Civilizing the State:

Civil Society and the Politics of Primary Public Health Care Provision in Urban Brazil

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A Dissertation Submitted in Partial Fulfillment of the

Requirements for the Degree of Doctor of Philosophy

in the Department of Sociology at Brown University

Providence, Rhode Island

May 2012

This dissertation by Christopher L. Gibson is accepted in its present form
by the Department of Sociology as satisfying the
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I managed and analyzed GIS data for a project that analyzes the spatial distribution of associations in São Paulo, Brazil. I categorized and coded a geo-referenced database of approximately 12,000 associations in the *município* of São Paulo, Brazil.

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2006 Research Assistant to Professor Patrick Heller *Providence, RI*
I managed quantitative data and conducted multivariate analysis on a database of key informant responses, administrative and financial records, and statistics on public good and private benefit provision by local governments in Kerala, India.

PROFESSIONAL RESEARCH CONSULTING EXPERIENCE

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As a research consultant, I developed an analytical framework for coding qualitative data on the economic mobility of historically marginalized groups in urban India. I trained field-based research teams in analyzing in-depth interviews, ethnographic observations, and cases studies.

2004 **The World Bank**, DECRG *Washington, DC & Jakarta*
As a research consultant, I produced qualitative analyses of local level conflict dynamics in Indonesia. I managed, analyzed, and trained field-based research teams in coding and analysis of in-depth interviews, ethnographic observations, and case studies of conflict and development.

TEACHING and CURRICULUM DEVELOPMENT

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2000 As a Program Director for El Pomar Foundation in Colorado, I co-developed curriculum used in a program that taught students in 120 Colorado high schools about the non-profit sector, volunteerism, community service, and philanthropy by creating mini-foundations in these schools.

PROFESSIONAL AFFILIATIONS

2011-12 **Duke University Center for Latin American and Caribbean Studies** *Durham, NC*
As a graduate student affiliate , I participated in an interdisciplinary working group of Brazilianists at Duke, whose research focuses on leftist politics and political parties, public health, poverty, popular culture, and contemporary history of Brazil.

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ACKNOWLEDGMENTS

I would like to thank the many generous key informants, whose thoughtful insights, patience, and willingness to share their stories proved indispensible for my learning in this project. The two years of fieldwork I conducted during 2009 and 2010 would not have been possible without generous support from several sources, including a Doctoral Dissertation Improvement Grant from the National Science Foundation, a Grassroots Development Fellowship from the Inter American Foundation, and a scholarship from the I.I.E./Fulbright Commission of Brazil. I particularly appreciate all of the support provided by Patricia Grijó of the Fulbright Commission office in São Paulo. I also greatly appreciate the year of support for dissertation writing that was made possible by a Dissertation Completion Fellowship from the Mellon Foundation and American Council for Learned Societies (ACLS). At Brown, the Graduate Program in Development (GPD) provided funds for the pre-dissertation fieldwork I conducted in 2008 and the Graduate School provided a semester-long fellowship for dissertation writing.

I also benefitted from the institutional support and relationships I formed through two host research institutes in Brazil: the *Centro Brasileiro de Análise e Planejamento (CEBRAP)* and *Instituto Fernando Henrique Cardoso (IFHC)*. At CEBRAP in São Paulo, my conversations with Haroldo Torres, Adrián Gurza Lavalle, and Vera Schattan Coelho helped greatly in charting the direction of the project during early stages. I also want to thank President Cardoso, whose time at Brown as an at-large professor greatly enriched my understanding of Brazilian history and politics.

The intellectual guidance of my dissertation committee was indispensible for this project. I owe Patrick Heller a special debt of gratitude, particularly for his mentorship, his exhortations to undertake fieldwork, for introducing me to the insights of sociological theory, and for exposing me to the inter-disciplinary community of scholars he has fostered at the Watson Institute. I thank Gianpaolo Baiocchi for patiently supporting my research and taking the time and energy to help me improve it. I thank Nitsan Chorev, who not only helped me become a better consumer of knowledge, but also helped me come to think of myself as a producer of it. I thank John Logan for pushing me to clarify and sharpen my argumentation in ways that have strengthened me as a scholar.

I would also like to thank Rich Snyder, whose wisdom and guidance during a challenging moment helped ensure that this project came to fruition. As I wrote this dissertation in Providence, RI and Durham, NC, several people provided sharp insights as well as encouragement. Jennifer Costanza, Esthér Hernandez-Medina, Shruti Majumdar, Sukriti Issar, Erin Beck, Oslec Villegas, Patrick Heller, and others provided helpful feedback through our writing group. During my last year of dissertation writing, John French of Duke University's Center for Latin American and Caribbean Studies generously included me in the Center's Brazil Working Group during a particularly rich period. I have benefited enormously from the community of scholars in the group, particularly Cristiani Vieira Machado and Alexandre Fortes.

I also want to thank my friends and family for their support throughout. Mike Edmonds refused to let me fail and for that I am eternally grateful. I doubt that this project would have happened without the intellectual mentorship and friendship of Michael Woolcock. Laurence Gibson, Shannon Gibson, Diana Gibson, Nick Stevens,

Gayel Gibson, Lee Gibson, Ruth Gibson, Gerhart Panke, and Elsie Panke, you all inspired and enabled me to reach this point in different ways…thank you, thank you, thank you. Finally, I would like to thank Katie Millar, whose inspiration as a scholar, free spirit, intellectual, human, and partner I lack the language to fully describe. Katie, your love, support, and patience mean the world to me.

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THE POLITICS OF PRIMARY PUBLIC HEALTH CARE AND HEALTH DEVELOPMENTAL STATES IN URBAN BRAZIL

In 1988, successful struggles for re-democratization in Brazil enshrined a new constitution that promised the right to free and universal public health care for all citizens. Specifically, Article 196 of the Constitution declares that: "Health is a right of every individual and a duty of the state, guaranteed by social and economic policies that seek to reduce the risk of disease and other injuries, and by universal and equal access to services designed to promote, protect, and restore health" (Brazil 1988).[1] In crystallizing universal and equal access to health care as a permanent goal of social policy, this provision sparked new and dramatic transformations in the national and urban politics of public health care provision after 1988. Known in Brazil as *sanitaristas*, civil society activists from the Sanitary Movement (*Movimento Sanitário*) for universal public health care and basic sanitation were at the forefront of these tectonic shifts in the country's politics of public health. Following their conquest in framing the constitutional right to health, sanitaristas allied with national state reformers and managed in 1990 to extinguish a pre-existing, dictatorship-era health bureaucracy (INAMPS) that provided curative, highly complex health services for formal sector workers but excluded the rest of the population from access. In that same year, they also succeeded in institutionalizing a new Integrated Health System (SUS) that both enacted the longstanding sanitarista ideology of universalizing rights-based access to primary, preventative health care and established

universality, equal access, community participation, and decentralization as the guiding principles of SUS.

Yet, commonly overlooked in many academic discussions of Brazil's public health system is the fact that, despite the Constitution's bold promises, these activists for universal health care suffered a major, parallel defeat in the 1988 assembly in which the Constitution was drafted. Namely, conservative actors from the private hospital industry and the budding health insurance industry defeated the statist proposals of Workers Party (PT) activists, sanitaristas, and other civil society activists from the Popular Movement for Health (MOP), who advocated a purely state-run system of health care provision that would have effectively dissolved connections the involvement of private market spheres in administering public health services. This defeat would prove to be as consequential for the universal and equalizing ambitions of universal health care activists as the Constitution's requirement that the state provide universal, free, and equal access to public health care. Combined with the fact that subsequent legal specifications of the Constitution assigned the lion's share of this responsibility to local governments, this defeat ultimately shifted the terrain of political struggle over how actively to institutionalize the universalizing ambitions of SUS to the level of the *município*.

Still, sanitaristas not only continued advancing their struggles to expand primary health care provision as a priority of the federal government, but also increasingly opened up a new front in their struggle for universal health care: the município or local government level. Gradually throughout the 1990s and early 2000s, major Brazilian municípios began to assume sole responsibility for providing the primary, preventative health care services around which sanitarista ideologies revolved. And as with the

reaction of some provincial Mexican governments to neoliberal federal policies regulating agricultural production (Snyder 2001), the reactions of the largest Brazilian municípios were diverse and dependent on the locally variable state-society configuration of actors that actively institutionalized SUS. While nearly all such large municípios possessed little funding and few pre-existing state capacities to deliver health care universally in 1990, some had made much greater strides toward delivering on the constitutional promise of free and universal public health care provision by 2011. This project develops a sociological explanation of this variation by analyzing the município-level politics of state transformation that drove these variable outcomes.

The central argument of this dissertation is that, alongside locally variable, structural factors that conditioned the timing, nature, and extent of health sector municipalization, three types of locally divergent civil society-state regimes – participatory regimes, clientelist regimes, and pragmatist regimes – explain much of the variation I observe in the intermediate outcome of state capacities to provide health care, as well as the ultimate outcome of primary public health service provision levels by 2011. I first maintain that these divergent regimes explain variation in a key intermediate outcome: the emergence, consolidation, or obstruction of local-level developmental states for the public health sector that I call "healthy states". I define healthy states as governance structures characterized by three robust capacities: first, cadres of municipally-employed, primary public health professionals; second, municipally-operated primary care clinics; and lastly, technical capacities to target health professionals and clinics to high epidemiological risk. I also argue that, by conditioning the rise, consolidation, or obstruction of local healthy states, divergent regimes account

for variation in the ultimate outcome under investigation in the project: the extent of expansion in municipal provision of primary public health care during the last twenty years. Using a descriptive quantitative analysis of a measure called the primary care appointment rate, this project documents substantial variation in the records of Brazil's most populous, capital-city governments in expanding primary service provision since 1988. Drawing on a comparative-historical analysis of cities, my inferential analysis shows that locally variable types of state-society regimes molded the levels of primary public health services that municipal states provided by 2011. They did so by molding the intermediating mechanism of state-building, particularly state-building of a kind that equipped municípios to expand this service provision in city regions characterized by historically low Municipal Human Development Indices (M-HDI).

Yet, to be sure, the passage of a new constitution and the enshrinement of rights to universal health care in 1988 did not magically re-set pre-existing balances of local power, nor did they carve out an un-encumbered, structure-less vacuums for the unfolding of these processes across urban Brazil. Even after re-democratization, municipal health politics continued to be colored by many, longstanding, path-dependent legacies, including the clientelist local politicians and engrained capitalist interests in the private hospital industry, whom the erstwhile military dictatorship actively fostered. Furthermore, SUS is fundamentally a system of multi-level governance that divides responsibilities for providing public health care among three levels of government (municipal, state, and federal) and assigns each level concurrent responsibilities for different portions of the system. As such, even though the same laws that established SUS also defined primary public health provision – the primary focus of this study – as

the sole responsibility of municípios (NOB 1991), it would be folly to assume that municipal politics unfold in a vacuum or that they are somehow impervious to the undeniable influences of state and level politics. In sum, locally variable, pre-existing political configurations and structural circumstances, as well as the primacy of state- and federal-government in structuring local regimes and the very nature of SUS as a system of multi-level governance, all conditioned the timing and depth with which local state reformers and sanitaristas proved able to municipalize the public health sector in the three cases examined most deeply by this study.

After 1990, this historical-structural process unfolded in three distinct ways across the large Brazilian municípios I examine. First, in Porto Alegre, pre-existing politics conditions and actors in state-level government of Rio Grande do Sul were generally averse to muncipalizing the public health sector during an early moment and directed existing resources towards lower-HDI rural regions of the state. In short, pre-existing circumstances were not especially propitious for the efforts of Porto Alegre's state reformers to assume responsibility for providing primary health care at an early moment. These structural factors and influences, which emanated from state-level, not municipal politics ultimately limited the less proactive efforts by a participatory regime of state-society actors to advance the ideology of universalizing access to basic health services. This resulted in comparatively modest expansion rates and levels of primary health service provision by 2011. On one hand, Porto Alegre's participatory regime achieved impressive gains in expanding one, key facet of a healthy state during the mid-1990s: primary health care clinics located in the city's generally lower-HDI and geographic peripheral neighborhoods. Yet the particular institutional outlets that the regime's most

active civil society activists adopted for affecting public goods policies offered few levers for influencing separate decision-making processes in which proposals to expand the ranks of municipally-employed primary health care workers largely foundered. Just as importantly as these other factors, the civil society agent of such pragmatic state-building efforts in the public health sector of other cities like Belo Horizonte – namely, sanitaristas – proved far less influential within the political party structures that controlled city politics during this period.

Secondly, in municípios like Rio de Janeiro and Salvador, clientelist regimes proved incapable of generating even the relatively modest levels of equalizing expansion witnessed in Porto Alegre because the isolation of all relevant civil societies from political and health policy-making influence ultimately left the ideology of state-building for the public health sector without an agent. In part, this was due to the fact that sanitaristas and progressive political parties became shielded from appreciable influence for different reasons in these three cities. In Rio de Janeiro and Salvador, where the left and left-center political parties with whom sanitaristas allied never won municipal power until very recently, sanitaristas lacked the proximity to state power that was required to formulate and advance a reform program. In Fortaleza and Recife, although the much-celebrated Workers Party won local power, the pragmatist public of sanitaristas struggled to advance their reform program until late in the 2010s. Yet, path dependent structural legacies also played a major role in negative cases, never more so than in Rio de Janeiro. In particular, the private hospital industry – and the clientelist ties that it forged with state actors in the city during Brazil's military dictatorship – loomed large in Rio's municipal

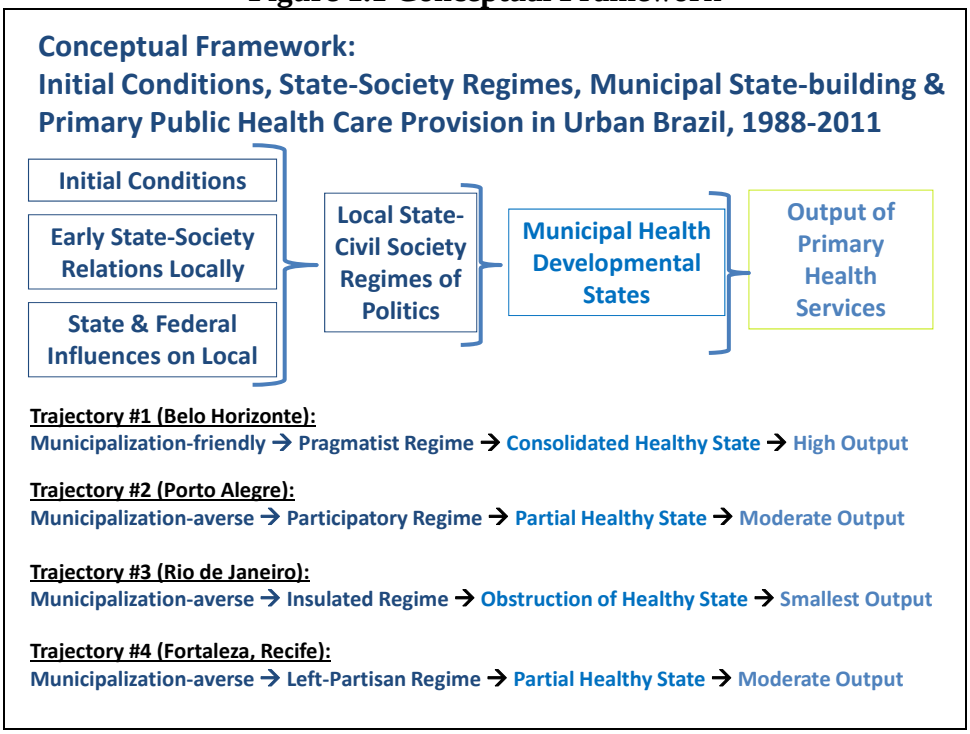
politics of health well into the 2000s, where they impeded more programmatic proposals of sanitaristas like Dr. Sérgio Arouca to reform the sector.

Finally, I show that Belo Horizonte attained the highest level of primary health care provision expansions witnessed in all of urban Brazil during the last twenty years for a combination of reasons related to the interplay of structure and agency. In an initial moment, perhaps none was more important than the generally supportive role of the state of Minas Gerais in catalyzing the municipalization of the health sector throughout the state, including in Belo Horizonte. Whereas in Porto Alegre and Rio de Janeiro, the state-level health bureaucracy exhibited heavily clientelist tendencies leftover from the country's military dictatorship, state government in Belo Horizonte was home to multiple, early experiments with the municipalization of primary health care provision. Further, venerable sanitaristas, who were early adopters of the movement's nationwide strategy of "occupying the state," in the heath bureaucracy of Minas Gerais government as well as Belo Horizonte's municipal state as early as 1983. Thus, pragmatist civil society actors in Belo Horizonte's municipal health secretariat encounter early political opportunities to begin building the health developmental state structures that were later consolidated during the early 2000s and endure into the present day.

Further, as in all other cities examined in this dissertation, sanitaristas in Belo Horizonte advocated a longstanding ideology of expanding the public infrastructure required to expand local state delivery of primary, preventative health care services. But unlike in clientelist regimes, sanitaristas maintained a formidable presence within a variety of left and left-center political parties that held local power for sustained periods. And unlike Porto Alegre's participatory publics, who effectively placed all of their reformist

ambitions in the basket of one political party (The Workers Party or PT), Belo Horizonte's sanitaristas advanced their agenda through the political platform of several left and left-center parties that won mayoral power and held sizeable seat shares on city council. The figure below summarizes these variable trajectories.

