991), Hood & Peters (2004), Bresser Pereira & Pacheco (2006)). Indeed, many of the public sector advances today in

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31 Weber's classic account identifies a rational-legal, or monocratic, bureaucracy as a hierarchical administrative body based on established rules and regulations, fixed jurisdictions, and meritocratic rules for employment and advancement (Weber 1978).
Brazil are linked to new public management-type emphasis on managerialism, including goals and performance assessment based on indicator measures.

Continuing in the line of public administration research—especially based on the British experience—the New Governance literature focused on fostering inter-bureaucratic cooperation by the creation of public networks (Rhodes 1996, Marsh & Smith 2000, Agranoff & McGuire 2004, Sabel 2005). These issue networks, or more broadly policy communities would facilitate collaboration between organizations to solve complex problems, therefore maximizing effectiveness under given resource or time constraints. Building trust and through ongoing interaction, these networks would lead to “governance without government” (Rhodes 1996). In the Brazilian public healthcare debate in specific, the attempted building of networks was done in conjunction with a broader participatory governance framework, to solve potential problems of democratic accountability or elite capture. Therefore, these accounts link successful healthcare reform and equity-enhancement on the active participation of civil-society representatives in local and state health councils (Conselhos Estaduais and Municipais de Saúde) (Avritzer 2009, Coelho 2006, Wampler and Avritzer 2004), or the involvement of members of the public healthcare movement (Movimento Sanitário, or Sanitaristas) (Fleury 1997, Paim 2007).

Though invaluable, these three approaches in for the most part miss the importance of political actors in these same processes. First, the bureaucratic politics literature focuses too strongly on intra-bureaucratic incentives, and focusing on the “Weberian” ideal type, assume isolation from political motivations. Yet, literature on Brazilian bureaucratic functioning from as far back as Furtado (1965), to the more recent work by Schneider (1991), Mainwaring and Samuels (1999) and Amorim Neto (2000), highlights the widespread practice of political appointments in the filling of key bureaucratic positions throughout the three levels of
government. While many rank-and-file bureaucrats are selected through apolitical, meritocratic means, politicized bureaucrats also permeate the bureaucracy, especially those in leadership and policy-formulation positions. Therefore, with their job prospects—and with it the ability to affect policy—directly tied to the political survival of the executive (and in many cases, also the balance of power within support coalitions), technocrats are much more mindful and responsive of politicians’ incentives than many scholars of bureaucratic politics would predict. Many top-level bureaucrats themselves are core members of the political group that held the state office.

Likewise, the New Governance literature misses the importance of political actors. While scholars in this tradition have focused on the functional needs and bottlenecks in generating intra and inter-bureaucratic coordination and cooperation, they have failed to identify the key role that political actors—within and outside bureaucracies—play in either greasing or throwing sand in the bureaucratic wheels. Likewise, much of the literature on state reform is based on the Weberian premise that political isolation leads to more efficient state institutions. Yet, I show that leading healthcare bureaucrats in Brazil are also political actors, and as such, highly responsive to the electoral incentives facing their political group. Additionally, where inter-bureaucratic and intergovernmental coordination is achieved—such as in the state of Minas Gerais—it is due to the state’s health officers acting with a mandate and political backing by the governor, who is primarily concerned with reforming the state in order to

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32 “Politicizing” the bureaucracy with appointments is not a new phenomenon, nor is it Brazilian-specific. Yet, as Schneider (1991) argues, the Brazilian case is unique when it comes to the extent of the practice. In the case of healthcare in particular, an internal study by the state health office in São Paulo identified that appointed command positions totaled over 10% of the entire workforce (Sala et al. 2006). This might not sound like a high number, but when compared to the fact that the vast majority of public personnel do not perform managerial tasks (i.e., they are doctors, nurses, janitors, etc), it is actually quite high. Additionally, this doesn’t necessarily mean that those appointed are unqualified or outsiders, as 85% of these were filled with career bureaucrats. Appointments in the healthcare bureaucracy tend to involve the advancement or reallocation of career bureaucrats who are either part of a political group directly or are recommended by a member of the political elite. If and when the said political group loses power, these bureaucrats either return to their original positions (i.e., physicians, planners, etc), or as is more likely with more senior personnel, move on to another municipality, state or federal office.
generate policy results, and based on those to make electoral claims strong enough to alter the state’s political landscape.

Finally, the Brazilian literature highlighting the importance of health movement participation and civil-society inclusion fall short as independent explanations. First, *Sanitaristas* are well entrenched in all levels of the public healthcare system. More importantly, the placement and autonomy of *Sanitaristas* is itself highly dependent on the political environment—many of them are “career” *Secretários*, changing seats between and across levels of government after every election. As a result, many *Sanitaristas* jokingly classify the SUS as a forest, while they—a Kin to monkeys—jump between branches. Therefore, the point is not to undermine the important role of *Sanitaristas*—I actually highlight their integral role in the public healthcare system—but rather to explain the political conditions in which they are granted autonomy and political backing to perform their jobs effectively. This brings us back full-circle to the relevance of the choices made by the political incumbents who hire, fire, and possibly delegate authority to them.

Furthermore, the emphasis on grassroots civil-society inclusion and participation needs to be qualified in terms of whose participation matters for what outcome. As the aforementioned literature has shown, there is plenty of evidence pointing to the beneficial effects of local health councils on the equitable distribution of health services (Coelho 2006) and on checks and balances on state officials. Furthermore, there is also considerable evidence of how participatory institutions empower stakeholders, legitimate decision-making processes, and increase transparency. However, in my fieldwork I found that most council discussions focus either on checks and balances or on what councilors call system “humanization,” namely, affecting the direct interface of the state with patients. Such issues range from politeness and equitable treatment of medical personnel, to hours of operation and accommodation of
patients and their families as they wait for services. Crucial state-level policies, however, such as the development of new programs or the distribution of federal and state resources, are hardly discussed in these councils until the policy has already been formulated, negotiated, and is ready for a rubber stamp of approval. In contrast, these state-level policies are avidly discussed in healthcare manager associations, and in the state and regional-level joint management commissions.

*Bringing Political Competition Back In*

How does one measure political competition? Classic works on party systems (e.g. Lipset & Rokkan 1967, Sartori 1976) argue that a key characteristic is the number of political parties. In his seminal work, Sartori identified two important dimensions, the number of relevant parties and the ideological polarization, with polarization bringing negative effects for democratic governance. Since then, the importance of counting the number of parties has led to the adoption of a more systematic method of counting “effective parties” (Laakso & Taagepara 1979), and the implication being that the number of parties matters for governability, since multiparty systems have different electoral logics, would lead to different allocation of policies. I combine these accounts’ focus on the spoils of elections (seats) while also considering the closeness of elections themselves (Boyne 1998), and the share of local contests won (O’Neill 2003).

Scholars who focus on party-systems in the younger less-institutionalized “third wave” democracies (Huntington 1991), such as Mainwaring & Scully (1995), Mainwaring (1999) argue that these earlier approaches needed to be supplemented by a measure of party-system institutionalization. In this line, the school of “Brazilian pessimists” (Ames 1995a, 1995b, Haggard & Kaufman 1992, Mainwaring 1999, Mainwaring & Scully 1995, Mainwaring & Shugart
1997, Lamounier 1989, Nicolau 1997) argue that the high degree of state intervention in the party system over time and the resulting electoral rules based on open-list proportional representation with single districts yield an non-institutionalized or “inchoate” party system with a large number of non-programmatic parties and low party discipline among a series of other ills.\(^{33}\)

However, another series of scholars working on Brazil argue that the claims of the “Brazilian pessimists” too easily dismiss Brazilian parties. Led by influential studies by Brazilian scholars Figueiredo and Limongi (1995, 1997, 2000), this school of argues that despite this electoral fragmentation, political parties do matter within the national assembly, shaping legislative voting behavior and executive allocation of resources (Amorim Neto 2000, Pereira & Mueller 2000, 2003; Meneguello 1998). Dantas (2008) argues that parties are also important venues for subnational political organization, with the incumbent governor’s party service and a pole that organizes subnational competition in towns without runoff elections (populations smaller than 200,000).

What is the effect of close competition? Though cutting at the problem from different directions, scholars agree that competition affects behavior through uncertainty of remaining in office. Grzymala-Busse (2007) argues that parties will exploit state unless credible competition provides the incentives to build oversight institutions and share power. Conversely, Alston et al. (2008) argue that a combination of competition and checks and balances determine whether incumbents will provide public or private goods. More specifically, they propose that

\(^{33}\) The “Brazilian pessimist” school can be eloquently summarized by Mainwaring: “Brazil has long been a case of notorious party underdevelopment. The most distinctive features of Brazilian political parties are their fragility, their ephemeral character, their weak roots in society, and the autonomy politicians of the catch-all parties enjoy with respect to their parties. Compared to parties in the other more developed countries of Latin America, Brazilian parties are singularly fragile. In fact, relative to the country’s level of economic development, Brazil may be a unique case of party underdevelopment in the world.” (Mainwaring 1995, p.354).
incumbents with short time horizons (greater uncertainty) will have fewer incentives to provide public goods, while those who expect to stay in power can afford to wait to reap their rewards. Sartori (1976) hinted at one point that competition can be “too heated”; likewise Montero (2001) argues that good government requires political conflict to be low, and Grzymala-Busse (2007) proposes that the relationship between the threat of replacement and state predation might be curvilinear (p.10, note.29). My work sides with the argument that the competitiveness alone cannot predict the behavior of institution builders. Competition can in fact be “too much”, and yield perverse incentives to incumbents. The plurality of political forces in turn affects the strategies available to those in power.

In sum, I have argued that despite competing claims for the relevance of bureaucratic, civil-society and economic factors in determining institutional outcomes in healthcare, these explanations are either mistargeted or incomplete. Rather, they should be considered in light of the electoral environments faced by state-level elites, which alter the strategies and opportunities available for shaping institutions that govern, among other things, subnational intergovernmental relations. Additionally, despite the focus on local (municipal) delivery, it is the decisions made at the state-level offices that provide environments that are either permissive or constraining of institutional change and coordinated healthcare.

**Research Design**

I use a two-pronged small-N research design that combines cross-case and within-case comparisons at the subnational level. The first benefit of a subnational comparison in this case is that it follows King, Keohane and Verba’s (2000) influential suggestion of augmenting the robustness of findings by increasing the number cases studied. Furthermore, it allows me to ask finer questions and observe variation that would be lost at the national level—thus avoiding
Rokkan’s (1970) aptly-named “whole nation bias”. Hence, instead of analyzing the institutional structure of the SUS as one system, I can observe its various iterations within Brazil. Methodologically, a subnational design also allows for much closer control of comparisons, and tackling internal variation (Snyder 2001a).

**Methods and Data**

The lion’s share of the primary and secondary data was gathered directly through two years of field research in Brazil during 2008 through 2010. Using a combination of targeted, referral (“snowball”) and random techniques, I conducted over 100 formal interviews that lasted anywhere from one to several hours. Interviews were semi-structured, composed of a standard module, and one that was tailored to the interviewee. I interviewed a wide range of current and former health officials, bureaucrats, health professionals and elected officials at federal, state and municipal levels, as well as renowned academics in public health. I observed and interacted with hundreds more during extensive observation of meetings and working sessions of SUS support institutions—joint management commissions, technical working groups, manager associations, and social councils—at federal, state, regional, and municipal levels. I also collected data on healthcare capacity and indicators from health offices and archival work.

To measure the variation on the dependent variable (state healthcare frameworks as institutional outcomes), I use a series of data collected during my fieldwork. To operationalize levels of decentralization, I use the percentage of municipalities (also weighted by population shares) that were granted additional responsibilities beyond primary care (Gestão Plena and Comando Único), as well as the percentage share of per capita resources for medium and high-complexity services transferred directly to municipalities as compared to the state offices. For measuring coordination, I gather information on planning and management tools for the
allocation of medical procedures (Programação Pactuada Integrada), regionalization (Plano Diretor de Regionalização) and the presence or absence of a functioning real-time medical referral system (which coordinates the patient’s actual navigation through the medical system). To measure the degree of discretion, I focus on whether distribution followed clear and established rules. If moneys and capacity were distributed through state plans formulated at state-level bargaining chambers, and in clear and regular fashion, I classify that system as cases of low discretion.

For my main independent variables, I use electoral data collected from the Tribunal Superior Eleitoral and Tribunais Regionais Eleitorais for the three states. I use electoral data from all elections since redemocratization (1988) in order to detail the state-level political environments incumbents faced. Finally, to flesh out the mechanisms that link electoral political incentives with institutional choice and bureaucratic behavior, I use data from my aforementioned qualitative interviews and my observations from the functioning of SUS institutions.

Case Selection

I selected three states that are fairly large (both in terms of geographic size and population), with historical economic and political importance in Brazil, and with considerable pre-existing scholarship to build my research upon. The choice of states was not random: scholarship in the 1990’s generally agreed on the existence of “three Brazils”—macro-regions based not on political divisions, but on human development levels; Bahia (representing low), Minas Gerais (mid), and São Paulo (high) are on the fault lines of these divisions. They represent
not only these broader regions of development, but also distinct political environments. Following the most different systems design (Przeworski and Teune 1970), the overall logic was to maximize variation in other potential independent variables, while also trying hard to find explanations that would be generalizable for the rest of the country. Case selection did not take the dependent variable (i.e. type of state healthcare framework) into account. In the following paragraphs, I provide a brief overview of each of the selected states.

_São Paulo_ is Brazil’s wealthiest and most developed state. It is highly urbanized (62 municipalities with populations over 100,000) and has leading industry and agricultural producers. The state has been historically powerful economically (being home to the coffee export economy and later the automotive industry) and politically: During the Old Republic, it alternated nominating the president with Minas Gerais in a tacit agreement known as the _República do Café com Leite_. Both long-standing presidents since re-democratization have come from _paulista_ politics (Cardoso and Lula da Silva). The political group based on the PSDB has won the state election all but two times since redemocratization. São Paulo has the highest levels of capacity in healthcare and is a magnet for the country’s top medical talent.
Figure 5: Map of Brazil

Table 5: Bahia, Minas Gerais and São Paulo Compared

<table>
<thead>
<tr>
<th></th>
<th>Bahia</th>
<th>São Paulo</th>
<th>Minas Gerais</th>
<th>Brazil</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Municipalities</strong>1</td>
<td>417</td>
<td>645</td>
<td>853</td>
<td>4,564</td>
</tr>
<tr>
<td>**Population (mm)**1</td>
<td>14.0</td>
<td>41.3</td>
<td>19.6</td>
<td>190.8</td>
</tr>
<tr>
<td>**Pop Density (per Km²)**1</td>
<td>24.8</td>
<td>166.3</td>
<td>33.4</td>
<td>22.4</td>
</tr>
<tr>
<td>**Urbanization (%)**1</td>
<td>72.1</td>
<td>95.9</td>
<td>85.3</td>
<td>84.4</td>
</tr>
<tr>
<td>**GDP ($ bn)**2</td>
<td>51.6</td>
<td>425.7</td>
<td>119.9</td>
<td>1,286</td>
</tr>
<tr>
<td>**GDP per Capita ($)**2</td>
<td>3,556</td>
<td>10,380</td>
<td>6,041</td>
<td>6,786</td>
</tr>
<tr>
<td>**Infant Mortality (per 1000 live births)**3</td>
<td>26.3</td>
<td>13.1</td>
<td>17.4</td>
<td>20.0</td>
</tr>
<tr>
<td>**Life Expectancy at Birth (years)**3</td>
<td>72.3</td>
<td>74.6</td>
<td>74.9</td>
<td>73.0</td>
</tr>
<tr>
<td>**Life Expectancy at Age 60 (years)**3</td>
<td>22.0</td>
<td>21.6</td>
<td>22.4</td>
<td>21.3</td>
</tr>
<tr>
<td><strong>HDI</strong>4</td>
<td>0.77</td>
<td>0.86</td>
<td>0.83</td>
<td>.82</td>
</tr>
<tr>
<td>**Below Poverty line (%)**3</td>
<td>50.8</td>
<td>26.9</td>
<td>14.9</td>
<td>30.6</td>
</tr>
<tr>
<td>**Illiteracy Rate (%)**1</td>
<td>17.3</td>
<td>4.7</td>
<td>8.7</td>
<td>10</td>
</tr>
<tr>
<td>**Basic Sanitation Coverage (%)**3</td>
<td>55.8</td>
<td>93.8</td>
<td>79.5</td>
<td>71.3</td>
</tr>
<tr>
<td>**Physicians (per 1,000)**3</td>
<td>1</td>
<td>2.4</td>
<td>1.8</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Medical Visits (per person/year)</strong></td>
<td>2.3</td>
<td>3.2</td>
<td>2.6</td>
<td>2.6</td>
</tr>
<tr>
<td>**Ill-defined Deaths (%)**3</td>
<td>14.1</td>
<td>11.2</td>
<td>6.4</td>
<td>7.7</td>
</tr>
<tr>
<td>**Private Insurance Coverage (%)**3</td>
<td>8.9</td>
<td>40.5</td>
<td>20.9</td>
<td>21.2</td>
</tr>
</tbody>
</table>

Minas Gerais also has a long history of national power. It was São Paulo’s junior partner in alternating power during the *Old Republic* period, and has a long history of cordial intra-state elite competition (Hagopian 1996). Though historically reliant on agriculture (cattle, hence the “milk” moniker) and mineral extraction, Minas has benefited the most from industry expansion outside of São Paulo (Montero 2002). It is a territorially vast and highly unequal state, with a wealthy and developed region that compares to São Paulo in the south, and a strikingly poor and underdeveloped region in the north, much more comparable to Bahia. *Mineiros* represent roughly 10% of Brazilian population, have a sense of historical importance, and their government plan boasts the goal of being the “best place to live and work” in the country. Minas Gerais has been widely cited as having “good governance” examples in its recent past (e.g. Montero 2002, Borges 2007).

Finally, Bahia is the poorest and least developed of the cases. Its capital city, Salvador, was the first power center during colonial times, and its economy has historically been based on agricultural production—though both its traditional and growing industrial and service sectors have nonetheless faced serious competitive difficulties. It is the only of the three states located in the Northeast region, in large part under arid and semi-arid conditions. Bahia has an unusual co-existence of a relatively lower level of urbanization than São Paulo and Minas (only 12 of 417 municipalities are have populations larger than 100,000), but its capital, Salvador, is the third largest urban center in Brazil, which further illustrates the discrepancies between the capital and the interior of the state. Since re-democratization, Bahia has been the political fiefdom of the Rightist party *Partido da Frente Liberal* (PFL), later renamed to *Democratas*, (DEM), which centered on the patrimonial-charismatic control of Antônio Carlos Magalhães (Souza 1995, Dantas Neto 2006a, 2006b). Brazilianists have labeled Bahia as a case of “dominant machine politics” (Borges 2007), “conservative competition” (Montero 2007), among other similar
categorizations. The Worker’s Party (Partido dos Trabalhadores, PT) won the governor seat for the first time in 2006, but some have argued that, rather than an enduring change in the political environment, conservative elites have maintained control over their rural constituencies (Montero 2010). Human development in Bahia is much lower than in the other two states in the sample, as is available healthcare infrastructure.

**Overview of the Work**

My study’s first contribution is a thorough institutional mapping of the public healthcare system. Therefore, in chapter 2, I flesh out SUS support institutions of three kinds that link policy formulators, executors and civil-society actors across the levels of government. I also provide a detailed institutional history of the healthcare sector in Brazil, and how it is affected by altering balance of power between levels of government. In chapters 3-5, I pursue within case analysis for Minas Gerais, São Paulo and Bahia, fleshing out the stories of how electoral environments shaped the choices of political incumbents, and how these in turn built healthcare systems in each state. Finally, in Chapter 07, I bring together some conclusions, while also discussing some of the study’s limitations and the unanswered questions that call for subsequent research.
Chapter 2: An X-ray of the SUS

The differences among state healthcare systems cannot be properly understood without historical and institutional context. To that end, this chapter provides a “primer” to the uninitiated on the Sistema Único de Saúde (Unified Health System, SUS), situating ourselves with its concepts, terms and actors. The empirical and historical detail has intrinsic value, but readers with less of a direct interest should nonetheless focus on a few “take home” points that are relevant for the work’s broader arguments: First, that though there has been significant service expansion, it has been riffled with conflict among sectors within the state apparatus, and reflecting the shifting balance of power in Brazil’s three-tiered federal system. Second, in an attempt to shed its historically centralized and distorted decision-making process, SUS designers built a complex web of supporting institutions. These institutions aim to include civil society in the policy process and to create vertical and horizontal networks for ongoing policy negotiation and implementation among state institutions.

The universalization of healthcare in Brazil and the resulting expansion in public provision is no small feat even, considered a significant equity enhancing reform even by otherwise critical accounts (Weyland 1996). By 2007, the public sector financed about 80% of all hospital admittances, over 95% of basic care interventions (Paim 2007), and over three quarters of the population rely solely on the public sector alone for their healthcare needs. Preventive care tasks such as immunization for measles, mumps and rubella (MMR) has reached virtually

35 Unless otherwise cited, data reported throughout this chapter is based on author’s tabulation of the Ministry of Health’s publicly available data Indicadores e Dados Básicos do Brasil 2009 (DATASUS 2010), available at: <http://www.datasus.gov.br/idb2009/>.
100% of the target population, and almost half of the total population (49.5%) is served by family healthcare teams (Programa de Saúde da Família, PSF). The public sector is also responsible for 90% of high complexity services such as chronic renal care (Coelho 1998). And while not all medications are provided free of charge, expensive and complex treatments such as anti-retroviral drugs are provided by the public sector. Despite still being in the minority, there has been a substantial shift in the hospital bed supply, with publicly-provided beds rising even when the private sector beds have declined (La Forgia & Couttolenc 2008).

Financially speaking, the public healthcare system is a large commitment to the public sector in Brazil. As a proportion of GDP, healthcare expenditures in Brazil are comparable to more developed countries (see Figure 6 below), though the participation of public sector financing is quite lower than other universal-type systems (e.g. 82% for the UK, 70% for Canada) (WHO 2010). Healthcare expenditures account for roughly 4% of total federal government expenditures (7% of non-financial expenditures) for 2008, and the Ministry of Health has the second largest sectoral budget in the federal government—trailing only Social Security expenditures. Though it remains the main financer of public services, the federal government has continued to shift spending subnationally, with the federal share falling from over 70% in 1990 to 50% in the late 2000s, mostly absorbed by municipalities (Ugá and Santos 2006, Frutuoso 2010). State and municipal governments have mandated minimums of 12% and 15% of

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36 Family health teams (PSF) are a multi-professional teams that provide first-contact comprehensive and “whole person” health services both in clinics and in ascribed population’s homes, particularly in rural areas. It has become the main strategy for expanding healthcare, covering 6% of the population in 1998 to 49.5% in 2008 (MS/SAS/DAB 2010). For more on the PSF see: Escorel et al. (2007), Machado et al. (2008), and Macinko et al. (2011).

37 While most domestic and international studies illustrate a preeminence of private over public spending (at a 3 to 2 proportion), Carvalho (2009) argues that once fiscal incentives to individuals and firms are factored in, the public expenditures exceed private expenditures slightly.
revenues respectively, with municipalities commonly exceeding minimums\textsuperscript{38} (SIOPS 2011). De Lima’s (2006) analysis of health-related federal transfers shows that for a large portion of smaller and poorer municipalities SUS transfers alone supersede local tax revenues.

Nevertheless, unstable and insufficient financing are almost unanimously denounced as the main roadblocks to achieving universal and better-quality care in Brazil (Cordeiro 2001, Levcovitz et al. 2001, Menicucci 2006, Dain 2007, CONASS 2009a, Mendes & Marques 2009, Paim et al. 2011).

**Figure 6: Health Expenditure as share of GDP (2007)**

![Health Expenditure as share of GDP (2007)](image)


UMI: Upper Middle Income, LAT: Latin America & Caribbean.

See appendix 01 for definitions.

Despite its aspirations to coalesce healthcare efforts into a unified system, the resulting health landscape in Brazil is far from it. There are two major sources of division: First, is the multiple and overlapping mandates within the state itself, with the health bureaucracies at each

\textsuperscript{38} The actual average share of municipal revenue spent on healthcare has grown from 13.4\% in 2000 (when the minimum was 7\%) to 20.3\% in 2010. Data available at: <http://siops.datasus.gov.br/evolpercEC29.php>
level of government being tasked as *gestores* (managers) with different shares of four main responsibilities: policy design/planning, financing, patient referral, and service provision (Noronha et al. 2008) The federal government, as major financer continues to be the principal designer and inducer of policies, along with regulating the private markets. Municipal governments were tasked with the direct provision of health services, particularly primary care, but due to the incredible heterogeneities, do so in uneven fashion. Finally, state governments had no clearly defined role for the first decade of the SUS, and since then, have been tasked with hierarchical integration of service networks in their territory. A second source of division is the co-existence with a large private sector. Though the system’s inspiration was a state-centered system with universal access such as the UK’s National Health Service, a pre-existing robust private sector holding the majority of hospital service capacity and a large private insurance market resulted in a “mixed system” (Campos 2007, Santos et al. 2008, Menicucci 2003, 2009) in which about a quarter of the population makes use of private health insurance, and half of all healthcare expenditures come from companies or out-of-pocket. As a result of previous state policies favoring private sector development, private providers are inexorably linked to the SUS— as of 2009, 65% of private facilities contracted services to the public sector, and 57% of publicly funded hospital admittances were provided by private facilities, both for and non-profit (IBGE 2010).