Figure 1.1 Conceptual Framework



My findings address sociological theories of development and inequality by demonstrating that while left-leaning political parties in local power were a necessary condition for the largest expansions in primary health care provision urban Brazil after re-democratization, so was the activism and infiltration of these parties by local, pragmatically-oriented civil societies. I argue that the largest expansion in primary public health care delivery occurred in the municipio of Belo Horizonte and to a lesser extent in São Paulo and Curitiba. I show that in Belo Horizonte, sanitaristas supplied the ideas and agents who successfully mobilized locally ruling left and left-center parties to build three

relevant state capacities for universal health care: municipal public health professionals; municipally-run, primary health care clinics; and local bureaucratic capabilities to target professionals and clinics to epidemiological risk. I contrastingly show that in negative cases of stagnant health service inequalities, local states struggled to develop these capacities because leftist parties were either unable to capture local power, as in the clientelist regimes of Rio de Janeiro and Salvador, or because leftist parties that did capture local power lacked or otherwise excluded otherwise influential cadres of sanitaristas from crystallizing state-building proposals for public health, as in the left partisan regimes of Recife and Fortaleza and the participatory regime of Porto Alegre.

Theorizing Development as Capability Expansion

These findings aim to dialogue with longstanding sociological theories of development and inequality. While sociologists of development disagree about causes of development, they increasingly agree that the *sin quo non* of development itself is no longer income or earnings but instead inclusive access to the kinds of "capability-enhancing" services (e.g. basic health care) that undergird Amartya Sen's now canonical definition of "development as freedom" (1999). Following the publication of Sen's *Development as Freedom* in 1999, sociologists and scholars from across the social sciences increasingly shifted away from defining development in the global South in terms of industrial growth and income expansion. Part and parcel of this shift was an increasing willingness to instead conceptualize development in Senian terms as the expansion of people's basic capabilities to "lead the kind of lives they value – and have reason to value" (10). In particular, a growing consensus arose among social scientists during the 2000s that development should be understood first and foremost as minimum

standards of health and well-being, which themselves prefigure the ability to actively make decisions about other development objectives, both personal and societal.

On the conceptual level, this project adopts a Senian approach to defining development as state provision of public goods and services that expand basic human capabilities of historically marginalized social categories. Particularly in urban Brazil, access to primary public health care is a quintessential example of capability-enhancing development. This is not only because it promotes what Sen calls the basic human capability to live the life one has good reasons to value, but also because state exclusion of Brazil's geographically-peripheral urban dwellers from access to such services left these groups at the very bottom of Human Development distributions, until very recently. As a measure of just how enacted development policies become in practice, this measure differs from other, classic measures such as "welfare effort," which instead capture a given nation-state's ratio of all revenues to GDP, for example, or its ratio of social security spending to GDP (Huber, Ragin, and Stephens 1993: 734). Although apropos to the paradigmatic cross-national studies to which they were applied (Bradley et al 2003; Huber et al 2006; Huber and Stephens 2001), such measures struggle to meaningfully operationalize actual redistributive development outcomes because wild fluctuations in the ability of local governments to transform funding into services preclude any simple equation of actual public goods *provision* with state *spending* on their provision. These deficits commonly lead scholars of large Southern democracies like Indonesia, India, and Brazil to adopt alternative measures of redistributive development that instead focus on the tangible material public goods that states actually provide, as opposed to the amounts they spend on provision, or the proportions of GDP or overall state spending that this

spending represents. A particularly common approach in recent development research (Appadurai 2002; Besley, Pande, Ramin, and Rao 2004; Besley, Pande, and Rao 2005, 2007; Chattopadhyay and Duflo 2004; Heller, Harilal, and Chaudhuri 2007; Marquetti, Campos, and Pires 2008; Olken 2007, 2010) and the one adopted in this article is to use measures of actually-existing public goods and services provided. Specifically, I examine the number of primary public health care services delivered by trained medical personnel, whom I link to the volume and density of primary health care centers and workers across cities and in given geographic spaces of the city.

This shift in the conceptualization of development represented a major advance for those who criticized previous definitions for overlooking more fundamental processes of capability-expansion, which industrial growth does not necessarily advance and often worsens. But it was not accompanied by an appropriately matched explanatory framework for hypothesizing the causes of capability-enhancing development interventions. As a result, even as the once-dominant definition of development as industrial growth faded and new, Senian definitions emerged, key elements of the explanatory models with which scholars predicted industrial development have endured. Although no similarly dominant explanatory framework arose to replace the once-authoritative model of the industrial developmental state, elements of that erstwhile model now reappear in emerging theoretical frameworks of Senian development and its contemporary origins in the global South. For example, Peter Evans argues that Senian development is likely to emerge from modern states that proactively deliver capability-expanding services like health and education in response to public processes of democratic deliberation about the ends and means of such interventions (2008: 13-14).

Specifically, he argues that a key contemporary analog to the industrial developmental state may well be a "21st century developmental state" that advances Senian development outcomes by pursuing more aggressive state action "in ramping up the effective delivery of capability-enhancing services" like health and education (Evans 2008: 13). Yet Evans also notes that the "21st century developmental state" may take on a broader multiplicity of institutional forms than the well-documented form of the 20th century developmental state did.

By drawing on a fieldwork-based examination of the institutionalization of constitutional rights to universal health care in urban Brazil since 1990, this dissertation proposes one tangible, institutional form that such 21st century developmental states are now taking: what I conceptualize as local-level "health developmental states", or "healthy states" for short. I define healthy states as formal governance structures characterized by three, key state capacities: first, large numbers of municipally-employed, primary public health professionals; second, formidable networks of municipally-operated primary care clinics; and lastly, technical planning capacities to target health professionals and clinics to high epidemiological risk. I argue that the historical process of constructing local-level healthy states across urban Brazil during the last twenty years has important implications for conceptualizing the 21DS and theorizing the conditions of its emergence. Specifically, this process suggests the need for a broader, four-sphere explanatory model of state-society relations that can accommodate how a decidedly pragmatist subset of civil society actors led state-building around one particular, capability-enhancing development objectives: namely, universal public health care provision.

Political Agents of a 21st Century Developmental State

I propose to help along accounts of the politics that might foster a 21st Century Developmental State – or "21DS," for short – by examining the kinds of local state-society regimes that have build, consolidated, or obstructed the rise of local-level health developmental states in urban Brazil during the last twenty years. My evidence suggests that a set of pragmatically-inclined civil society actors from the *Sanitarista* Social Movement played a decisive role in building and consolidating local healthy states by occupying more traditional channels of politics and foregoing the deliberative institutions emphasized in Evans' account. This movement of health workers and public health system users is largely led by professionals and defined by a core ideology focusing on universal public health care provision. I argue that the effectiveness of sanitaristas invites a re-consideration and potential broadening of three propositions about the nature, roles, and mobilizational capacities of civil society actors, who may advance the construction of the 21DS across the global South. In Evans' model, relevant civil societies are fundamentally deliberative in nature, in need of mobilization by state actors, and are typically more effective in executing capability-enhancing interventions than they are in mobilizing broad political support for them in the first place. By contrast, I find that pragmatist civil society actors were effective agents for constructing health-focused 21DSs in urban Brazil because their odd mixture of political opportunism, a universalizing ideology, and a broad penetration of other leftist spheres such as unions and political parties ultimately permitted them to devise a discreet but nontrivial state-building project around which they mobilized a broad range of other, more deliberative civil societies as well as organized labor and state actors. In short, pragmatist civil

societies constitute one conceptually distinct political agent for cultivating the new and more involved modalities of embeddedness that are required for constructing the 21st century developmental state.

In Evans' model, the kinds of civil societies that are likely to matter for constructing a 21DS exhibit three central qualities. They are fundamentally deliberative in nature, in need of mobilization by state actors, and typically more effective in executing capability-enhancing interventions than they are in mobilizing broad political support for them in the first place. First, the model hints that the kinds of civil society actors and institutions, who would most likely make significant contributions to the construction of a 21DS, are inherently deliberative in their approach to influencing politics. Specifically, capability-enhancing development and the "21DSs" that advance it are predicted to emerge from "deliberative institutions and the broad based connections between state and civil society that they entail" because they "are the only way to ensure either the flows of information necessary to guide the allocation of public resources (Evans 2008: 18). This is because deliberative institutions and the kinds of information flows they permit are likely to result in "co-production" in service delivery that can improve both the selection of desired investments and effectiveness in delivering the capability-expanding services that such chosen investments should promote, in theory.

Second, the model proposes that the kinds of state-society relations most likely to construct a 21DS would involve bureaucrats and politicians mobilizing civil society activists around state-building objectives, not vice-versa. Here, state actors themselves initiate and build the state-society relations required to construct a 21DS: "In order to be able to create effective state-society linkages, the state must facilitate the organization of

counterparts in 'civil society'" (Evans 2008: 16). In short, the directional arrow within the state-society relations likely to construct a 21DS necessarily run from state to civil society, with bureaucrats and politicians mobilizing activists around state-building objectives.

Third, the framework suggests that civil societies may be effective in helping the state plan and execute capability-enhancing intervention, once state actors have already made the difficult political commitments to undertake such planning and interventions. The framework is less clear, however, that civil societies themselves can more actively build political support to make such commitments in the first place. While "efficient allocation of capability-expanding investment requires a much broader set of information" that civil societies provide and while "the state needs their active engagement in the delivery of those services in order to insure that the investments produce the desired effects" (Evans 2008: 15-16), civil societies contribute information and generally behave in curiously docile way that belies how social movements mobilized political support to create welfare states, health, and education systems in Europe, for example.

Applied to construction of health developmental states in urban Brazil, then, several discontinuities arise between these three propositions and the observable record of recent state-building for public health. First and foremost, deliberative institutions have commonly failed in actually influencing the politics of state-building for public health, even if these politics permitted improved flows of information between state and civil society actors. For example, I find that the municipal health council (MHC), a civil society-occupied deliberative institution whose participants are empowered by the Brazil

constitution to veto public health budgets that they find lacking, rarely if ever plays this function in practice. In three cities (Belo Horizonte, Porto Alegre, and São Paulo, I find no record of such MHC vetos actually leading to changes in the content of budgets, as is legally required. This suggests that civil societies working through deliberative institutions may be overpowered by state actors, who do not share an agenda of state-building for public health. Yet in two of these three cities – Belo Horizonte and São Paulo – large developmental states have arisen anyways. This suggests that other kinds of civil societies working through other, non-deliberative types of institutions may nevertheless play a role in constructing the 21DS. Often, connections between civil societies and the state take on different, decidedly non-deliberative forms, which nevertheless advance specific state projects to expand capabilities such as the expansion of primary, preventative health services.

Co-production may be crucial in actual service delivery (e.g. a patient receiving medical attention or a student participating in a classroom to learn a lesson) but neither co-production nor deliberative institutions are necessarily the only or most effective means by which civil societies can press state actors to deliver these services in the first place. One assumption underlying theories of co-production is that social networks are sufficient to dissolve information asymmetries between state and civil society actors such that state politicians and bureaucrats can enact the desired preferences of civil societies. Yet, the passage of information, preferences, and ideas from civil society actors toward state actors across the more porous membrane of a deliberative democratic institutions does not necessarily ensure that state actors will act on this new information, once they receive it. Indeed, a key feature of modern states is a certain resistance to ideas,

information, and demands for specific actions that civil societies place on governing elites.

A second discontinuity arises between the proposition that "the state must facilitate the organization of counterparts in 'civil society'" – and the empirical reality I discovered that something closer to the reverse is true for cases of healthy state construction in urban Brazil. My evidence instead suggests that activist from the sanitaristas social movement provided much of the impetus, not only to institutionalize the universal right to publicly provided health care in Brazil, but also to construct the local-level state institutions that would broadly deliver the most basic, primary care services. A third continuity arises when we consider that actors from the Sanitarista movement were key mobilizers to enshrine and then institutionalize a universal health system in the first place. Thus, civil society was far from limited to either making far less consequential (though nontrivial) decisions about the types of investment necessary to institutionalize that system or to engage in the co-production of health service provision.

Civil Society-led Regimes & Health Developmental States

Examining the variable local records of Brazilian civil society and political parties in advancing or inhibiting the progression of sanitarista ideologies ultimately brings new light to bear on conditions for the emergence of the 21DS. These implications emerge from my finding that two elements of pragmatist regimes – left-leaning party rule and what I define as pragmatist civil societies – were individually necessary and jointly sufficient for building the local, healthy state structures that ultimately rolled out equalizing expansions to occur in urban Brazil during the last twenty years. On the most fundamental level, the study hypothesizes that locally variable regimes of state-society

politics shaped the presence or absence of equalizing expansions by conditioning state-building and policymaking processes in the municipal public health sector. Said differently, three qualities of pragmatist regimes were individually necessary and jointly sufficient for sustained equalizing expansions in the public health sector across urban Brazil during the last twenty years: first, a distinctively pragmatist cadre of politically connected sanitarista activists; secondly, left-leaning mayors in local government; and third, a particular form of state engagement with pragmatist civil societies that I call "associational corporatism".

As noted above, some of Brazil's most populous capital cities (Belo Horizonte, Recife, São Paulo, and Curitiba) witnessed robust expansions in primary public health care provision after 1988, while others like Porto Alegre experienced more modest expansions, and still other municípios like Rio de Janeiro, Salvador, and Fortaleza exhibited almost undetectable levels of expansion. As existing sociological theory suggests, the role of local political party politics, in general, and left-leaning mayors, in particular, played an undeniable role in affecting these variable outcomes. But while my findings suggest that the presence of left-leaning mayors was crucial during an initial period known as municipalization, I find that by themselves, left-leaning mayors were insufficient for equalizing expansions to occur.

Although the exact timing of their rule varies slightly in each city I examine, the political leanings of key mayors during the period known as health sector municipalization was undeniably influential in defining the direction of urban health care reform across urban Brazil after 1989. More specifically, left-leaning and left-center mayors were present in all cases of equalizing expansion in urban Brazil. These key left-

and left-center mayors were Patrus Ananias (1993-96, PT), Dr. Célio de Castro (1997-2000, PSB), and Fernando Pimentel (2001-2008, PT) in Belo Horizonte. In Porto Alegre, they were Tarso Genro (1993-96 and 2001-02, PT), Raul Pont (1997-00, PT), and João Verle (2003-04, PT). In Recife, they were Jarbas de Andrade Vasconcellos (1993-96 and 1986-88, PMDB), João Paulo Lima e Silva (PT, 2001-08), and João da Costa Bezerra Filho (2009-present). In São Paulo, they were Luíza Erundina (1990-92, PT) and Marta Suplicy (2001-04, PT). And in Curitiba, they were Jaime Lerner (1989-93, DEM) and a host of other pragmatist from a variety of parties. Brazilian analysts note that left-leaning mayors in the município of São Paulo were essential in the very decision of município governments (called *prefeituras*) to municipalize the primary public health sector across urban Brazil (Coelho 2008). This process of municipalization involved signing juridical agreements with the federal government that gave prefeituras sole legal responsibility, not only for providing primary health care services, but also for managing existing primary health care facilities and administering the (formerly federal) employees who worked in them. Because it imposed both these new managerial responsibilities with the financial burden of bank-rolling primary care provision, not all mayors in major Brazilian cities were eager to move ahead with municipalization. To be sure, the urban Brazilian prefeituras which performed the worst in delivering primary public health care featured long and relatively sustained rule by right- and center-right mayors, who generally waited as long as possible to initiate municipalization.

But the integration of pragmatist publics into decision-making about state-building and policymaking in the public health sector was also necessary for the largest primary health service expansions to occur. As a social movement with strong foundations in the

medical profession and linkages to left-leaning parties, politics, and democratization efforts, the material relevance of sanitarista ideologies and actors first emerged early as the early 20th century, when Brazilian public health doctors who trained in Europe returned to Brazil. These doctors began working on epidemiological research projects aimed at documenting diseases throughout the country and improving living conditions that caused major public health problems, including malaria, yellow fever, bubonic plague, and smallpox. These efforts were especially concentrated in rapidly urbanizing city centers like Rio de Janeiro and São Paulo. Sanitarista ideologies planted firm roots within Brazilian politics of health during the first decade of the 1900s, when the venerated public health doctor, Oswaldo Cruz, established these efforts as direct of the state-supported Brazilian Sorotropic Institute, which would later become Brazil's National Public Health School (ENSP-Fiocruz) and bear Cruz's name. A main doctrine of sanitaristas was to target improvements in basic infrastructure like sewage, sanitation, running water, and improved basic living conditions that would help prevent infectious diseases from spreading throughout urban populations by reducing disease vectors. And while public health doctors associated with the institute also researched, treated symptoms, and developed cures for infectious diseases, Brazilian health historians argue that a defining ideological tenet of sanitaristas throughout the 20th century was a focus on developmental projects that would prevent diseases from spreading (Escorel and Teixeira 2008; Escorel 2008).