Scholars have argued that the existence of an economically powerful private healthcare sector makes the emergence of a public system in Brazil puzzling (Menicucci 2003, Falleti 2010). The development and shape of healthcare institutions in Brazil are in large part the product of a highly mobilized movement of public healthcare specialists and practitioners referred to as the *Movimento Sanitário*, or *Sanitaristas*. But the extent to which the Sanitaristas were able to push forward their plans for healthcare institutions and the implementation of healthcare policies
were, unsurprisingly, shaped by broader social, economic and political processes of change in Brazil. One is the process of regime change from authoritarian to democratic government. Democratization permitted the claim to universal healthcare provision as a right of citizenship, and the backlash against centralized authority opened the way to decentralization and the empowerment of subnational actors. But public healthcare provision was also shaped by the conflicting nature of Brazilian federal institutions, including the pendulum-like concentration of power at different levels of government. Therefore, to lay the foundation for properly understanding the empirical puzzle at hand, a significant part of this chapter will be dedicated to the institutional history of the public healthcare sector through the lens of inter-bureaucratic and intergovernmental relations.

It is also important to understand that though “founded” in 1988, the SUS was hardly created from scratch. Rather it was cobbled together like "bricolage": mish-mashing new institutional materials with leftover structures from previous periods (Grzymala-Busse & Jones Luong 2002). Early SUS implementers had to deal with a history of institutional fragmentation within the federal government, including the incorporation of a much larger bureaucracy previously connected to the social security sector (the INAMPS)—known for an internal culture of insulation and centralized decision-making. In addition, this institutional absorption grandfathered a large number of public employees who were transferred to subnational governments but who account for over 60% of the Ministry of Health’s active staff.

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39 Municipalization of basic healthcare services started before 1988 and culminated in the 1990s. By 2000, 84% of the ambulatory network was under municipal responsibility (compared to 22% in 1981), providing 90% if all ambulatory services. (Arretche 2003).
40 The Instituto Nacional de Assistência Médica da Previdência Social, INAMPS, was a parastatal institute attached to the Ministry of Social Security, and charged with managing the provision of healthcare services to the insured.
Furthermore, the SUS had to work with the existing healthcare services capacity, with a curative-based pre-existing healthcare network based on hospitals, and regressive supply-based financing. Confronting these harsh institutional legacies from previous periods made the tasks of providing equitable care particularly more daunting.

In spite of this—or many will argue because of it—the public healthcare advances in Brazil are also interesting because they occurred in tandem with the development of a rich associational space. In its goal to provide more democratic, decentralized and integrated care, public healthcare actors created institutions that not only provide access points to the medical profession and organized civil-society, but also supply for ample room for horizontal and vertical negotiation, deliberation, and coordination among state actors. These include councils for deliberation and oversight (Conselhos de Saúde)—including healthcare workers, management and patients—associations of municipal and state managers (COSEMS, CONASEMS, and CONASS), and technical joint commissions for vertical negotiation between levels of government (Comissões Intergestores). Though they vary widely in their efficacy and levels of institutional development, where these institutions work, they have provided the necessary venue for intergovernmental and inter-bureaucratic cooperation and for significant trust-building across healthcare-specific and broader political actors.

This chapter is organized as follows: First, I build on primary and secondary accounts to provide the main historical and institutional benchmarks that led to the current state of public healthcare in Brazil, both pre and post-universalization. This includes an authoritarian period of institutional fragmentation and favoring private sector development. In response, social forces

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42 Supply-based financing refers to the fact that budgets and monthly contracts were designed not based on a study of patient demand, but rather on available service supply. It is considered regressive because it continues to reward areas with existing medical services, at the detriment of those still in need.

43 Though these institutions are no longer unique to healthcare (Abrúcio & Sano 2007, Sano 2008), they are still strongest and most developed in their indigenous sector (Fleury & Lobato 2009).
mobilized in a Sanitary Reform Movement, pressuring the state to universalize healthcare and shift the focus of public expenditure during a broader process of democratization. Since then, levels of government have fought over the system’s operational design, resulting in periods of uncoordinated decentralization, followed by attempts at federal rebalancing under state coordination. Finally, I present the SUS institutional structure, which makes the Brazilian healthcare experience unique in a comparative perspective, and sets the grounds for the broader study of subnational variation in healthcare.

The History of Shifting Public Healthcare

The Pre-SUS Landscape: Segregated, Curative Care and ‘Passing the Buck’

In a way, the main features of Brazilian healthcare—uncoordinated government action, segregated coverage and quality of services, and a counter mobilization of public health intellectuals—can be traced back to Brazil’s early history. Prior to the 1930’s, the state took no part in the healthcare sector; those who could afford care would pay doctors as liberal professionals, with the few existing missionary hospitals (Santas Casas de Misericórdia) providing nonprofit care in major urban agglomerations (CONASS 2011m). Brazil’s imperial government’s first public health institution, the Junta de Higiene Pública, reflected an urban conception of health and thus delegated sanitary control to municipal governments, charging them with controlling the outbreak of epidemics, particularly in port cities (CONASS 2011a).44 Healthcare responsibilities were transferred to state governments in 1891, as part of a larger power shift through which increasingly influential regional elites deposed the Emperor and founded a federal republic. The transfer of mandate had little practical effect on the nature of

44 Brazil was a colony of Portugal until 1822, when it assumed a monarchical, or imperial regime. The imperial phase came to an end with the proclamation of the republic in 1889.
Public health strategies: In the early 1900’s the first state-led health interventions continued to focus on cities (to control epidemics such as yellow fever or the bubonic plague), and to a much lesser extent, endemic rural diseases (Paim 2007, Frutuoso 2010). There was a tension between the positivist public health academics and the uneducated populace at large—public health campaigns, conducted almost in “military fashion” (Paim et al. 2011) by medical intellectuals sought to impose hygienic discipline on society and were ill-received (Nunes 2000). Concerned with cross-state contamination in disease outbreaks in the 1910s, public health intellectuals joined to form the Liga Pró-Saneamento (Pro-Sanitation League), pressuring state elites for coordination of national policy. This led to the foundation of the National Department of Public Health (Departamento Nacional de Saúde Pública, DNSP) in 1919, re-centralizing public health policies in a national body that coordinated state action while maintaining their autonomy. Public health intellectuals, in charge of health offices in prominent states, successfully argued to state leadership that the potential loss of autonomy was outweighed by the public health and cost gains from centralized action (Hochman 1998, Nunes 2000).

With state governments providing campaign-type public health interventions, individual-level curative services remained unregulated until the 1920s. During this period, the formally employed negotiated social welfare benefits directly with their employers. When the state first introduced legal requirements for social protection (including healthcare services) it built upon and reinforced these pre-existing disparate institutions. The Elói Chaves Law, instated in 1923, regulated company-specific funds (Caixas de Aposentadoria e Pensões, CAPs) to provide pensions, disability and healthcare services—funded by contributions from employers and employees. This social insurance model of financing translated into vast inequalities in the

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45 The most famous of such instances is known as the "Vaccine Riot," in Rio de Janeiro in 1904, when the popular masses took to the streets in response to compulsory smallpox vaccination led by Oswaldo Cruz (Sevcenko 1984, Paim et al. 2011).
breadth and quality of services, depending on the affluence of individual companies and sectors of the economy. Furthermore, since only large companies could afford funding CAPs, the vast majority of the population had no guaranteed access to social services, such as the large informal sectors, the urban poor, and—as a concession the powerful rural group in congress—rural workers (Pereira 1988, Weyland 1996, Viana & Machado 2008, Falleti 2010, CONASS 2011a).

Significant, though still restricted, expansion of healthcare services occurred under Getúlio Vargas’ Estado Novo regime (1930-1945)—a strongly centralizing response to a long period of state-level preeminence known as the República Velha (Old Republic). Partly in reaction the global economic slowdown in the period, Vargas expanded state intervention in both economic and social sectors, particularly labor relations (Santos 1979, Duarte 1999, CONASS 2011a). Vargas looked to the growing urban employed as a political base, and cemented these ties by constructing corporatist-statist institutions, consolidating labor laws, creating highly-active and protective labor courts, and greatly expanding social security coverage. In exchange, Vargas created single, centralized unions for each profession, and instated mandatory contributions. As part of this process, the myriad of CAPs were replaced by trade-specific pension institutes (Institutos de Aposentadoria e Pensões, IAPs), but inequities in breadth and quality of services were reinforced, using selective privileges to acquiesce and compartmentalize organized labor (Collier and Collier 1979, Santos 1979, Weyland 1996, Falleti 2010).

46 Esping-Andersen (1990) defines a conservative/corporatist state as a welfare regime based on the preservation of status differentials within society resulting in minimal redistributive impact. Schmitter (1974) argues that in state corporatism systems, hierarchically ordered representative corporations are created and maintained as auxiliary and dependent arms of the state.

47 Maddison (1992) argues that the Vargas reform expanded social security coverage from a meek 150,000 to over 2 million by 1940.
The resulting configuration of the Vargas institutions provided the initial shape of the healthcare and social security sectors in Brazil, and would continue to impact service provision in subsequent decades. Among these key characteristics were centralization of decision-making at the federal level, a social insurance scheme’s requirement for financial self-sufficiency, institutional fragmentation and a focus on private-sector provision (Aureliano & Draibe 1989). The technocratic reliance on a social insurance model served as a rationale for constraining social security coverage for decades (Mendes & Marques 2009). Furthermore, it made the expansion of care to the disenfranchised unpopular with those already covered, since it would require additional contributions and potential dilution of service quality.\footnote{Menicucci (2006) points out how, though supporting the sanitary reform in a formal sense, labor unions do not provide practical political support because they fall back to defending their historical right to differentiated healthcare.} Meanwhile, the centralization of financial and decision-making powers at the federal level would create an “authoritarian legacy” (Abrúcio & Sano 2009) of the top-down decision-making style and bureaucratic insularity that would severely hinder health sector governability for much of the early SUS years.

The splitting of healthcare responsibilities within the state also provided for a long-term legacy of institutional fragmentation. While curative healthcare services were part of the IAP mandates, governed by the Ministry of Labor, the much smaller public health efforts (concerning prevention of disease outbreaks or care for the informal sector and unemployed) fell under the auspices of the Ministry of Health and Education and were financed by residual general tax revenues (Rodriguez Neto 1997). These institutions fought fiercely for mandates, budgetary allocations and personnel (Weyland 1996). Fragmentation was also a major problem within each body: The Ministry of Health became an independent institution in 1953, but within it, multiple departments split along lines of service, target populations and/or regions, with little
coordination among them (Lobato & Burlandi 2000). The Ministry of Social Security fared no better: in the 1960s, the IAPs were rolled up into one national social security institute (Instituto Nacional de Previdência Social, INPS) in the attempt to standardize coverage and benefits. However, directors of the previous institutes fought to maintain the privileges of their economic sectors, political clout, and control over sources of political patronage (Falleti 2010, McGuire 2010). These legacies of institutional fragmentation would almost derail sanitary reform efforts during democratization, and continue to hinder the unification of health efforts under the SUS (Weyland 1996, Paim & Teixeira 2007, Viana & Machado 2008).

Finally, the system’s initial preference for subcontracting a large portion of healthcare services to the private, for-profit, sector would cause systemic distortions once it became Brazil’s bureaucratic authoritarian regime (1964-1985) main method of expanding services.49 The goals of the military elite were to use the state to spur modernization and economic development. In the healthcare sector, the national government channeled subsidies and cheap credit to expand the private medical sector, particularly private hospitals (Frutuoso 2010, Paim et al. 2011). As a result, hospital beds in the private sector grew from 14% of the national stock in 1960 to 73% in the mid 1970’s (Lobato & Burlandi 2000). At the same time, the state supported the system’s operation by subcontracting the majority of the private sector’s capacity on a fee-for-service model. Lax controls over the quality or quantity of services delivered led to a proliferation of overcharging, disproportionate investments in more lucrative higher complexity services, and the continued concentration of capacity in the more profitable regions such as the urban Southeast (Frutuoso 2010, McGuire 2010).

49 O’Donnell (1973) defines a bureaucratic authoritarian regime as based on the action of modern technocrats and a professionalized military institution with the goal of economic development and as a result of the political and economic pressures of economic development in South America. For more on the Brazilian military regime see Stepan (1971, 1973).
As the military regime’s initial policies led to an explosion of economic growth in the early 1970’s, the ever more precarious health conditions became an increasingly prominent blight on the Brazilian military’s internal and external images. The Geisel administration (1974-1979), seeking social as well as economic development, was determined to use some of the economic windfall to quell political unrest by increasing minimal social security coverage to rural workers and expanding the availability of medical services. The institutional divisions within the federal bureaucracy had a regressive effect on expansion: technocrats from social security were weary of managing or extending healthcare provision since its expenditures were not easily quantifiable and controlled as a contribution-based social insurance scheme. They fulfilled the presidential mandate by focusing on expressed demand for healthcare in curative services. In urban areas, coverage was broadened by opening up emergency rooms to the uninsured (Weyland 1996). The continued lack of oversight allowed private hospitals to exploit the state as a guaranteed buyer of services, and the number of billed emergency cases grew drastically in the following years, as did doctor visits and costly high-complexity services. As the world economy buckled with the oil shocks of the late 1970’s, economic growth came to an

50 The inclusion of rural workers, resulting in a tenfold expansion of social security coverage (Falleti 2010) was the first instance of welfare expansion not based on a contribution scheme (Weyland 1996, McGuire 2010).

51 Reflecting its growing political and economic importance, social security grew into its own ministry Ministério da Previdência e Assistência Social (MPAS), and the provision of healthcare services has been spun-off to a parastatal institute under its umbrella, the Instituto Nacional de Assistência Médica da Previdência Social, INAMPS.

52 The financial and social impacts of these choices cannot be understated. The lower remuneration for doctors visits compared to hospital stays led Brazil to the lowest ratio of visits per stay in a 1980 cross-national study (cited in McGuire 2010). Likewise, higher remuneration for caesarean sections led to a long-term shift in the share of c-section procedures in Brazil. The proportion of such procedures doubled between 1970 and 1980 (Barros et al. 1986, Faúndes & Cecatti 1991), and despite corrective policies starting in the 1980s, Brazil has the second largest rate of unnecessary c-sections in the world, accounting for 15% of the world stock (Gibbons et al. 2010, Victora et al. 2011): 80% of non-SUS births are c-sections, totaling over 47% of all births in Brazil (versus the WHO recommended 10-15%) (ANS 2008). Similar distortions have shifted renal replacement therapy spending disproportionately from transplants to hemodialysis (Coelho 1998).
abrupt halt, public debt exploded, and social services produced large deficits. The military regime strained to support its existing healthcare system, which was at the same time expensive, low-coverage and substandard quality.\textsuperscript{53} Conditions aligned the interests of the authoritarian leaders with a brewing movement for progressive healthcare reform.

\textit{Mobilization in Response to Healthcare Shortcomings}

The dismal state of health conditions in Brazil in the 1970’s—the aforementioned large swaths of the population with no access to healthcare, but also the increasingly dire conditions caused by rapid migration to urban centers following industrial growth—led to growing frustration and unrest of a variety of actors with an interest in public health. An informal movement of public health practitioners, academics, students, unions and other social groups began, in response, to coalesce into the \textit{Movimento Sanitário}, (Sanitary Movement, henceforth \textit{Sanitaristas}). Starting at the local level—within public health departments in leading public universities,\textsuperscript{54} and experiments with local provision by municipalities—these actors shared a desire to expand the reach of healthcare services beyond the formally employed and to shift the expensive and curative-based nature of the Brazilian healthcare sector. Sanitaristas settled on a three-pronged strategy to politicizing healthcare: producing theoretical and practical knowledge, disseminating ideology, and finally active political involvement and “occupying spaces” within the state (Fleury 1997, Paim 2007, Falleti 2010).

Though renewed in its vigor, Sanitaristas built upon a history of health sector mobilization and action. Recall that the first instances of mobilization dated back to the Pro-

\textsuperscript{53} The insurance model also hindered public healthcare, as it is tied to the business cycle. Since pensions and healthcare were funded out of the same pool, but the former were legally set, the shortfall due to declining contributions was cut from the latter.

\textsuperscript{54} Particularly at USP and UNICAMP in São Paulo, ENSP in Rio de Janeiro, UFBA in Bahia and UFMG in Minas Gerais (MS/SGEP 2006, Paim 2007).
Sanitation League in the 1910s (Hochman 1998). Public health intellectuals and top bureaucrats had participated in national health conferences as far back as 1941, raising issues such as the design of national campaigns, delineating and coordinating activities across levels of government, and indentifying the need for a combined national health strategy (CONASS 2009a). Many of the reform proposals that would be taken up in the 1980’s were already under discussion in the Third National Health Conference held in 1963, including expanded participation (though in that case limited to selected members of the bureaucratic rank-and-file) and decentralization of health services to municipalities (CONASS 2009a, Frutuoso 2010). The health sector was composed of various segments with sometimes conflicting interests, resulting in uneven mobilization capacity over the years. The repressive turn in the broader political environment with the instatement of the military regime in 1964 derailed civil society mobilization, putting many of the public healthcare issues on hold for most of the subsequent decade.

With the demobilization at a national level in the early years of the military regime, Sanitaristas regrouped at subnational public health departments, where they conducted important experiments in community-based medicine which would serve as policy models as well as political rallying points later in the 1970s. State health offices in Minas Gerais and Pernambuco sponsored pilot community health programs in the towns of Montes Claros and Caruaru (MS/SGEP 2006) aimed both at expansion of care but also as laboratories to test “simplified” and inexpensive high-impact services to rural populations. The lack of private-sector presence in the area allowed these professionals to focus on preventive care and to make the first attempts at regional organization, as towns were organized into “program areas” with human and installed capacity being distributed across this structure (Escorel 1995, FIOCRUZ
2006, UNIMONTES 2007). With the initial success these projects, Montes Claros in particular became a center for development and dissemination of Sanitarista thought.

With the economy deteriorating and public healthcare in precarious conditions, the Sanitarista proposals became increasingly attractive to the military brass, despite the former’s association with the political Left. For one, expanding coverage would serve military goals of state expansion into the territory (Santos 1985, Hochman 1998, Falleti 2010). In addition, as the military regime gradually expanded political rights and allowed moderately contested elections, appeasing the disenfranchised not only avoided a potential source of political unrest but also catered to constituencies of the official party’s candidates. The central government created expansion programs (PECs) out of these early models and staffed them with the Sanitaristas who had led the projects in Montes Claros and Caruaru. The most significant of such programs, the PIASS, extended state presence to the destitute and financially unattractive Northeast region. At the same time, Sanitaristas within the bureaucracy made proposals to tackle the national-level problems resulting from the INAMPS model.

As the military regime’s political repression softened to a certain extent, remobilization and the outright political lobbying were once again viable (though still dangerous) strategies from the broader movement. In 1976, disparate members of the Sanitary Movement joined to

55 Most early Sanitaristas were members of the outlawed Brazilian Communist Party (Partido Comunista Brasileiro, PCB), known as the partidão.
56 The official party of the regime was the ARENA (Aliança Renovadora Nacional), and the moderate opposition was allowed to run under the banner of a single opposition party, the MDB (Movimento Democrático Brasileiro). Despite policies that appealed to the masses, such as expanded social protection, MDB candidates made significant gains in the 1974 legislative elections.
57 The PIASS (Programa de Interiorização das Ações de Saúde e Saneamento) was developed by the IPEA, an independent research institute funded by the Ministry of Planning, and executed by the Ministry of Health. Though initially focused on the country’s poor Northeast region, the program later included municipalities in all regions. The PIASS is lauded as a first policy requiring major inter-bureaucratic coordination (bureaucrats from the Ministries of Health, Social Security, Planning and Interior were directly involved). Policy results were mixed, with lack of subnational managerial and medical capacities, as well as limited funding, bringing the program to a quick stall.
form its first formal institution, the Brazilian Center for Health Studies (Centro Brasileiro de Estudos de Saúde, CEBES). CEBES would serve as a main venue for the development and dissemination of public healthcare knowledge (Rodriguez Neto 1997, Paim 2007). Having grown out of scholarly conferences, CEBES rooted Sanitarista proposals in its members’ academic credentials, while also burrowing their healthcare expansion plans as part of the broader process of democratization. As the movement accumulated momentum domestically, Sanitaristas took the World Health Organization’s (WHO) Declaration of Alma-Ata’s emphasis on primary care strategies as international legitimization of their proposals, and reinforced their push for reform in the public healthcare institutions (MS/SGEP 2006).

With a backdrop of continued economic deterioration, the military’s last president, João Figueiredo (1979-1984) continued to slow opening in the political and policy spheres. Emboldened, Sanitaristas made Congress a major theater for their dissemination and mobilization strategies (Rodriguez Neto 1997). Academics from CEBES and ABRASCO held a public symposium in the Câmara dos Deputados (Lower House) in 1979, where they discussed the connections between access to healthcare and democratic rights, and presented the first blueprint for a national and unified healthcare system (Fleury 1997, Paim 2007). The event had important political after-effects: First, Sanitaristas were able to create alliances with elected officials of both parties who were sympathetic to the healthcare cause. With their increasing political access, Sanitaristas were also able to expand their presence within the state, taking

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58 While there is no official “founding date” for the Sanitary Movement, authors and interviewees agree on the CEBES foundation as a cornerstone of the movement. Furthermore, its academic journal, Saúde em Debate, hosted the forefront of academic discussion of state healthcare reform (Fleury 1997, Paim 2007).
59 The WHO held an international conference on primary healthcare in 1978, where international delegates expressed the right to healthcare, broadly defined, and that preventive and primary care strategies should be the main approach to solving the world’s health inequalities by the year 2000. Text of the declaration available at: <http://www.who.int/hpr/NPH/docs/declaration_almata.pdf>
60 The Brazilian Association for Graduate Studies in Public Health (Associação Brasileira de Pós-Graduação em Saúde Coletiva, ABRASCO) was founded in 1979. As the name suggests, it served as an academic branch of the movement, making widespread use of scientific-based evidence to support its proposals.
positions in the Ministry of Health, and Social Security and even some portions of the powerful Ministry of Planning (particularly the research institute, IPEA). The main strategy for state reform, “occupying spaces” was now well underway.

With increasing presence of Sanitaristas within the national bureaucracy, the Figueiredo administration made two major advances in the provision of public healthcare: First, when confronted with the collapsing social security system, the government sought solutions in an inclusive body, creating an opening for the first major instance of participatory decision-making. In the CONASP (Conselho Nacional de Administração de Saúde Previdenciaria), bureaucrats invited in Sanitarista academics and, for the first time, civil-society representatives to help come up with solutions to the financial crisis in social security. The broader set of actors resulted in an alliance of the more radical Sanitaristas with medical professional associations (who had a shared interests in expanded public provision and a shift to primary and ambulatory services), inflicting the first major losses to the large health sector business associations61 (Paim 2007). Furthermore, in the CONASP meetings, top Sanitaristas made personal connections which led directly to their appointment to the “crown jewel” of the public system at the time, the INAMPS. Once in control of the parastatal’s large service network, they designed and implemented the Ações Integradas de Saúde (Integrated Health Actions, AIS), a policy model that contributed to solving multiple problems in the INAMPS system: First, it shifted funds from the private to the public sector, which the state could more closely control. In doing so, it also cut costs: the federal government contracted services from subnational governments paying less (sometimes half) of those paid to private providers. Finally, though the funds were limited, it greatly

61 Chief among them were institutional representatives of private hospitals (FBH, ABH), clinics and other health services (FENAESS), and private insurance (ABRAMGE), as well as pharmaceutical, medical device, and material suppliers (Costa 1996).
expanded funding available to subnational governments, jumpstarting decentralization and the formation of subnational capacities (Rodriguez Neto 1997, MS/SGEP 2006).62

By 1984, however, the military regime’s financial and political crisis continued; the incremental shifts in social policy and inclusion could not prevent the waning political support for the pro-regime forces. Opposition parties made significant inroads when direct elections were extended to state governor in 1982, winning 10 of 22 states, including most of the larger and more developed ones.63 Despite widespread national mobilization for direct presidential elections in 1984 (known as the Diretas Já movement), the military maintained a managed pace of liberalization by having civilian candidates compete in an electoral college of state representatives. Tancredo Neves, a prominent political figure from the state of Minas Gerais, became the consensus candidate of the opposition, and defeated the military-backed Paulo Maluf in the indirect election. As the transition to democracy accelerated, the Sanitaristas were strategically placed within the bureaucracy and in the upcoming government’s political alliance to affect change.

**Redemocratization: Universalization Despite Infighting**

Democratic opening did not bring the immediate clear path to health reform that most Sanitaristas expected. Tancredo Neves died before taking office, leaving Vice-President-elect José Sarney, a last-minute deserter of the pro-military party, to rule over the transition government (1985-1989). Sarney’s cabinet was composed of a conflicting coalition of forces from across the political spectrum. While and Sanitarista and leftist forces staffed the top

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62 Municipal governments were required to develop planning documents in order to be eligible for INAMPS partnerships. A total of 664 (mostly larger) municipalities participated in the AISs between 1982 and 1986, representing 70% of the national population (Cordeiro 2001).

63 The MDB, renamed PMDB, won 9 states including São Paulo and Minas Gerais. The PDT (Partido Democrático Trabalhista, Democratic Labor Party) won the state of Rio de Janeiro.
positions in both Health and Social Security, the concurrent presence of conservative forces within government would lead to severe infighting during the process of drafting the new constitution. Reassured by the liberalizing political conditions, many considered that Sanitary Movement precepts such as the unification of the state’s health efforts under one structure were inevitable. Therefore, the political and administrative “big fish”—the spoils of the INAMPS network—became the primary target for immediate reforms.