During the early 1990s, however, sanitaristas became much more than a social movement with a strong ideological bent on universal health care provision; they also became agents of nationwide political project to enact that ideology, in practice. Re-

democratization opened a space that enabled prominent sanitaristas to align their political project of building new state capacities to expand primary, preventative health care to with the agendas of progressive political parties that increasingly found themselves in local power throughout urban Brazil. Existing studies and my own fieldwork findings document that sanitaristas were highly influential in the national politics of public health during this period (Escorel 2008). Yet, no systematic, cross-city comparative analyses of local state-building in the public health sector exist to adjudicate whether sanitaristas had similar influence in the local politics of health, which became increasingly consequential for actual health service delivery outcomes during the 1990s and 2000s. Indeed, prominent sanitaristas like the venerated public health doctor Sérgio Arouca counted among the framers of the constitution and themselves drafted its passages declaring health to be a universal citizenship right in Brazil. However, commonly overlooked amidst the celebratory emphasis on this undeniable achievement is the fact that Arouca, other sanitaristas, and leftist elements within the nascent Workers Party also lost a key political battle in drafting these passages during the Constitutional Assembly of 1988. In particular, a more sweeping, *etatist* proposal of sanitaristas to establish the nation-state as the exclusive provider of public health services ultimately met with defeat in the assembly. Instead, capitalist actors from various quarters, including the private hospital industry, instead won support for a contrasting proposal that allowed private sector sub-contracting of publicly financed health services.

On many levels, this political defeat was highly consequential for sanitaristas and for the institutional contours of what SUS would become and how it would operated across urban Brazil. Perhaps most fundamentally, it effectively established the private

sector hospital industry as a major provider of health services to the very lower classes, which it had systematically excluded from access during the authoritarian era. Recognizing that the favored and most efficacious avenue for enacting universal public health care – the nation-state as exclusive care provider – had effectively evaporated, sanitaristas attempted to salvage this defeat by targeting the local level as a new terrain of political struggle for their project of building a universal health care system (Jeager 2010). Not surprisingly, however, the levels of membership, organization, ambition, and ultimately the political orientations of sanitaristas toward realizing this shared goal varied widely across the country's most populous municípios. And during the 1990s, as Brazil's most populous municípios assumed full legal responsibility for providing the most basic public health services universally – a task for which they were ill-equipped – the same old ferment of sanitarista activism brewed but with a commitment to the local not previously witnessed in contemporary Brazil.

To be sure, sanitarista attempts to universalize public health care provision generated important reactions from other actors, some of whom opposed to and were outright hostile towards sanitarista proposals, and others of whom were supportive of sanitarista efforts to transform their ideology into tangible state structures, capacities, and policies. These reactions ranged from support for the state-building project among influential leftist political parties in power, to resigned acceptance amongst certain labor unions such as the respective doctors' unions in particular states, to counter-offensives against the project, and even collusive rent-seeking from capitalist quarters. Yet these reactions, too, can also be partly explained by the type of regimes politics at work during the critical juncture period following re-democratization and the concurrent local and

national institutionalization of SUS. Thus, regimes help account for major contrasts in the performance of these municípios in confronting and, in some cases nearly reversing previously engrained patterns of miserly and heavily unequal service provision.

The constitutionally-enshrined right to universal health care both reflected and launched continued social mobilizations for universal health care by *sanitaristas*. Commonly overlooked, however, in many retellings of the contemporary political history of health in Brazil is the fact that the advent of SUS also represented a monumental political defeat for sanitaristas. Though technically called a "singular" health system, SUS is in fact a system that mixes private sector and state provision of publicly-financed health services. The more sweeping, *etatist* proposal of sanitaristas met with defeat when the diverse group of framers who drafted the Brazilian constitution ultimately voted on the passage ironing out the contours of the country's new public health system. Presented by the iconic sanitarista Dr. Sérgio Arouca[2] during the drafting of the constitution in the Constitutional Assembly of 1988, a coalition between sanitarista activists, the Popular Movement for Health (MOS), and radical tendencies within the Workers' Party (PT) instead proposed a popular, proposed amendment that would have made the state the exclusive health care provider in Brazil.

Ultimately, however, representatives from the private sector hospital industry, which the military dictatorship fostered between 1964 and 1985 by outsourcing most of its provision of health services through these entities, defeated the amendment. Wary of the fatal ramifications of a fully *etatist* system for their own existence, the private hospital lobby instead inserted an eleventh-hour provision securing the possibility of sub-contracting of public services to private health care providers, in general, and to the

hospital industry, in particular. To this day, the so-called "integrality" provision of the constitution's Article 198 (Brasil 1988: Article 198) plays a commonly overlooked, but outsized role in shaping the contours of public health care provision in Brazil by institutionalizing the ability of the private sector to siphon away public financing for health care to expensive, high complexity procedures. (Avritzer 2008; Rodriguez and Neto 2003) In short, SUS was the system that sanitaristas could get, not the fully *etatist* system that they wanted.

In response to this landmark political defeat, sanitaristas took their struggle to reform public health care provision to local levels of government and to the municipio-level, in particular. Sanitaristas aimed to realize SUS's principles by taking an active, hands-on role as politicians and bureaucrats in federal and local governments that institutionalized SUS within Brazil's most populous cities. After the creation of SUS in 1990, local governments called *munícipios*[3] assumed chief responsibility for universal provision of the primary, preventative health care services around which prominent health movement activists and state reformers hoped to re-orient the country's public health system. Thus, despite the principle of universal health care, the state-society politics through which state reformers went about enacting the constitutional promise of universal health care varied dramatically across Brazil's most populous cities. While the country-wide trend is one of a general expansion in access to the most basic forms of health care, this expansion was far from uniform across Brazil's most populous cities. These divergent sets of politics would have enduring consequences for long and grossly unequal patterns of access to public health services throughout urban Brazil

Alternative Explanations

The relevance of multi-level governance in the health sector is a prominent alternative explanation of primary service provision that this project takes seriously. According to the federal legislation that created SUS in 1990 (Brazil 1990: 8142, 8080), the public health sector became a "concurrent responsibility" of all three levels of government: the federal, state, and municipal levels. Political scientists such as Celina de Souza note that municipalization in Brazil created substantial ambiguities regarding which level of government is ultimately responsible for providing particular services (1998). To be sure, the public health sector is a prime example of this considerable ambiguity. I take these undeniable, state-level influences into account in several ways. First, the project focuses on a sub-set of the public health services sector – the primary public health care sector – for which these ambiguities are less pronounced than for the public health sector as a whole. Analysts of the Brazilian public health sector and a broad cross-section of my own key informants commonly point out that these ambiguities confound analyses of "who does what" when it comes to the combination of federal, state, and local government employees who jointly provide medium- and high-complexity public health services, typically in hospitals or emergency rooms. Yet they also note that municipalities alone deliver the low-complexity services that are provided in primary health care clinics (Coelho 2010; Escorel 2010). Additionally, Brazil's national health law assigned municípios responsibility for providing health services at the "entry gates" into SUS. Nevertheless, the following chapter examines data demonstrating sustained growth over time in the actual degree of municipalization.

Second, I consider state-level factors by using descriptive statistics to compare primary service provision in the three municípios examined most deeply in this study, as well as on the two encompassing levels – metro region and state-level – in which these municípios reside. I also find that the proportion of all municipal spending on primary public health care that originated from the state-level was relatively constant across cases. If the hypothesis was correct that state financing plays a game-changing role in primary health care delivery – namely, that states finance capital city municípios in some such municípios far more than in others – then this proportion should vary widely and should be higher for municípios with greater coverage rates. Although some states like Belo Horizonte's encompassing state of Minas Gerais funded municípios to a far greater extent than both Rio de Janeiro's home state of Rio de Janeiro and Porto Alegre's home state of Rio Grande do Sul, state funding to the three capital city municípios I examine in the study was far more constant and quite low for most years considered, suggesting that other factors are likely at work. None of this is to say, however, that state-level factors have not played a key role in the timing and onset of municipalization because they have.

Third, I examine relevant agreements between municipalities and both state- and federal government and find that in all three municípios, such agreements shared a common feature: in both absolute and proportional terms, they tended to prioritize municípios aside from the capital city municípios that I examine in this study. In the state of Rio Grande do Sul, particularly during the period of PT rule between 1998 and 2002, state support of municipally-provided public health care targeted largely rural areas far beyond the município of Porto Alegre and its encompassing metro area. In Rio de

Janeiro, state government was similarly limited in its support of primary public health care provision by the município of Rio de Janeiro.

In the state of Minas Gerais, a major program called Saúde em Casa and a related program that promoted the construction of primary care clinics across the state largely targeted a mixture of support for rural municípios and some of the municípios that comprise the metropolitan region but had little effect on the município of Belo Horizonte. My knowledge of this project and analysis of its contributions to the municipal health secretariat's financial statements for 2006, 2007, 2008, and 2009 found that contributions by this state program only began in 2006 and never contributed more than $5.8 million reais (in 2009) per year to basic attention, an amount which represents only about 5% of its $114 million real budget. However, none of this minimizes the fact that Belo Horizonte has been a major beneficiary of physical capital, especially during municipalization in 1992, when it received dozens of basic health clinics from the state. Nevertheless, I find little evidence of sizeable differences across Belo Horizonte, Porto Alegre, and Rio de Janeiro in the relative weight of their encompassing states' financing of primary public health care in these particular capital city municípios. In the concluding paragraph of this dissertation, I offer some additional implications for other alternative explanations that arise from literature in the sociology of development.

Research Design

Based on the sub-national comparative method outlined in Snyder (2001), the methodology of the project is to develop a structured, focused comparison of three case studies in which the central outcome to be explored is the post-1988 transformation of state capacity to deliver primary health care services to the SUS-using residents of

Brazil's largest capital city municípios. The main analytical method to be used is process-tracing (Bennett and George 2005) of the rise of such state capacities in some of these municípios and not others.

Unit of Analysis

The unit of analysis in the study is the Brazilian município. The município is a level of government in Brazil, which has no exact correlate within the United States' system of local government. The closest analog would be if city and county governments in the U.S were fused into one entity. In this proposal I use "município" in contrast to "city," which I instead use to refer to the encompassing metropolitan regions of which each município in the study is but one component. I avoid translating município into "municipality" not just because many Brazilian scholars tend to avoid doing so but also because this may confuse municípios with the sorts of city governments that one finds in countries other than Brazil when, in fact, municípios often possess something like the combined territorial jurisdictions of a U.S. city and a county.

Municípios are a relevant unit of analysis because their governments, which are called *prefeituras* or City Halls, hold sole responsibility for implementing primary care provision within their borders. Although even epidemiologists recognize the importance of politics to health service provision in Brazil, these analysts often glaze over local, município politics. We are told somewhat monolithically that "the resounding success of primary health care in Brazil is the result of the 1988 constitution, which made access to it a universal right." (Kepp 2008: 877) In practice, however, the municipal state hires and oversees the teams of doctors, nurses, and health professionals that are tasked with providing these and other services to the vast majority of citizens. And actual service

provision within cities is highly uneven because it relies on state capacities for service provision that were constructed to varying degrees during the period of recent Brazilian history known as municipalization. Studying município*s* has the benefit of isolating how one complex of political institutions – the *prefeitura*, and the *prefeitura*'a health secretariat – have or have not built the capacities required to meet constitutional requirements, federal and sometimes also legal demands for service expansion.

I have avoided selecting the overall metro areas of these município*s* because several município*s* compose such overall metro areas. Selecting metro areas complicates analysis because multiple município*s* drive expansions in service provision in some areas of the metro area and contractions in others. There is no government entity that holds sole responsibility for the entire metro areas of Brazil's largest cities and often intra-metro differences in service provision are also tied to differences in the state capacities of município*s*. Because these differences in state capacity are not well understood by scholars and because a study of cross-metro area variation would require studying multiple município*s* within the same metro area, selecting multiple large metro areas as the unit of analysis for a largely qualitative study of state capacity is analytically too unwieldy and not feasible practically. And examining município*s* still allows one to examine hypotheses about the state-society relations, which factor into public service provision on an administrative level that matters the most to citizens in search of the realized right to primary health care.

Case Selection

I selected three cases for in-depth examination in the project – the município*s* of Belo Horizonte, Rio de Janeiro, and Porto Alegre – and conducted more limited

fieldwork in the municípios of Recife, São Paulo, and Fortaleza. The central challenge I faced in arriving upon these selections was to balance the following three criteria: 1) the practical need to select a sufficiently small number of cases for a process tracing exercise that examines the origins of expanded state capacity to provide primary health services; 2) the inferential need to select case that permit a generalizable explanation of service expansion; and 3) the need for theoretically interesting cases, namely those whose comparisons to one another permit a consideration of the contributions and limitations of the two-sphere model of development.

To begin selecting a manageable number of theoretically interesting cases, I first identified a sample frame of possible cases that included all large (over 1 million person) capital city municípios in Brazil. I excluded Brasilia because in addition to not being a state capital its status as the federal capital involves a politics of município-federal government relations that are of a qualitatively different nature than those between large state capitals and the federal government. Because Brazil's federal health ministry allocates SUS resources to municípios based on their overall populations, the municípios of large capital cities tend to attract disproportionately greater total amounts of federal funds for primary health care than other, less populous municípios, even those within the same metro region. For example, because their populations hovered just above 1 million residents in 2009, Guarulhos and Campinhas (the second and third largest municípios within the encompassing metro area of Brazil's true mega-city, São Paulo) attracted far fewer resources than the município of São Paulo, who population was over 11 million. Further, large capital city municípios are in a league of their own, in terms of total

population; Campinas and Guarulhos are the only two non-capital city municípios having IBGE-estimated populations over 1 million residents in 2009.

This makes large capital city municípios particularly interesting cases for students of changing urban service inequalities since they permit an examination of how well municípios with relatively sizeable amounts of SUS funds have transformed this funding into services and infrastructure. (Naturally, the flip side of this reality is that they are also faced with addressing comparatively larger populations.) Ultimately, the similar population sizes of large capital city municípios make them more relevant to compare to one another than to non-capital cities because this comparison provides a modicum of control over a common but generally unsatisfying alternative explanation of variation in service provision: sheer budgetary resources at the disposal of a municipal government. The cases selected for the project provide the benefit of having similar amounts of federal SUS funds, due to their similar population sizes.

I then selected cases from this sample frame that maximized the range of observable variation in the 1988 to 2010 change in the appointment rate I discussed above. I am interested in explaining cases that met or exceeded the WHO's appointment rate threshold of 2.0 because these cases indicate to me a município that has effectively built state capacities to broadly provide primary health care, comparatively speaking. This indicates a downward penetration into society via new delivery mechanisms such as physical infrastructure and trained health professionals who provide actual primary care services. Five possible cases meet these criteria: Curitiba, Porto Alegre, Belo Horizonte, Recife, and São Paulo. Partly for reasons related the problems of scale I discussed above, I excluded São Paulo from focused examination in the project because it is clearly in a

league of its own, in terms of the demands placed on its City Hall by a more than 11 million person population, over 6 million of whom relied exclusively on SUS throughout the 2000s.

These considerations led me to the conclusion that Porto Alegre, Belo Horizonte, and Rio de Janeiro best fit my desired comparative structure of municípios with comparable population sizes, the same political status as capitals within their respective states, and comparable service demands but different outcomes in terms of primary service provision. Most importantly, the central criteria observed in selection the cases was the maximization of variation on observations of the dependent variable of the study, changes between 1988 and 2010 in the primary appointment rate. This selection captures nearly the full range of observed variation among large Brazilian cities with Belo Horizonte capturing the country's top-performing município, Rio de Janeiro representing the most under-performing municípios in the country, and Porto Alegre offering a surprising case of service expansion just above the median. In the following chapter, I examine the relationship between Belo Horizonte's pragmatist regime, its impressive record of primary care provision, and the intervening mechanism of state-building in the public health sector that connects this ultimate outcome and process.

The Analysis to Come

Chapter 2 both provides essential background on the Sanitary Movement, the institutional architecture of SUS, while also introducing central theoretical debates about the nature of civil society and its potential for influencing state politics. It draws particularly on Jeffrey Alexander's theory of civil society (2006) for key building blocks for the conceptual framework I construct in the following chapter.

Chapter 3 develops this conceptual framework for distinguishing state-society regimes of politics from one another and hypothesize their effects on local state-building and ultimately primary health care delivery. The chapter develops three conceptual foundations of state-society regimes: types of social actors who embed themselves within key state structures, these actors' modes of engaging the local state, and the range of political parties that actively condition these engagements. Highlighting how various configurations of these foundational concepts ultimately constitute "pragmatist," "participatory," and "clientelist" regimes, the chapter introduces an analytical framework for analyzing how these regime types affect local state-building and ultimately service provision in the primary public health sector.

Chapter 4 defines the central outcome of this project as post-1988 transformation in the local state capacity of large, capital-city municípios to deliver primary health care services to historically poor and excluded citizens. The chapter measures this concept using the outcome of changes over time in municipal state provision of primary health care using a measure called the primary appointment rate. The appointment rate is a ratio of the total number of primary public health services provided by the município to the total number of exclusive SUS users in the município. But although the primary appointment rate constitutes the central outcome under investigation in this project, it is an outcome that is indelibly linked to at least three intermediate outcomes, including the municipally-employed or contracted health care professionals who provide primary care, the clinics in which they provide these services, and an array of technical planning capacities that municipal governments require to allocate clinics and health professionals

toward pressing epidemiological risks that vary widely across regions within the same município.