The presence of Sanitarista leaders across the Health-Social Security divide failed to lead to the anticipated consensus. In fact, the political battles regarding the transfer of the INAMPS to the Ministry of Health came close to breaking the Sanitaristas apart on multiple occasions (MS/SGEP 2006), which the private sector exploited to extend the survival of the favorable model. Tension arose between Sanitaristas leading the INAMPS, who thought therein lied the financial and bureaucratic firepower to exert change, and those in the Ministry of Health, which had significant shortcomings as a bureaucratic body but rode the “social mandate” of being the heir to the public health sphere. While Ministry of Health officials pushed for unification “from above”, with the combination of federal bureaucracies at the center leading subnational and network reform, those heading the INAMPS argued for unification “from below,” which would slow the pace of central unification. This strategy entailed decentralizing the INAMPS service network to states and municipal health offices through the AISs, and combining federal efforts as the subnational experiences required them. Health Minister Sant’anna tried to break the

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64 Waldir Pires, from the left portion of the PMDB, was named Minister of Social Security, appointing Sanitarista Hesio Cordeiro to head the INAMPS. Another Sanitarista, Eleutério Rodriguez Neto, was named Deputy Minister of Health. Carlos Sant’anna, an otherwise conservative politician, was named Minister of Health, but quickly picked up the movement’s banners. Sérgio Arouca, an established Sanitarista leader was appointed headed FIOCRUZ, a public research institution and public health school (Paim 2007).

65 This tension was augmented by political pressures from subnational actors, favoring decentralization, and conservative politicians, who wanted to maintain access to patronage sources in the INAMPS state offices. For a first-hand account from the Sanitaristas within the INAMPS, see interviews with Cordeiro and Temporão in MS/SGEP (2006), pp. 75-81.
stalemate by pushing through legislation for the immediate transfer of the INAMPS to the Ministry of Health. In response, Social Security Minister Pires interceded, arguing that rather than continuing to replicate the centralized and isolated practices of the previous system, the process of unification should be deliberated in a participatory setting—a national health conference (Paim 2007).

With the Sanitary Movement under internal strain, over four thousand participants representing various social forces gathered for the 8th National Health Conference in March 1986. The conference was chaired by Sergio Arouca, head of the research institute FIOCRUZ, who commissioned a series of preparatory academic papers that debated sanitary reform more broadly (beyond administrative reform). The meeting also served as a fulcrum for gathering the experiences in the many municipal and state-level preparatory meetings, bridging academic and civil society discourses, with the goal of developing one consensus blueprint for public health going forward. Widely attended and heatedly debated, the conference resulted in a report that highlighted the importance of healthcare as a universal right of citizenship, broadly defined to include socio-economic determinants. It also presented specific proposals for institutional reform, such as the gradual statization of health services, the concentration of state efforts in the Ministry of Health, and the decentralization of the provision of healthcare services to municipalities. The final report is a microcosm of the conflicted nature of the Sanitary

66 The 8th Conference was purposely designed to be inclusive of civil-society and contrast with the technocratic conferences with limited participation in the past (CONASS 2009a).
67 The final statement’s first item defines health as resulting from “the conditions of nourishment, habitation, education, income, environment, work, transportation, employment, leisure, freedom, access to and property of land, and access to healthcare services. It is ... the result of the forms of social organization of production, which can generate great inequalities in the standards of living.” (CNS 1986) Translation mine.
68 Herein lied an important victory for local governments, who benefited from the particular historical conditions in Brazil that identified the many faults of the previous system, including corruption, high costs, and low quality with centralization and authoritarianism. Municipal delivery became the popular solution
movement, with an interesting confluence of radical discourse—chastising authoritarianism, the private medical and pharmaceutical complex, and calling for the statization of medicine and default on foreign debt—and more pragmatic search for consensual “art of the possible” (being strategically vague on non-consensus points such as operational transition and sources of financing).

Over the course of the subsequent year, a committee was tasked with drafting a final report for the conference, to serve as a subsidy for the healthcare discussions in the Constituent Assembly. In the meantime, political forces within the bureaucracy and across levels of government continued to fight over the more immediate administrative reforms. Empowered by the democratic legitimacy from two subsequent direct elections (Abrúcio 1998, Samuels 2003), state governors pushed for decentralization of the INAMPS networks to state health offices. A new Social Security Minister, Raphael Magalhães, was under immense pressure from the broader Sanitary Movement to transfer the INAMPS to the Ministry of Health, while also facing internal resistance from INAMPS bureaucrats who refused to be “demoted” to subnational governments, who they feared to be less capable and less solvent. Magalhães ultimately caved to state-level pressures and decided to follow the strategy of unification “from below,” transferring power over the INAMPS networks to state governments in the Sistema Unificado e Decentralizado de Saúde (SUDS). State governments, keen on the resources being offered, quickly signed up for the SUDS. Though the language in the SUDS contemplated decentralization to municipalities as well, in practice, they greatly strengthened the relative

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based both on democratic as well as efficiency grounds. For more on the confluence of events opening an unlikely window to universalization and decentralization, see Viana & Machado (2008).
importance of state offices (Ugá et al. 2003) and had virtually no effect on municipal experiences (Pimenta 2007).  

The INAMPS-led SUDS reforms were ill-received by a large portion of the Sanitary Movement members outside the Ministry of Social Security, who feared its acceptance would dilute the more radical reform efforts. They transferred their efforts to the National Commission on Sanitary Reform (CNRS), tasked with drafting the final report to the 8th Conference, and subsequently the Constituent Assembly. By doing so, they were able to frame the discussion on big-picture and more politically visible issues such as the long term face of healthcare and confront the center-right politicians who, having no tangible alternative, conceded to a narrative of “reclaiming the historical social debt” (Lobato & Burlandi 2000, Fleury in MS/SGEP 2006). Though the Constituent Assembly process was anything but smooth, including moments of conservative realignment, the Sanitary Reform Movement ultimately prevailed. The resulting health section of the Constitution practically reproduced the 8th Conference report, universalizing the right to healthcare, combining health efforts in a unified system favoring public provision, calling for decentralized and hierarchically integrated delivery, and community oversight. The outcome is impressive especially considering the lack of widespread popular mobilization in support of healthcare reform, and the powerful private medical providers who vociferously denounced the proposed statization of healthcare. Once again, agreement was

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69 Sanitaristas from within the INAMPS argued that the SUDS was always intended as a transitional step to the SUS, necessary in order to develop the necessary subnational capacities the system would require. Furthermore, they claimed that it was a guaranteed operational step towards decentralization within a fluid and unpredictable political environment. Weyland (1996) argues that it is an example of “rampant” bureaucratic politics derailing radical reform efforts.

70 Only 54 thousand people signed the petition for a popular amendment for public healthcare in the Constituent Assembly, compared to 3 million signatures supporting land reform, which was nonetheless kept off the Constitution (Paim 2007). Escorel, a leading Sanitarista scholar, refers to this lack of widespread public support as the “ghost of the absent class” (see MS-SGEP 2006, p.64. Translation mine), only made worse by the Sanitaristas refusing to make broader alliances with other social welfare sectors in the discussions.
made possible by framing the articles in terms of “big principles,” leaving operational specifics (including financing) to be determined by infra-constitutional legislation, and by reaching out to the political Right by ensuring the survival of an independent for-profit medical services and health insurance private sector (in “supplementary fashion”).

_The SUS’s First Decade: Federal Decrees, “Autarchic Municipalism” and a Missing Middle_

While many sectors of the Movimento Sanitário felt they had “won the war” for public health with the creation of the SUS in the 1988 Constitution (Rodriguez Neto 1997), the real difficulties would lie deep in the operational trenches, and far from the public eye. There, a less mobilized Sanitary Movement would face the organized resistance from entrenched private and bureaucratic interests, as well as the contrary rationalizing efforts coming from a broader structural adjustment program that dominated the state’s agenda in the 1990s. Following the passing of the Constitution, the Leftist Sanitaristas were surprised by the almost immediate change in the political winds. A backlash from conservative forces led to the ousting of Sanitaristas at top positions in the INAMPS, while bureaucratic resistance sabotaged the SUDS strategy from within the INAMPS.\(^{71}\) The recoil took on full force with the election of the conservative Fernando Collor de Mello (1990-1992) as Brazil’s first democratically elected president since the early 1960s. Once in office, Collor adopted neoliberal economic policies focusing on structural adjustment, reducing the size of the state and favoring private enterprises. To tame rampant hyperinflation, Collor undertook “draconian” measures towards the state and the economy, slashing social sector budgets and seizing private assets (Weyland

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\(^{71}\) President Sarney ousted Cordeiro from the INAMPS, replacing him with a conservative, José Serrão (Weyland 1996). Serrão reinstated anti-unification career bureaucrats to top INAMPS positions and reopened INAMPS state offices that had been closed down with the SUDS, reestablishing politicians’ access to patronage appointments and appeasing federal bureaucrats (Paim 2007).
resulting in recession and unemployment. While the Ministry of Health was not completely closed off to Sanitaristas (especially those who focused on rationalizing efforts rather than expansion), critical positions were guaranteed to President Collor’s cronies. In conjunction, these policies diminished the state’s ability to expand healthcare actions and eroded wages and healthcare service fees paid out by the government.\textsuperscript{73}

Under inhospitable economic and political conditions, the last major healthcare battle fought in the Legislative arena concerned the SUS’s legal benchmark: the \textit{Lei Orgânica da Saúde} (LOS) (National Health Act) (Brasil 1990a). Despite the conservative resurgence in the 1989 elections, Sanitaristas were able to reproduce the successful strategies from Constituent Assembly and passed a National Health Act that delineated the general organization and sources of funding for the SUS in favorable terms. However, President Collor vetoed large portions of the LOS, including those concerning the proportion of government spending earmarked for health expenditures, the automatic transfer of healthcare funding to subnational units, the timetable for the extinction of the INAMPS, and the creation of participatory institutions (Weyland 1996, Paim 2007). The decentralization of service provision, as the only portion of the reform that fit with the government’s neoliberal outlook, survived the presidential veto. However, the unfunded nature of the decentralization of the law as approved led to the resurgence of federal power, initiating a period of centralizing, or “tutelary” decentralization (Cordeiro 2001).

The organized response to Collor’s vetoes to the LOS marks a silent change of the guard at the forefront of the national healthcare policy debate. As the broader Sanitary Movement

\textsuperscript{72} For more on the Collor administration, see Weyland (1993).

\textsuperscript{73} Diminishing wages broke the support of public and private sector unions, who turned to recovering wages and protecting their pre-existing services, while the discrepant fees caused an adverse selection in which only the inefficient and state-dependent providers remained in the public system (Lobato & Burlandi 2000).
lost steam due to economic hardship, corporatist divisions, and a general lack of élan, subnational health managers (*Secretários de Saúde*)—the new actors with most interest vested in the new system—took the lead (MS/SGEP 2006, Paim 2007). They headed the political reaction which led to new negotiations in Congress, which ultimately led to the approval of a second law (Lei 8142, Brasil 1990b) addressing many of the holes created by the Collor vetoes, creating participatory institutions (health councils and conferences) and making them a prerequisite for receiving federal health transfers. Subnational managers took advantage of their central position in the debate to permanently enshrine themselves in the SUS participatory infrastructure—guaranteeing state and municipal manager representation in health councils tied to their respective manager associations (COSEMS, CONASEMS and CONASS). Secretários from the poorer regions were able to align their individual interests with the broader Sanitarista equity-enhancing goals and reached limited redistribution in financing, as the law called for a minimum of 50% of federal transfers to be determined by population criteria rather than previous model which was based solely on service production (*séries históricas*).

With the National Health Act and its compliment determining the broad strokes of the national health system, the prominent arena of negotiation moved definitively from the Legislative to the Executive domain (Arretche 2004), initiating a long process of institutional development led by the Ministry of Health, and fiercely contested by the subnational *Secretarias de Saúde* (health offices). One of the most notable differences was that, in the operational realm, feasibility rather than aspiration became the guide. In practice, this meant that legislation mandates took a back seat to a pragmatic and *de facto* independent process of administrative reform. Nothing exemplifies the conflict between the democratic aspirations and the rancid authoritarian legacy of the INAMPS than the first set ministerial decrees following the signing of the LOS. Issued mere days after the signing of the 8142 Law—which tasked a National Health
Council with deliberating and overseeing national health policies—the INAMPS unilaterally issued the *Norma Operacional Básica 01-1991* (Basic Operational Norm, NOB-91) reinforcing the INAMPS fee-for-service model and reclaiming discretion over automatic transfers approved in the Health Acts (CONASS 2007, Ugá et al. 2003). Though it finally transferred the INAMPS under the umbrella of the Ministry of Health, it nonetheless prolonged its life. The institute remained as a parastatal institute (*autarquia*), responsible for its personnel and the direct payment of medical providers, which continued to favor curative services. Furthermore, in creating a direct channel between the federal government and municipalities—municipal governments could apply directly to the Ministry of Health for specific partnerships (*convênios*)—the NOB-91 further weakened the role of state governments (Médici 1996, Mendes 1998, Viana & Machado 2008), who had already lost power and funding in the change from the state-centered SUDS to the municipal-based SUS. Despite vocal protests that the NOB was unconstitutional and reduced subnational managers to mere contractors for the federal government, the INAMPS used its control over the purse to ultimately have its way, and over a thousand municipalities signed federal partnerships (Levcovitz et al. 2001).

With President Collor caught in a large corruption scandal, healthcare actors reconvened for the 9th National Health Conference in August 1992. The conference proceedings heavily criticized the Collor government both for its “crisis of ethics” and for refusing to follow the Constitution and National Health Act. Benefitting from favorable political conditions and

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74 In language and in title, the NOB was a legacy of the INAMPS methods and culture. It was contested both politically and legally upon its publication, forcing two subsequent reissues (Carvalho 2001). Despite continued resistance, NOBs were the main tools driving institutional development across multiple governments until 2005 (Levcovitz et al. 2001, Noronha et al. 2008). For a critique of the NOB strategy see Carvalho (2001) and Goulart (2001).

75 The pragmatic needs of operationalizing laws that only express “big picture” aspirations is many times lost to the majority of Sanitarista scholarly production, since the scholars were also the participants. Those more distanced accounts recognize that, though heavy handed, they were a “necessary evil” to create a decentralized healthcare system whose basic units, municipal health offices, for the most part did not exist.
pro-municipal policies in the NOB-91, *Secretários Municipais* were at the height of their influence at this point in time. Municipal leaders chaired the 9th Conference, therefore controlling its agenda. As a result, the Conference’s final report, titled “Municipalization is the way” ("Municipalização é o Caminho") (CNS 1993), (echoing the title of the previous national meeting of municipal managers (CONASEMS 2002)) proposed federal policies that prized local thinking, ignored the need for coordination, and provided direct and indirect incentives for the expansion of municipal medical capacities.76

President Collor was impeached by Congress in December 1992, and his replacement, Vice-President Itamar Franco (1992-1994) was more supportive to the SUS project. Franco appointed a pro-SUS federal deputy, Carlos Mosconi, to head the dissolution of the INAMPS (finalized by Law 8689, in June 1993) and named prominent municipal Sanitaristas to top positions within the Ministry of Health.77 Under these new forces, Ministry of Health policies continued to push administrative and financial decentralization. With Ministry support, the municipal association (CONASEMS) introduced a proposal for a new Operational Norm that would eliminate federal discretion over subnational transfers. After six months of deliberation at National Health Council, the new decree—NOB-93—was approved, including operational advances and further empowering municipalities. First, it created rules for automatic transfers between the federal government and states and municipalities, through the creation of health-specific funds that were kept separate from general operational accounts (transferências fundo-

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76 In particular, the creation of federal-municipal fee-for-service partnerships that only paid based on services rendered joined with the lack of available funding for medium complexity ambulatory services or for state-level coordination programs (Cordeiro 2001, Dourado & Elias 2001).
77 Once the INAMPS was rolled into the Ministry of Health, it was combined with the *Secretaria Nacional de Assistência a Saúde*, SAS. Gilson Carvalho, a former municipal manager and one of the leaders of the municipal association (COSEMS) in the state of São Paulo was named the SAS director.
At the same time, the NOB-93 took a pragmatic approach to the heterogeneity in subnational capacities in that it did not guarantee immediate automatic transfers to all actors. Rather, it created three levels of management certification which would determine the extent of municipal access to responsibilities and resources. Illustrating the level of SUS subnational development at the time, only 24 municipalities had reached the highest level of certification, gestão semiplena, by the end of 1994 (Heinmann et al. 1998), and 137 by 1996 (Levcovitz 2001).

Rather than building up both municipal and state capacities in tandem, the NOB-93’s municipal emphasis came at the expense of state offices. Since the large part of actions transferred to municipalities were once state responsibilities, many state offices found themselves without a mission, what Mendes called a period of “identity crisis” (SES-MG 2004). Municipalities were encouraged to take on new responsibilities, and to be fully “sovereign” in the construction of their health systems, being free to ignore state guidance. What is more, once municipalities achieved higher levels of certification, they were completely shielded from state oversight, which were cutoff even from data access. Finally, while the NOB-93 reinforced the Constitution’s call for state-level coordination of municipal action, it failed delineate specific coordination guidelines, and did not include financial support or incentives for the tools with which states could do so, such as medium complexity (ambulatory and diagnostic) services or medical referral (Cordeiro 2001). Feeling underprivileged, and suffering human capital flight, state health offices lagged in their implementation of the SUS, in many cases dragging out in the formation of councils, commissions and health funds (Carvalho 2001). It is particularly telling

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78 Fund-to-fund transfers are widely lauded as the operational crux upon which the multi-level SUS can function. Because they are automatic once approved, they allow for long-term subnational planning and give weight to contracts. In addition, they empower state, and especially municipal government to make their own policy choices (as opposed to receiving payment for services rendered), and to oversee local providers, who now have to be responsive to local demands, at the danger of losing contracts.
that no state had achieved certification under the NOB-93 rules as late as 1997, when the NOB-93 was replaced (Levcovitz et al. 2001).

The NOB-93 further exemplifies the transition of the health sector from one spurred by broader social mobilization to the resurgence of technical and political actors (albeit from new sectors of the state). During the long and contested initial meetings of the National Health Council, public managers and bureaucrats from states and municipalities often found themselves conducting side-meetings with Ministry of Health technocrats in the hallways, where they discussed more intricate operational details of policies. Out of this experience, the NOB-91 had called for a formal joint-commission composed of public managers and bureaucrats from the three levels of government dubbed the Comissão Intergestores Tripartite (Tripartite Management Commission, CIT), but it had failed to catch on during the highly centralizing norm.

Under the new norm, managers negotiated a strengthening of the CIT joint-commission and reproduced the model subnationally, forming bipartite commissions at the state level (Comissões Intergestores Bipartite, CIBs). The following section of this chapter provides more detail on these important institutions, but suffice it to say for now that they provided a necessary venue for the negotiation of operational conflicts amongst managers, unfettered by the ideological, time consuming, and many times conflict-prone participation of the broader Sanitary Movement and civil-society forces. And to the extent that their mandates overlapped with portions of the council mandates, they broached power from them (Miranda 2003).

The development of the SUS structure was not immune from the crisis factors hindering state action throughout the 1990s. With inflation reaching triple digits and economic growth stagnant, predatory behavior entailed between ministries at the federal level and across levels of government. With declining contributory receipts, the Ministry of Social Security often
delayed, and eventually withheld mandated transfers to the Ministry of Health.\textsuperscript{79} Short for cash, the Ministry of Health in turn delayed transfers to subnational governments. Considering the level of inflation, delays were particularly harmful to the municipalities who had been certified as full managers. Overdue bills to providers were monetarily indexed, yet nominal federal transfers no longer covered the original expenditures upon arrival. As the overdue bills piled up local providers, even those historically public-sector dependent, shut down services to the public sector, leaving the decentralized “buck” in municipal hands.

While macroeconomic stabilization after 1994’s \textit{Real} Plan and the election of President Fernando Henrique Cardoso (1995-2002) solved many ills and re-strengthened the state, it did not solve the healthcare sector’s financial shortfall. Macroeconomic stability was at the top of the new government’s agenda, and hence, the conservative Finance and Planning Ministries held enormous sway over the other ministries. Domestic and foreign pressures at the height of the neoliberal wave also dampened the SUS’s expansion: Health Minister Adib Jatene fought forcefully for additional resources to cover the hole left by the withheld Social Security funds. Jatene mobilized a broad coalition of political forces within the Executive and the Legislature, finally securing a source of additional funding in a temporary financial transactions tax (CPMF), which was projected to bring an additional R$ 4 billion (28%) to the healthcare budget. The debate over the CPMF in Congress finally saw the collapse of the Sanitary Movement’s bases: the within-the-state Sanitaristas—desperately needing funding to fulfill their legal mandats and seeking to keep their jobs—backed the proposal, while the political parties in the Left and labor unions voted against the additional tax. To prevail, public managers found unlikely allies in the far Right, where representatives backed by the private hospital and clinics associations

\textsuperscript{79} Healthcare funds were set as 30\% of the broader Social Welfare budget in the Constitution’s transitory guidelines. However, health expenditures were at a disadvantage when earnings decreased because pensions had set levels (and were legally enforceable) while health expenses were residual.
combined forces to prop up the system on which both sides were dependent. While Jatene ultimately succeeded in attaining the CPMF, the tax ultimately became his pyrrhic victory. The financial ministries quickly sterilized its inflows by diverting other sources of funding by similar amounts (the CPMF rose from 29% of the health budget in 1997 to over 90% in 2005) (Mendes & Marques 2009). Later still, as the federal government pursued a broader state reform project and sought financial flexibility, the Executive passed legislation that allowed the central government to seize back avoidable expenditures (mostly investment) leading to a further decrease in health sector budgets. In protest, Minister Jatene resigned, and was substituted by former hospital manager Carlos de Albuquerque, emphasizing the turn towards managerial efficiency.

In this environment, the health sector debated a new Operational Norm for most of the year 1996. Working within the imposed financial constraints but benefitting from more capable subnational actors, the NOB-96 introduced important advances, simplifying categories for municipal certification, and introducing per capita financial incentives for primary care, which resulted in a great expansion of funding for poorer municipalities. The simplified certification structure and financial incentives led to high subnational adoption: By the year 2000, 99% of municipalities had been certified (the vast majority as primary care managers, and the residual sought full management rights) (CIT 2010). At the same time, the NOB-96 reintroduced roles for state-level governments by calling for the establishment of coordination instruments. The main such tool, the Programação Pactuada e Integrada (PPI), created a platform through which municipalities could collectively match resources and service capacity for secondary and tertiary care. A municipal manager could elect to keep their per capita resources when services were available in their territory, or—in the case of most smaller and more remote municipalities—
automatically transfer resources to neighboring municipalities for a guarantee of services.\textsuperscript{80} State-level intermediation was seen a critical in order to prevent inter-municipal bullying or hoarding of resources where capacity was absent.\textsuperscript{81} Despite the introduction of these important advances, the NOB-96 was highly contested both at the national and subnational levels, suffering a large number of patchwork revisions before being finally rolled out in 1998. And while most of the changes it introduced would not bear fruit for another couple of years, it is nonetheless an important benchmark for the reintroduction of state governments as active participants in the management of their health systems, and the beginnings of state system differentiation.

\textit{Bringing the States Back In}

After a first decade tasked with creating basic subnational capacities in order to implement a decentralized system, the SUS’s second decade would focus on integrating disparate municipal systems though regionalization. This coincided with a political shift within the Cardoso administration, when a José Serra, a prominent member of the president’s party, took over the Ministry of Health. This brought the health sector into the political core of the Cardoso administration, after a decade of pining at the political fringes of national cabinets. Though met with distrust by Sanitaristas, in part due to partisan motivations, but also because of his lack of experience in the health sector, Serra’s political clout brought immediate benefits

\textsuperscript{80} This was negotiated down to the individual service. For example, if the per capita allocation of a small municipality was for 5 tomographies, the \textit{Secretário} could elect how many would be done locally, and how many would be sent to each neighboring municipality or sometimes to distant larger centers.

\textsuperscript{81} The initial PPI process fell short of the desired in most states. As a result of municipal inequalities and lack of active state management, the few completed PPIs ranged from merely bureaucratic (in the sense that they were abandoned after planning stages), to further fragmenting municipal systems (when municipal governments chose to keep resources for services that they did not provide, creating incentives for service duplication), to finally cases in which municipal governments with full certification took advantage of their smaller neighbors by taking their resources but failing to provide services.
to the sector. First, he used his political strength to shield the Ministry of Health from political allotment, duplicating the strategy of creating “pockets of efficiency” within the state (Evans 1995) by hiring technically competent and non-partisan staff (Paim 2007). As part of the Cardoso government’s wider state reform project, he led the introduction of important managerial reforms, such as establishing performance criteria. Serra also took on visible projects at the national level, confronting multinational pharmaceutical companies in order to lower the costs of providing antiretroviral medications to HIV/AIDS patients, threatening to have the federal government break international patents if necessary. This salient victory did a great deal in terms of winning legitimacy with Sanitarista and civil society groups, as well as reclaiming a narrative of policy success to a public sector that was commonly portrayed as chaotic, ineffective and inefficient.

Serra’s Ministry of Health reinforced its inductive capacity to assuage the subnational disparities in healthcare capacity. To pursue this strategy, the Ministry fought two major fronts: First, it needed to ensure a minimum standard of financing for the entire sector. Serra and the subnational leadership pressed for a pending constitutional amendment to regulate sources of healthcare financing (EC-29), which determined minimum levels of spending for state and municipal governments (12 and 15% of revenues, respectively), and while they failed to earmark a specific proportion of the national budget, the amendment ensured the subsequent growth of the federal healthcare budget by a minimum of the previous year’s GDP growth. Second, in order to increase quality and rationalize costs, it created policies that would bring about the resurgence of state-level planning and management. The introduction of the last of the operational norms, the NOAS, emphasized regional planning and hierarchical integration. The NOAS focused municipal action in primary care by including a more extensive set of procedures under the primary care funding block and augmenting family health team incentives, and
providing additional funding for state governments to take on medium complexity services. But it tied existing and new resources through systemic planning instruments (the aforementioned PPI, and a regionalization plan (*Plano Diretor de Regionalização*, PDR)) that organized municipal systems in a broader framework of territorial division of resources. State-level certification (and with it access to a new source of financial incentives) was tied to approval of these documents in subnational support institutions (joint commissions and health councils), and municipal certifications now hinged on the regional designs.82

By delegating state offices as the arbitrators of the PDR development process, the NOAS greatly reinforced state-level power. State-level technocrats, in charge of operationalizing the complex sets of rules for region-delineation, including existing service capacity and access to transportation infrastructure, finally found a new *raison d’être*. Many state offices went further and designed their own regional policies in addition to federal guidelines. Increased power to determine policy led to political strengthening, as regionalization did more than equalize resources across regions. Central to the idea of building up scale is concentration of resources in regional “poles”, which would be benefitted both in the present and in the future with increased resources. In many cases—where differences in size and existing patient flows indicated a clear candidate—the regional pole choice involved little discussion. However, in the many others where no single municipality stood out as an obvious target, a political battle between neighbors broke out, and gave the state offices a position to make choices.

The NOAS process, though important, was far from smooth. Following Serra’s vision for a strong inductive force for the Ministry of Health, the MS was accused of steamrolling the

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82 In practice, this meant municipalities were no longer free to apply for certification of whatever services they saw fit. The CIB (state joint commission) and the CIT (federal joint commission) could only approve certifications that were within the parameters of the approved PDRs.
Norm through participatory institutions, and producing a technically complex and overly bureaucratic document harkening back to the INAMPS methods. Furthermore, in order to induce specific behaviors from municipalities, it multiplied the use of smaller decrees and further fragmented funding sources into hundreds of project grants ("little boxes") (Viana & Machado 2009). Municipalities in particular resisted it fiercely, and even state managers challenged its rigidity in seeking one top-down framework for the entire country. After a national discussion in the Tripartite Commission, the NOAS was reissued in 2002 (Menicucci et al. 2008), but many of its more transformative policies failed to be immediately implemented. Nevertheless, some state governments took the NOAS mandate and established their position as managers and coordinators of their state system.

The emphasis on regional planning wouldn’t come to fruition until after the diametrical power shift in national politics, with the election of president Luis Inácio ‘Lula’ da Silva (2003-2010) from the Partido dos Trabalhadores (Workers’ Party, PT). A Leftist in power brought renewed hope to the more radical segments of the Sanitaristas, who believed Lula would abandon the rationalizing policies of the Cardoso administration, and open the path to expand the state’s capacity to deliver services directly. Sanitarista leaders long connected to the PT, such a prominent academics from the UNICAMP’s public health school were appointed to second-tier positions with the Ministry of Health, and negotiations ensued for a new form of operational advancement within the health sector. While many such hopes were dispersed (conflict between the more radical Sanitaristas and the more pragmatic center of the the PT led to the ousting of the UNICAMP Sanitaristas from the Ministry of Health soon thereafter), Lula’s commitment to monetary stability led to no immediate jump in financing, as Sanitaristas had hoped for. The first Lula administration had three health ministers, but like the early Cardoso ministers, they suffered in the political fringes of the government and failed to make major
contributions. Humberto Costa, Minister for the first two years, introduced the emergency system (SAMU) which would eventually become a major project in Lula’s second administration. José Saraiva Felipe, a Sanitarista from Minas Gerais and with experience in the early Montes Claros project was sacked in less than a year as a response to political infighting between the PT and the PMDB, Lula’s two major support parties.

Nonetheless, the main institutional advance under the Lula administration was published in 2006, titled the Pactos de Saúde (Health Pacts), replacing the practice of Operational Norms for good. The change in name illustrated a broader shift in approach: rather than determining one-size-fits-all rules that subnational governments could elect to join, the new system allowed managers to sign agreements in which they proactively selected which specific actions they wanted to take responsibility for. This had many important benefits, such as diminishing overlapping responsibilities (Menicucci et al. 2008), and allowing local managers to take into account differences in local realities and capacities. The pacts themselves were broadly deliberated over years of negotiations in CIBs and the CIT. It further empowered subnational managers by consolidating the over one hundred project grants in the NOAS structure into 5 blocks, with greater managerial latitude for their application. It introduced performance indicators (for management and for health outcomes) and reinforced the PDR and PPI tools, which had some time to become internalized and build consensus with health sector actors across levels of government. Finally, it introduced an additional regional management body, the Colegiados de Gestão Regional (CGRs) where neighboring municipalities created ongoing managerial relationships, as opposed to financial planning more common in the CIBs.

In sum, the first section of this chapter illustrates the conflicting development of the public healthcare system. While the state has extended coverage and tried to reform the models of care and also the way in which levels of government work together, there has been an
incredible resilience of the practices of previous institutions, including a prominence of expensive curative services, institutional fragmentation, and semi-authoritarian tendencies at the center. Despite significant advances in the reach and quality of services provided, severe heterogeneities and inequalities persist throughout the country. And while municipalization bore some of the promised fruits, including the formation and managerial advancement of a multitude of local actors, and a vast laboratory for institutional experimentation and learning, municipalization, in its unfettered or “autarchic” version also served to augment subnational inequalities. Furthermore, the duplication and inefficient use of the finite resources made the health system vulnerable to the main string of attacks by the center-right and international financial institution criticism: that the SUS’s shortcomings were not a matter of funding, but of how the funds were spent.

Nonetheless, there have been significant managerial advances in the SUS’s initial two decades. For one, municipal governments learned, rather painfully, that they couldn’t shoulder the task of delivering health services by themselves. Particularly as they rose to the challenge of managing their municipal systems, many municipal managers came to understand the importance of pooling resources and efforts with neighboring municipalities, and the need for state-level coordination and aid with higher complexity tasks. The current state of the art has reintroduced the state governments into the system and reinforced the importance of cooperative institutions. The associational space has continued to develop in this time, maturing under the Lula administration. In this “maturity” actors have moved beyond merely administrative and financial redistribution reforms, to starting to debate the model of health service provision, emphasizing primary care tasks that bring the most benefit to the underserved population, and will eventually lower the overall health bills. Main unsolved issues
continue to be the availability of human resources, especially away from urban centers, and integrating municipal and state systems to maximize citizen access to services.

**Navigating the SUS Institutional Structure**

With a better understanding of the historical ebbs and flows of Brazilian public health, let us now survey the resulting institutional landscape surrounding the public health system. As the literature on bureaucratic politics and governance has identified, one of the main tasks in implementing complex national policies is building trust among actors, maintaining open information flows and solid joint decision-making structures. As we have seen, the Brazilian health sector had historically faced centralized and exclusionary decision-making, and implementation was further complicated by institutional fragmentation. At the same time, the Left-leaning counter-authoritarian nature of the public health movement was highly participatory. Combined, these two flows created an impetus for grounding the SUS in a network of “relational instruments” (Frutuoso 2010, translation mine) which would represent subnational interests at the center and ensure representation of additional actors in the policy design process, limiting the influence of the large medical-industrial complex.

There are three major types of institutions that surround the SUS. The first, and most widely known, are the *Conselhos de Saúde* (health councils), which take the old design of corporatist institutions (forums with representation by the state, capital and labor) and expand it to include civil-society representatives. But the councils are not the only relevant institutions to the healthcare story. Public managers and technocrats also meet in monthly joint-commissions (*Comissões Intergestores*) to negotiate healthcare policies and the distribution rules for federal resources. A third type of institution, manager associations, rose outside of the legal framework of the public system, with subnational managers attempting to reap the
benefits of collective action, and nonetheless have become an intricate part of the process through which policies are developed and consensus built. Taking advantage of their central position in the new system, subnational managers as a profession made their associations intrinsic parts of the SUS associational space, rewarding those with historical ties to the public health movement.

While the health councils are widely celebrated and studied, the other important institutions are seldom the subject of academic inquiry, and practically unheard of outside of the public health literature in Brazil. This dissertation’s main argument rests on the importance of the broader SUS institutional infrastructure, and in particular, the behavior of the state-level joint-commissions. Therefore, this section provides the basic institutional vocabulary to subsidize the reader’s understanding of their action in state-level systems (Table 6 and Figure 7 below).

83 Most of the literature on the associations (CONASS, CONASEMS, and state COSEMS) are institutional histories (eg. CONASS 2007a, 2011; Pimenta 2007; COSEMS-SP 2008). Sano (2008), and Abrúcio & Sano (2009) have studied the CONASS in comparatively versus other policy sectors. For the national-level CIT, see Miranda (2003), and for the CIBs in the states of Rio de Janeiro (de Lima 1999, 2001) and Bahia (Guimarães 2003). The Ministry of Health has funded a national survey of state-level CIBs, but results have not been published at the time of this writing.
Table 6: The SUS Institutional Framework

<table>
<thead>
<tr>
<th>Institution</th>
<th>Composition</th>
<th>Responsibilities</th>
<th>Institutional Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Councils</td>
<td>50% Civil Society (specific civil-society organizations vary)</td>
<td>Deliberate healthcare priorities</td>
<td>Councils aggregate up levels of government (Local council members sampled for municipal councils, and similarly to state and national councils)</td>
</tr>
<tr>
<td></td>
<td>25% Health workers (including scientific community)</td>
<td>Permanent oversight over implementation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25% Management (including private sector)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manager</td>
<td>CONASS (national, 27 state secretaries)</td>
<td>Horizontal negotiation, building political consensus</td>
<td>Elect members for joint-commissions (CIBs and CIT) and Health Councils</td>
</tr>
<tr>
<td>Associations</td>
<td>CONASEMS (national, municipal secretaries)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>COSEMS (states, municipal secretaries)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint-Commissions</td>
<td>CIT: 1/3 Ministry of Health, 1/3 leadership of CONASS, and 1/3 leadership of the CONASEMS</td>
<td>CIT: Design national health policies, financing rules for subnational governments</td>
<td>Some COSEMS boards are representative based on CGRs (rules vary)</td>
</tr>
<tr>
<td></td>
<td>CIBs (state level): 50% state representatives (normally state office division heads), and 50% leadership of municipal association</td>
<td>CIBs: Distribution rules for federal transfers, state health policies, service and management certifications.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CGRs (micro-regional level): All municipalities in the micro-region, 1 state representative (state voting eligibility varies)</td>
<td>CGRs: Collective management of services, joint problem-solving and network design</td>
<td></td>
</tr>
</tbody>
</table>
Once approved at the CIT, policy is published by the Ministry as a *portaria*, and goes into effect.
Conselhos de Saúde – Interest incorporation and Civil-Society Inclusion

The most prominent and celebrated of healthcare institutions in Brazil are the Conselhos de Saúde, or health councils. They are the culmination of the participatory roots of the public healthcare movement, grounding high-level state policy-making, and combining representative and participatory forms of governance (Avritzer 2010). They have two main responsibilities: the deliberation of healthcare policy priorities, and concurrently, permanent oversight over their implementation. Their composition is itself the result of the broad Sanitary coalition: From the more radical elements of healthcare movement came the emphasis on making civil-society representatives (in this case under the umbrella definition of usuários, or patients) 50 percent of the membership. The portion of the Sanitaristas connected to the state reinforced the necessity of bringing in representation from upper management and the sectors involved in the provision of public healthcare: therefore the other half of the membership incorporates management, healthcare professionals (doctors, nurses, leading public health universities). Finally, due to the arrangements made in the negotiation for the Lei Orgânica da Saúde, representatives from private providers (both non- and for-profit) also guaranteed spots within the councils.

The introduction of health councils across levels of government was contested despite their general provision in the Constitution. President Collor, governing immediately after the 1988 Constitution came into effect, vetoed the portions of the LOS that created the councils, and even after the compromise of the participatory law, delayed their implementation. Despite their pre-existence in some PT-led municipalities (particularly in the state of São Paulo), the vast majority of mayors resisted the determination to create participatory councils. Therefore, in the

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84 The academic and legal terminology in Portuguese is “controle social” (literally: “social control”), which clearly does not translate well into English. Nevertheless, the term in Portuguese refers, “fundamentally to the participation in the decision process over public policies and to the control over state action.” (CONASS 2009, p. 10). (Translation mine).
early 1990s, the Conselho Nacional de Saúde (CNS) was the standard-bearer for national policy deliberation (ironically, even while the bureaucracy continued to act in unilateral fashion towards subnational managers). The CNS had existed formally since the late 1930s, though in its previous iterations, it functioned as an intra-ministerial consultative body. It began to take it shape when the Sanitaristas, within the authoritarian structure, took part in their still-irregular meetings, and were expanded when, in 1987, half of its seats were assigned outside the bureaucracy to “persons of notorious capacity and proven experience in health.” After the passing of the participation law (8142, in December 1990), and the subsequent negotiations for determining which organizations and professional associations would have seats in the council, the CNS became, however briefly, the main arena for debating healthcare policy. In its heyday, the CNS passed a large number of resolutions to guide the formation of the new health system bodies, but also to determine health policy priorities (Figure 8 and Table 7 below). At its most active, during the Franco and first Cardoso administrations, the CNS passed 4.5 and 3 resolutions on average per session. Notice however, that even at its height, the Council was less deliberative than it was an oversight body. Almost 40% of all resolutions concern the creation of committees, naming members of committees, and other internal matters. And at its peak, around one third of resolutions involved active oversight of the national executive. However, the CNS lost its centrality to the policy process as the joint-commissions rose to prominence. Even more troubling is the substitution of the more assertive resolutions by recommendations, which grew in number in the second Cardoso term, and in the Lula administrations.

85 Based on the CNS’s institutional history, available at <http://conselho.saude.gov.br/apresentacao/historia.htm>
The behavior of participatory institutions at the national level is quite different from the local level, considering that at higher levels of aggregation because they become more representative than directly participatory institutions. While the level of the discussion is certainly more developed, having cherry-picked members from across the national territory, maintaining mobilization is harder considering the levels of detachment from the local experiences especially of patient representatives. The real expansion occurred subnationally,
with the proliferation of state, municipal, and local councils which resulted from their being eligibility criteria for federal transfers. By 2009, only 225 municipalities (4%) did not have active municipal councils.\textsuperscript{86} In response to national guidelines tying the existence of councils to federal transfer availability, over half of municipalities had instated their health councils in the first five years (Figure 9).

![Figure 9: Municipal Health Councils by Year of Foundation](image)

Local health councils are the most capillarized form, centering on each health facility (community health depot or family health center). These are composed by management, labor and patients. They govern the daily operation of the health center, and as such, tend to deal with minutia of the interface of the state with society. Most local council discussions focus on administrative issues or on what councilors call system “humanization,” namely, affecting the direct interface of the state with patients. Such issues range from politeness and equitable treatment of medical personnel, to hours of operation and accommodation of patients and their families as they wait for services. While policies are hardly ever discussed at this level, direct oversight is most present at this stage, with patients filing complaints over staff behavior, unit performance, and provision (most often lack thereof) of specific services and procedures.

Municipal councils are the main units of the participatory system. For smaller municipalities, they can provide a real opportunity for direct democracy, bringing together the town’s health manager, the representatives from the main providers (public or private) into a direct interface with the patients. In larger cities, there tends to be an overrepresentation of left-leaning groups and avoidance by the upper-level health management and of the private sector providers.

Needless to say, there is an immense variation in the nature and effectiveness of health councils at each subnational level. Councils in smaller municipalities suffer from vulnerability to political control by the mayor and interest group capture (Fleury 2011). Furthermore, like any other interest aggregating body, discussions tend to fall under the control of the better organized and relatively powerful groups (e.g. the highly-mobilized HIV/AIDS CSOs). Politicization, with conflict across the Left-Right spectrum (a common critique from the Right is that the Left has designed and empowered councils so that they can govern even when they lose elections), and even within the Left is common within the councils, with local representatives using the health council to then launch political careers in the elected city councils. The most glaring variation, however, is in the level of capacity of council members (Avtizer 2009, Cortes 2009, Fleury 2009). This is particularly the case for the representatives of patients, who come with very different levels of understanding. During an observation of a State Health Council meeting for the state of São Paulo (which I would argue is a most-likely case of success, given the richness of associational life in the state, as well as a higher level of economic development), most of an eight-hour day was spent debating whether council members who were present could amend voting rules in order to be able to lower the quorum to pass a resolution.

Likewise, the proliferation of councils and subnational conferences might be responsible for the waning impact of subsequent national health conferences. A CONASS study shows a
proliferation of resolutions (from 49 in the 8th and most important conference, to over 850 in the 13th in 2007) (CONASS 2009a). They indicate “potential loss of substance” and unfeasibility of the implementation of all of them. Likewise, the fabric of social movements changed substantially in Brazil as throughout the world, with a proliferation and pulverization of interest specific associations. Some scholars have also argued that, as movement leadership more actively participates in the design and execution of social policies, they lose the close links with their original social bases (Fleury 2011).

One of the most difficult things has been to properly educate council members of the actual mandate of councils, and the limits of council action. Many council members, motivated by the desire to transform public action, believe that they (individually or collectively) have preeminence over executive or legislative representatives. At their inception, this led to a political conflict between the city councils (elected representatives) and health councils. Technical barriers add to previous images of elitism and exclusion, generating distrust between the civil society representatives and the state (CONASS 2009a). For example, Escorel and Bloch (2005) highlight that in some National Conference reports; civil-society delegates propose legally punishing managers who do not fulfill conference deliberations. State council presidents (when they are not upper-level management) want to interfere in managerial discussions in the CIBs. This increases the likelihood that managers will attempt to sidestep the councils.

The consensus remains that health councils are the main spaces for participation oversight over public health policies (CONASS 2009a). While previous scholarship and publicized local experiences have undoubtedly had impact on the face of the face of public healthcare, bringing civil society closer to the state and including those who the state had for the most part excluded, I argue that health councils are not the arena in which health policy is actually fought and made. In some instances, they have been relegated merely in order to sidestep the
complications that derive from information asymmetries, both due to the complexities of modern medicine and of state institutions. But in other cases, they are purposefully ignored or treated with contempt. One of the major formal responsibilities of health councils is the approval of health budgets. But just like elections do not necessarily make a democracy, the approval of state and municipal budgets does not exemplify the original goals of health councils. Commonly, budgets are provided late, with little technical subsidy and councils are squeezed against time. Likewise, major policy elements are approved, but commonly not deliberated, and hardly opened for discussion. But if they are not being deliberated in the councils, where do the policies come from?

Manager Associations – Horizontal Aggregation

CONASS – National Association of State Managers

In many ways, the CONASS is the older sibling of all SUS support institutions, and the first defenders of subnational interests in the national arena. It was founded in 1982 by state health secretaries who, dealing with similar challenges in responding to the WHO’s Alma-Ata mandate and the social challenges caused by rapid modernization and urbanization, sought a collective platform to exchange information and increase the visibility of public healthcare issues. With large swaths of urban populations uncovered by the Social Security system in the early 1980s, the CONASS’s early goals were lobbying the Planning and Finance sectors of the federal governments for health-specific transfers, and the decentralization of the INAMPS network to states (CONASS 2007a). As the democratic transition gained momentum with the liberalization of state governor elections in 1982, state health secretaries were in a strong position to pressure the federal bureaucracy for administrative reform even within the broader Constituent Assembly process. As a result of the CONASS’s relative strength during this period,
the INAMPS based the transitory SUDS system on decentralizing its large service networks to state governments.

The CONASS was an active and integral part of the public health coalition throughout the early SUS, even if it did participate in the process of the relative weakening of its members relative to municipal governments. Perhaps because of the ideological precepts that many of the early state health secretaries shared as members of the Sanitary movement, state offices backed municipal-based decentralization of health services and continued to defend the SUS from other sectors within the state. During the first decade of the SUS, the CONASS also took on the role of institutional educator, hosting a series of training workshops and developing legal and academic studies in order to subsidize managerial decentralization. Nonetheless, it took state healthcare managers as a group most of that first decade to find a new role for themselves, and to finally make use of their mobilization in order to extract concessions from the Ministry of Health and municipalities, reemphasizing the coordination role of state governments in the NOAS operational norm in 2001.

The CONASS has a series of comparative advantages compared to other SUS associations. First, by the nature of its select size (27 state representatives), collective action and equity in regional representation comes much easier than in the more diverse municipal associations. Turnover is also much smaller at the state-level cabinet than in municipal governments. Likewise, no matter how financially strapped, state governments in general have a more solid base of financing and better access to human resources that the average municipality. Therefore, CONASS meetings and policy discussions are generally a step above the others. The common interest in the SUS commonly supersedes the partisan differences among state governments, with state health secretaries of opposing political factions coexisting and cooperating. For these reasons, and the common grounding in the Sanitary Movement, Sano
(2008) and Abrúcio & Sano (2009) argue that the CONASS is perhaps the most successful model of horizontal mobilization and cooperation across the many economic sectors that have attempted to duplicate its model. Lately, CONASS has been pushing to become more active in the broader political agenda, closely following and pressuring Congress over health issues, particularly new sources of financing, and yearly budgets (CONASS 2009b).

**CONASEMS – National Association of Municipal Managers**

As the CONASS is to state health managers, the CONASEMS (*Conselho Nacional de Secretários Municipais de Saúde*, National Council of Municipal Health Secretaries) organizes their municipal counterparts. The institutional history of the CONASEMS reflects the stages of municipal development as healthcare actors: While state managers were formally meeting in the early 1980s, many fewer municipalities had municipal health office experiences to build a collective body. Therefore, from the very beginning, municipal collective action was an elite movement of the few cities with Leftists governments (particularly in the states of São Paulo and Minas Gerais) and that had developed primary health strategies. After sporadic meetings in the 1980s, municipal managers benefitted from the broader mobilization in the 8th Health Conference to come together and form an association, literally on the steps outside the venue (MS/SGEP 2006). The CONASEMS was founded in 1988, predating in many cases municipal associations in the states, but took a prominent role as an institutional actor in the negotiations of the National Health Acts, and entrenching themselves in the SUS support infrastructure.

As the first section of this chapter has discussed, municipal managers, empowered by the decentralizing *zeitgeist* of sanitary reform and democratization, were big winners in the early SUS. They used their mandate to take leading positions in the Ministry of Health, and ensure the continuing of policies that favored municipal development. Yet, despite this early
success, it is important to highlight the significant difficulties municipal managers face in mobilization compared to their state counterparts. Their initial relatively small numbers and the higher representation of Leftist parties led to political division and a questioning of legitimacy. Therefore, at the same time that they negotiated nationally, they had to expand their representation, “converting” new municipalities to the cause in order to increase their ranks. The vast majority of municipalities in Brazil are small (about 50% have populations smaller than 10 thousand, and almost 80% have less than 25 thousand), with limited sources of funding and managerial capacities. Representing this large group (over 5,500) of actors is a complicated task, with a lot of energy having to be devoted to devising formulas to represent municipalities across different cleavages, including regions, states, municipal size, and political parties. Unlike the CONASS, a meeting of representatives from across the country is much more expensive and logistically complex. Bringing this expanded set of representatives from across the country is so expensive that the CONASEMS meets less often as a body than the others, with the executive board making a larger share of decisions in a more restricted participatory setting.

**COSEMS – State-level Association of Municipal Managers**

The CONASEMS is an aggregation of state level associations (COSEMS). Unlike the bottom-up nature of much of the public health movement mobilization, the CONASEMS did not “bubble up” from state-level experiences across the country, as only five “state chapters” existed prior to the national body (Pimenta 2007). Rather the experience in most states was the reverse, with national level legislation spurring subnational action. As the participation law called for management participation and granted key positions to be filled by state-level manager associations (such as in the joint commissions and state health councils), entrepreneurial municipal managers rose to lead the adoption of the model in their state. Even
then, spurring mobilization was slow in many states, as it took almost 15 years after the SUS foundation for all states to have active COSEMS.

The organizational capacities and political tinge of state COSEMS vary greatly as a result of their local political environments, as we will see in the case study chapters. But they share a common success in bringing together municipalities that, out of their mutual distrust, ended up duplicating capacity and competing for finite state and federal resources. State-level COSEMS were able to convince a large share of municipal managers that they had more in common than conflict. A particularly important strategy was that they should always provide a united front when facing state-level actors, and developed meetings and background studies in order to subsidize this consensus-building. Over the years, COSEMS executive boards have become more representative of regions, sizes and partisan alliances. In some cases, they have become more professionalized as well, increasing their technical capacity, which results in successfully extracting greater concessions from the states.

Comissões Intergestores – Vertical Negotiation

Managers and technocrats from the three levels of government negotiate health policies in joint-commissions called Comissões Intergestores. While not originally envisioned as a part of the SUS support structure, managers and technocrats realized fairly quickly that decentralizing healthcare would require technical discussions and negotiation in a different kind of environment from the health councils. As the National Health Council meetings were underway, representatives from the three levels of government often found themselves in “hallway meetings”, from which they determined the need for a deliberative body to deal with operational and managerial issues. Frustrated with the information and time costs of the broader participatory council, the CONASEMS leadership introduced a resolution to the CNS in
1991, forming the manager-only body. Municipal leaders argue that they had to work hard to keep out other members who wanted to participate (MS/SGEP 2006). Though created in 1991, the CIT really didn’t pick up steam until the publication of the NOB-93, which really set the system in motion in a cooperative fashion (meaning, not like the INAMPS). Once the managers found more traction in these meetings, the councils lost their place as the prominent arena of health policy discussion, particularly because their mandates overlapped (Miranda 2003, Silva & Labra 2001).