Chapter 5 offers an analysis of the local politics of universal health care provision in the 2.5 million-person município of Belo Horizonte. First, the chapter acknowledges key elements of the state-level context that were propitious for early municipalization of the health sector and a relatively longstanding, synergistic set of state-society ties in the sector that pre-date re-democratization. Then, using quantitative data and spatial mapping, the chapter sets the stage for examining major transformations in the município's public health state after 1993 by describing the defining context that state reformers faced upon taking power of the local state in 1993: an entrenched, center-periphery pattern of spatial inequality in which residents of Belo Horizonte's peripheral city regions faced disproportionately larger health risks than residents in central city regions. Next, the chapter conceptualizes the proximate cause of these equalizing expansions in the município after 1993: the construction of what I conceptualize as Belo Horizonte's health developmental state or "healthy state," for short, the defining features of which were increased numbers of risk-targeted basic health clinics and municipal health professionals in peripheral city regions. Then, drawing on my in-depth interviews with key informants and archival documents from two newspapers, and minutes of Municipal Health Council minutes, the chapter argues that the ultimate driver, not only of Belo Horizonte's equalizing expansions but also of the healthy state that executed them was the city's "pragmatist regime" of state-society politics in the public health sector. I argue that what Belo Horizonte's "pragmatist" regime composed of a pragmatist public from the Sanitarista Movement, several organized labor unions, and multiple state

reformers together advanced sanitarista ideals by constructing a health developmental state composed of the three state capacities outlined in the previous chapter.

Chapter 6 analyzes the intermediate case of an unconsolidated healthy state and modest service expansions in Porto Alegre's 1.5 million município. I first show that Porto Alegre experienced comparatively modest expansion in its basic public health care provision during the 2000s. I trace this outcome to the ways in which interactions between state-level government and a participatory regime on the municipal level in Porto Alegre during the 1990s and early 2000s ultimately limited expansion of public employment for primary public health care delivery. While no other large Brazilian município built more primary care clinics during this era, the participatory public that advanced these capital improvements simultaneously encountered few levers of control over the expansion of public employment.

Chapter 7 examines the negative case of minimal primary public health care expansion and an obstructed health developmental state in the over 6 million person município of Rio de Janeiro. The clientelist regime reached its apogee in 2005, when public exposure of massive corruption and underperformance in the city's administration of hospitals led the federal Health Ministry to completely take over management of hospitals and many clinics, an arrangement which remained in place until recently. Before this period, data show that Rio constructed few primary health care clinics and hired few dedicated primary health workers to work in the network of clinics they did manage. Ultimately, these deficits vis-à-vis other cities like Belo Horizonte and Porto Alegre owe much to path-dependent legacies of pre-1988 health policy in Brazil, which

fostered a bloated and highly inefficient private hospital industry that effectively preserved its clientelist ties with Rio's government well into the mid-2000s.

Chapter 8 concludes by re-visiting key theories of development and the role of civil societies in promoting developmental processes in the global South. I offer a brief discussion of how the findings of the study defy alternative explanations from this and other literatures, while also offering complementary insights. Next, I turn to the institutional architecture of SUS, the recent history of the sanitarista movement, and their implications for our understanding of primary health care provision across urban Brazil since re-democratization.

Notes:

[1] In effectively mediating then-ubiquitous neoliberal pressures to instead shrink social policy, the success of these efforts to create a universal health care system contrasts sharply with usual patterns across the global South (and in far wealthier countries of the global North like the United States).

[2] Arouca, a public health doctor well-known across Brazilian health politics, played a decisive role in integrating civil society input into the re-designing of the Brazilian public health system. Among his other roles, he served as President Sarney's Minister of Health as Brazil made its transition to democracy between 1985 and 1990. In this capacity, he helped organize and make the Eighth National Health Conference a dialogue between state actors and civil society about the intended contours of the new federal health bureaucracy that he would replace the erstwhile, authoritarian-era system he helped extinguish. Cordeiro (2004) provides a useful many roles in the changing health system during this era.

[3] The *município* is a level of government in Brazil, which has no exact correlate within the United States' system of local government. The closest analog would be if city and county governments in the U.S were fused into one entity. Throughout this dissertation, I use "*município*" in contrast to "city," which I instead use to refer to the encompassing metropolitan regions of which each *município* in the study is but one component. I avoid translating *município* into "municipality" because doing so risks confusing *municípios* with the sorts of city governments that one finds in countries other than Brazil.

CHAPTER 2.

BACKGROUND AND THEORETICAL PERSPECTIVES ON THE SANITARISTA MOVEMENT AND BRAZIL'S UNITARY HEALTH SYSTEM (SUS)

Explanations of variation in primary public health care expansion across large Brazilian cities[1] – and their relevance for authoritative sociological theories of development – cannot be fully articulated without first highlighting key features of the historical and institutional contexts in which health care reform arose and evolved on national and state levels. The first portion of this chapter describes key moment in this history and provides background on Brazil's Unitary Health System (the *Sistema Único de Saúde, SUS),* its main principles and bureaucratic structures, and the state-society politics through which civil society actors from the Sanitary Movement (*Movimento Sanitário*) and key political society figures institutionalized SUS as a system of multi-level governance. The second portion begins to situate SUS within existing sociological theories of civil society and state-society relations, first by calling attention to fundamental discontinuities it exhibits with currently dominant Habermasian frameworks, and then by highlighting continuities between what Jeffrey Alexander calls the "regulative institutions of civil society" and SUS as an institutionalized social movement ideology of health as a universal right. In demonstrating how sanitaristas played decisive roles in the nation-state politics of institutionalizing SUS nationally, the chapter also lays the analytical groundwork for coming empirical chapters, which

similarly show that the locally variable integration of sanitaristas into state-society regimes of politics on state and municipal levels was similarly consequential for the institionalization of SUS principles to different extents in different cities.

Despite what the name "Unitary Health System" might suggest, the SUS is far from one, uniform public health care system with a consistent, nationally-homogenous, on-the-ground presence across the country, or even across urban Brazil. In this chapter, I begin by examining how national and state level politics of public health led a SUS that – as a system of multi-level governance through which federal, state, and local governments share concurrent, often overlapping responsibilities for guaranteeing universal access to a wide range of public health services – exhibits a byzantine institutional architecture, which itself varies quite dramatically across the otherwise quite similar capital city municípios examined in later chapters. In part, this is because SUS has proven to be quite malleable by political and civil society actors, which themselves have varied widely across both time and the spaces of Brazil's largest capital city municípios. Precisely because SUS has operated and continues to operate as a multi-level governance institution, the actors who molded the local institutionalization of SUS in a given capital city município typically hail from multiple, overlapping levels of national, state, and local politics. The malleability of SUS by localized actors and institutional legacies meant that município-specific institutionalization processes would be deeply molded by particular configurations of state, social movement, and capitalist actors, who animated the three (municipal-, state-, and national-) levels of state-society politics that converge in any given município.[2]

While the central argument of this dissertation is fundamentally one about local politics, state and federal levels of state-society politics molded these local processes in ways that cannot be discounted. In particular, politics of provincial state and the nation-state, which evolved from a bureaucratic authoritarian state into a federal nation-state predicated on representative democracy state during the mid 1980s, also molded the general institutional structure that SUS took within large, capital municípios in undeniable ways. Amidst these shifts, the transformation of a universal public health care ideology into state programs for advancing it across urban Brazil can be examined by tracing the evolution of both key institutional structures of the national public health state, as well as interventions by political society and civil society actors to transform these structures in the image of that ideology. In particular, this chapter argues that sanitarista activists were not just formidable players in the politics of public health that played out within municipal government; they also played key roles within state and federal- level politics of creating a national public health state. I pay particular attention to relations between political society actors and the sanitarista activists, who constituted the principle advocate, midwife, and architect of Brazil's institutions for realizing the ideology of universal public health care.

Sanitaristas and National Health Provision before the Unitary Health System (SUS)

Struggles for public health have a long history in modern Brazil, dating at least to the late 1800s. During nearly all of these struggles, public health professionals and other, non-professional activists for the sanitary living conditions that promote health have played important roles, even during periods that well pre-date the crystallization of the movement into the set of ideologically coherent and highly organized political actors that

became a formidable political force during the 1980s. To be sure, health professionals and their unions (and clandestine pre-union structures before them) were prominent players in struggles for re-democratization and universal health care during the 1970s and 80s. In the simplest formulation, Brazil's Sanitary Movement was (and is) fundamentally a movement of health professionals and actors connected to the health sector, who shared a social medicine approach to health problems and sought through its political practices, ideologies, and theories to transform the health sector and improve health conditions and health assistance through the realization of citizenship rights. As the movement developed into a tightly articulated political force toward the end of the 1970s, it was primarily constituted by members of the student movement, particularly medical school residents, as well as academics, researchers, intellectuals, teachers, and writers associated with the Brazilian Center for Health Studies (CEBES). Yet, well before it achieved anything like this kind of organization, a certain orientation of Brazilian public health professionals toward participating in the politics of public health care is evident in key figures and institutions dating to the 19th century.

Sanitaristas and National Public Health during the End of the Old Republic

An early, landmark moment in the pre-history of the Sanitary Movement was the creation of the Federal Sorotropic Institute (*Instituto Soroterápico Federal*) in 1900 by the Brazilian Republic. In 1889, following its transition from a monarchical empire to a republic, the Brazilian state became increasingly active in controlling the spread of infectious diseases such as bubonic plague throughout Rio de Janeiro, then the national capital. Based in the capital, the institute would later be re-named the Oswaldo Cruz Institute (*Instituto Oswaldo Cruz*) for the pioneering doctor who became its second

director (after Barão de Pedro Affonso), following the end of Cruz's term in 1903 as Health Services Director of the Republic. Although the primary purpose of the institute during this era was its creation of serums, vaccinations, and research on the many public health problems then plaguing urban and rural regions of the country, the institute was then and is now marked by considerable prestige within the political establishment of the country – and to a certain extent, internationally as well, as its studies have filtered through international public health circles. Cruz played a major role in personally attracting to the institute a cadre of public health professionals, some doctor trained internationally in Europe, who were themselves steeped in a problem-solving ethos around addressing public health issues throughout the country (Escorel and Teixeira 2008: 333-342; Hochman 1998).

This prestige and the critical mass of public health professionals that Cruz himself gathered through the institute played no small part in catalyzing bureaucratic structures of an incipient public health state, as well as seminal civil society organizations that agitated for the expansion of basic health care provision and the improvement of living conditions to prevent disease epidemics such as bubonic plague and yellow fever, particularly in urban areas but increasingly in rural areas, as well. In 1918, some of the public health intellectuals associated with the Sorotropic Institute and led by the institute scientist, Belisário Penna, formed the Pro-Sanitation League (*Liga Pró-Saneamento*), an early civil society organization that agitated for a coordinated national policy of state interventions to address public health problems and less than sanitary living conditions throughout the country's vast rural regions (Escorel and Teixeira 2008: 353). In 1919, Pro-Sanitation League activists led by Penna recruited other prominent scientific researchers,

intellectuals, military officers, writers, and even the President of the Republic from 1914 to 1918, Wenceslau Brás, in successfully agitating the Republic to establish its first truly consolidated bureaucratic state agency for systematically addressing public health on a national scale, the National Department of Public Health (*Departamento Nacional de Saúde Pública*, *DNSP*) (Escorel and Teixeira 2008: 333-342).[3] The DNSP and the expanded national role it would mean in addressing basic living conditions throughout the country was a highly controversial proposition, especially for traditional oligarchs in states like São Paulo, Minas Gerais, and Rio de Janeiro, who stood to lose some of their considerable autonomy from national government that they had accumulated during the country's Old Republic between about 1870 and 1930. Yet disease outbreaks had become so widespread and problematic for these traditional oligarchs' agricultural fortunes – and for the problem of maintaining laborers with a minimal level of human functioning – that Pro-Sanitation league activists proved successful in persuading them to accept DNSP interventions (Nunes 2000).

The Lasting Legacy of Vargas-era Health Institutions

As with many elements of Brazilian contemporary history (Skidmore 2010), the presidency of Getúlio Vargas's New State (*Estado Novo*) regime between 1930 and 1945 proved to be a fateful period for health politics and the institutional architecture of health policy, which witnessed a gradual weakening of state and especially municipal states alongside a dramatic increase in national power. Though largely a function of perhaps more overarching political strategies of Vargas's populist dictatorship, it can also be argued that the politics of national health policy during the regime witnessed a general pattern (although with exceptions) of decline in the influence of sanitaristas, at least

relative to the pre-Vargas era at the close of the Old Republic. In several fundamental ways, more encompassing processes of political centralization that defined the Vargas era proved consequential, not only for the institutional architecture of national health institutions at the time, but also for vestiges of them and analogs that endured well into the contemporary period.

One way in which Vargas era reforms lingered into the re-democratization period was institutionalizing public health provision, which defined the public that would be entitled to services as formal sectors workers. This arrangement remained in place, though in different forms, until the beginning of re-democratization and the crystallization of SUS in 1990. This arrangement arose from the Vargas regime's active intervention not only in the national economy but also in social service sectors including the health sector. In general terms, these interventions included crystallizing labor laws (CLT) still in place today, constructing corporatist institutions for wage bargaining, and generally expanding the reach of social security protections on an unprecedented scale in Brazil. Yet, Vargas created separate labor unions according to profession and instituted profession-specific pension institutes (*Institutos de Aposentadoria e Pensões, IAPs*). IAPs effectively reproduced pre-existing inequalities in access to social services by entitling only formal sector workers to access (Escorel and Teixeira 2008: 356-66).

A second, lingering vestige of the Vargas era emerged from his regime's steadfast removal of municipal state power to administer state health facilities in their territory, which became subjected to more centralized forms of control by Vargas' regime and state governments. First, through the so-called Capanema reforms of 1937, Vargas de-emphasized the role of municípios in providing health services by converting the DNSP

into an agency called the National Department of Health and Social-Medical Assistance (DNSAMS) and subsuming it within the more encompassing Ministry of Education and Health (MES). In effect demoting the DNSAMS and many of the influential health professionals who administered allowed Vargas to instead pursue an end to all municipal provision of services by assigning service provision responsibilities to state governments and installing national administrators within state governments to execute the policy themselves (Escorel and Teixeira 2008: 361-63).

A third legacy of the Vargas era would be the tendency for nationally-provided health care to become predominantly treatment-oriented (as opposed to oriented around prevention) and geared toward controlling specific infectious diseases through increasingly centralized and complicated national bureaucratic structures. With the support of the Rockefeller Foundation, Vargas's regime created the National Yellow Fever Service in 1937, the Northeast Region Malaria Service in 1939, and the National Health Department (DNS) in 1941, whose director administered offices in every region of the country and exerted a strong hand in the work of state governments by appointing officers to high-level posts within them. Also created during this time within the DNS were National Services for Tuberculosis, Yellow Fever, Cancer, Malaria, "Mental Diseases," Sanitary Education, Control of Medicine, Port Health, Biostatistics, and Water and Sewage (Escorel and Teixeira 2008: 363).

Lima, Fonseca, and Hochman (2005) and Escorel and Teixeira (2008) argue that an enduring legacy of the increasing centralization and specialization of the national public health bureaucracy (and in the nation-state more generally) during the Vargas era was a stark separation between public health and preventative medical assistance. Public health

interventions under the command of Vargas's MES was primarily directed toward controlling and eradicating endemic and infectious diseases that threatened the entire national community, rather than those that threatened specific groups. Public medical assistance was individualized and focused predominantly on individuals striken by disease that prevented them from working. The growing chasm between public health and preventative medicine would define Brazil's national public health system into the contemporary period and magnify the Vargas-era movement toward organizing medical assistance for individuals through private market transactions while limiting public health interventions to nationwide epidemiological threats.

Perhaps the most enduring institutional legacy of Brazil's bureaucratic authoritarian regime for the future institutional architecture of the public health sector was its growing reliance on the outsourcing of public health service provision to the private hospital industry and its associated capitalist entities, particularly the private health insurance industry. As part of a larger pattern of subsidizing private industries (Evans 1979), the military regime heavily subsidized and extended large lines of national credit to the hospital industry in an effort to expand the reach of curative health care. Yet this resulted in an engorged private sector hospital industry that provided 73% of all hospital beds in the country by the mid 1970s, compared to only 14% in 1960 (Lobato and Burlandi 2000). Further worsening the situation, the regime created a state-run company (*autarquia*) called the National Institute of Medical Assistance of Social Welfare (*Ministério da Previdência e Assistência Social, INAMPS*) to operate this arrangement under the umbrella of the encompassing Ministry of Social Welfare and Assistance (*Ministério da Previdência e Assistência Social, MPAS*). Serving as a major

tool of political patronage between the authoritarian regime and the private sector health industry, INAMPS adopted a fee-for-service model that proved highly prone to billing abuses, massive overarching, and a general pattern of hospitals responding to the perverse incentive that INAMPS created for billing more of the lucrative, highly complex services that it reimbursed most handsomely. By 1974, MPAS had the second largest budget in the government, behind only the Union itself (Escorel and Teixeira 2008: 402). With a large national budget for funding hospital procedures, privately administered emergency rooms proliferated in large urban areas of the country's wealthiest Southern and Southeastern regions, including São Paulo, Rio de Janeiro, Porto Alegre, and Belo Horizonte. Owing to a general lack of oversight by INAMPS, these emergency rooms and private hospitals took full advantage of its guaranteed service buyer by dramatically increased billing for lucrative, high-complexity and emergency procedures.