The original conception was for the CIBs especially to be transitory (Levcovitz et al. 2001) until full decentralization was achieved by states and municipalities. Yet, as subnational managers learned the benefits of ongoing negotiation, they chose to make CIBs permanent, making them the privileged venue for most questions of financing and decentralization. are approved in CIBs. In the resurgence of state power, CIBs became important venues for state-level management, since the consensus rules allowed state offices a de facto veto power over accreditation of new services for municipalities and the allocation of federal transfers. Furthermore, these meetings have become a major source of information for municipal managers, and where municipalities can collectively defend their interests with states. A typical CIB meeting involves approval of municipal management reports, accreditation of specific providers by municipalities, and transfers of earmarked funds either between municipalities or from state to municipalities. This first part of the agenda is generally approved ad referendum, since it is the result of previous meetings by the technical groups (câmaras técnicas) in which

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87 "In the National Health Council, in April 1991, on behalf of the CONASEMS I introduced the proposal for the creation of the CIT ... To avoid bringing every subject to the Council. It was a difficult meeting, for everyone wanted to participate and we wanted the commission for the managers.” (MS/SGEP 2006). Translation mine.
issues are discussed more at length and where a decision is reached. When both sides fail to reach an agreement on an issue, these tend to not make the agenda.

Though successful arenas for intergovernmental negotiation, the joint-commission model is not without flaws. For one, there is an inherent power differential between the levels of government. At the federal level’s CIT, it the disproportionate sway of the Ministry of Health, since it still provides over half of the total resources for the system. With the control over the purse comes not-so-soft power which the Ministry coerces subnational actors at threat of sending money elsewhere. Likewise, state-level governments are in similar positions when facing municipalities, particularly if they strike at the fault lines of the much more heterogeneous group of municipalities. The most obvious example of this influence is the control of setting the agenda, which most state offices do, and a few invite municipal “additions.” This ultimately brings the end-result of policies much closer to the preferences of the higher-level of government. The cynical claim would be that these are merely rubber stamping, and the federal government seeks to gain legitimacy for its policies in these institutions. At the same time, it seems that the natural simmering of policies up these institutions tend to be more effective for the implementation of policies. NOBs that were unilateral had significantly harder time with implementation (91, 93, and later NOAS). Later on, given more time and experience by all actors and the chances to learn from the negotiation and implementation process, the development of new norms has come significantly easier. So despite the NOAS attempt to push regionalization from the top, regionalization really came at full force when it was part of the Health Pacts, four years later.

A recent addition to this "family" of institutions is a micro-regional chamber (Colegiados de Gestão Regional, or CGRs) in which neighboring municipalities discuss management issues that are of immediate concern to their health region. They are meant to fill two lacunae which
are not well addressed by the CIBs: First, while the CIBs are large and representative, membership in the CGRs is small and direct. Second, while CIB discussions tend to center on resource distribution and programming, CGRs are meant to also govern daily operation as well as policy deliberation. Discussions in the CGRs range from asking advice in case of difficulties in handling private providers, planning specific exchange relationships between municipalities, and more recently planning of regional integration of systems such as emergency medical services. Municipalities also discuss how to divide the investment of federal and state funds amongst themselves, and whether to invest in new or shore up existing capacity. Additionally, since they are the "closest to the ground", the CGRs are meant to be where mistakes or subversions of the system are caught. For example, while CIBs, CESs tends to approve management reports ad referendum (in practice, rubber stamping), it is assumed that due to local knowledge, this is where neighboring managers would catch CMSs that do not function properly or are abused or bullied by mayors and SMSs. While the results of the oversight component might be less clear, CGRs in São Paulo are clearly a progression in terms of creating micro-regional thinking.

**Conclusion**

In conclusion, one of the most important points to take from this chapter is that, though named “single” or “unified”, the healthcare system in Brazil is actually a patchwork of coexisting systems that only in certain conditions work together. Managing the SUS at their level of government is incredibly complex, not only due to the inherent difficulties of healthcare provision, but also because of the complicated layering and overlapping institutional structure. And indeed, how these structures function varies greatly across locales (both states and municipalities). In some conditions they do fulfill their roles of becoming successful “relational instruments” (Frutuoso 2011) and advancing solidarity in intergovernmental relations.
This chapter provided the necessary historical and institutional vocabulary in order to proper under the tasks and the challenges faced by state and municipal actors while they built they healthcare systems. The reader should keep in mind two main points: First, that the development of the SUS at the national level is rifled with conflict, across levels of government, but also between different portions of the state. Second, that the institutional support structure grounds the SUS in a rich associational space, and one particular institution, the state-municipal joint-commissions (CIBs) are the unseen arena where state systems are designed and implemented. With this knowledge, we now move to the empirical case studies.
3. Plural Competition and Healthcare Coordination in Minas Gerais

With a better understanding of the conflicting realities of Brazilian healthcare, let us return to our opening hypothetical and live a day in the life of a chronic-condition patient living in the small town of Cristália (population 5,760) in northern Minas Gerais. As figure 10 illustrates, the northern part of the state is a clustering of poverty and low human development (Cristália has a human development index score of 0.65, considered medium level) and has limited health capacity. There are only 4 health facilities in the town (basic healthcare units) with 3 family health teams (one doctor each) covering 73% of the population. There is no medium or high complexity service capacity in the near vicinity. Yet, among this environment of scarcity, our patient is still likely to find good care. The local Family Health doctors can access the state’s electronic medical referral system to schedule her an appointment (depending on the level of care needed, either in the micro-regional pole, Grão Mogol, or the macro-pole Montes Claros), and once her appointment is scheduled, she can use the state’s patient transportation system to reach her appointment.

Though the SUS has advanced greatly in terms of decentralization of primary care, system integration is one of the key areas in which it has struggled. Yet, the state of Minas Gerais has greatly advanced in this area in particular. Municipalities provide a substantive

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88 One could say, as many have, that the issue remains unresolved. Just recently, a Pan American Health Organization (PAHO) spokesperson named coordination as one of the critical bottlenecks in the Brazilian public healthcare system. See O Globo, “Saúde sofre com falta de recursos e gerenciamento precário,” 09/30/2010.
portion of the state’s healthcare services, but the state level office not only ensures that it is organized hierarchically but equitably funded.

It does so by determining and enforcing policies for resource distribution, capacity construction and network operation in the state. It was able to overcome the resistance of private providers and municipal managers by investing in planning and management tools, but also through including these actors in the policy process by actively fomenting SUS consensus-building institutions such as the Câmaras Intergestores Bipartite (CIBs), and Conselhos de Saúde (health councils). Within these institutions, the Secretaria Estadual was able to foster municipal compliance by curtailing the state’s own discretion over the state’s healthcare

89 Municipalities in Minas Gerais spent on average 36% of public healthcare expenditures in the period 2000-2007, compared to a national average of 26%. This is particularly alarming in that the share grew consistently throughout the period, reaching 40% in 2006. (DATASUS 2010)

90 As we’ve seen in Ch. 02, the Câmaras Intergestores are joint management commissions in which state and municipal managers negotiate the formulation of state healthcare policies, grant procedural certifications for services, and most importantly, negotiate the distribution of federal programmatic transfers. They are composed by equal number of seats for state and municipal representatives, and as such are consensus institutions. Municipalities are represented as a group by their elected representatives in the Municipal Managers Association (Conselho dos Secretários Municipais de Saúde, COSEMS). Conselhos de Saúde (health councils) are institutions for civil-society inclusion and oversight. They are composed of representatives of public managers, providers, clients and universities at each level of government.
budget—choosing to distribute a large portion of state monies to the other healthcare actors through clearly established and equally available channels. Engaged in a system that allowed for their participation as well as with the desired financial incentives, municipal and private actors accepted state coordination—if not seamlessly, then in a much more developed fashion than in any other state in Brazil.91

That the mineiro healthcare framework most closely approximates the constitutional goal for a collaborative federalism (to the extent that any do) is puzzling both empirically and theoretically. Geographically, Minas Gerais faces internal diversity that mirrors that of the larger Brazil, with substantial inequalities between the center and peripheral regions, as well as the wealthy southern regions and the poor northern ones (see figure 10). The state’s size alone provides additional challenges—Minas is slightly larger than France—only made worse by an incomplete transportation infrastructure. No less important, the geographical and topographic diversities translate directly into differing epidemiological local realities, making the actual health needs of individual municipalities and regions distinct.92 Coordination tasks are therefore more complex from the state’s perspective, and collective action prospects among municipalities would seem less likely.

Politically, the building of institutions that provide public goods rather than patronage sources in Minas seems like no less of a conundrum. Leading scholars of Mineiro politics have highlighted the oligarchic nature of the state’s political arena (e.g. Hagopian 1996). Different political and historical accounts have consistently classified the state’s political culture as

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91 Municipal acceptance of state coordination is far from than perfect. Neighboring rival municipalities sometimes refuse to properly refer their patient flows through established guidelines and institutions, and local politicians still interfere with patient access to services. On intra-state variation in coordination see Fundação João Pinheiro (2008).

92 Differing epidemiological realities/needs is a problem shared by the other two states in the sample, both pretty extensive in their own right. It is, however, significantly more pronounced in Minas.
conservative, risk-avoiding and emphasizing collusion between elites and pragmatic centrist (Bates 1997, Wirth 1977). Throughout most of the state’s history, elites have maintained their economic and political dominance by maintaining access to the state apparatus, which they would then use to distribute patronage to their constituencies. If these accounts are true, then Minas Gerais hardly sounds like the kind of place where political and bureaucratic actors would have interest in creating institutions that would limit incumbents’ discretionary use of state resources, take risks with policy innovation, or clearly delineate the behavior of subnational units.

Furthermore, the outcome in Minas is also a conundrum when one considers the financial underpinnings of the system. Data on the state’s expenditures in healthcare shows that the state government “underspends” in healthcare. Despite attempts at “creative accounting” when submitting state accounts to the state and national health councils, state-level officials have candidly admitted in participatory institutions that they do not spend enough of the state’s budget in healthcare to fulfill national laws. The state office spends the smallest portion of the bill for its own citizens: For every per capita dollar spent in the public healthcare system in Minas Gerais, the state office is responsible for only 17 cents (the national average for the state level is 22 cents), while municipalities spend 36 (compared to a national average of 26). And despite having the third largest state economy in Brazil, the state ranks 24 out 26 in state-level

93 Conflict between the national executive and legislative powers at the time of the SUS’s foundation eventually left financing to be determined at a later stage. The unfinished Healthcare Amendment (Emenda Constitucional 29) sets that states must spend 12% of annual revenues, municipalities 15%, and that the Union must grow its current expenditures by the previous year’s GDP growth. However, there is debate as to what constitutes healthcare related expenditures. States and the federal government argue for a broad definition, including projects such as such as expanding basic sanitation. Municipalities, overtaxed with local service provision, argue for a tighter definition around services. The National Health Council weighed in on the matter (Deliberation #322/2003), particularly denouncing expenditures on pensions, “private” health expenditures such as public servants special health plans or military, and sanitation. Enforcement, however, is precarious, since the EC29 sits in Congressional limbo.

94 See for example the minutes for the 76th ordinary meeting of the CIB-MG, on 03/26/2002.
expenditure across the country\textsuperscript{95}. Considering the established under-financing of the public system as whole, low state expenditures would lead one to doubt the capacity of Secretaria Estadual de Saúde in Minas Gerais to accomplish much in terms of healthcare advances, or to be able to create incentives for municipal compliance.

Figure 11: Per Capita Spending in Health by Level of Government

IDB 2009 (DATASUS 2010).

Therefore, it is particularly intriguing how the Secretaria Estadual in Minas Gerais managed to make greater inroads toward cooperative federal institutions in healthcare than any other state in Brazil. I argue that this outcome is less surprising when one considers these factors in conjunction with the development of democratic practices in the state, and how growing political competition interacted with the structure of power relations among state elites. I draw attention to how an increasingly competitive electoral arena interacted with the plural nature of political groups provided specific incentives: In addition to the effects pointed out by Grzymala-Busse (2007) where uncertainty provided incentives for building good

\textsuperscript{95} Author’s calculation based on the data in DATASUS (2009). Available at \texttt{<http://tabnet.datasus.gov.br/cgi/idb2009/matriz.htm>}. 

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institutions, I argue that the need to differentiate one’s political group from competitors provided the impetus for delivering policy “victories” in the form of good public policies. The pluralized political arena made discretionary control of public healthcare institutions less viable. If state officials could not coerce and overpower municipal actors from differing political allegiances, the next best option was to “control” outcomes through close coordination. With engaging and distributive and coordinative policies, state elites in Minas Gerais were able to transform healthcare institutions and the provision of healthcare services to the population. But in addition, through state policies that were widely accepted and lauded across municipalities, the political group led by the PSDB’s Aécio Neves was able to alter the nature of political competition in Minas Gerais, making the group under his leadership disproportionately favored in the present Minas political landscape.96

The case of Minas Gerais highlights important portions of my broader argument. First, it presents the key features that lead to greater vertical and horizontal coordination between state and municipal healthcare systems. The institutional landscape that coordinates managers as political actors leads to the coordination of care, improving patient access and healthcare outcomes. Next, by focusing on the characteristics of political contestation within the state, it argues that coordinative and inclusive institutions where competitiveness is assuaged by pluralism. Finally, it highlights that the successful outcomes of intergovernmental cooperation are due to political factors—namely the mandate given to the state-level health office by the governor, and the political backing the office received throughout the difficult task of coordinating municipal and private actors in the healthcare sector. Engaged in such a state framework, municipalities and civil-society actors flourished.

96 Aécio Neves da Cunha is a prominent political figure of the Center-Right party Partido da Social Democracia Brasileira (PSDB). He is a member of a traditional political family in Minas Gerais, and has an extensive political career of his own. A more detailed political history will be provided later in the chapter.
The development of Minas’ health system under the SUS had four main phases: First, a stage of uncoordinated municipalism (much like the rest of Brazil). Second, a failed attempt at “coordination from below” through the use of municipal consortiums. After a period of re-strengthening but tension under Governor Itamar Franco, Minas finally moved to the breakthrough stage of coordinated care under Aécio Neves.

**Pre-SUS Healthcare in Minas: Early Regionalization Attempts**

Though the state healthcare office existed in some form since the late nineteenth century, it only became a standalone institution starting in the late 1940s, with a limited mandate over epidemic prevention and immunization. Facing the great inequalities particularly in the state’s northern region, the state health office led by Fernando Megre Veloso sought to expand the reach of the basic healthcare provision to the Minas hinterlands as early as the early 1970s. In a partnership with Tulane University in the United States and funding from USAID, the state office sent trained medical staff to northern Minas first through a program called *Sistema Integrado de Prestação de Serviços de Saúde do Norte de Minas* (SIPSSNM). These healthcare specialists founded a research institute in the local city of Montes Claros called the *Instituto de Preparo e Pesquisas para o Desenvolvimento da Assistência Sanitária Rural* (IPEDASAR) centered around the concept of bringing “simplified” health and family planning to the rural population (FIOCRUZ 2006, MS/SGEP 2006, UNIMONTES 2007). This trek into the hinterlands of Minas would serve as a laboratory to many of the important concepts that would serve as pillars for the SUS decades later: First, since private healthcare providers had no presence or interest in the region, these early *Sanitaristas* were able to focus on primary, community based care. Second, the first attempts at regional organization were put in place, with municipalities being divided into “program areas”, with human resources and installed capacity being distributed
through this planning structure. Though the IPEDASAR was later decommissioned, during a short period it served as one of the major centers for the development and dissemination of *Sanitarista* thought, which would build up over the following fifteen years and fuel the arguments for transformation of the public healthcare landscape (Escorel 1998). While municipalities at this point were not yet relevant healthcare actors, the experience with deconcentration in northern Minas, especially once federal programs such as the *Programa de Interiorização das Ações de Saúde e Saneamento* (PIASS), and later the *Ações Integradas de Saúde* (AIS) served to fuel the Sanitarista emphasis on both decentralized and regionalized care (Falleti 2010).97

One other important institutional choice occurred in the late 1970’s: The state healthcare office shed the direct control of its public hospital network to a state parastatal named *Fundação Hospitalar do Estado de Minas Gerais* (FHEMIG). Spinning off Fhemig was conducted at the time to increase managerial effectiveness and isolate its funding. There would be an unexpected important effect much further down the line, however. Without direct responsibilities in the management of public hospitals, the state-level office was able to focus time and resources on management and coordination of the public system as a whole, rather than on direct provision. Fhemig is responsible for 20 hospitals in the state of Minas Gerais, and no more than 6% of hospital admittances in the state (Fhemig 2010).

It would appear therefore, that even before the creation of the universal public healthcare system, Minas Gerais had certain pre-existing conditions—latent coordinative capacities, if you will—that would at least in part explain the turn of events twenty years later. Yet, the existing state health bureaucracy had a different focus—being responsible for direct provision of basic healthcare services such as health posts—than would be required within the

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97 Refer back to chapter 02 for a more detailed explanation.
SUS structure. Outside of the “healthcare missions” in northern Minas, the existing regional offices throughout the state were merely deconcentrated administrative outposts, and were staffed primarily through political patronage. As we will see in the next section, the institutional changes and shuffling of responsibilities once the SUS came into play rendered this existing bureaucracy practically inert.


Despite this established history of attempting to expand state presence through its territory, especially in the hinterlands, the state office in Minas nonetheless collapsed to the period of malaise that followed the foundation of the SUS. Two major institutional changes were ushered in with the new system. The most prominent was the rise of the municipalities as healthcare actors. Second, the switch in the role of the states offices from provision to policy formation and coordination. This had two reinforcing effects on the state-level healthcare: First, recently empowered as healthcare actors, the majority of municipalities had no idea how to perform or manage these healthcare tasks. So they looked at the existing human resource pool—these were either the decentralized former INAMPS employees or current state-level office employees. The former INAMPS employees, which were in much higher number, nonetheless had a different set of skills and experiences—with the institution’s focus on curative secondary and tertiary care—than municipalities required. State-level office bureaucrats and healthcare professionals had more relevant public health experience, which made the attractive hires for municipal governments. With new responsibilities while also benefitting from federal incentive policies that made it possible for municipalities to pay higher salaries than the state

98 Common practice is that the legislator with most votes in a region is allowed to staff state positions.
99 As we saw in chapter two, the INAMPS was the federal parastatal that provided social-security and employment-based healthcare services.
level, municipalities succeeded in poaching the state’s best employees. Municipalities therefore became stronger at the expense of the state-level office—crippling the state’s ability to provide much needed guidance as municipalities branched into healthcare provision.

The state healthcare office was not merely a passive actor while its top bureaucrats were pulled away. Rather, the state’s overt policy at the time also encouraged this movement. Governor Hélio Garcia, elected for a second time to the state office, nominated a Sanitarista and PMDB\textsuperscript{100} member José Saraiva Felipe as State Health Secretary in 1991. Saraiva Felipe, a doctor who had worked in the PIASS program in Montes Claros, had subsequently served as the municipality’s health secretary. As a “hardcore” Sanitarista, Saraiva Felipe believed wholeheartedly in municipalization of healthcare services, which he actively pushed from within the state office. In addition to the ideological and professional predispositions, Saraiva Felipe also faced trying financial times while at the helm at the state level. Federal decrees under President Collor de Mello (1990-1992) pushed an early neoliberal agenda, curtailing the size of the state as a whole. The years after Collor’s impeachment were no easier—as hyperinflation and a financial crisis practically paralyzed the public sector as a whole. Facing a state office that could not afford to maintain its key personnel, while also attempting to figure out what its new role should be, municipalities were practically left free to design their municipal systems to the extent that they knew how and responding only to local political incentives.\textsuperscript{101}

\textsuperscript{100} The Partido da Movimento Democrático do Brasil (Democratic Movement Party, PMDB) is a centrist political party, evolved from the single opposition party during the Brazilian authoritarian regime to a non-programmatic amalgamation of clientelist regional elites. It has declined from the height of its powers during the democratic transition in the 1982 gubernatorial election, but is still a large political player, having been part of the national coalition government with both center-right (PSDB) and center-left (PT) governments.

\textsuperscript{101} Local political incentives differ from the medical-service necessities. Sanitarista perception of the matter was that municipal managers would spend resources primarily on basic care capacities, hiring general-practitioner doctors and building basic health facilities. And while many mayors responded to these needs, many more responded to popular perception that good healthcare is based on the availability of specialist doctors and local hospitals. Therefore, many mayors diverted a large portion of
Vilaça Mendes (Pestana & Mendes 2004) refers to this period of the Minas state-health office as one of “identity crisis”, and “autarchic municipalism”. Responding to new incentives from the Ministry of Health, where additional funding could be requested with the opening of new services, municipalities aggressively expanded their secondary and tertiary capacities, raising the number of municipal hospitals and clinics. Most of this capacity construction occurred disconnected from regional planning or existing human resources. With only incipient control and support institutions, municipalities also made and broke pacts with their neighbors to fit their local needs. For example, one of the most important and extensive organizing tools in the early SUS formation was organizing revenue flows and municipal exchanges in a process called Programação Pactuada e Integrada (PPI). In the PPI municipalities had to collectively match their per capita resources (federally transferred) with the existing capacity to provide medium and high complexity services. So, if a small municipality had funding for a given procedure but not the capacity, it would allocate those funds to a neighboring municipality that provided that service. In return, the manager of the neighboring municipality committed to accepting patient referrals covered by these funds. However, in the absence of an established knowledge base to serve as a guideline, many municipal managers were given an excessive benefit of the doubt—which they used to be overly optimistic in their assessment of what procedures they could perform locally, both for their own demand but also how much they would be able to absorb from their neighbors. The financial part of the exercise had little follow-up when it came to the actual flow of patients. Many municipalities kept their resources in the town’s budget but continued to refer patients to other municipalities (most often to Belo Horizonte, the state capital) for care. It was also quite commonplace for larger municipalities to

finite municipal resources into building politically visible, but expensive and ineffective ambulatories and hospitals at the expense of primary care.
take advantage of resources transferred from smaller towns but not guarantee the services in return. In other cases, small municipalities built municipal hospitals and diagnostic and treatment clinics in specialized areas despite their lack of human resources or economies of scale\textsuperscript{102} considerations. At this point in time then, the general picture in Minas Gerais looked quite similar to the majority of other states with regards to unchecked decentralized management and poor coordination and oversight from the state office.

\textbf{1995-1998: Fostering “Coordination from Below”}

In 1995, riding the coattails of Fernando Henrique Cardoso’s successful financial stabilization plan, PSDB politician Eduardo Azeredo won the election for governor in Minas Gerais. Yet Azeredo’s election was very close and widely contested affair. In an uncommon turn of events, at least in the Brazilian runoff system, Azeredo lost the first round by 11 points (1.2 million votes) to PMDB’s Helio Costa, but managed to turn the tide and beat Costa by 1.3 million votes in the second round. The outcome of the 1994 elections dispersed power between different political groups (figure 12 below): Two different parties elected senators (PFL and PTB) than the gubernatorial finalists, and a total of 11 different parties had representatives elected for the state’s federal and state legislatures, with the political group led by the centrist (and clientelist) PMDB electing the largest bloc in both legislatures.

\textsuperscript{102} Economies of scale refers to decreasing average total cost from increased production, but also in quality gains from increased practice.
In this fragmented political environment, Azeredo tapped a medical school professor Rafael Guerra from the Federal University of Minas Gerais (UFMG) to be his health secretary. Though a respected academic, Guerra was not a member of the governor’s political core. This translated into restricted access to the governor’s decision-making circles, having to accept political nominations for central and regional bureaucratic appointments, and an inability to ensure greater budgets from the state planning office.103 Facing a shortage of financial and political resources, Guerra’s main policy as Health Secretary was promoting the pooling of neighboring municipalities into health consortiums. This had been fueled by the quick realization, especially by smaller municipalities, that they could not attract specialized medical personnel to staff local hospitals and clinics at a reasonable cost.104 The major proposed benefits

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103 Guerra would nonetheless join the PSDB, and has successfully been elected a federal representative for the state of Minas Gerais following his stint as health secretary.

104 The shortage of doctors outside large population centers is so acute that doctors have virtually all the leverage in the employment negotiation. As a result, municipal managers bid up their neighbors and raise the price for hiring doctors. Even then, they must also accept flexible and less-than-ideal commitments:
of consortiums were to make medical technologies and personnel more affordable by allowing municipalities to pool and share resources. This institutional arrangement would potentially resolve local collective action problems, since municipalities would no longer have to compete for medical personnel, or have to build redundant (and potentially under-utilized) facilities. In that they allowed municipal managers to decide what specialties were necessary based on local knowledge, the pro-consortium policy was in line with “municipalist” thought. In essence then, Guerra’s policy was to outsource “coordination from below” to municipalities. Since the state level office could not, or would not coordinate municipal action, it promoted municipalities organizing themselves.\(^{105}\)

Nonetheless, a state policy based on fostering municipal health consortiums fails to address important policy and political issues that made them necessary in the first place. Rationalization and integration are not guaranteed, since the same actors with conflicts of interest are expected to resolve collective action problems on their own\(^ {106}\). The lack of a higher level of government to enforce equity and supersede local power differentials many times result in institutional arrangements that enhance rather than reduce local distortions. By the end of the Azeredo/Guerra administration, the health landscape in Minas Gerais looked no more likely to figure out the SUS puzzle than any other state in Brazil.

\(^{105}\) The consortium policy has since been downplayed, though not abandoned. Minas Gerais currently has a total of 64 consortiums, covering 82% of the state’s municipalities (SES-MG 2010).

\(^{106}\) In the absence of a macro-view agent such as the state office, municipalities tend to continue to respond to local incentives, and tend to “spread the wealth”, dividing the placement of services in different municipalities. This does not solve issues of service quality or increased access that come with economies of scope. It also does not break the relative power position of local providers with municipal managers.
At the same time, the *Secretaria Estadual* made use of its institutional powers to prevent further loss of power. The Ministry of Health published the Basic Operational Norm 01/1996 (NOB-96), the linchpin of which was the opening up of space for further decentralization. Municipal managers could apply for additional responsibilities beyond basic care—responsibilities which would be matched with access to additional federal funding. As municipalities across the country flocked to apply for certification, the *Secretaria Estadual* under Guerra fought fiercely to prevent it. While a quarter of municipalities were granted certification in the first year of eligibility in São Paulo, the *Secretaria Estadual* in Minas only approved 39 applications, fewer than 5% of municipalities. The state-level office also interfered more openly to prevent the certification of smaller municipalities—only 9 certified municipalities had less than 25,000 inhabitants (versus 40 in São Paulo, 92 in Brazil) and none had populations below 10,000 (13 in São Paulo, 20 in Brazil). Municipal managers of the period highlight that though understanding, Secretary Guerra was adamant in his position that granting municipal certifications in large quantities, and especially to smaller less capable ones, was counterproductive to the state system as a whole.

SUS support institutions and municipal representation was also incipient during this period. Municipal managers had already associated under a representative association, the *Conselho de Secretários Municipais de Saúde* (COSEMS), but the association had limited resources and capacity to aggregate a wide range of municipal managers. Multiple interviews with municipal managers active in this period indicate inter-municipal conflicts due to differences in size (large versus small municipalities) and region (northern versus southern regions of the state) as major roadblocks to collective action. Furthermore, the lack of adequate technical information (due to the low level of dissemination of basic information technology) generated frustration both among municipalities, but especially when confronting the claims
made by the state office in the CIB joint-comission. A later president of the COSEMS labels the meetings at this time as tumultuous “guessing games.”\textsuperscript{107} However chaotic, this period nonetheless produced sluggish institutionalization in the health sector, policy learning by both state and municipal actors, and the introduction of \textit{Plano de Saúde da Família} (Family Health, PSF)\textsuperscript{108} in Minas Gerais.

\textbf{1999-2002: Military Discipline is What the SUS Needs?}

Former president Itamar Franco was elected Governor of Minas Gerais in 1998—beating Azeredo who was not only an incumbent but also had the backing of the reelected President Cardoso. Franco was a unique political figure in many ways: As stand-in President between 1993 and 1994, he nominated Cardoso as Minister of Finance. The success in stabilizing inflation catapulted Cardoso to the presidency, but by then Franco felt underappreciated by his appointee. He was openly hostile to the recently reelected President by the time he took office in Minas Gerais in January 1999, immediately declaring a moratorium on state debts to the Union, and as a result, sending the Real in a tailspin.\textsuperscript{109} With Minas Gerais in default of its debts with the federal government, the state’s sources of financing were closed out, from federal tax transfers to credit lines with international financial institutions. Furthermore, Franco’s eccentricity was particularly visible in his choice of Health Secretary; he appointed Carlos Patrício Freitas Pereira—an Army General with no previous healthcare-sector experience—in an effort to instill discipline, loyalty and to “clean up” perceived corruption in the \textit{Secretaria Estadual de Saúde}.

\textsuperscript{107} Author’s tranlastion. Actual quote “As reuniões eram cheias de ‘achismo’.”
\textsuperscript{108} The \textit{Plano de Saúde da Família} is a strategy for bringing basic healthcare to rural and/or needy populations based on multidisciplinary medical teams that visit families in their homes. It focuses on preventive health as opposed to treating diseases. [More on PSF here].
\textsuperscript{109} See for example, \textit{The Economist}, “Itamar Franco Takes His Revenge,” 01/14/1999, and “No Peace for Brazil’s President,” 01/21/1999.
At the same time, Franco shared in the Mineiro myth of state-builder and civic duty—in healthcare, this translated into a renewed mandate for the state-level office to reclaim a guidance position with municipalities. Patrício appointed Luis Márcio Araújo Ramos, a public healthcare technocrat, as his deputy. While his administrative freedom was limited, Ramos had a good understanding of the state’s sub-regional needs. The Secretaria Estadual recruited many of its former employees, including many top planners, to return to central office. They were in place when the Ministry of Health’s NOAS decree in 2001 and 2002 re-focused healthcare systems towards regional integration. Re-organized, the Minas state health office reacted quickly in the development of tools for regional planning—especially when compared to other states. The Plano Diretor de Regionalização (PDR)—the regionalization plan—was conducted jointly by the state office and municipalities, making use of local and regional participatory institutions. The process in Minas Gerais was concluded by late 2001, and officially published (having been approved by the state’s CIB and State Health Council) by 2002. This PDR followed Ministerial guidance for regional planning, yet developed its own methodology, organizing the state into micro, meso and macro regions that would govern both resource and patient flows.

Likewise, a major revision to the PPI, which governs intermunicipal compensation for patient flows, was finished in Minas by 2001. By this revision, Minas’ PPI had evolved into an easily updatable (and therefore adaptable) management tool. Municipalities and the State office could adapt allocations in response to changes in patient flows—this provided incentives for municipalities to fulfill their referral commitments at the real danger of losing funding. The extent to which this is an accomplishment in and of itself can only be properly understood comparatively. The first PPI in the state of São Paulo was only completed in 2007, a process which took significant political and financial resources by the state office despite a higher level of healthcare capacity in Paulista municipalities. Despite this late development, municipal
managers still commonly complain the tool is hard to update, and therefore it is in practice a bureaucratic rather than managerial exercise. Likewise, that the state of Minas Gerais was able to produce a fully functional PPI (especially in its adaptability) is no less of a feat. While the first PPI was finalized in Bahia in 2003, it stayed in place without major revisions until 2008. Devoid of necessary revisions, the PPI in Bahia was abandoned by municipal and even state managers, who managed financial and patient flows without it.\textsuperscript{110}

One reason why Minas Gerais was able to move at a more advanced pace in creating not only bureaucratic plans but also working management tools was the early development of participatory institutions (of the management kind) at a sub-state level. And here, Minas’ previous experiences in coping with internal diversity paved the way. The high number of municipalities (853) and geographic distances\textsuperscript{111} increased the opportunity and financial costs to municipal participation. State and municipal managers moved early to build deconcentrated joint commissions at regional levels (CIBs Regionais). Two facets of these institutional choices are of relevance. First, there are two sub-state tiers of CIBs—a smaller “CIB micro” where every member municipality is represented, and an intermediate “CIB macro” where each micro-region sends representatives. The relevance of this feature is that it, by virtue of practice, it allows municipalities to make links and form collective identities within their regions, rather than merely amongst their immediate neighbors and taking those interests to the state level. Second, by constructing these institutions early, following NOB-96 guidelines that split membership equally between municipal and state-level representatives, the Secretaria Estadual was able to guarantee greater control (due to the embedded veto power) of policy debates even at the local

\textsuperscript{110} Bahia’s state and municipal managers are-for all intents and purposes-developing the PPI as a management tool in 2009-2010 in the manner in which Minas Gerais had done starting in 2001.

\textsuperscript{111} The furthest straight-line distances are 986 Km (612 mi) North-South and 1,248 Km (775 mi) East-West.
level. In contrast, states which did not develop regional participatory institutions until later years, followed a different model—called Colegiado de Gestão Regional (CGR)—in which state officials had one seat, and are therefore outnumbered by municipalities. The early creation of these local and regional institutions had many beneficial effects for Minas’ healthcare sector—empowering municipal actors (and their collective representation in the COSEMS), creating successful regional experiences, and strengthening SUS support institutions as the main pathway to distribute resources and patient flows. Hence, Minas’ ability to successfully produce and implement the management tools as required by federal decrees at a much faster pace than other states in Brazil.

Despite, or perhaps because of these developments, the relationship between the Secretaria Estadual and municipal managers was particularly tense during the Franco administration. Municipalities complained that the state Health Secretary was unapproachable, prone to top-down decision-making, and at times even hostile to municipal demands. Despite the fairly developed jointly-accorded management tools, peripheral municipalities complained that the “municipal elite” (larger municipalities, or municipalities whose managers led the COSEMS) had preferential access to “cabinet agreements”, where money was being distributed outside joint-commission mechanisms. A particular cause of friction was the state office’s low levels of investment in state healthcare system and not honoring financial agreements with municipalities as a whole. Municipalities were especially upset at the state’s low levels of investment in the healthcare system (see figure 13 below). While the state increased investments significantly between 2000 and 2001, municipal outlays increased at a much greater rate. This greatly taxed mayors’ ability to maintain local governments and provide other social services.
At this point, however, municipal managers had organized themselves in response to the developments in the healthcare system in Minas Gerais. The experience of increasing drain on municipal finances while unable to provide integral (and sometimes even basic) care to their populations highlighted the need to extract additional resources from the state and federal governments. Likewise, having built up and managed municipal consortiums gave many municipal managers an appreciation for collective management. As we’ve seen, the development of Minas’ regional joint-commissions, had also activated collective behavior. Soon, municipalities learned that SUS institutions such as the CIB gave them great leverage to affect state behavior, especially considering the dire financial straits the state government found itself in. Under the leadership of Myriam Araújo, the COSEMS in Minas Gerais was able to hold the state-level “hostage” in one important occasion. Under the NOAS/01 reforms, states as well as municipalities had to apply for Ministerial certification in order to receive additional funding from the federal government. As part of the certification process, state-level offices had to develop a series of management plans (discussed above). But before these could be submitted to the Ministry of Health, they had to be approved by the CIB—where municipalities held half the seats. During the process of the PPI development, the hole in the state-level contributions became particularly visible. Organized politically by the COSEMS, municipalities voted in block at...
the CIB, rejecting the state’s application for certification until it had found enough funding to cover this hole (R$ 38 million). This delayed the Minas state office from certification by two months. Franco and his staff were able to guarantee this additional sum from Ministry of Health, through new partnerships, since it was in both levels’ interests that the state join the certification program.

As seems fitting due to his unorthodox style and previous presidential track-record, the Franco administration’s final effect on healthcare was mixed. The state’s central bureaucracy greatly increased its managerial capacities by re-acquiring top talent. This was done mostly through a claim of service/calling to career bureaucrats than through financial incentives, as the state could still not afford to pay higher salaries than municipalities. Regional institutions were fostered, with beneficial results both for municipal empowerment and engagement. This allowed Minas Gerais to move more efficiently and effectively in designing the planning and management tools as mandated by Ministerial decrees. However, the manner in which state leadership behaved within these forums left a bad taste in mouths of municipal managers, and hence many fought within SUS institutions to change state positions. By the end of the period especially, due to quickly degrading fiscal crisis position of the state government, the state-level office fell behind on it obligations with the Ministry of Health, failed to fulfill contracts with municipalities and providers, and fell in arrears with its own staff—straining these relationships. Minas’ healthcare framework showed promising, though by no means fully established, signs of

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112 Bloc voting is the norm in such institutions, since municipal managers are supposedly representing municipalities as a group, rather than their home municipalities. Municipal consensus is achieved in COSEMS meetings immediately preceding CIBs. Very seldom do municipal managers break rank and vote individually.

113 CIB-MG Minutes, September-November, 2002.

differentiation and of becoming closer to the model of cooperative federalism the Federal Constitution envisioned for public healthcare.

Table 8: Governors and State Health Managers in Minas Gerais 1990-2010

<table>
<thead>
<tr>
<th>Period</th>
<th>Governor (Party)</th>
<th>SES</th>
<th>Healthcare Specialist?</th>
<th>Main Policies &amp; Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995-1998</td>
<td>Eduardo Azeredo (PSDB)</td>
<td>Rafael Guerra</td>
<td>Yes</td>
<td>Municipal Consortiums</td>
</tr>
<tr>
<td>1999-2002</td>
<td>Itamar Franco (PMDB)</td>
<td>Carlos Patrício</td>
<td>No (Army General)</td>
<td>Re-emerging state office, Return of HR</td>
</tr>
<tr>
<td>2003-2006</td>
<td>Aécio Neves (PSDB)</td>
<td>Marcus Pestana</td>
<td>No (Politician)</td>
<td>State as coordinator, Regional organization</td>
</tr>
</tbody>
</table>

a) Replaced in last year of term by José Maria Borges, after he left office to compete in the 1994 elections.
b) Azeredo lost the first round to Helio Costa (PP), but rallied in the second round.
c) Replaced in last year of term by Wilmar Oliveira Filho, after he left office to compete in the 1998 elections.
d) Replaced in last year of term by Marcelo Teixeira (Adjunct), after he left office to compete in the 2002 elections.
e) Replaced in last year of term by Antonio Jorge Marques, (Adjunct) after he left office to compete in the 2010 elections.

The Breakthrough to Coordinated Care

The 2002 elections contrasted democratic development with economic stagnation both for Minas Gerais and for Brazil at large. The country faced once again a credibility crisis—this time fueled in large part by foreign investors panicking over the likely victory by Leftist candidate Luis Inácio Lula da Silva (PT)—and years of economic stagnation. However, Brazilian democracy had continued to develop over the last decade, with a broadening of overall political competition (Sátyro 2006, Borges 2007) and direct challenge by media and civil-society of old-style clientelistic politics. By this time, Aécio Neves, a rising political power in the state of Minas Gerais, had consolidated enough political support to appear as the candidate for governor of

Starting in 1994 (1995-1998 term), Executive and Legislative elections have been concurrent for both Federal and State governments.
Minas Gerais for the national-incumbent PSDB. Neves is the stereotypical Mineiro politician—soft spoken, pragmatic, and well-received in diverse political circles. He also carried the political pedigree from his grandfather, nationally-renown Tancredo Neves, who was famous for his conciliatory abilities. Based on a broad coalition that brought backing from disparate forces such as President Cardoso and Governor Franco, he was able to attract mayors from competing political parties (though mostly of traditional center-right tendencies) to back his candidacy. He was elected governor in the first round with 57% of the vote in 2002. Upon his election, Veja, a leading national weekly ran a story highlighting the incoming gubernatorial class, and noted “Aécio’s victory combines the old politics of collusion with logistical richness and the marketing strength of current campaigns.”

Neves’ perception was that Franco and his predecessors had failed to created a foothold in Minas’ shifting political constituencies because of an inability to manage state institutions to offer policy results. While still President of the Câmara dos Deputados, Aécio Neves began plotting his strategy not only to run for governor of the state of Minas Gerais, but also to develop a reform program that would transform state institutions, generating visible policy victories with the goal of altering the nature of political competition in the state. In the policy side, Neves tapped a team led by Antonio Anastasia, who developed a platform based on a New

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116 Aécio Neves da Cunha entered Minas’ political life at 21, as his grandfather’s personal secretary when he was elected governor in 1982, Brazil’s first election since the 1960s. He was elected for the Câmara dos Deputados (House of Representatives) in 1987, participated in the Constituent Assembly, and was reelected for three more terms. His political ascension had him as the PSDB candidate for the mayor of Belo Horizonte in 1992—his only outright electoral defeat to date. He rose to national prominence during the Cardoso administration, assuming the position of Government Parliamentary Leader in 1997, being the PSDB’s highest voted deputy in 1998, and presiding the Câmara dos Deputados in 2001.

117 Electoral results and calculations throughout this chapter are based on data from the Tribunal Superior Eleitoral <http://www.tse.gov.br> and the Tribunal Regional Eleitoral de Minas Gerais <http://www.tre-mg.jus.br>.

Public Management-type model,\textsuperscript{119} with an emphasis on performance indicators and management by results. Once elected, Anastasia was named Planning Secretary, and led a government-wide reform program named \textit{Choque de Gestão} (Management Shock), the turnaround plan that introduced the new management model, stabilized the state’s finances, and normalized payments for state employees. The initial stabilization required significant cost-cutting, but the state’s improved fiscal position later made federal and IFI funds available for financing projects in the state.

In healthcare, the Neves administration’s strategy was united technical knowledge with political backing. Anastasia tapped Eugênio Villaça Mendes, a \textit{Sanitarista} with experience in the early regionalization projects in northern Minas, who had spent his time away from the state as a consultant for the Pan American Health Association, and creating micro-regional planning in the Northeastern state of Ceará. Mendes would later lead the development of Minas’ new health plan, introducing important new concepts to the state’s regional planning. At the same time, they were weary of the common tale of bureaucratic plans that fall short due to political isolation. Therefore, Mendes and his team petitioned for a Health Secretary that was a political insider. They found Marcus Pestana, a member of the \textit{Mineiro} and national PSDB core. Pestana had a varied public-sector management experience, having worked in diverse sectors as Telecommunications and Environment at the federal level in the Cardoso administration. Pestana also carried some political weight of his own, having been elected as a state legislator for Minas in the southeastern \textit{Zona da Mata} region. Though Pestana had no previous healthcare experience, he was quickly “catechized” by Villaça’s view that the main role for the state health

\textsuperscript{119} As Rhodes (1996) points out, the term New Public Management (NPM) refers to introducing private-sector like methods to managing the public sector, with an emphasis on explicit standards, performance measures, results-based management, value for money, and closeness to the customer. For more on NPM see Barzelay (2001) and Hood (2007).
office should be coordinative. This tandem illustrated the Neves administration approach to
governing healthcare in Minas Gerais: politically-backed technical coordination. Pestana’s
political connection to the governor and the PSDB base was able to guarantee consecutive years
with new funding for the healthcare sector, and had direct access to the governor. He would
also guarantee the political support and softening required to make Villaça’s technocratic plans
politically viable and understandable to the political class in municipalities.

As I argued at the outset of the work, close electoral competitiveness generated incentives for tight control of state institutions in Minas Gerais. As we have seen in the comparative analysis of state frameworks (Ch. 03), one way in which this became visible in the healthcare sector was the openness (or lack thereof) of state-level offices to further decentralization of health resources and responsibilities to be managed directly by municipalities\(^{120}\). State officials in Minas Gerais were resistant to certification requests by municipalities both in the NOB-96 and NOAS-01 models—which we could see quite clearly by the fact the amount of municipalities granted certification (and with it, the resources and management freedoms over secondary and tertiary care) were significantly lower in Minas Gerais than the national average (7 versus 12%, CIT 2010), and states that were particularly open to decentralization, like São Paulo (25%).

The plural political conditions in Minas Gerais however, also softened the centralizing tendencies from close political competition. While in Bahia, the conflation between high competition and polarized clustering led to both centralizing and discretionary tendencies, the plural number of relevant political players in Minas Gerais made this strategy less feasible (see

\(^{120}\) Once again, the level of decentralization is referred to in a relative sense, since the SUS is highly decentralized. Further decentralization refers to the transfer of secondary and tertiary care responsibilities (and funding) to be managed at the municipal level through Full Management certifications (Gestão Plena), versus the baseline primary care responsibilities.
The political landscape was divided very closely between four political groups. Furthermore, the smaller political parties together added up to an increasingly large portion of the state. A total of eight parties held at least 5% of municipal executives in the state and their participation only grew with each subsequent election. In such a political landscape, the administration could not expect afford to play discretionary political favors successfully. In addition, the state’s historically derived political culture that prized union over fractionalization also made such options less attractive. Therefore, in such an environment where the incentives from political competition interacted with those of pluralized political organization, the impetus to control got translated into the “next best” option—which was a higher probability of operational control coming from close coordination. As a coordinator, the state-level office could potentially shape the face of healthcare system by leading policy development, strengthening institutional channels, and system operation.

Figure 14: Municipal Distribution in Minas Gerais by Party

Source: TSE.
The state office increased its coordination powers by the development of planning tools which would govern the state’s investments in the sector. Benefitting from both the in-house knowledge base of the 2001 PDR and municipal experiences, the team led by Villaça both simplified and brought in new concepts to the PDR revision in the first year of Neves administration. In addition to organizing regions hierarchically based on technical complexity,
the state plan now also emphasized economies of scale and scope. This choice had a practical effect in concentrating state investments within regions. Rather than atomized investments, the state plan would create (or in this case reinforce) local winners, at the expense of a more dispersed strategy. But at the same time, the plan also took into account distance and travel times in order to minimize the travel time from remote municipalities. The PDR revision was approved by state and municipal managers in October meeting of the CIB in that same year.

Once in place, the updated regional plan served as the guiding principle behind the other major “structuring projects” with which the state office sought to organize different portions of the health sector. One is of particular interest, because of the political salience of hospital construction and maintenance. The Pro-Hosp states as its main goals the strengthening and quality enhancements in the state’s existing hospital sector. In practice, however, the program deals with an ornery issue—that of underperforming local and regional hospitals. Out of the close to 600 SUS-contracted hospitals in Minas, the program concentrated support and improvement funding on only 136 hospitals—those deemed “socially necessary”. By its strategy, consolidating investments in regional and micro-regional poles, the program in essence starves off underperforming and redundant smaller hospitals, who already struggle financially. Based on the PDR regions, the first stage of the program allowed public and non-profit hospitals in macro-regional poles to apply for support. To strengthen local managers and regional participatory institutions, hospitals that wished to be contemplated had to have

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121 Economies of scope refers to the cost and quality gains achieved by performing multiple synergistic activities and procedures in the same facility or region. For more on these concepts see [Public Health cites here].

122 Programa de Melhoria e Fortalecimento dos Hospitais de Minas Gerais.

123 A World Bank study on the Brazilian hospital sector showed that a disproportionate part of beds are supplied in small facilities (60% have less than 50 beds), that are expensive (costs are on average 15% higher), inefficient, and even so have a low occupancy rate (58% of facilities have occupancy rates lower than 30%) (La Forgia and Couttolenc 2008).
their applications approved by regional CIB joint-commissions in order to be considered at the state level. A second stage of the program brought additional funding to micro-regional poles. It continued to steer funding towards the hospitals that fit the state’s vision of scale, since only hospitals with capacities over 100 beds were eligible (with exceptions made only for the largest hospital in regions where no hospital reached the size). In addition, it also rewarded hospitals that cooperated with its neighbors, since at least 25% of the patient flows had to be referrals (from other municipalities). Accepted hospitals were also selected jointly by a specific state/municipal joint committee. The Pro-Hosp succeeded not only in strengthening more efficient and regionally distributed hospitals, but has also started to trickle down into hospital closings. The number of small hospitals serving the SUS in Minas Gerais has decreased by 151 by 2009.124

Likewise, the Secretaria Estadual in Minas built specific tools to manage the actual flow of patients. I already discussed the PPI to great length—while it is a planning and bureaucratic tool in other states, in Minas, because of its real-time adaptability; it becomes a management tool as well. Additionally, Minas Gerais has developed a state-wide electronic patient referral system—a system that matches patient demand and service supply across municipalities. Dubbed SUSFácil (EasySUS), the system is based on referral centers spread across the regional hubs, connecting the referral doctor in the local primary care clinic with the higher-complexity providers. The state office in Minas built the system from scratch at significant cost (an initial investment of $15 million, and a monthly operational cost of $1 million) (SES-MG 2010). As we have discussed in other parts of the work, coordination of this kind is costly not only financially, but especially politically. Both municipalities and providers, especially in relatively affluent parts

of the state, prefer autonomy over coordination. To enforce compliance requires significant operational capacities from state offices as well Public data show that the referral system now regulates over 60% of Minas’ patient flows (SES-MG 2010).

Planning tools of varying levels of complexity are far from novel. In his seminal work, Seeing Like a State, James Scott showed how human hubris brought about catastrophes, be it in forced relocations in Africa or the Great Leap Forward in China. In Brazil, the authoritarian regime likewise attempted to build an administration run by technocrats and isolated from the politically-infested parts of the state (O’Donnell 1973, Stepan 1971). In addition, Minas Gerais was not the only state to build PDRs and PPIs—both documents were pre-requisites for state certification under the NOAS/01 guidelines, which all states eventually received. Therefore, more important than the tools themselves is the process through which they were created, enforced and legitimized. Building on the Franco administrations advances, but particularly on its shortcomings, the Neves administration in healthcare changed the state’s approach to the other actors within the Minas healthcare sector. They chose to pursue and enforce policies in a manner that included municipal actors in the policy process, and strengthened SUS support institutions. Politically, Pestana’s presence as Health Secretary and member of the political core meant that municipal and legislative actors could not sidestep healthcare institutions in the hope for preferential treatment in such overt ways as in the state of Bahia.

As an effect, the state’s CIB joint-commission is vibrant and broadly attended. It brings together a large number of municipal managers, despite the large distances that they must travel. While most agendas and policy decisions are decided in subcommittee meetings with COSEMS representatives, the meetings are nonetheless vibrant with municipal participation. Unlike other states, official membership is not enforced—voice is open to all managers and technocrats who wish to participate. Due to the large number of participants, the meetings are
held in a large auditorium (see figure 17 below) with one representative only from the state and municipalities at a head table.¹²⁵ The Minas CIB is also broadcast on close-circuit television to the entire state, with open phone lines for participation.

Figure 17: CIB Joint-Commission Meeting in Minas Gerais

As cultural and political histories of Brazil have amply shown, the elite has always benefited from the ability to circumvent of selectively apply laws and regulations. By strengthening collective bodies and processes, the state office attempted to lock in the enforcement of its vision for state health institutions, hence diminishing the danger of takeover by opponents in case of electoral loss. But the strength of the technical plan stands also on its political enforcement. While, similar management tools exist merely in parchment in Bahia, in Minas Gerais, even the governor’s ancestral town and political base was denied special treatment when it requested to become a regional pole. Since it did not fit into the pre-determined criteria from the PDR, the state office repeatedly denied São João Del Rey’s requests to be upgraded to macro-pole status. It’s neighbors took upon themselves to enforce

¹²⁵ In contrast, as we will see in the other case studies, official membership in other states is enforced for voice and votes, and state and municipal managers sit on opposite sides confronting each other.
what they saw as the state's rational and fair plan for resource distribution, and stood against it in the regional CIB. Likewise, when hospitals owned by state legislators seek public support, they have been forced to adapt to meet state-level requirements.