Sanitarista Counter-movement and their Interrupted Policy Impact after 1964

Before the military coup of 1964, sanitarista critiques of the country's centralized, inefficient, costly, and highly unequal national health policy led to corresponding proposals that entered into circulation within the Ministry of Health. In 1962, the ministry's director Souto Maior delivered a groundbreaking presentation at the XV Higene Congress in Recife that emphasized the vicious cycle between poverty and poor health, presented a more broader view of what should constitute state health assistance, and offered proposals for consolidating a new sanitary policy that would focus on decentralizing responsibility for their provision to municipalities. These and other proposals continued to be discussed at the Third National Health Conference a year later in Rio de Janeiro, which served as an administrative meeting in which a central topic of

debate was developing a strategy for municipalization that would solidify a new model of public health service coverage that would emphasize basic attention provided by nurses and other health professionals. According to Fadul 1978 (cited in Escorel and Teixeira 2008: 381) 2100 of the country's 3,677 municípios in 1963 lacked any health service facilities whatsoever. The conference aimed to address this by marshalling national government resources to assistant every Brazilian municípios in creating basic services. But as with progressive civil society movements beyond the health sector, the military coup nipped these proposals in the bud, before they could be enacted. Indeed, it was not until the restoration of democracy during the 1980s that these proposals would again gain purchase and win support on the national level.

Even so, between the end of the 1960s and the beginning of the 1970s, during the most vigorously repressive period of the authoritarian regime in Brazil, the Sanitary Movement's critique of these and other major problems with the country's health system began to crystallize into a more consolidated ideology of social medicine that emphasized the universal right to primary, preventative, and holistic health services. As we will come to below, scholars argue that the movement did not develop into an articulated movement with an overarching political ideology until the late 1970s (Escorel 2008). Yet, key texts of sanitarista during the 1960s – particularly Sergio Arouca's *The Preventionist Dilemma: Contribution to the Comprehension of Preventative Medicine* (2003) and Cecília Donnangelo's *Medicine and Society: The Doctor and his Labor Market* – offered key statements of the philosophy of social medicine that suffused the ideology later crystallized by the movement (Paim 1981). More importantly at the time, sanitaristas began successfully altering the pedagogy of the country's major medical schools and

linking the philosophy to larger, then underground resistance struggles for a broader set of democratic citizenship rights. The construction of its ideology throughout the 1960s also owed much to the diffusion into Brazil of ideas surrounding holistic, preventative care then circulating widely throughout medical and public health communities in the United States. Also important was the role of the Pan American Health Organization (OPAS) in applying social science approaches to analyzing the ways in which national and local governments were involved in providing health care to certain populations while excluding others in more precarious social situations.

Yet key scholars of (and actors in) the Sanitary Movement (Escorel 2008: 394) demonstrate how sanitaristas in Brazil made these ideas their own by adapting them to better address the unique history of the nation state in defining a quite narrow view of what constituted medical assistance. A key law associated with a major reform of the countries universities in 1968 mandated the creation of Preventative Medicine Departments (DMPs) in all of the country's state-supported medical schools. It was within the DMPs of major university campuses throughout the country that sanitarista ideologies began to coalesce into more articulated formulations and tangible pedagogies of preventative, social medicine and applied experiments for applying them through alternative experiences with service provision in university-supported hospitals and clinics in the city's largest municípios. The defining feature of changes to medical school curricula was the addition of a historical-structural approach to examining the roots of health problems through Marxist, dialectical materialist approaches and class analysis that analyzed how vulnerable classes become ill in the first place. This approach emphasized how economic structures created unequal distributions of disease among

different classes. Until 1970, community medicine programs within the medical schools remained connected to the DMPs, with which they organized field practice for the training of medical interns and residents, who sought to favor alternative visions of medicine that eschewed hospitals and favored holistic medicine. Many alumni from the medical schools of Belo Horizonte's Federal University of Minas Gerais (UFMG) and Porto Alegre's Federal University of Rio Grande do Sul (UFRS) described their training and experiences in community medicine programs based on these curricula as a defining important moment in their politicization around struggles for universal health care and democratic rights.

If medical school students, interns, and residents constituted a first foundational social pillar of the movement, two other groups constituted similarly fundamental bases: activists in the student movement and associated with the Brazilian Center for Health Studies (CEBES); and a relatively broad group of professional academics. A second social base of the movement included a sub-set of the student movement that was associated with CEBES and began in 1974 to organize debates around themes of community medicine called Study Weeks on Community Medicine (SESAC). Especially concerned with deepening theories of preventative medicine, these students stated the purpose of SESAC as convening students, teachers, and professionals to debate the social, economic, and political determinants of health structures as well as community health practices in development. Among other important developments, a key tenet of Sanitary Movement ideology – "sanitary consciousness" (*consciência sanitária*) or the concept individual and collective action to achieve health as a right of the person and an interest of the community – also emerged from SESAC, which met weekly through 1979

(Berlinguer 1978 cited in Escorel 2008). The concept of sanitary consciousness crystallized by the student movement ultimately formulated and fused together what ultimately became two key central tenets of the movement: insistence on democratization of the country and opposition to the privatization of the health sector. CEBES served as a major agent in articulating sanitary consciousness with the percolating movement for democratization. It did so primarily through founding and maintaining the journal Health in Debate (Saúde em Debate) to articulate, deepen, and link the social medicine tenets of the mobilization to larger ideological currents in a broad array of social movements and ultimately diffuse these debates throughout academia (Escorel 2008).

This leads to a third major social pillar of the movement: teachers and research scholars, particularly from institutions of higher educations. Scholar/activists in the movement such as Sarah Escorel and Sonya Fleury, a director of CEBES, argue that this pillar was primarily responsible for consolidating the ideology of the movement, reproducing and building knowledge, and producing agents through the creation of courses and curricula throughout university across the country. Training of human resources in the health sector was a critical role played by these agents through the decentralization of regionalized training of sanitaristas, the initiation of institutionalized transformations within universities in the curricula and training of residents in social medicine and preventative medicine, and advanced degrees in public health. In the words Escorel, all of these instruments “were important for the consolidation and hegemony of the social medicine proposal in the training of human resources for public health” (2008: 412, my translation). More generally, the inclusion of professionals within the movement no doubt capitalized upon the structural positions of scholars and doctors and nurses in

training, who by virtue of their middle class positions within the occupational structure and a certain amount of prestige (in the case of the academics), remained proximate to the political class whom they hoped to influence with their ideology of health, democracy, and the state as the sole provider of health as intertwined, universal rights of all citizens. Perhaps not surprisingly, the resulting political strategy that emerged from these three bases of students, academics, and theorists with proximity to the political class was one which emphasized the dissemination of its ideology, the production of knowledge, and perhaps most importantly, the orientation toward a Gramscian self-understanding of "occupying the spaces" within the democratic state (Fleury 1997).

With this collection of actors and strategy crystallized, sanitaristas soon began making headway in national health politics. With foot-dragging by the military regime's last president, João Figueiredo, drawing out the process of democratic opening, sanitaristas mimicked other social movements for democratic rights at the time by targeting Congress with their proposals for transforming the national health system. Beginning in 1979 with a broadly publicized public forum in the Lower House of Congress (*Câmara de Deputados*) in which they presented a proposal for a nationalized unitary health care system, professors from CEBES and students from the Brazilian Public Health Graduate Studies Association (ABRASCO) increasingly convened open discussions with elected officials and bureaucrats in which they drew linkages between democracy, municipalization, and health (Fleury 1997). In addition to propagating their ideology in a public, though still comparatively disempowered access of national government, such symposia had the added benefit of creating social connections between sanitaristas and elected officials, who supported the projects they proposed and the larger

project of universalizing access to health care. And even before the return of nominally democratic arrangements in 1985 would allow for a flood of sanitaristas to occupy high-level government posts within INAMPS and later the Health Ministry, a trickle of these activist made their way into key state.

Prime among them was Eleutério Rodriguez Neto, who occupied a post within the Executive Committee of a quasi-participatory council convened by the Figueiredo regime to seek solutions for addressing the increasingly dire straits of the social security system, which was long connected to the country's provision of health services for workers through the bureaucratic agency (MPAS) that housed both programs. Presided over by Aloysio Salles, the Consultative Council of Worker Health Administration (CONASP) was composed of 14 members appointed directly by Figueiredo, as well as representative of 6 agencies, 2 business associations, 2 workers confederations, and a doctor's association (CFM). For the first time during the era, civil society representatives, including sanitaristas, became actively involved in contributing proposals for the redesign of welfare state institutions. More importantly for the future of the health system, sanitaristas like Rodriguez Neto made social connections to Salles and other state officials through the CONASP and these connections proved invaluable when Salles initiated an analogical process for reforming INAMPS and invited a broader array of sanitaristas to participate. By January of 1984, these inroads into federal policymaking began to bear fruit. The ministry's creation of AIS and a similar predecessor to it (PAIS) itself represented the beginning of a path-breaking shift away from both the centralized stranglehold that federal government had on health service provision as well as the narrowly circumscribed entitlement to those services that formal sector workers alone

enjoyed. The AIS constituted perhaps the first, tangible re-orientation of national health policy around cooperation between the three levels of government, decentralization of powers to municípios, and the privileging of health services provision to a broader swath of the population than just formal sector workers.

Sanitaristas and Public Health during Democratic Transition

With the advent of democratic transition period in 1985 new political opportunities emerged for sanitarista activists, who had grown increasingly vocal in their criticism of INAMPS's inefficiencies, exclusivity, and abuses as well as the generally poor state of living and health conditions across Brazil. In 1985, President José Sarney appointed a number of prominent sanitaristas to high-level positions in the federal Health Ministry (MS), including Dr. Sergio Arouca as president of the Oswaldo Cruz Foundation and Dr. Hésio Cordeiro as president of INAMPS, enabling these sanitaristas to infuse the country's public health politics with proposals for the re-organization of the country's public health system. A story too long to fully recount here, the salient point is simply that sanitaristas took an increasingly active role in occupying key politically appointed office, first in the bureaucratic forerunner of SUS – SUDS – and the in SUS itself.

Institutional Architecture of SUS as a System of Multi-Level Governance

The legal foundation for SUS first emerged from Article 196 in the Brazilian Constitution of 1988, which declared state-provided health care to be a universal right of all citizens. Specifically, the Constitution declares that "health is a right of all and a duty of the state, guaranteed through social and economic policies aimed at both the reduction of risks to disease and injury and universal as well as equal access to actions and services

for the promotion, protection, and recuperation [of health]" (Brasil 1988). Yet, as with the Brazilian Constitution, in general, the article required additional legal specifications by the federal government to be put into practice. In 1990, the passage of two National Health Laws (*Leis Orgânicas de Saúde 8142, 8080*, Brasil 1990a, b) created a National Health Fund to be financed through taxation and created a multi-level network of Health Councils that favored the participation of civil society. Article 4 in Section II of Law 8080 declares that: "The conjunction of health actions and services, provided by organs and federal, state, and municipal public institutions of the direct and indirect actions of the mandated functions of Public Power, constitute the Unitary Health System (*Sistema Único de Saúde, SUS*)" (Brasil 1990b: Section II). Through additional language, the law also preserved a space for the private health sector, while solidifying the responsibility of all three levels of the Brazilian state for regulating, financing, and overseeing the provision of health services.

Thus, despite the struggles of activists like the venerable Sanitary Movement activist, Dr. Sérgio Arouca, for an *etatist* system of universal public health care provision, SUS instead became a multi-level governance institution that reserves a space for the private market provision of health services. In this sense, the Constitution's passages regarding universal health care stopped short of realizing the ambitions that framers such as Arouca and other sanitaristas that harbored for a truly unitary system of exclusive service provision by the state. Indeed, proposals floated by Workers Party (PT) activists and sanitaristas for the elimination of private sector health service provision failed to overcome resistance from entrenched interests in the private hospital and health insurance industries,[4] who allied with representatives of key right and right-center political parties

to defeat them during the Constitutional Convention. Thus, while maintaining a space for both a private and public health system in Brazil, and while reserving the right of the state to regulate private sector provision of services by the private hospital and health insurance industries, this constitutional and legal framework nevertheless enshrined key tenets of the ideology that sanitaristas had long espoused and pursued through multiple political outlets, including the clandestine Brazilian Communist Party (*PC do B*), despite brazen repression by the military dictatorship during the 1970s and 1980s.[5]

The National Health Law of 1990 established five main principles and directives that were intended to guide the institutionalization of SUS on all three levels of government across the country: 1) universality of access to all levels of health care; 2) equality in public health care provision; 3) integration between more and less complex levels of care; 4) civil society participation; and 5) political-administrative decentralization. For current purposes, the last of these directs was perhaps most consequential for the primary public health care sector. It emphasized two tenets: first, the decentralization of responsibility for providing services to municipal governments and secondly, hierarchical integration (*hierarquização*) across three levels of attention (high, medium, and low complexity services) and regionalization of the full network of care-providing facilities. Especially relevant for the coming analysis of primary public health care provision is that these early legal efforts to specify how SUS should operate established the entry points into SUS – particularly through basic health care clinics that provide primary, preventative health services – as the principle responsibility of municipal states (*prefeituras*).

Institutional Architecture of SUS

On each level of government, the primary bureaucratic structures of SUS within the state came to reside within the executive branch. These agencies are called health secretariats on both the municipal level (*Secretarias Municipais de Saúde, SMS)* and state-level (*Secretarias Estaduais de Saúde, SES*). The principal bureaucracy on the federal level is the Ministry of Health (*Ministério de Saúde, MS*). Responsibilities among these three levels of government are complex, involving entangled sets of multiple and overlapping jurisdictions, which have themselves changed over time. In general, however, managers (*gestores*) of SUS on these three levels are jointly responsible for four broad categories of action: 1) policy planning and design; 2) financing; 3) regulation of public service providers and private markets; and 4) direct provision of health services. Yet the breakdown of more responsibilities between federal, municipal, and state governments for pursuing such actions has not been consistent across different regions of Brazil or across all time periods since the passage of Law 8080 in 1990. Indeed, a defining quality of SUS as a multi-level governance institution itself was a certain flexibility that lawmakers and activists anticipated would be necessary for a country as territorially large and diverse in terms of public health challenges as Brazil.

Nevertheless, it is possible to offer a few general observations about the breakdown of responsibilities across the federal, state, and municipal levels. In general, the federal Health Ministry is responsible for coordinating the system as a whole on a nationwide basis, especially by developing the participation of states and municípios in SUS and offering them technical assistance and especially financing for service provision and other key actions. As the chief source of all SUS financing, the federal Ministry of Health

(MS) has been and continues to play the leading role in formulating policies, pursuing adherence of other government levels to them, and regulating the private provision of health services. Further confounding this already intricate system of multi-level health governance is the co-existence of SUS as a public health system alongside private sector hospital and health insurance industries – and the responsibility of the federal level for regulating these sectors.

State-level managers of SUS are generally responsible for planning a regionalized, statewide system of cooperation between municípios and for developing technical and financial cooperation between them. Although state governments historically had no clearly defined role within SUS, the MS eventually tasked states with integrating the service provision that occurs within their territory (Noronha et al 2008). One prime example of a state playing such a role would be Belo Horizonte's home state of Minas Gerais, which Alves notes is particularly active in coordinating the service provision of municípios, though it provides comparatively few actual services itself (2012: 15-16). Yet, as coming chapters demonstrate, Belo Horizonte and other capital city municípios tend to enjoy far more autonomy and room for self-determination that nearly all other municípios in a given state, in part because of their ability to supplement federal and state resources with contributions from their own tax bases.

Finally, in theory, the principal responsibility of municípios is management of the system within its territorial bounds through oversight and execution of public service provision as well as the regulation of private health care providers. State and the federal Health Ministry are generally limited to providing public health services themselves on a temporary basis or in specific and justified circumstances. As the coming analysis of SUS

in the município of Rio de Janeiro shows, however, Rio in 2005 was on such example in which the federal Health Ministry (MS) cited massive bureaucratic under-performance and corruption in revoking the prefeitura's responsibilities for providing a broad range of health services. In its place, the MS stepped in and took over several key roles, including the management of the network of hospitals throughout the municípios.

In practice, beyond these general prescriptions for dividing labor in the administration of SUS among the country's three levels of government lay a somewhat haphazard practice of disjointed and un-coordinated actions among them within the territorial space of the large, capital city município. Furthermore, this practiced division of labor has itself varied substantially over time, even within the same município. Coming empirical discussions in later chapters of the municípios of Belo Horizonte, Porto Alegre, and Rio de Janeiro articulate major shifts in the breakdown of responsibility and relationships between the federal, state, and municipal organs of SUS within the territory of these three cases. This analysis shows the major changes over time that occurred in the local organization of SUS *within* each of these cases differed *across* cases. Thus, even across cases that are similarly large, comparatively developed (economically), capital city municípios of the country's generally wealthiest South and Southeastern regions, we observe substantial variation within and across cases in the pace and nature of changes over time in the management of SUS as multi-level governance institution.