But the critical question remains: considering the costs of participation and individual losses from accepting state coordination, how can we explain municipal acceptance of the state-led system? In essence, the state office accomplished this by the not-unusual means of creating financial incentives for participation and cooperation. Ten percent of the state’s health budget was directed at financing and strengthening municipal capacities to provide primary care—a role the state did not (and in most other states does not) have any responsibility to engage in. With regards to coordination incentives, the Pro-Hosp monies rewarded hospitals that accepted patient referrals from neighboring municipalities. At the same time, the state office sought to diminish intermunicipal conflicts over scarce resources by acting as a lender of last resort—it created a fund with which to ensure proper funding for municipalities that accepted patient referrals beyond their declared responsibilities (Câmara de Compensação, compensation chamber). This way, rather than checking specific municipal allocations in the PPI before treating patients, municipalities could treat patients under the guarantee that the state would cover the shortfall in the SUSFácil referrals.

But most importantly, the Secretaria Estadual generated municipal trust by curtailing its discretion over resource distribution. As I mentioned briefly above, the state of Minas Gerais shed the direct provision of healthcare services early on with the creation of Fhemig. But its policy to stay out of provision is better seen in its choice not to continue to expand Fhemig’s network of hospitals when it had the opportunity to do so. Unlike São Paulo and Bahia, where the state offices continued to see their role as continuing to expand the direct provision of services, the state office in Minas Gerais kept its budget free to invest solely in municipalities
and non-profit private providers. This non-competition makes the state a more credible partner and arbiter. And by channeling state monies through jointly commissioned programs with clear standards and open applications, the state office was able to get municipalities from wide-ranging political allegiances to buy into its vision of a health system. And as the wheels were acquiring momentum, the state now has the veiled threat of removing its financing from whatever municipality or provider that does not fulfill its requirements.

As a result of these state policies and particularly strategies of implementation, the first set of results yielded the buy-in by a politically diverse group of municipal managers into the state’s proposed healthcare framework. With municipalities as newly-acquired allies, the state office was able to reign in private providers, and created a self-reinforcing virtuous circle of institutional strengthening. It is particularly telling that despite low state investments in healthcare, both in absolute and in relative terms—something municipal managers in Minas Gerais will announce at every possible opportunity—municipalities are still tied into the state’s project. With rational organization, Minas Gerais was able to do more with less. Its healthcare indicators show significant improvement. [Maps and tables of Minas-specific health indicator changes will go here.]

Building not only on the visible policy victories, but from widespread legitimacy in the political class, Aécio Neves became a political superpower in Minas Gerais. While he had to accept an (rightist) PFL-appointed vice-governor during his first term, he had enough independence to forego that arrangement and appoint Anastasia—his “super manager” as vice-governor by the reelection campaign. He was extremely well evaluated by Mineiros with 76% approval rates at the end of his term by the population126 and by the media.127 In 2010, his

political might led not only to a humbling defeat of President Lula’s PT in Minas Gerais, but also illustrated his long coattails. Anastasia went from unknown technocrat to winning the governorship in the first round (a transfer of 6 million+ votes). Neves also extended his support to former governor Itamar Franco in the Senate race, who walked with him throughout the campaign, and came back to defeat strong PT candidates, like the popular former mayor of Belo Horizonte Fernando Pimentel, despite backing from President Lula.

Conclusions

In this chapter, I argued that state-level coordination is the key factor which makes the healthcare framework in Minas Gerais most closely approach the ideals of cooperative federalism that shaped the federal SUS legislation. Coordination in Minas Gerais was made possible through extensive use of planning and management tools by the state-level bureaucracy, such as a strong regional plan, an adaptive financial and patient flows tool, and electronic patient referral. Municipalities and providers accepted coordination by the state office because the state provided financial incentives to participation and cooperation, and most importantly, because the state office forfeited its discretion over how specific municipal allocations would occur. By channeling state resources through jointly-determined programs, the Secretaria Estadual fostered participatory institutions, and strengthened municipal actors.

Achieving good governance in healthcare was more than a merely technocratic story, but also a political one. In Minas, sound technocratic plans came together due to their political backing. This political support was obtained first by the governor giving the Health office a mandate and the guarantee that its attempts to clearly set and follow standards would not be

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127 See for example, O Tempo, “Aécio Deixa o Governo como Referência de Gestor Público,” 03/21/2010, or O Estado de Minas, “Moradores de BH e Interior Estampam Apoio a Aécio em Despedida,” 03/31/2010.
undermined by political back channels. It later became reinforcing, as pluralized municipal representation bought into the system’s institutions. The design of these institutions are not solely the product of political enlightenment—rather, they are a strategy constructed in response to a specific political environment, one in which highly competitive and pluralized electoral competition provided centralizing tendencies, but also curtailed concentrated or discretionary options.

In part this institutional outcome is due to the mineiro political culture, which has long been defined by centrisn, pragmatism, and fluid intra-elite collusion. Interestingly, even the programmatic parties such as the PT are tempered in Minas: In state elections, the PT has ceded important senatorial and gubernatorial elections to PMDB old-style clientelist politicians. More tellingly, PT and PSDB leaderships in Minas Gerais—mortal enemies on the national level—coalesced into an alliance for the mayor of Belo Horizonte in 2008. There, Aécio Neves joined forces with the PT’s outgoing mayor Fernando Pimentel to elect a third-party candidate Mario Lacerda (PSB). The cabinet in Belo Horizonte reflects a broad-spectrum of political associations, including a PSDB-appointed Health Secretary and a PT former Health Secretary as a Planning Secretary. Though the election was closer than analysts expected with the joining of two leaders of such high popularity, they managed to win nonetheless.\(^{128}\) And despite this alliance, Neves still strongly pursued the election campaign for Franco, edging out Pimentel from the Senate.

Two sobering tales must be acknowledged. First, is that there is clearly something special about Neves as a political actor and leader. As the Veja quote from earlier in the chapter pointed out, he has one foot in the old oligarchic politics for which Minas has long been known for, but also another in the reformist pool. During his widespread reform program, of which healthcare was only one part, his popularity only grew, making him a proposed foil for the vastly

popular President Lula, and as an aspiring presidential candidate from the opposition. After his
election to the Senate in 2010, both local and national media depicted him as the
unquestionable statesman of Minas Gerais, and heir to his grandfather’s legacy. Much like the
current doubts as to how Dilma Roussef will be able to follow in Lula’s shadow, many question
Anastasia’s ability to govern in Neves’ wake. This chapter nonetheless has attempted to
illustrate the impact Neves’ administration as a result of a gifted politician reading the incentives
in a highly competitive and pluralized electoral environment, and devising a strategy to alter this
political scenario.

Second, is that while the institutional changes in Minas Gerais were designed with an
eye on “locking in” the new approach to governance, the institutions cannot perpetuate
themselves completely independently from political support. In 2010, when Pestana, the State
Health Secretary, gave up his post in order to compete for the upcoming legislative elections\textsuperscript{129},
there was a real panic by state and municipal healthcare actors that the health office might be
handed to PMDB actors such as those from previous governments. An extraordinary session of
the Minas Gerais CIB was held in order to quickly distribute all pending monies in the
compensation chamber so that existing commitments would be ensured. Though Pestana
managed to convince the core of the political group to promote his adjunct to interim status,
and with Anastasia’s victory he later was appointed in full-time basis, this nonetheless reveals
the political imperative underpinning state reform and responsible running of state institutions.

\textsuperscript{129} Brazilian electoral Law requires all public officials who plan to run in upcoming elections (normally held
in October) to relinquish their posts by the end of March of the election year. Incumbent Executives who
run for reelection are exempt from this rule.
“On one side, we had ease in municipalization because [the state office] began to transfer everything. On the other, we did not count with a partner, [a] coordinator of the process, [a] financial supporter.”

4: Political Continuity and Health System Fragmentation in São Paulo

Let’s return once again to our introductory hypothetical, and revisit the life of the a chronically-ill patient in Amparo (population 65,800), a town 130 Km away from the capital city of São Paulo (about a two-hour trip, considering the curvy and hilly roads), and about half that distance from the city of Campinas, its regional economic and medical referral center. Amparo is a first-mover in Brazil in terms of developing primary care capacities, having housed the pilot program for the Family Health program, and is home to the UNICAMP medical school’s residence program in family health. The town’s hospital needs are covered by two nonprofit, publicly-funded hospitals: the Beneficência Portuguesa, and the Santa Casa Anna Cintra. Like most hospitals in smaller municipalities, these are small (under 50 beds), with low occupancy rates and low technological capacity. No matter how well-covered in terms of basic care, Amparo’s ability to provide access to care ends when the patient’s condition requires higher complexity services. The staff in Amparo’s municipal health office will then try to contact the referral doctor at the regional office in Campinas, as well as the referral hospitals, following predetermined patient flows for which Amparo has already paid for. As leading hospitals in the region and in the country, the city and university hospitals in Campinas are constantly overwhelmed; therefore she will probably not get an appointment or be guaranteed service. Amparo’s “referral policy” therefore consists of renting buses daily to drive managed chronic care patients to Campinas. Many times, these buses return at the end of the day with patients

130 Gastão Wagner de Souza Campos, former president of the COSEMS-SP, Former Executive Secretary of the Ministry of Health, and Professor of Public health at UNICAMP. Emphasis added. Interview available at COSEMS-SP (2008).
not having received care. No matter how close she is to quality care, the fragmented nature of public healthcare system in São Paulo nonetheless diminishes her access to healthcare services.

In addition to capturing a microcosm of the healthcare system in São Paulo, Amparo is an interesting segway into the case of São Paulo because of its unlikely political prominence. Since 2000, the town has been a stronghold of the Partido dos Trabalhadores (PT), and it has served as the home base for the leadership of the municipal health managers’ association (COSEMS) for the state. Sanitaristas with connections to the PT have found a willing resting place in Amparo: the relatively small and well-functioning municipal system requires less daily attention of its Secretária Municipal, freeing her to engage in the time-consuming and labor intensive technical and political negotiations headed by the COSEMS both at the state level, but also nationally. Outmatched in the political dispute for the state executive, but overrepresented amongst Sanitaristas, the PT municipalities use the SUS support institutions to strongly contest the state health policies such as the outsourcing of public hospital management, and the lack of state-level coordination. However, from the stability of a five-term incumbency, the PSDB forces leading the state health office can afford to chose when to concede, and when to ignore municipal opposition and conduct health business as usual.

São Paulo is the wealthiest state in Brazil and has the largest and most developed healthcare network in the country (including 99 out the country’s 340 thousand physicians, and performing over 40% of all organ transplants). And yet, state and municipal healthcare actors have failed to build an integrated healthcare system. In this chapter, I build on the state healthcare framework explanation which I developed in chapter 1 to show how this outcome is less puzzling when we consider the incentives derived from political competition in the state of

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131 Aparecida Linhares Pimenta was vice-president twice and president once, Maria do Carmo Carpintéro, took over both positions in 2009.
São Paulo. Plural political forces in the state, particularly in the political Left, pushed the state for decentralization and from within the SUS support institutions, sought equitable and rule-based distribution of federal healthcare transfers. At the same time, there in an unparalleled continuity in government and in the state-level office in the state of São Paulo, with members of the same group (PSDB) in power since 1995. Unthreatened by the opposition, state incumbents pursued a dual strategy: focusing on maintaining and expanding their hospital network on the one hand, and aggressively decentralizing other health responsibilities to municipal governments. The resulting healthcare landscape in São Paulo therefore is fragmented, with disparate municipal and state systems, and for which state officials have no incentive to pick up the costs of coordination.

Figure 18: São Paulo, Population and Human Development

This chapter is organized in the following fashion: In the first section, I provide a quick history of the pre-SUS healthcare system in São Paulo, laying out the strong presence of Leftist Sanitarista municipal managers, and the powerful state-level network of service provision. Next, I show how the SUS in São Paulo embraced municipalism, and—when left to their own avail—local governments struggled and expanded their networks inefficiently. Finally, I link the political conditions in the state the repeated failures to impose coordination on municipal actors, which
can be seen in the initial failure and late adoption of a functioning PPI\textsuperscript{132}, a “path of least resistance” approach to regionalization, and the lack of a medical referral system to govern the state network.

\textit{The Pre-SUS development of Healthcare in São Paulo}

As we saw in chapter 2, though the early conception of healthcare in Brazil was local and urban, the responsibility over public health concerns (hygiene and control of epidemic outbreaks) was assigned to state-level governments in 1891 as part of a broader process of power transfer from the centralized monarchy to the federal republic. Home of a booming export agricultural sector, the state of São Paulo was at a relative strong position to finance the creation of research and hospital facilities. The city of São Paulo was home to leading public health researchers and practitioners of the time, under whom the State Sanitary Service opened isolation hospitals and research centers responsible for leading discoveries in tropical medicine (Mascarenhas 1973, Mendes & Oliveira 2009). The Sanitary Service also created Brazil’s first health code, and tested public campaigns to combat epidemics like yellow fever that would then serve as an example for those in the national capital, Rio de Janeiro, and other large cities. (Santos 1980). While improvements in sanitary conditions were fairly quickly disseminated across paulista society, a growing labor class of migrants, and the economic pressures of an export economy generated demands for individual health services beyond the mostly preventive services provided by the state (Mehry 1985, Nunes 2000). Companies and later parts of the state began a social insurance model of care that would become the major provider of

\textsuperscript{132} The \textit{Programação Pactuada e Integrada} (PPI) is a tool that matches resources with medium and high complexity service capacity. Every municipality is allotted federally transferred \textit{per capita} resources for these services, but few have the capacity to provide them. Through the PPI, municipalities allocate funds to a neighboring municipality in exchange for a commitment to serve referred patients.
care for most of the 20th century; the state of São Paulo nonetheless had the most established and most successful public health institutions in the Old Republic (Hochman 1998).

As economic and social development increased the relative wealth of the employed classes through the first half of the 1900s, public health practitioners began to raise concerns with the inadequate state of the public network of hospitals by the early 1960s. The old institutional model of the state health office—organized as independent disease-specific networks such as tuberculosis or Hansen’s disease—began to buckle at the new healthcare needs of a changing society. For one, the existing network was designed to support long-term patient isolation and treatment, which advances in medicine by that point had made obsolete. Starting in 1967, State Secretary Walter Lesser133 harnessed the public health practitioners working in the state system in order to completely redesign the state health office—both as an institution and as a healthcare network—abandoning the duplication that came with individual disease-centered lines, and creating multipurpose health centers to treat the majority of patients in one place (MS/SGEP 2006, Mendes & Oliveira 2009). The state also created a career track within its bureaucracy for holistic public health doctors, dubbed “Médicos Sanitaristas” (sanitary doctors) who were put in charge of these new health units. These Sanitaristas would later rise to lead the health departments in municipalities as well as the state office, jumpstarting the municipal health movement in São Paulo.

While important, Lesser’s institutional reform were insufficient to address many of the healthcare bottlenecks in the state system and health conditions continued to deteriorate. By the late 1970s internal studies already identified some key problems that should by now sound quite familiar: The lack of an underlying plan to guide hospital construction led to a

133 Lesser was State Secretary of Health for São Paulo for most of the 1970s, under three governors (1967-1971, 1971-1979).
concentration of beds in the capital and other areas of the state, while leaving large voids in the majority of the territory. Non-profit hospitals, with capacity generated for the old healthcare needs, suffered from low occupancy rates, and yet there was no policy in place to dampen their proliferation. And finally, the fragmented nature of the hospital system, devoid of hierarchical coordination, hindered patient access (Mendes & Oliveira 2009).

In the early 1980s, Sanitaristas entered the federal government and would eventually design the Ações Integradas de Saúde (AISs), a model which would shift state funding from the private to the public sector, the Secretaria Estadual in São Paulo designed an audacious program to expand the network of public healthcare facilities around the city of São Paulo. In the first free elections for state governor since the 1960s, the PMDB—then the single official opposition party—fielded André Franco Montoro as the consensus candidate. The PMDB at this point housed a diverse group of opposition forces. A diverse group of Sanitaristas (with forces which would eventually split to the leftist PT, the catchall PMDB and later the centrist PSDB) put together the “Montoro proposal”, delineating the plans for expansion of public (non-insurance) provision in the state (Mercadante 2008). With partial financing from the WHO and the World Bank, the state office designed the Programa Metropolitano de Saúde, which envisioned a five-fold expansion of basic health units (492 new facilities), and the construction of 40 new hospitals. But as the transition to democracy accelerated, the unlikely alliance of disparate opposition forces faltered. The future-PT leaders led strikes against the Montoro government, despite widespread presence of Leftist Sanitaristas in leadership positions in the state health office. Finally, the PMDB suffered an internal schism, with the programmatic half that would
eventually leave to form the PSDB\footnote{Including Fernando Henrique Cardoso, Montoro, Mario Covas, and José Serra.} tacitly denying support for the party’s candidate in the 1986 elections, Orestes Quércia (from the party’s pragmatic/clientelistic wing).

As municipal actors began to mobilize as part of the grassroots public health movement which would lead to the municipalized SUS, the state health office began a slow process of changing its institutional infrastructure in order to properly cope with a decentralized system. Of note, the SES changed its purely administrative field offices in the territory from 24 large regional offices to a more capillarized design of 62 local offices (Ersas), designed to more closely interface with municipal governments and to oversee the operation the state’s healthcare facilities within their jurisdictions (Junqueira 1996). Despite Quércia’s clientelistic bend, his appointed Health Secretary, Dr. José Pinotti fought to continue to expand the public system, particularly as the social security system’s INAMPS began decentralizing its network to states. Pinotti took a joint appointment as the INAMPS’ director for the state of São Paulo, and governed the implementation of the SUDS system, in which the INAMPS decentralized its service network (five times larger than the state health office’s network) to state governments. The SUDS was particularly beneficial to the state government in São Paulo, since it was there that the INAMPS network was the most extensive. As the state prepared to receive the INAMPS hospital and ambulatory facilities, it also began to decentralize the basic care units to municipalities (except at the capital).

Though Pinotti was a committed Sanitarista, he could not avoid Governor Quércia’s penchant for patronage politics which colonized all sectors of the state executive. Regional health offices, with their informal political allotment norms and low institutional resources, were particularly ripe sources for patronage and corruption. Despite the state health leadership trying multiple institutional designs to curb this predatory behavior, regional offices continued
to be the weak link in the state’s chain (Mercadante 2008). Also under Quércia, a second phase of *Programa Metropolitano* was initiated in 1988, aiming to build 187 basic health units and 22 new hospitals, but most construction projects were halted before completion (Mendes & Oliveira 2009), illustrating the abandonment of the public system during the political and economic turmoil of the final years of the democratic transition (preceding the 1989 presidential election).

*The early SUS – Tutelary Municipalism and Loss of State Power*

Previous chapters have by now established the inevitable loss of state-level power in the healthcare arena in the initial years of the SUS. It is nonetheless interesting to see how exactly this process took shape in the case of São Paulo, since the health office was historically relatively well established and powerful, and since it had one of the better performances in the implementation of the SUDS, inheriting a quite extensive healthcare network from the INAMPS. Recall that immediately upon taking power, President Collor initiated a series of harsh macroeconomic stabilization reforms, while also drastically cutting spending from social sectors. Re-empowered under President Collor, conservative forces at the INAMPS/Ministry of Health issued the SUS’s first operational norm (the NOB-91), which created new co-financing partnership rules restricted subnational management. Furthermore, the NOB-91 created direct channels between municipalities and the federal government, entirely sidestepping state governments as intermediaries. Strapped for cash (and in many instances, happy to be able to cut the sometimes corrupt middlemen), municipalities accepted the federal government’s INAMPS-based model of production-based payment, which eliminated state and municipal latitude in planning healthcare actions.
With the loss of its previous attributions (the direct provision of basic healthcare services) the state office’s period of “identity crisis,” as it searched for a new reason to be, was in full swing. Furthermore, this was compounded by the state’s political environment. Luiz Antonio Fleury, Quércia’s political heir was elected governor in 1990. Fleury represented the merely pragmatic catchall centrist remnant of the PMDB, since the leftist and centrist forces had exited to form the PT and the PSDB. He continued to dismantle the state health office, slashing healthcare budgets and allowing the prices paid for services and personnel to become dated. As state-level salaries fell below those which municipalities could offer, substantive human capital flight to municipalities ensued (Junqueira 1996). Fleury nominated three different Health Secretaries during his four year term (Table 9), compounding a sentiment of instability and lack of prestige within the state government. Demoralized and underpaid, the state-level health office staff fell to the side of the healthcare debate in state, and the state’s contribution to the overall healthcare expenditure dropped significantly.

With an unstable relationship with the state office, municipal managers bypassed the state level all but entirely and negotiated decentralization at the federal level. The NOB-93 Operational Norm created the tripartite joint-commission at the federal level to govern and negotiate operational decisions among levels of government, and determined the formation of bipartite joint-commissions (CIBs) at the state level to govern the SUS implementation subnationally. Municipal members, relatively powerful during this period, were able to tie municipal representation in these bodies to their associations, forcefully guaranteeing the state-level associations a place at the table for subnational discussions. The state-level office in São Paulo was weary of the municipal managers association the state office fended off municipal participation, even attempting to pressure mayors to found a separate selection process for municipal representation in the state commission. However, top positions at the Ministry of
Health by 1993 were occupied by former municipal leaders, especially former leadership of the São Paulo COSEMS. They used the inductive and normative power of the Ministry of Health to ensure the creation of bipartite committees in São Paulo, and the relative strength of municipalities within them. With Ministry of Health support, paulista municipalities jumped early on decentralization. By the end of 1994, 19 municipalities had been certified at the federal level to fully control their healthcare systems, becoming completely independent from the state-level (COSEMS-SP 2008).

Table 09: Governors and State Health Managers in São Paulo 1990-2010

<table>
<thead>
<tr>
<th>Period</th>
<th>Governor (Party)</th>
<th>SES</th>
<th>Healthcare Specialist?</th>
<th>Main Policies &amp; Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991-1994</td>
<td>Luiz Antonio Fleury Filho (PMDB)</td>
<td>Nader Wafae Vicente Amato Neto Cármimo A. de Souza</td>
<td>Yes (Doctors/Professors)</td>
<td>Turnover and Gridlock</td>
</tr>
<tr>
<td>1995-1998</td>
<td>Mário Covas (PSDB)</td>
<td>José da Silva Guedes</td>
<td>Yes (Doctor/Professor)</td>
<td>Decentralization, Expansion of Network</td>
</tr>
<tr>
<td>1999-2002</td>
<td>Mário Covas (PSDB)(^1)</td>
<td>José da Silva Guedes</td>
<td>Yes (Doctor/Professor)</td>
<td>Continuity</td>
</tr>
<tr>
<td>2003-2006</td>
<td>Geraldo Alckmin(^2) (PSDB)</td>
<td>Luiz Roberto Barradas Barata</td>
<td>Yes (Doctor/Professor)</td>
<td>Expansion of Network, Ambulatory services</td>
</tr>
<tr>
<td>2007-2010</td>
<td>José Serra (PSDB)</td>
<td>Luiz Roberto Barradas Barata</td>
<td>Yes (Doctor/Professor)</td>
<td>Continuity</td>
</tr>
</tbody>
</table>

\(^1\) Covas died in 2001 while in office. His deputy, Geraldo Alckmin took office as governor for 2002.
\(^2\) Alckmin stepped down in March 2006 to compete in the presidential elections later that year. Cláudio Lembo was governor for the remainder of the year.

*Eight Years under Covas and Guedes: Embracing Municipalization*

After being defeated by Fleury in the 1990 gubernatorial election, the PSDB’s Mario Covas “reclaimed” power to the group by winning the 1994 gubernatorial elections by a healthy
margin (+25% in the first round, 12% in the runoff).\textsuperscript{135} The year 1994 was a good one for the PSDB: Riding the honeymoon of Cardoso’s successful monetary stabilization plan, the PSDB made large gains in São Paulo, doubling its share of federal legislative seats, and later was the top vote getter for municipalities (221). Covas, a respected PSDB leader tapped former Minister Adib Jatene’s staff members for his health office, and appointed José da Silva Guedes, a Sanitarista who had worked as a doctor for the state and municipal systems, and who had management experience in the Ministry of Health and at the municipal level for the city of São Paulo. A college professor, Guedes had been a member of the National Health Council representing the scholarly community during the episode of President Collor’s vetoes to the National Health Act. Building on that experience as well as in his time with the local councils in the city of São Paulo, the state-level health office under Guedes embraced the SUS support institutions, strengthening the state health council (CES) and willingly negotiating with municipal leadership in the state CIB.

As an early member of the Movement for Sanitary Reform, Guedes shared the early SUS’s eagerness to decentralize healthcare responsibilities to municipalities. Therefore, the SES-SP began to decentralize its vast primary healthcare network to municipal governments almost immediately (predating the subsequent operational norms). To properly adapt the SES to its new role and relationship with municipalities, Guedes sought to once again reform the institutional blueprint of the State Office. Since the state office was longer responsible for services, Guedes felt that the highly capillarized 64 Ersas, including direct administration responsibilities were no longer necessary. He therefore returned to the previous design of 24

\textsuperscript{135} I say reclaimed because though Governor Montoro was elected under the PMDB, he was one of the founders of the PSDB.
regional divisions, a move which Guedes (2003) argues cut unnecessary costs and 800 patronage positions.

When the NOB-96 rules expanded the range of responsibilities that could be assumed by municipalities, a significant portion of municipal managers in the state of São Paulo were eager to apply. But unlike the cold reception they received during the Fleury government, they found that the state health office under Guedes was not only willing, but also encouraging municipalities to apply for the new certification. The SES’ openness to decentralization was partly ideological and partly instrumental. While a big supporter of municipalization, Guedes also wanted to maintain an active role for the state health office. Other state offices that did not have hospital networks were at a loss with what to do with themselves in the early SUS years. But São Paulo had an extensive pre-existing network, only made bigger by the INAMPS decentralization. Since ensuring access to medium and high complexity services was one of the responsibilities set out for states in the SUS design, he therefore chose to focus on maintaining and expanding the SES’s large network of hospitals and ambulatory services. But operating a hospital network, especially one so large, is technically and financially draining. Therefore, allowing municipalities to claim responsibility of health actions in their territory was beneficial from an instrumental standpoint in that it freed up the state’s institutional resources. With health offices in the three levels of government converging, São Paulo had the largest adoption of full management certification in the first year of eligibility (152 municipalities), almost half of all certifications in the country (Figure 19 below).
The state’s plans for fully stepping away from primary care were hindered by a political confrontation with another powerful political group in São Paulo. The city of São Paulo, governed by the populist former governor and military-backed presidential candidate Paulo Maluf, refused to join the SUS. Rather, the city implemented an isolated system called the *Plano de Atendimento a Saúde*, PAS, which fully privatized the management of the city’s healthcare network (16 hospitals, 30 medium-complexity facilities and 99 basic health units) to a medical cooperative (Pinto et al. 2009, 2010). While the municipal government argued that the model was the only way to generate efficient healthcare provision given financial constraints, healthcare actors and institutions reacted with strong aversion. Over 10,000 of the city’s health workers protested and refused to work under the system, creating large voids in the provision of basic care (Pinotti 2000). After the São Paulo Municipal Health Council filed a formal protest at the national level, the Ministry of Health froze federal transfers to the city of São Paulo, further degrading the city’s health conditions (Pinto et al. 2009). To cover such a large portion of the state’s population without care—the municipality of São Paulo alone accounts for over 27% of the state’s population—the state office maintained its own network of basic units in São Paulo.
(around 200 facilities) and initiated a Family Health strategy in the underserviced periphery (Mendes & Oliveira 2009). \textsuperscript{136}

\textit{State-level Coordination Failures}

While the relationship between state and municipalities was cooperative with regards to decentralization, the relationship in the support institutions (state council and CIB joint commission) did not run as smoothly. The Covas administration introduced a facility management model called \textit{Organizações Sociais (OSs)} which would de facto outsource the management (though not ownership) of facilities to non-profits. The purported gains were in efficiency, cost control and managerial flexibility (since the OS was legally a non-profit, it was not governed by the strict rules of state action, more easily hiring and firing employees). However, this was strongly contested by unions and the PT municipalities in the state health council. Meanwhile, in the CIB, the relationship was “bumpier” than one would initially except, given the ease with which states and municipalities solved decentralization requests. This led to two concurrent failures to coordinate municipal action under the Covas/Guedes tenure: When the Ministry of Health introduced a new operational norm in 2001 (the NOAS) with a greater focus on regional integration, it attempted to jumpstart a more active role for state-level health offices by requiring the development of two organizational tools—a resource-exchanging platform (PPI), and a regionalization plan to govern the equitable distribution of resources over the territory (PDR). Despite having more developed state and municipal networks, and also despite having the country’s top medical professionals, the state of São Paulo failed to produce both documents under the Covas/Guedes tenure.

\textsuperscript{136} The city of São Paulo would not fully rejoin the SUS structure until 2001, under the Marta Suplicy (PT) administration (2001-2004). The SES-SP then decentralized 200 basic health units to the city, and over 6,000 employees (Vieira & Mendes 2009).
The first such tool, the PPI, aims to ensure citizen access to referral services by allowing municipalities to exchange service commitments with each other. Therefore, smaller municipalities that have federal resources for higher complexity procedures but do not have the capacity declare where they want to allocate the resource (a neighboring municipality that has a history of providing the service) in exchange for a commitment by the receiving municipality that they will accept and treat the patients that are channeled to them. Developing a PPI is an incredibly complicated process: municipalities have per capita allocations for hundreds of procedures, which translate into a specific number of procedures they are entitled per year. The per capita allocations can be derived from either Ministry of Health parameters or by historical supply data. State-level technocrats must first analyze the existing patient flows, and then present this allocation data to municipal managers in a series of meetings throughout the state. In these development meetings, municipal managers, generally organized by region, then confirm existing flows or reallocate their procedures. The vast majority of municipalities come to the meetings with very little information on their own flows. However, they do know exactly how many procedures they are entitled to, and want to negotiate them down to the level of individual procedures.\textsuperscript{137}

Developing a PPI from scratch based on need would be much easier than adapting current flows which are based on available service supply and historical production. However, that would require an active coordination hand by the state-level office in order to organize statewide flows, and most importantly, would also require the introduction of additional resources (“new money” as Secretaries call it) to fill gaps in funding and to address short-term

\textsuperscript{137}A real-life example: Aporá, a small town in northeastern Bahia has the right to 30 high-complexity gastroenterology procedures (such as endoscopies) for the entire year. In the last PPI revision, it chose to reallocate the funds for 15 of those procedures to a smaller and closer municipality Sátiro Dias, who’s Municipal Secretary openly lobbied to receive patients and funds from its neighbors for a newly-accredited facility that performed this specialty.
losses for municipalities who currently receive funds and patients. With the federal government unable to provide additional funding (Brazil faced yet another financial crisis in the build-up to President Lula’s election in 2002), the state office would have to fill in the financing holes. Yet, the SES had its money tied up in its own hospital network, and refused to commit additional resources. In São Paulo, therefore, the first PPI process was conducted with no additional funding. This complicated the endeavor tremendously, as redistribution suddenly became a zero-sum game among municipalities. With no financial contribution to the system, the state did not have the “moral” standing to direct municipal action. Therefore, despite an extensive negotiation between state and municipal representatives in the CIB throughout most of 2000 and 2001, there was no agreement by the end of Covas’ (and Guedes’) second term in office.

Likewise, the NOAS required the design of a regionalization plan (PDR), which would organize the state territory in regions which would then be used to determine new healthcare investments as well as organize patient flows. The choice facing state offices at that point was either to use pre-existing political or administrative subdivisions as health regions, or build its divisions from the ground-up based on epidemiological and health service needs. It will come at little surprise that the latter option is significantly more complex and costly. Drawing out a healthcare map of a state requires clear planning guidelines (will divisions be based on geographic distance, municipal sizes, pre-existing installed capacity, or what combination of other factors?), knowledge of intra-state epidemiological trends and local knowledge of transportation and health capacities. In addition, it also requires a significant expenditure of resources and man-hours by a central staff (even more so if the SES will include the municipal and civil-society sectors in the design process). On the other hand, pre-existing administrative divisions of territory were commonly drawn based on political spheres of influence (for example, carving out areas of influence by federal and state legislators) and hence are not the most useful
for organization and planning. The choice for a healthcare-specific division of territory might also generate additional managerial costs in that the partition would be different from the existing administrative structure. Finally, one cannot underestimate the political costs of pursuing technocratic division of territory; municipalities that are homes to local political divisions see it as a loss of power and prestige, and state employees in those regional centers seldom take well to displacement.

Given these difficulties, and with its energy and resources directed at its own network, the state office once again decided it was not worth upsetting local and regional actors by making substantive changes to its territorial organization. It followed the path of least resistance, using its existing administrative structure (the 24 regional offices, and micro-regions that almost exactly reproduced the 60+ old Ersa offices). The resulting PDR from this process was an operational failure. In the absence of state coordination, there were negligible changes to the organization of municipalities, and municipal governments were left to their own avail within their regions. Richer and larger municipalities continued to conduct their business without regard for regional needs, and smaller municipalities, crowded out by their larger counterparts, continued to be excluded from decision-making and remained underserved. Bargaining chambers within the regions were in stalemate, and quickly became emptied. The state’s decentralization strategy actually made matters a bit worse: Since the majority of larger and richer municipalities already had full management certification (which gave them practically unfettered financial and operational freedom) they had little incentive to cooperate with smaller ones. Small municipalities in turn had no way of removing their financing. Finally, the state itself discredited the model by not using the PDR’s design to govern distribution rules at that stage.
To understand why the state office failed (or refused) to coordinate municipal action given its financial strength and strong electoral mandate, let us look at the distribution of power among political forces in the state—particularly the plural number of distinct powerful groups (figure 20 below). Notice that though the PSDB won the state government by a sizeable margin, political power over the remaining elected positions was more evenly distributed across four or five groups. In practice, this meant that regional blocs of mayors and legislators had significant political resources to deter state action. However, unlike the highly contested competition for the state government in Minas Gerais, the Covas administration was more secure in its hold of the state level. Institutionally, the state health office in São Paulo also had “bigger fish to fry”, namely, taking care of its own hospital network. Confronting municipalities would not yield immediately obvious dividends for the state office or for the state government. Hence, rather than confront or acquiesce, the state continued its dual approach: take care of its own portion of the system, and letting municipalities do the same.

Figure 20: Political Landscape in São Paulo, 1995-2002

Source: TSE.
2003-2006: Increased State-Municipal Tensions under Alckmin

The stalemate at the end of the Covas administration, which ultimately led to the fizzling of the organizational tools as part of the NOAS accreditation process was worsened by the political environment in the subsequent term. The 2002 general elections provided a polarizing set of results which confronted the PSDB’s now perennial control over the state of São Paulo, with a diametric shift in national politics, with the PT taking national office for the first time under Lula. The PT’s victory in the national level and the subsequent entrance of leading PT-connected Sanitaristas in the Ministry of Health strengthened the Leftist municipal actors within the state. Riding Lula’s coattails, the PT’s proportion of the São Paulo legislators increased, and was increased by the national alliance with the centrist PMDB. However, as the remainder of the political parties became smaller players in the PT x PSDB contest, the system approached a two-party competition (Figures 21 and 22 below), shifting the logic of political competition and opposition through the SUS institutions. This polarization of state versus municipal leadership had further negative effects on the state network’s fragmentation. Facing a more obstructive and adamant opposition from the COSEMS-led municipalities, the state office withdrew even further from the municipal part of the system, and focused even more strongly on expanding and running its hospital network.
Figure 21: Political Landscape in São Paulo, 2003-2006

![Political Landscape Chart]

Source: TSE.

Figure 22: Partisan Representation in the COSEMS-SP

![Partisan Representation Chart]

Source: TSE (for Municipal results) and internal COSEMS-SP documents. COSEMS executive boards are comprised of 22 seats, elected for 2-year terms. Partisan representation in the COSEMS reports the party of the mayor.
After winning the state (re)election\textsuperscript{138} Geraldo Alckmin transitioned Luiz Roberto Barradas Barata, the deputy Health Secretary under Guedes, to the top position at the SES. This ensured continuity within the ranks of the health office, but also changed the overall tone of the SES-municipal relationship. While Guedes’s personal history made him more open to the techno-political negotiation with municipalities in the CIB, Barradas brought a purely technical, and somewhat rigid approach to governing the state’s health system (Barradas was notorious for refusing to schedule appointments with municipal representatives). Furthermore, Barradas was first and foremost a hospital network manager; under his tenure, the state of São Paulo concentrated investment heavily in its hospital network, opening 5 new hospitals in the city of São Paulo (including a new Cancer Institute), and 8 in the broader metropolitan region (introducing circa 3,000 new beds). By 2007, the share of inpatient hospital procedures conducted by the state’s own network rose from 12% of all procedures in the state in 1995 (Covas’ first year) to 28% (Oliveira & Mendes 2009). The conjunction of Barradas’ personal style and also the strength coming from continuity and incumbency led to a sterner positioning of the SES in the state’s joint commission. While the state was cooperative in the negotiation of distribution rules governing federal transfers, it continued to keep state resources and investment decisions off the negotiation table.

As figure 22 (above) illustrates, while part of the rigidity in the state-municipal relationship came from Barradas’ approach, the other portion came from the strengthened position of the PT forces within the COSEMS-SP. A state healthcare Secretary under Governor Montoro once joked: “But Mr. Governor, everybody in the [public] healthcare sector is from the Left.” This self-selection meant that Leftist and, in São Paulo specifically, PT-connected forces

\textsuperscript{138} Alckmin was Covas’s vice-governor. He took office for the last year of Covas’ term after the governor’s death.
were always prominent in the state’s municipal health leadership. But the politicization of the COSEMS reached new heights in 2003. While the PT expanded its share of municipal executives over the years, it nonetheless remained a much smaller than its legislative representation. Yet, the PT’s health managers were more active and mobilized, and had disproportionate control over the COSEMS in São Paulo for most of the 2000s (both in terms of the relative participation in the executive board, but particularly in the top leadership positions). This had immediate practical implications, with the COSEMS being a de facto opposition force, despite the fact that the PT controlled a small portion of the state’s overall municipalities. The COSEMS during this period strongly decried the state office’s refusal to channel resources to aid municipal systems (a stance that was easily supported by the municipal class). But it also strongly contested the state’s policy of using OSs (outsourced management) as a way to flexibly expand the hospital network (a union/leftist issue), making for contentious meetings in both the state CIB and especially the state health council.

AS a result of this political deadlock, the fragmentation of São Paulo’s healthcare system increased during the Alckmin administration, and the system’s operational bottlenecks reach the worst condition to date. The state continued to almost single-purposefully invest in high complexity services, while municipalities built primary care, and sometimes secondary care without organization. This left a hole in the capacity to treat short-term conditions, such as ambulatory and diagnostic services, which connects the two types of care. With no system to govern medium complexity through the system, ungoverned “spontaneous” patient demand spilled over into the high complexity hospitals. Needing to somehow govern the incoming flow of patients, the high complexity network in practice started backtracking and in essence “regulating itself”. This is suboptimal for multiple reasons: For one, the hospitals have neither a specialty nor a mandate to do so. Second, for no nefarious set of reasons, individual facilities
tend to look out for their own needs first. Therefore, referral decisions were being made based on the receiving facility’s preferences (i.e., picking procedures that were more profitable or for which the public reimbursement were higher or fulfilling teaching needs).

The healthcare sector spent the majority of Lula’s first term negotiating a new set of institutional rules to govern the system—breaking with the rigid culture of the top-down institutional norms, towards a more flexible, cooperative, and participatory set of rules called the ‘Health Pacts.’ Therefore, major advances and negotiation in the state’s CIB during this period were limited. Towards the end of the term (2006), as Governor Alckmin became the leading candidate within the PSDB to challenge President Lula at the upcoming election, state-municipal interactions became increasingly politicized and polarized, bringing state-level negotiations and advances to a practical standstill until the next administration.

**2007-2010: Two-Track Approach under Serra**

The 2006 elections changed the political environment in São Paulo in some subtle but important ways. José Serra, the former Minister of Health under Cardoso and former mayor of city of São Paulo, won the election for state governor in São Paulo in a landslide (58% of first round votes, and a 26% margin over the second place candidate). At the same time, Lula struggled more than expected to defeat Alckmin in the presidential election. Though he ultimately won reelection, Alckmin’s late surge to force a runoff strengthened the PSDB. The change in governor also had more direct impacts on the healthcare sector. Despite being a doctor by trade, Alckmin did not have policy experience nor did he involve himself directly with the running of the SES. Serra, on the other hand, had been a prominent Minister of Health. During his tenure at the federal level, he developed more established view on the role for state governments and for the São Paulo healthcare system in particular, while also developing an
extensive set of connections from putting together his Ministerial staff. The NOAS operational norm, which had an expanded coordinative role for state governments, was developed under Serra’s time as Minister. Now at the state level, he brought on part of that staff that could address the state’s glaring failures in this area.

Figure 23: Political Landscape in São Paulo, 2007-2010

A key change made at the top of the SES was Serra’s recruitment of Renílson Rehem de Souza, the former director of the Ministry of Health’s largest subdivision under Serra, as the deputy Health Secretary in 2007. The informal power division was such that Barradas would continue to run the state’s hospital network and own programs, while Rehem would be the contact person in the relationship with municipalities. He took over for Barradas as the state’s representative at the CIB, and took on as big projects the adequation of the state of São Paulo under the new Health Pact norms. As part of this process, Rehem would have to redress the state’s failure to produce the two organizational documents (the PPI and the Regionalization Plan). Rehem’s experience and openness to negotiate with municipalities brought him instant praise from the COSEMS leadership, who published in an internal editorial that there was a “unique opportunity” to reach agreement with the state office in this new term.
Improvements in cooperation were also positively affected by a broadening of the COSEMS representation. The Pactos de Saúde introduced micro-regional committees Colegiados de Gestão Regional (CGRs), which capillarized municipal manager participation in the joint management of their regional operational needs. The COSEMS then expanded its council of representatives from 14 to 64 (one representative from each CGR). This had two effects: though the PT forces were still at the forefront, it made the COSEMS more representative of the regional and political forces across the state. This in turn softened the municipal stance in some discussions. At the same time it strengthened the association’s position of representative of all municipalities as opposed to the Sanitarista-led “elite”, which made it easier for the state negotiators led by Rehem to justify the need for concessions. The COSEMS president for the 2007-2008 term, Jorge Harada, was also a frank negotiator, who defended municipal interests, but also negotiated in good faith.

Weary of the previous inability to come to consensus, Rehem changed the state’s approach to negotiating the PPI—creating from the outset a joint working group, composed by equal numbers of state and municipal técnicos, to make decisions collectively. The working group (GT-PPI) then set out to deal with the two major sources of contention: First, there were redistributive concerns among the municipalities themselves, among municipalities that stood to gain and lose with reallocation of resources. At the same time, the growth of the state network’s participation in the production of hospital procedures brought forth collective fears that the recalculation of flows would lead to recentralization of resources to the state level.¹³⁹ To address these issues the state proposed a 5% cap on reallocations during the first revision—i.e., no municipality would stand to gain or lose more than 5% of its current allocation. This

¹³⁹ This is one of the dangers of having the state office “compete” with municipalities for resources—that municipalities don’t see the state office as a leveled arbitrator. Compare this to the situation in Minas Gerais, where the state is not a main service provider, and therefore is not feared to hoard resources.
assuaged the first type of fear. While municipalities would be free to assign their medium-complexity allocations, the GT-PPI would oversee the reallocation of high complexity services more closely, to avoid crippling the current network. Finally, the state proposed sizing flows based on need as a first rule, with historical production used only when no other way was feasible (e.g. instances when no information was available or the resulting deficits would be too large). This greatly improved the equity in distribution. After a two year process of negotiation, state and municipalities were both moderately satisfied with the results. A total of 290 municipalities had gains, and 255 had losses (77% of which had losses under 2% and only 7% had the maximum loss of 3.2% resources). To assuage the loss of resources to the state level (originally sized at R$270 million) state and municipalities lobbied jointly to the Ministry of Health, who issued new transfers to curb municipal losses to R$ 43 million.¹⁴⁰

Another key change was harnessing the knowledge gained during the extensive negotiation exercise into a dynamic management tool, as we have seen in Minas Gerais. Revisions were set to be done every trimester, so that municipalities could continue to reallocate resources based on their changing needs and to ensure they received treatment for their patients. And while the ease of use of the system is not as straightforward as the one in Minas, municipalities have reported the ability to change their flows when needed.

Concurrently with the PPI revision, the planning office in the SES set out to redesign the state’s regions in the PDR. As we have seen, the state has historically struggled with territorial division, switching strategies multiple times over the years (Mendes & Oliveira 2009). After the merely parchment redesign in 2002, a proper planned PDR revision was prepared under the Health Pact rules. Having learned from past mistakes, the state office combined a strategy of generating the large design of regions at the center (17 regions in total), and decentralizing the

¹⁴⁰ CIB-SP meeting minutes, July-October 2008.
micro-regional subdivisions to the municipalities. In practice, the municipalities in each regional division deliberated and chose their subdivisions based on a flexible set of guidelines. The central office conducted their own regionalization studies, but in the end decided to forego their technocratic plan in order to allow for the more democratic bipartite division which respected local regional identities. This is visible particularly in the case of the Campinas region, where municipalities that were historically linked to the city of Campinas as former boroughs and were still highly dependent on referring services to the larger city, nonetheless decided to splinter into a separate micro-region. Municipal managers there argued that—though they were still highly dependent on Campinas for services—it was politically necessary and desirable to create their own capacity and intra-regional flows. This would only happened, they argued, once they “cut the cord” from their larger neighbor. Conversely, the group of municipalities known as *Circuito das Águas* (where our initial example, Amparo, is located) was included in the Campinas micro-region despite being much closer to another center. This illustrates that the design of a health region is as much a political as it is a technical exercise.

Also unlike the *Mineiro* solution, which designed divisions around regional “pole” municipalities, the distribution of state and federal funding also does not follow a strictly pre-determined plan. Rather, once resources have been allocated either at the CIB or by the central state office, the *Secretários* deliberate in the CGMRs to decide their best use. The process of decentralization continued to expand, even to include municipalities and the CGMRs in the development of the SES’s own service network. While the SES unilaterally decided where (which municipalities within the macro-regions) it would place its new network of medium-complexity ambulatories (Ambulatórios Médicos Especializados, AMEs), it also engaged the municipalities when it came to picking the specialties that the regional AME would contain. The benefits of São Paulo’s current model are significant in that it allows municipalities to share investments in
more equitable fashion, and reinforces a dynamic of municipal partnership among equals rather than subservience to a local pole. The costs of decentralization are the atomization of the network (leading to increased need for patient travel) and the potential capture of resources by powerful local bosses.

Under the Barradas/Rehem team, there were therefore some co-management gains in the state system. In part, this was guaranteed by the state decentralizing the choice of region to municipalities, but also due to the state’s introduction of some state funds to be transferred to municipalities. One example is the introduction of a rescue and support program for non-profit hospitals, called Pró-Santa Casa. The state channeled state resources (up to R$ 32 million in the first year) to relatively larger hospitals (over 30 beds) that provided regional services (a minimum of 20% of procedures needed to be from regional referrals). The state used the PDR to distribute it equitably, assigning one hospital per micro-region (64) but allowing the municipal CGRs to pick the hospital based on their local needs. The state would provide 70% of the funding for the program to the 30% from the pooled municipalities. If the hospital provided macro-regional services (multiple CGRs) then the state would pick up 100% of the financing. The program was incredibly popular with municipalities, having since been expanded: The Pró Santa Casa II contemplated 109 facilities throughout the state with a budget of R$ 87 million.141

*The Failure to Coordinate Medical Referral*

Given these significant advances in coordination achieved by the SES under the Serra administration, it is particularly telling that São Paulo—despite having the largest healthcare and most technologically advances network in the country—has yet to develop a statewide electronic medical referral system. Though not completely inexistent, the current arrangement

in São Paulo is both arcane and cumbersome: Each regional office has referral doctors that work through paperwork and phone lines to distribute patients through the hospital network. But since the process is incredibly time-consuming, referral of emergency cases is done once the patient is already being treated, as a bureaucratic exercise to ensure the financial flows. Once again, this is what healthcare workers call the “network regulating itself”, a mix of spontaneous transport of patients, providers and doctors calling facilities directly to ensure treatment of their patients, among many other wily strategies. This is failure is interesting because it is not a technological failure: The Ministry of Health has offered an indigenously developed software platform (SISReg) that has been in operation for over a decade. Though the platform is cumbersome, it nonetheless functions, and is used by a few states such as Bahia. There are also private alternatives—the state of Minas Gerais created a partnership with a foundation in order to develop its system, the SUSFácil at considerable expense, even though its budget is significantly smaller than that of São Paulo. Likewise, larger cities such as São Paulo and Campinas have developed their own internal referral systems, but that are disconnected from each other and from the state’s system.

Rather, it is a political failure, resulting from the nature of São Paulo’s health network and the incentives derived from the political environment. As I argued in chapter 1, imposing coordination is costly operationally, financially, but especially politically in that it involves ‘saying no’ to powerful actors. In a political environment with pluralized powerful forces (controlling municipalities, but also state and federal legislators who have regional zones of influence) these costs are high because they have enough strength to oppose state action either in the legislative or SUS institutional arenas. Having established a secure hold on state power, and spending most of its energy managing and growing its hospital network, the SES finds that it is not worth the political risk or the operational trouble to bring these disparate actors together. While this
system is chaotic and costly for the patient, it is in many ways an equilibrium status quo where state hospitals are always working at full capacity, experienced municipal managers know how to navigate the system and work contacts in order to find spots for their patients, local politicians control access to local providers, and the providers over-report their capacities and cherry-pick the patients that are less complicated and more profitable to treat. Therefore, in a political environment where innovation and risk-taking is unnecessary, a critical statewide IT system for patient referral continues to be avoided, leaving patients facing a fragmented system.

Recently, the expansion of Ministry of Health funding for emergency medical services (Serviço de Atendimento Móvel de Urgência, SAMU) has disseminated emergency referral technology across the country. Since the SAMU ambulances must find where to deliver the patient, their referral centers have started to, in practice, serve as local referral offices. As the SAMU coverage expands, perhaps they will find an inherent operational solution for the political conundrum, by linking up into one state-wide and eventually national system. But the emergency referral system cannot cover the broader needs of the health network, including scheduling visits and managing chronic care patients.

Conclusion

In this chapter, I have presented evidence from the case of São Paulo to show how the incentives from the political environment have shaped the face of the state’s healthcare network. In an initially plural environment, but with the state under secure control, the state health office decided to aggressively decentralize responsibility over municipal systems to local governments, so that it could focus on developing its own hospital network. As the national, state and health-specific political alignments changed, the system in São Paulo became similar
to a two-party system, between the state PSDB forces and the municipal PT leadership. The relationship between the state and municipal health managers became confrontational, resulting in the state continuing to focus on its own healthcare solutions and municipalities built an increasingly fragmented healthcare system. Finally, when the COSEMS became more representative of the entirety of municipal forces, and the state office made its approach to network design more flexible, a few important though limited advances were possible.
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