Federal Regulation of Public Health Sector Decentralization and Municipalization

Perhaps the primary instrument of the MS for regulating decentralization in the health sector between 1990 and 2006 was the issuance of a series of directives called

Basic Operational Norms (*Normas Operacionais Básicas, NOBs*), later called Operating Norms for Health Assistance (*Normas Operacional da Assistência à Saúde, NOAS*). In 2006, a new directive called the Health Pact (*Pacto pela Saúde*) did away with the systems put in place by all prior NOBs and NOAS and defined a new system aimed at streamlining and narrowing the channels through which the federal government had transferred what one author found was over 80 distinct categories of health financing streams to both state and municípios between 1988 and 2001 (Carvalho 2002). Yet all three sets of directives constitute important guideposts for the project in coming chapters of understanding the historical-structural progression of municipalization in the particular capital city municípios that this project examines. This project examines NOBS, NOAS, and the Health Pact as statements of how, during a given time period, the federal MS sought to decentralize the health sector in varying ways by: 1) providing technical assistance to state and municipal managers of SUS; 2) incentiving (or not) the adoption of particular management models for providing different types of health services; 3) offering (or not) recommendations and support for training of SUS human resources; 4) prescribing (or not) procedures for evaluating of local delivery systems, services and practices; 5) making available (or not) research funding; and 6) and mandating (or not) new bureaucratic procedures for regulating service provision networks (Machado 2002; Noronha 2008 et al).

More fundamentally, NOBs and NOAS generally went about normalizing and coordinating the process of health sector decentralization in three ways. First, the NOBs defined different management duties of federal, state, and municipal levels regarding planning and programming health attention, payment, execution, control, evaluation and

auditing of actions and services provided in the ambit of SUS managers in state and local government. Second, these directives prescribed mechanisms and negotiation spaces through which state, federal, and local SUS managers could resolve disputes. Third, and perhaps most importantly, they crystallized formal responsibilities and financing prerogatives related to the transfer of federal resources, cost, and remuneration of services associated with the different management conditions of states and municípios. In the 1990s, MS issued four NOBs (MS 1991, 1992, 1993, 1996) and another two in 2001 and 2002 (MS 2001, 2002), which by then had themselves adopted a revised name of Operating Norms for Health Assistance (*Normas Operacional da Assistência à Saúde, NOAS*). Perhaps not surprisingly, given the stakes implied by these directives for state and local governments, the process of formulating and implementing each NOB and NOAS was highly contested within the National Health Council (CNS). In these CNS debates, state-level and municipal-level SUS managers fervently resisted some decrees such as NOB 91, which generally preserved Vargas-era legacies of a centralized financing structure for health, while they supported more favorable decrees that delivered them more autonomy such as NOB 93 and especially NOB 96.

Thus, between 1990s and 2006, the formal responsibilities and prescribed conditionalities that federal Health Ministry demanded of cities and states in exchange for receiving SUS funds changed no fewer than five times with the issuance of successive NOBs, NOAS, and the Health Pact in 2006, each of which replaced its predecessor. Noronha et al (2008: 457) and multiple informants point out that these decrees were ephemeral, in nature, and not necessarily adopted in a whole-hearted manner by all SUS managers in anything approaching a uniform way, even across the cases under

investigation in this project. On their face, these frequently changing decrees would not seem like a particularly effective or systematic way for federal government to encourage state and particularly municipal governments to build relevant state capacities for service provision. As fundamentally Weberian institutions that typically thrive upon predictability and routinized sets of procedures for managing service delivery systems, Municipal Health Secretariat officials (including those examined in this study) encounter frequently changing conditionalities attached to federal funding can post what one respondent described as the challenge of hitting a moving targeting. Yet, as later chapters demonstrate, a given município's adoption of some (and not other) of the models of attention suggested by NOBs and NOAS had particularly important longer term relevance for the institutional architecture that SUS came to embody within cities. In particular, the timing and extent to which a given município adopted models of basic attention such as the Family Health Program would prove especially consequential for the extent of primary health service provision that município's achieved between the late 1990s and 2011. Yet the federal financing arrangements spelled out in various NOBs and NOASs would constitute the overarching context within which municipal governments could shift toward providing more basic health services themselves.

Sub-national Variation in the Municipalization of the Health Sector and SUS

In spite of these multiple, though shifting attempts by the federal government to normalize the decentralization of the health sector by regulating how provincial and local states institutionalized SUS local, this process unfolded in a highly uneven manner across urban Brazil after 1990. In part, this was due to delayed, insufficient, and less than systematic decentralization of federal financing. This a pattern, in turn, placed a heavy

premium on urban state-society regimes of politics and the willingness and capacity of key actors within these regimes to pursue municipalization anyway. Table 2.1 (below) delineates some basic differences across cities in the timing and nature of municipalization in the cases examined in coming chapters.

Table 2.1 Process of Municipalization in Three Cases

	Belo Horizonte	Porto Alegre	Rio de Janeiro
Year of Municipalization	1992	1994	1996
Initial Management Status	Full	Partial	Full
How Municipalization Occurred	Joint agreement by sanitaristas serving as state & municipal health secs.	Sanitaristas in município overcome initial resistance of state gov.	Initiated by state level

Yet certain structural constraints on these sub-nationally variable efforts, which themselves emanate from extra-local sources, are undeniable. Prime among them was the fact that well into the 1990s, the distribution of all public health spending throughout Brazil by the three levels of government continued to echo an authoritarian-era pattern in which the federal government accounted for the vast majority of expenditures. Disputes between the national executive and legislative branches of government at the time of the SUS's founding in 1990 eventually left financing to be spelled out in subsequent years. Though largely un-enforced, the passage of Amendment 29 to the Constitution (*Emenda Constitucional 29, EC 29*) in 1990 mandated that states must spend 12% of annual revenues, municipalities 15%, and that the Union must expand its current expenditures by the previous year's GDP growth. Yet, the question of what constitutes healthcare related

expenditures remains a controversial topic today, with states and the federal government arguing for a broad definition that would include projects such as such as expanding basic sanitation. Often, municipalities, heavily burdened with local service provision beyond just the health sector, have pressed for a tighter definition around services. Enforcement of the EC29 currently sits is limbo because of Congressional disputes about whether and how to enforce the mandates.

Thus, change to the former centralized system of health financing was far from immediate as path dependent legacies of the country's most immediately prior health care bureaucracy (INAMPS) – and its primary means of paying for public services by reimbursing private providers – continued to play a role in disarticulating efforts by these cities to effectively municipalize the public health sector. Whereas the federal proportion of all public health expenditures was 75% in 1980 (with states spending 18% and municípios 7%), the federal proportion had decreased only slightly to 72% in 1993, although municípios (18%) had eclipsed states (12%). By 2007, however, the federal share had fallen to about 48% with munícipios accounting for about 28% and states only about 24%. (Ugá and Porto 2008: 489 for 1980; author's calculations using SIOPS 2010 for 2007 figures).

Despite these nationwide patterns, the proportion of spending by the three levels of government in a given territory depends to a great extent on the territory in question. This study focuses neither on the nationwide provision of primary health services, nor on their provision across states, nor on their provision within all Brazilian cities. While other analysts examine the public health care provision across such sweeping geographic areas such as the entire territory of Brazil (McGuire 2010) or state governments (Alves 2012),

this study has a far more modest goal of examining primary public health care provision within Brazil's most populous capital city municípios, which I define as having at least one million residents in 2010.

While state-level supplements and direct contributions to municipal delivery of primary public care (and their capacities to do so) must be taken into account, the table below suggests that they are perhaps more limited in scope than much existing literature argues.

Table 2.2 Per Capita Public Health Expenditures by Levels of Government

State	Year 2007									
	TOTAL	Federal	% of Total	Rank	State	% of Total	Rank	Mun.	% of Total	Rank
MG	372.36	156.12	41.93	11	67.09	18.02	25	149.15	40.06	1
RJ	493.45	232.96	47.21	8	113.17	22.93	20	147.32	29.86	11
RG	394.38	213.13	54.04	1	39.91	10.12	26	141.34	35.84	5
	Year 2000									
	TOTAL	Federal	% of Total	Rank	State	% of Total	Rank	Mun.	% of Total	Rank
MG	155.96	89.06	57.10	15	16.67	10.69	23	50.24	32.21	2
RJ	258.16	183.38	71.03	5	27.7	10.73	22	47.08	18.24	9
RG	201.68	120.02	59.51	14	37.29	18.49	15	44.37	22.00	7
Source: Author's Calculations using IDB (2009)										

In 2007, both Rio Grande do Sul (the encompassing state-level government of Porto Alegre) and Minas Gerais (the state level government Belo Horizonte) ranked last (26th at 10%) and next to last (25th at 18%), respectively, among all Brazilian states in the state government share of all SUS spending within their territories. Rio de Janeiro's proportion of 20% also placed it in the bottom quartile. Although Rio Grande do Sul's investment of nearly 40 reais per capita represents over 27 reais per capita fewer than Minas Gerais's 67 reais per capita, perhaps the more salient point is that the combined spending of the

federal and municipal governments throughout both states account for similarly large proportions of all per capital public health spending in both states (about 82% in Minas Gerais and nearly 90% in Rio Grande do Sul). This proportion was a similarly disproportionate share of all spending (about 77%) in Rio de Janeiro, as well. In 2000, similar patterns prevailed as well with state government accounting for an even small proportion of total spending in all three states (about 89% in both Minas Gerais and Rio de Janeiro and 81% in Rio Grande do Sul).

In sum, state government shares of public health spending within the encompassing states of all three municípios examined in this study were relatively small (never greater than 23% and usually far less) throughout the 2000s. But while the modest increase in state government's proportion of all spending throughout the 2000s in both Minas Gerais and Rio de Janeiro echoed a nationwide trend, Rio Grande do Sul moved in the opposite direction during this period, declining from 18% in 2000 to 10% by 2007. This trend – along with the fact that spending by various levels of government throughout the territory of a state has only limited insights for our understanding of spending by all three levels of government within the territory of a given capital city município – suggests the need for a sharper focus on spending by all three levels within the territory of these municípios.

When we first consider spending by the municípios of Belo Horizonte, Porto Alegre, and Rio de Janeiro, some surprising divergences emerge. In 2010, the most recent year for which systematic expenditure data are available, Belo Horizonte did not spent the most of all three cities on basic attention in per capita terms, as one might expect based on its stronger record of primary care provision. I have chosen to focus here on Rio de Janeiro's 2009 spending of $39.19 reais per capita on basic health (10.56% of all

spending) because it is a far more telling indicator of its performance throughout the 2000s.[6] Indeed, both Rio de Janeiro and Porto Alegre out-spent Belo Horizonte in basic attention during the initial years of the 2000s. Although by the mid 2000s, Belo Horizonte had overtaken Rio in this category, it is notable that in all years examined, Porto Alegre out-spent both of these cities throughout the 2000s.

Table 2.3 Per Capita Municipal Public Health Expenditures

Município	Expenditure Type	2002		2010*	
Belo Horizonte		Amount (reais)	% of Total	Amount (reais)	% of Total
	Total	220.43		679.76	100%
	Admin	86.03	39.03%	241.98	35.60%
	Basic Attention	6.74	3.06%	60.54	8.91%
	Hospital	116.82	52.99%	363.32	53.45%
Porto Alegre					
	Total	353.06		580.35	
	Admin	21.98	6.22%	59.31	10.22%
	Basic Attention	49.23	13.94%	88.83	15.31%
	Hospital	271.67	76.95%	381.46	65.73%
Rio de Janeiro					
	Total	184.73		371.00	
	Admin	78.67	42.59%	4.41	1.19%
	Basic Attention	9.08	4.91%	115.55	31.15%
	Hospital	96.38	52.17%	236.91	63.86%

Source: Author's calculations using SIOPS (2009); * For Rio de Janeiro, I use 2009 data instead of 2010 data in order to provide a more apt representation of its performance throughout all years of the sequence prior to 2010.

Yet this also indicates that financing of human resources is also likely to matter for the performance of SUS more generally.

Sanitaristas, SUS, and State-Society Relations in Theoretical Perspective

How are we to conceptualize the state-society relations conditioning this evolution over time in the municipal health sector? Such relations constitute a central topic of

inquiry for social scientists of politics in Latin America and beyond (Baiocchi 2003; Collier and Collier 1993; Mahoney 2001; Migdal 2001). In invoking the concept of state-society regimes, I address a tradition of social science thought that theorizes the state, not as a monolithic or fixed entity, but as a nexus of power relations between the politicians and bureaucrats who compose state institutions and the social actors who manage to embed themselves within those institutions. Following recent scholarship in this tradition, which addresses how non-state, non-market actors factor into such relations (Avritzer 2002, 2009; Baiocchi 2005; Baiocchi, Heller, and Silva 2011), I examine the variable roles that a third, theoretically-distinct group of civil society actors plays in constituting and affecting the actions of local state-society regimes.

Building upon foundational accounts, which emphasize baseline features that all civil societies share, I contrastingly highlight a plurality of civil societies, whose political projects and forms of engagement with state actors and institutions not only differ from one another in decisive ways, but also differentiate the capacities of certain civil societies to advance their ideologies from within such regimes. This section sets-up this work in two main steps. First, I point to tensions that arise when attempting to reconcile such empirical realities with dominant conceptualizations of state-society regimes. Secondly, I highlight several theoretical insights and questions for further elaboration that recent efforts to "bring civil society in" to the study of such regimes ultimately raises for scholars of politics

Existing literature on national political regimes and local state-society regimes usefully ground accounts of how local regimes of civil society-led politics affected state-building and policy outcomes in the public health sector of contemporary urban Brazil.

Yet because authoritative frameworks of state-society regimes tend to highlight three actors – capital, labor, and state actors – they constitute a starting point for exploring additional questions surrounding the involvement of civil societies. Whether due to civil societies playing marginal historical roles within such regimes or owing to analysts' focus on material dimensions of politics traditionally considered to be the exclusive purview of politicians and market actors, civil society actors are largely absent in canonical studies of capitalist development and democratization (Rueschemeyer, Stephens, and Stephens 1992), developmental states (Chibber 2003; Evans 1995; Kohli 2004), and the politics of organized labor (Silver 2003). A similar observation can be made for path-breaking works in both the urban sociology of the United States. Highlighting how actors from the real estate industry maximize exchange values of public spaces, the growth machines literature on American cities persuasively demonstrates how capitalist actors routinely dominate urban regimes in ways that dramatic shrink the possible use values that such urban spaces otherwise permit (Logan and Molotch 1987). Taken together, these accounts helpfully provide a conceptual foundation for examining state-society regimes by emphasizing how capital accumulation and the quest to accumulate access to coercive state power constitute two defining logics of politics within such regimes.

Beyond general agreements that state-society relations mold state action and define the capacity of states to purposefully advance capitalist development (Chibber 2003; Evans 1995; Kohli), scholars adopt diverse theoretical traditions in conceptualizing the particular qualities of such power relationships and the specific social actors that they are thought to encompass. For example, Joel Migdal re-configures a key Bourdeuvian

concept in defining the state as: “a field of power market by the use and threat of violence and shaped by (1) the image of a coherent, controlling organization in a territory, which is a representation of the people bounded by that territory, and (2) the actual practices of its multiple parts (2001: 16). Gianpaolo Baiocchi, Patrick Heller, and Marcelo Kunrath Silva invoke the same tradition in developing a distinct relational framework of different types of state-society relations (2011). In adopting the contrasting, Marxian framework of configurational class analysis that Brenner (1976) did perhaps the most to crystallize, other major studies of Latin American politics highlight the outsized historical roles that key market actors played within the institutional configurations of power that define national political regimes. Following Ruth Berins Collier and David Collier, whose *Shaping the Political Arena* remains a definitive piece of scholarship on state-society regimes in Latin America (1991), James Mahoney adopts what he calls a relational approach to conceptualizing national political regimes in his comparative-historical study of liberalism in Central America (2001).

A central virtue of such relational approaches is their focus on how struggles for political power mold different state and social actors’ dealings with one another. Calling the concept of regime “a relational concept referring to a set of institutions,” Mahoney usefully draws attention both to “the organization of the center of political power (e.g., the structure of governmental roles and processes) and to formal and informal relations between government and society (e.g., mechanisms of representation and patterns of repression)” (2001: 46). This framework sharply differentiates national regimes based on the nature of the ruling governmental elite (e.g. personalistic dictators, democratically elected politicians, or military authorities) and the primary means through which this

governmental elite generate support or compliance from social groups (e.g. coercion, electoral mobilization, or patronage).

Yet, the local regimes of state-society politics examined in coming chapters differ from authoritative conceptualizations of national political regimes in several key respects. First, these local regimes defy much of what one might expect to define local politics within a national political regime defined primary by an embrace of formal democratic procedures like free and fair elections. For example, some local regimes of supposedly democratic politics in urban Brazil today exhibit palpable features of the patronage politics that defined the country's populist dictatorship under Getúlio Vargas. Conversely, local regimes in other cites involve more direct and empowering forms of state-society relations than just the free and fair elections implied by a democratic national political regime. To be sure, local regimes are embedded within and shaped by the national political regime in which they are situated. In Brazil since 1988, this national context roughly corresponds to the ideal-type of a formal democracy in which elected politicians compete for the reins of state power based on their ability to mobilize sufficient voter support. Nevertheless, local regimes are not reducible to these qualities of the overarching national political regimes that they help constitute. The local regimes examined in this study are multiple, internally heterogeneous, and endemic to the local state and social actors. These actors ultimately constitute and sometimes transform the kinds of power relations that prevail within spatially-discreet urban agglomerations that roughly cohere to the political boundaries of the Brazilian município, but are also clearly shaped by actors on state and federal levels.

Secondly, a growing body of empirical evidence and my own fieldwork suggests that civil society actors can sometimes become influential actors within such regimes, defying what an initial generation of scholarship on state-society regimes and the Brazilian transition to democracy argued. For scholars who analyzed Brazil's transition to democracy during the late 1980s and 1990s, the politics of the country became infamous for a nation-state frozen by a clientelist bureaucracy and crippled by a lack of state capacity to deliver social services broadly throughout the population (Dagnino 1998, 2006; Weyland 1995, 1996). A new generation of political scientists now continues is this mold by using increasingly sophisticated methodologies for delineating newer and ever more specific manifestations of clientelist (Nichter 2008) and elite-driven politics beyond Brazil (Humphries, Masters, and Sandbu 2006). In describing a "Thrasymachan tradition" in political science literature, which encompasses these studies, Jeffrey Alexander highlights these literatures' entrenched skepticisms regarding the possibility of self-organized civil societies autonomously engaging state actors (2006).

In direct contradiction of such longstanding skepticisms, political sociologists increasingly demonstrate how civil societies came to play influential roles in the local politics of some Brazilian cities and other larger developing world democracies during the 1990s. Of particular theoretical import is the well-known case of Porto Alegre, Brazil, where multiple scholars documented civil societies influence into the politics of public goods provision through non-clientelist engagement with the local state via institutions of participatory budgeting (Baiocchi 2005; Baiocchi, Heller, and Silva 2011). Such studies offer careful and textured accounts of how these institutions expanded the density of civil society associations and deepened civic life. Among the many, path-breaking theoretical

contributions of such works is their nuanced demonstration of the sharp differences between these participatory politics and the brand of clientelistic politics that both the Thrasymachan tradition and other works such as Javier Auyero's *Poor People's Politics* (2002) highlight. In doing so, this recent sociology of civil society contributes an important corrective to scholars of clientelism, who nearly preclude the very possibility that state-society regimes might include autonomous, self-organized, and politically influential civil societies (Stokes 1998).

Finally, newer accounts of state-society relations in urban Brazil generally emphasize one distinctively deliberative subset of the many civil societies that characterize these politics. During my fieldwork for this project, however, another set of influential civil society activists from the Sanitary Movement defied any easy characterization as participatory or deliberative in their means or ends within the politics of state-society regimes. Unlike civil society activists from movements for participatory democracy, who privileged deliberative norms as their preferred means and ends in politics, these "sanitaristas" adopted decidedly pragmatist goals and approaches to advancing core tenets of their ideology. While they tended to prioritize the venerable sanitarista ideology of universalizing access to the most basic forms of health care, they did not always or most consequentially pursue this end by cultivating deliberative processes in which a wide cross-section of society could engage in a reason-giving debate about the way to achieve this end. Nor were sanitaristas particularly eager to engage or organize deliberations about the meaning or value of universal health care as an end unto itself.

In sum, dominant conceptual models of civil society and its role within state-society regimes are often a poor fit for many other empirical civil societies in urban Brazil, which

prove influential in the politics of public health and redistribution,[7] more generally. Even recent work, which has done the most to advance debates about the roles of civil societies with state-society regimes struggle to account for a complex and locally variable set of such actors and regimes across urban Brazil. Drawn from Habermas' theory of the public sphere, Leonardo Avritzer's dominant conceptualization of participatory publics (2002) suggests, for example, that deliberatively-oriented civil societies become influential, not because of a capacity to exert political power in the mold of political societies, but because the force of their arguments prove capable of winning the day among the political societies that devise and execute social service policies (Avritzer 2009).

By insisting that such civil societies necessarily maintain their autonomy from political societies, a certain dissonance arises between such a conceptual model and many empirical civil societies, which exhibit decidedly non-deliberative approaches within urban Brazilian politics. For example, Anne Mische points to a multitude of Brazilian civil societies, not all of which exhibit the insulation from political party structures that Avritzer assumes: "Avritzer elides the point that the 'autonomous' social movements and civic associations that he sees as constitutive of new, innovative forms of social organizations were permeated through and through with partisan associations" (2008: 344). Instead suggesting that multiple and divergent modes of democratic communication are what distinguish civil societies from other social actors and from state actors, she urges that "we should look at the different ways in which partisanship and civic life come together" (Mische 2008: 339). For instance, Mische defines urban Brazilian youth movement activists as "partisan publics" in part because of their embeddedness within political party networks.

As I will come to below, Brazil's sanitaristas fit neither the conceptual mold of a participatory public nor that of the partisan publics that Mische articulates. To first lay a conceptual foundation for articulating these key differences, I next examine both insights as well as disjunctions that the entrance of a particular branch of sociological theory of civil society has infused into recent discussions of their sources of power within state-society relations.

Bringing Civil Society in to State-Society Regimes: Insights & Disjunctures

The recent scholarship of Avritzer, Mische usefully expands longstanding notions of state-society regimes by demonstrating that civil society actors can sometimes play significant historical roles within regimes that other accounts assume to be utterly dominated by market and state actors. At the same time, this move to bring civil society in to the study of regimes introduced a new set of unresolved questions surrounding the sources of political power that such civil societies prove empirically capable of drawing upon. These questions are indelibly linked to the ways in which key sociological theories define civil societies and their modes of engaging the local state. Nowhere do these questions surface more noticeably than within recent accounts of local politics in urban Brazil.

In his path-breaking account of the politics of participatory democracy in Porto Alegre, Gianpaolo Baiocchi argues that the 1990s witnessed "a rupture and transformation of the polity, with the creation and establishment of an empowered participatory regime" (2005: 37). This empowered participatory regime stood out from prior regimes in at least three central ways. "Instead of selectively recognizing claimants in civil society, as had been the case under tutelage, the administration in the empowered

participatory regime opened participatory avenues to all of Porto Alegre's citizens. And instead of reserving the power to arbitrate among different claims for itself, under the new regime, the state empowered participants themselves to negotiate over demands." (2005: 48). Further, the regime also had the important effect of expanding the density of self-organized and autonomous civil society organizations throughout the city.

In comparative work that broadens the reach of these findings, Baiocchi, Heller, and Silva further argue that the participatory budgeting arrangements, which were the defining institutional feature of Porto Alegre's regime during the 1990s, similarly improved the autonomy and self-organizing capacity of civil societies in other Brazilian cities, as well (2011). In structuring their analysis, these authors also helpfully contribute a parsimonious typology of civil society-state relations in local politics. The two defining parameters of this typology isolate whether civil societies themselves are "autonomous" or "dependent" on the state and whether their demand-making is "institutionalized," "discretionary," or "excluded" (Baiocchi, Heller, and Silva 2011: 34-38).

Beyond just contributing an incisive framework for demonstrating the positive effects of participatory budgeting arrangements on civil society across several Brazilian cities, this framework simultaneously introduces two central questions for further exploration by scholars of state-society relations. First, it revisits the question of how best to define and conceptualize civil societies themselves. For example, one might usefully ask whether internal qualities of civil societies vary in other, consequential ways that transcend just their degree of self-organization. Second, typologies of civil society "demand-making" on the state introduce additional questions about the relationship of civil society demand-making to more encompassing patterns of civil society embeddedness within the local

state. For example, in a "institutionalized" demand-making best thought of a singular, internally homogenous mode of engaging the state or do multiple types of more encompassing patterns of civil society engagement with the state shape a variety of internally heterogeneous modes of "institutionalized" demand-making?

Dominant Conceptualizations of Civil Society

One dominant conceptualization of a politically influential civil society in Brazil is that of the "participatory public," defined by Leonardo Avritzer and his colleagues. Brian Wampler and Avritzer define participatory publics as "organized citizens who seek to overcome social and political exclusion through public deliberation, the promotion of accountability, and the implementation of their policy preferences" (2004: 292). Other scholars of Brazilian democracy and civil society adopt somewhat broader definitions of civil societies as: "the institutions, practices, and networks of voluntary life that are oriented toward and legitimate themselves in terms of publicness" (Baiocchi, Heller, and Silva 2011: 26). These scholars also recognize divergent conceptualizations such as those of Jeffrey Alexander, who instead defines civil society as "a solidary sphere in which a certain kind of universalizing community comes to be culturally defined and to some degree institutionally enforced" (2006: 31). At the same time, the empirical analysis in such work tends to focus on a more overtly political and publicly-minded version of the voluntary associations that Robert Putnam and his colleagues emphasized in their account of civil society associations in Northern Italy (Putnam, Leonardi, and Nanetti 1993).

Beyond their shared empirical focus on participatory budgeting arrangements in Brazil, what these recent conceptualizations share is considerable deference to Jürgen Habermas' theory of the public sphere and its definition of civil society. In his most

consolidated specification of the definition he originally formulated in *The Theory of Communicative Action* (1984), Habermas describes civil society as "composed of those more or less spontaneously emergent associations, organizations, and movements that, attuned to how societal problems resonate in the private life spheres, distill and transmit such reactions in amplified form to the public sphere. The core of civil society comprises a network of associations that institutionalizes problem-solving discourses on questions of general interest inside the framework of organized public spheres" (1996: 367).

Yet Habermas' definition of civil society and recent operationalizations of it expose an unavoidable problematic that arises for scholars aiming to show how civil societies can become influential but autonomous actors within state-society regimes. In short, such accounts must articulate how civil societies influence state action but in theoretically distinct ways from how capital and labor's leverage market power, and how politicians and bureaucrats wield the state's coercive apparatus. Such an account would ideally respond to the many, penetrating criticisms that own Habermas' accounts of civil society (Habermas 1984, 1996) and others' extensions of it (Cohen and Arato 1992) sustained for eliding questions of power relations (Dillon 1999; Fraser 1991). One particularly problematic deficit of the theory lies in its troubled account of how civil societies can exert influence within actually-existing regimes of state-society politics in which various forms of power is the currency of exchange.

For theorists such as Jeffrey Alexander, this deficit in the theory and conceptualization of civil society is symptomatic of the larger problem that "Habermas lost his sociology" (2006: 15) in his successfully introduction of communication theory into the Marxist tradition of critical theory. "It is fine to say that democracy must be

deliberative and reasonable, that there are principles that should guide public discussion. But it is simply not true that such idealizing principles actually grow out of speaking, deliberating, or being active in the public sphere…Speaking is encased in language games." (Alexander 2006, 16) If one accepts that civil societies who enter into state-society politics inevitably succumb to playing such language games of one kind or another, Habermasian theories lose their ability to explain how civil society might become efficacious in such settings while still exhibiting a fundamentally deliberative ethos.

In other words, the real-world, empirical contexts in which civil societies might hope to deliberate are likely to diminish and likely eradicate their purportedly defining capacity to produce inter-subjectively generated meanings through deliberative processes in which the force of the better argument, not market or state power, wins the day. Particularly when civil societies with a purportedly deliberative ethos enter politics, the discursive terrain almost always shifts in ways that militate against deliberation. Civil societies in politics typically face the daunting prospect of practicing deliberative modes of decision making within contexts that more closely resemble Bourdieuvian fields of power than they do Habermasian ideal speech communities. While social scientists are acutely aware of this discontinuities between such empirical realities and Habermas' conceptualization of civil society, recent sociological research on Brazilian civil society has gone the furthest in attempting to reconcile this contradiction.[8]

Avritzer's paradigm of participatory publics and the relational model of state-society relations of Baiocchi, Heller, and their colleagues both emphasize that civil societies should be defined and differentiated from one another primarily by their autonomy from

state actors in “political society”. As such, a tension arises between such conceptualizations and the panoply of ways in which the empirical accounts of Mische and other scholars (Abers and Keck 2009) show civil societies to be suffused with political party and state actors for whom access to state power is a central currency of exchange.

Dilemmas of Agency for Habermasian Civil Societies within Bourdieuvian Fields

If Habermasian conceptualizations of civil society face clear dilemmas of agency in a social world of structured, decentralized power, recent theorizing aims to reconcile these dilemmas by acknowledging that state-society politics often unfold within something like Bourdieuvian fields of power (Baiocchi, Heller, and Silva 2011; Chaudhuri and Heller 2003). Such explanatory projects face the tall task of accounting for how civil societies – which the Habermasian tradition defines as regulated by influence generated through a deliberative, communicative ethos, a public orientation, and a corresponding aversion to wielding decentralized power – can actually acquire forms of influence over state action, which themselves require actors to wield power within Bourdieuvian fields.

First, because Bourdieuvian field theory offers an account of social structure that largely precludes the very possibility of agency, this theoretical tradition offers little guidance for conceptualizing how a Habermasian civil society might acquire and exert power and agency within state-society regimes of politics that play out within fields of power. In particular, such accounts offer little defensible way of accounting for the ways in which civil societies mount political projects aimed at propagating generalized, society-wide solidarities. Put simply, because Bourdieuvian field theory tends to understand efforts at constructing solidarity as social actors’ own misrecognitions of their

own and others' efforts to dominate one another by manipulating their positions within more fundamental, underlying fields of power, it not only proves incompatible with the very notion of civil society as a solidary sphere, but also precludes the very possibility of civil societies exerting agency. As such, it cannot account for my empirical findings from urban Brazil about the ways in which civil societies acquire and exert political power from within state-society regimes.

Second, Habermas' framework commonly struggles to illuminate the ways in which civil societies exert political influence outside of just law and Constitution-making. In part, this is because Habermas' assumption that civil societies exert influence by creating normative consensus based on reason-giving deliberations ultimately struggles to account for how civil societies might avoid the de-politicizing and ideology-narrowing processes of influence-brokering and power politics through which law, constitution-making, and other sets of politics unfold. Habermas offers no empirically-grounded political sociology of how it is that pragmatically-oriented civil societies might survive with their universalizing ideologies intact when they engage in Gramscian wars of position in which they confront powerful state and market actors from within the redoubts of civil society regulative institutions (besides law) such as political parties and state offices.

What these deficits suggest is that a genealogy of state-society regimes may well benefit from differentiating, on the one hand, various types of actors who make claims on the state by becoming embedded within its structures in divergent ways and, on the other hand, the types of engagements that ensue between such actors and state officials. In the remainder of this chapter, I build upon this existing work by reviewing an alternative theory of civil society that proves more useful for the following chapter's project of

developing a model of state-society regimes of politics that meaningfully categorizes and integrates longstanding accounts of particular regime types with my own fieldwork findings about a new type that I call the pragmatist regime. I construct this model, first by conceptualizing several distinct styles of social actors' engagement with the local state, and then by articulating how the different sets of social actors who become embedded within pivotal state structures during key moments ultimately adapt these styles according to constraints imposes by different types of ruling political parties. To be sure, the same fundamental tensions arise between alternative conceptualizations of civil societies with universalizing ideologies and encompassing social contexts defined by power relations that induce regressions toward the mean of narrow and particularistic political projects that maximize the pre-ordained superiorities of narrow political and economic elites. But other sociological theories, which instead propose that civil societies are never purely autonomous from the state but are instead characterized by an omnipresent inter-penetration of civil and non civil spheres into one another, provide a useful starting point toward resolving this tension.

Jeffrey Alexander's Theory of Civil Society

Prime among such alternative theories is Jeffrey Alexander's theory of the civil sphere, which instead proposes that ineradicable boundary tensions between civil and non civil societies predominate such that neither are ever entirely autonomous from one another. Indeed, Alexander proposes to shift the focus in defining civil society away from these actors' purported autonomy from the state and onto the ways in which publics produce solidarities that encompass a comparatively narrower or broader scope of social actors beyond just themselves.

Alexander posits that the civil society actors should be defined, not by a proclivity to form voluntary associations which Tocqueville emphasized, nor even by a communicative, public-orientation alone. Rather, he argues that the single most important defining feature of civil societies is their orientation towards the production of generalized, society-wide solidarities. Here, I adopt and build upon Alexander's baseline definition of civil society "as a solidary sphere, in which a certain kind of universalizing community comes to be culturally defined and to some degree institutionally enforced" (2006: 31). Drawing on Durkheim, Alexander argues that binary, symbolic codes constitute the foundation of civil society insofar as they provide the fundaments from which cultural frameworks emerge for classifying the motivation, relationships, and institutions of social actors into opposing categories of pure and polluted. Themselves constructed from these codes, two dimensions of norms, rewards, sanctions, and other mechanisms of social organization constitute the landscape of civil society.

First, more ideologically-oriented communicative institutions include civil associations, public opinion, mass media, and polls, while regulative institutions "creat[e] messages that translate general codes into situationally specific evaluations and descriptions (2006: 70)". In highlighting associations as a particularly central, communicative institution, Alexander emphasizes and extends upon Robert Putnam's understanding by arguing that "it is not the mere fact of associating that defines a grouping as civil, but what is associated with it, and whether these other factors orient an association to engage with the broader solidarity groupings that exists outside itself…and whether in relation to these it displays a communicative intent" (2006: 98-99). Associations do so by facilitating the kinds of face-to-face interactions that "foster sturdy

norms of *generalized* reciprocity and encourage the emergence of social trust" (2000: 20, my emphasis).

A second dimension of civil society, which particularly informs this dissertation's approach to defining civil society actors, includes more materially-oriented "regulative institutions of civil society" such as political parties, state offices, voting, and law. These institutions "articulate solidarity in concrete and specific ways, not only through the definitions of moral behavior they project but by sanctions and rewards" (Alexander 2006: 70). In Alexander's framework, these institutions do not merely perpetuate the power-brokering capacities of otherwise anti-normative state structures but instead regulate their operations and subject them to control by civil society. They do so by exerting "civil power," which amounts to "solidarity translated into government control" (2006: 110). Law constitutes "the ultimate regulate institution of the civil sphere, the sanction at the base of the medium of civil power, the efficient cause bending state power to civil will" (Alexander 2006: 150). But civil power permeates political parties and state offices, too, and differentiates these institutions from other, non civil institutions like the economy and the "material and organizational force" of the state itself (Alexander 2006: 108). While partially dependent on these non civil spheres for inputs, civil society "pulls together these inputs according to its own normative and institutional logic. This is to say that the solidary sphere we call civil society has relative autonomy and can be studied in its own right" (Alexander 2006: 54).[9]

In addition to all civil societies' lack of pure autonomy from other non civil actors, Alexander usefully highlights that internal qualities of civil societies vary in kind, as much as in the degree of this relative autonomy. Later in this chapter, I devise a

framework of state-society regimes that posits a range of state engagements with civil societies and other actors. These engagements vary according to both the degree and kinds of autonomy that state actors achieve from civil and other non civil actors. But Alexander's conceptualization also draws attention to equally fundamental vectors of difference in the internal qualities of civil societies. In particular, he focuses attention on the varying social scope and reach of the solidary ties that civil societies aim to construct. For Alexander, communicative and regulative institutions of civil society articulate both inclusive and exclusive relationships in the sense that they translate general codes into situationally specific evaluations and descriptions that ultimately serve to define membership in civil society itself. On the one hand, all civil society communicative institutions share an orientation toward justifying such descriptions and evaluations by publicly broadcasting them in a way that cultivates communicative interchanges about them.

However, I call attention here to almost certain empirical variability in the scope of social actors that different regulative institutions enlist when propagating the generalized, society-wide solidarities that first emerge from communicative institutions. In particular, some regular institutions such as voting in free and fair democratic elections enlist nearly the whole of society (excluding youth) in bending the state toward a given notion of civic will. Others, such as political parties and offices of the state enlist a decidedly smaller range of actors in regulating state actions on behalf of civil society. Yet when considering the ultimate reach of solidarities produced, what might be crudely thought of as this "supply-side" of solidarity-production within regulative institutions may well matter every bit as much as the "demand-side" of the communicative institutions that first

construct these meanings by translating the general codes into situationally specific evaluations and descriptions.

I propose that we might usefully differentiate civil societies not solely by the presence or absence of a given civil society's autonomy from state actors, but instead by the scope of social actors that their particular regulative institutions enlist when propagating generalized, society-wide solidarities. I return to this in the following chapter, which typologizes civil societies partly on this basis. But while "the institutions of civil society crystallize ideals about solidarity within and against others in specific terms" (Alexander 2006: 70), I focus attention not just on how inclusive or exclusive such ideals are themselves, once produced. I also examine how broadly or narrowly circumscribed the set of actors is who participate in producing those ideals from within regulative institutions ultimately. For example, a participatory public represents an exceptionally broad group of civil society actors who participates in actively regulating state actions around the delivery of public goods through their involvement in the regulative institution of participatory budgeting (Baiocchi 2005). By contrast, the partisan publics that Mische (2008) articulates are arguably a far narrower sub-set of youth movement activists, who are also actively involved in the regulative institutions of progressive political parties.

During my fieldwork, I came to think of activists from the Brazilian Sanitary Movement as a kind of "pragmatist public," which strives to mobilize state action around the ideology of universalizing access to public health care by invading the regulative institutions of office and political parties. Before coming to this argument, however, it is first important to look beyond just the internal qualities of civil society to examine a broadly ranging set of civil society engagements with the state. While existing work

isolates the demand-making of civil society as a relevant vector of comparison, I next call attention to the ways in which these narrower patterns of demand-making depend upon more encompassing and variable modes of civil society engagement with the state through regulative institutions.

Conceptualizations of Civil Society Demand Making

The model of state-society relations proposed in Baiocchi, Heller, and Silva (2011) helpfully defines "institutionalized" modes of demand-making as consisting of "rule bound, regularized, and transparent procedures of demand-making consistent with the relational notion of citizen". It also differentiates such institutionalized modes of civil society demand-making from the kinds of "excluded" modes that characterize both totalitarianism and the authoritarian arrangements that prevailed during Brazil's military dictatorship. Further, the typology introduces additional questions about the relationship of civil society demand-making to larger patterns of civil society embeddedness within the local state. In particular, are institutionalized modes of demand-making singular and internally homogenous? Or do multiple and more encompassing patterns of civil society engagement with the state shape a variety of internally heterogeneous modes of institutionalized demand-making? How are we to account for the ways in which civil societies attempt to exert agency within politics through patterns of demand-making that are shaped by these structured sets of civil society engagements with the state?

In examining this model, other scholars note that "the most desirable category of 'institutionalized' demand making encompasses too many different kinds of pluralism, too many varieties of polyarchy, in Dahl's terms. The push and pull of interest groups in Washington, DC, is one form of highly institutionalized demand making that is rule

bound and highly structured, if not always transparent, as is European neocorporatism" (Fung 2011: 864). For example, to the extent that certain interest groups hold far greater sway in demand-making by virtue of their differential abilities to contribute unlimited amounts of campaign financing to politicians, an "institutionalized" mode of interest group politics would seem to incorporate the "discretionary" elements of demand-making, which the framework relegates to a separate category altogether. Similarly, the category of "discretionary" demand-making collapses into one category what may alternatively be viewed as multiple forms of discretionary demand-making, some of which could be argued to exhibit institutionalized features. The particular form of discretionary demand making that the typology highlights – namely, those which are "contingent on connections to a broker/patron" (2011: 34-35) and are, in this sense, un-institutionalized – differ in important ways from other discretionary forms of demand making that are highly institutionalized and, some would argue, democratically legitimate, as well. Prime examples include European neo-corporatist arrangements that give representatives of organized labor the discretion to broker wage-setting agreements with capital, using state mediators (Schmitter 1974).

Still other modes of civil society demand-making could be viewed as simultaneously "discretionary" and "institutionalized" insofar as they place into policy-making roles similarly small groups of civil society actors, who nevertheless differ in crucial ways from clientelist brokers, patrons, and elected union leaders. For example, it was not uncommon during the 1990s and 2000s in major Brazilian cities like Belo Horizonte for elected politicians to effectively cede discretion for devising public health policies to civil society elites from the Sanitary Movement, who ephemerally occupied key political

appointee roles within elected government. During my fieldwork, I came to think of the resulting type of state engagement with civil society as a kind of "associational corporatism" because – during the nearly twenty-five year period I examined – the invasion of key state offices by representatives of an imagined community of civil society activists, who called themselves the "mineiro sanitarista party," achieved an expansive level of routinized controlled over planning initiatives and advanced sizeable state-building projects in the municipal public health sector. These arrangements resemble labor neo-corporatist arrangements in the sense that this routinized control of health policymaking rotated amongst an ever changing cast of individual sanitarista activists, who maintained firm footings within civil society associations that stand quite apart from the offices they occupied and the parties that appointed them.

These arrangements clearly differ from the ways in which labor unions in European neo-corporatism delegate to agreed-upon brokers the discretion to negotiate on the behalf of unionized workers. Such arrangements certainly raise dilemmas of "assumed representation": namely, sanitaristas' claims to represent civil society interests clearly lacked anything like the democratic procedures that political scientists use to characterize representation of electorates by legitimately chosen politicians (Gurza Lavalle and Houtzager 2010). Further, the access of sanitaristas to these offices certainly depended on (a wide range of left and left-center) political parties winning municipal power. Nevertheless, these dilemmas do not nullify the palpable ways in which such patterns of civil society demand-making were simultaneously institutionalized and discretionary in their demand-making.

More modestly, these findings suggest that efforts to conceptualize state-society regimes may benefit from looking beyond the false-dichotomous metric of rule-bounded versus discretionary claims-making to illuminate a conceptually broader and more variegated set of ways in which civil societies and other social actors engage the state. One result of this shift would be a wider and more textured conceptualization of civil society-state regimes, which could illuminate an important set of state-society engagements that existing frameworks largely overlook. In particular, they would prove capable of illuminating a conceptual middle ground of state-society regimes in which civil societies engage the state in a more agentic and autonomous fashion than the "affirmative," "prostrate," and "bifurcated" ideal types of non-participatory democracy suggest, but in a less radically decentralized way than the "mobilized" democratic relations of participatory democratic demand-making articulates (Baiocchi, Heller, Silva 2011). In the following chapter, I aim to build upon the insights of such frameworks in ways that speak to these formidable challenges of conceptualizing state-society regimes of politics in urban Brazil and articulating their influence on the development of key local state structures in the public health sector.

Notes:

[1] In 2010, the ten most populous capital city municípios accounted for nearly 18% (34,126,122) of Brazil's 190,732,694 people. When we include the surrounding metropolitan regions of these ten municípios, they account for 31.6% (60,262,796) of the country's total population (IBGE 2011).

[2] By virtue of the country's three-tier, federalist system of governance, each Brazilian município is necessarily a confluence of the intersecting politics that permeate the country's three levels of government: the union or federal government, the states (26), and the municípios (5,564). But how these politics intersect in Brazil's largest capital city municípios differs substantially from other, less populous, non-capital municípios. This is partly because both the federal and state governments tend to relate to capital city municípios much differently than they do to non capital city municípios. For example, although municípios throughout Brazil hold primary legal responsibility for delivering primary health services, it is

not uncommon for state governments to adopt an active role in contributing financial resources to the provision of these services in rural, non-capital city municípios. However, in capital city municípios, including the three examined in this study, such contributions are far less substantial I proportional terms.

[3] To a considerable extent, these institutional advances during the 1920s and 1930s represented a significant departure from the far more decentralized approach of the Brazilian empire (between 1822 and 1888) to managing public health problems. During this earlier era, through institution such as the *Junta de Higiene Pública*, the Empire effectively delegated responsibility for managing disease epidemics and other major health problems to municípios.

[4] The very existence of these two industry actors owed much to the main authoritarian-era institution for providing health care, the National Institute for Medical Assistance in Social Security (*Instituto Nacional de Assistência Mêdica da Previdência Social*, *INAMPS*). INAMPS provided almost exclusively curative, typically complex health services through a system of contracting these private sector hospitals and health insurance companies aligned with them. A broad array of informants criticized INAMPS for clientelist arrangements so brazen and widespread that the term "Inampist" (*inampista*) entered the vernacular of health care professionals and activists in urban Brazil as a way of referring to these arrangements.
[5] Indeed, many of the respondents interviewed for this study reported having been jailed for months or years as a result of their clandestine organizing for the return of formal democracy, citizenship rights, and the universal right to health.

[6] Rio de Janeiro's leap in spending to nearly $115.55 reais per capita during 2010 was unprecedented in its history and owed much to the end of César Maia's prior, 8-year, highly clientelist mayorship, which compelled the federal Ministry of Health to strip município of its full management status over the health system. Although this downgrade left Rio with responsibility over only basic attention, this failed to actually increase the município's spending on basic attention until Eduardo Paes replaced Maia in office during 2009.

[7] One intriguing question for future consideration surrounds the political origins of recent policy interventions that have improved standards of living for poor populations across the country. Commonly credited to the Workers' Party, analysts credit the introduction and expansion of Bolsa Família, Brazil's conditional cash transfer program (along with recent, strong economic growth) for raising tens of millions out of economic poverty across the country during the last ten years.

[8] Beyond Brazil, other analysts of deliberative processes in India find evidence, not of Habermasian deliberation, but of quite a different and more ominous reality of agonistic competition (Ban and Rao 2009; Rao and Sanyal 2010).

[9] Alexander's concept of civil society's relative autonomy is clearly distinct from prior conceptualizations of relative autonomy as state actors' independence from capitalist actors but simultaneous tendency to advance policies that benefit capital (Poulantzas 1976).

CHAPTER 3

A CONCEPTUAL FRAMEWORK OF STATE-SOCIETY REGIMES IN THE PUBLIC HEALTH SECTOR OF URBAN BRAZIL

This chapter develops a conceptual framework for differentiating several types of state-society regimes of politics and articulating key distinctions in how they condition local policymaking and state-building in the primary public health care sector of urban Brazil. On the most fundamental level, I define local regimes of state-society politics as temporally and spatially variable and dynamic sets of power relations between ruling political parties, state, and social actors, who embed themselves within and around relevant state structures.[1] My starting point for conceptualizing such regimes is that a wider range of social actors than is commonly recognized may not only embed themselves within key state structures, but may also develop qualitatively distinct types of relationships with key state actors and ruling political party actors, once embedded. As a whole, the literature on state-society regimes tends to discount the possibility that civil society actors, in particular, can come to play influential roles within the undeniably structured spaces of such regimes.

In the chapters that follow, I propose to invert this assumption. I do so by reconciling an alternative, empirical account of state-society politics in the Brazilian public health sector with a newer theoretical literature on the sociology of civil society. Empirically, coming chapters demonstrate how a decidedly pragmatist set of civil society

actors from the Sanitarista Movement in urban Brazil effectively invaded and harnessed the political power of key "noncivil" state and political party institutions to advance their socially minded ideology of universalizing basic public health care provision. But the conceptual foundations necessary to theoretically ground this re-telling are largely absent in the dominant sociological literature on civil society, which largely embraces Habermas' theory of a civil society defined by an inherently deliberative ethos. To provide a more persuasive account of how these civil society actors prove sufficiently powerful and autonomous to become politically influential, embedded actors within the local state, I instead aim to reconcile my empirical findings with Jeffrey Alexander's theory of the civil sphere (2006), which regards civil society's defining feature not as a deliberative ethos but as the capacity to produce generalized, society-wide solidarities by advancing universalizing political projects from within "regulative institution of civil society" that include elected and appointed state offices.

To launch this discussion, the first section of the chapter reviews the approaches that the developmental state, civil society, and participatory institutions literatures adopt in conceptualizing the roles of civil society within state-society configurations. The second section develops three conceptual foundations of framework that I develop for conceptualizing state-society regimes: types of social actors who embed themselves within key state structures, these actors' modes of engaging the local state, and the range of political parties that actively condition these engagements. The chapter's third section conceptualizes several regime types that are particularly relevant for existing theory and the analysis to come in subsequent chapters. I conclude the chapter by previewing the broader conceptual framework that coming chapters apply in analyzing the effect of such

divergent regimes on state-building and ultimately service provision in the primary public health sector.

Challenges in Conceptualizing Regimes of Local State-Society Politics

I approach the tricky analytical issues involved in conceptualizing state-society regimes by adopting and expanding upon complementary insights from the developmental state and civil society literatures reviewed in the previous chapter. I first borrow from the developmental state literature and expand upon its arguments about state-society embeddedness and its limitations. A central contribution of this literature is the finding that key state actors, who formulated industrial policy and undertook state-building for industrial expansion and other forms of capitalist transformation, were themselves embedded within the social networks of market actors in consequential ways. For example, Peter Evans found that the post-World War II Korean developmental state, its co-creation of *chaebols*, and its crystallization of pivotal industrial policies all depended upon the social networks that state bureaucrats and politicians first forged with industrialists while receiving their graduate and undergraduate educations (1995). Examining the more conflictual way in which the mobilizations of organized agricultural and industrial workers in the South Indian state of Kerala crystallized institutional arrangements that resembled European labor neo-corporatism, Patrick Heller (2000) demonstrates how organized labor transformed its demands into key class compromises by crystallizing institutional mechanisms for state-mediated wage-setting. The emergence of such "democratic developmental state" structures reminds us that organized labor – not just capital – has played decisive and politically influential historical roles in transforming the character and composition of key state-society configurations.

Yet, neither the developmental state literature nor the democratic developmental state literature goes so far as to argue that civil society actors can prove similarly influential (as capital and labor) in affecting state actions from within state-society regimes of politics. Addressing state interventions in which civil societies played at best marginal historical roles, few accounts take the prior step of defining civil society as a conceptually distinct actor from organized labor. Those accounts which address civil societies directly commonly demonstrate how such actors – lacking the political power required to autonomously influence politics – succumb to the de-politicizing and co-opting influences of state, market, and international actors like the World Bank (Ferguson 1994; Li 2007). In such accounts, civil societies often lack the autonomy required to remain sufficiently independent of state actors to advance their ideologies and proposals from inside the state. For example, complementary literature on clientelism in Brazil and throughout Latin America articulates how brokers within civil society organizations that lack the autonomy to challenge the state commonly provide politicians with various kinds of electoral support in exchange for public goods provision and other material benefits (Auyero 2001; Gay 1999; Nichter 2008).

Indeed, both the developmental state and clientelism literatures offer good reasons for skepticism about the likelihood of civil societies becoming sufficiently self-organized and politically powerful to translate their claims into state action in the efficacious ways that capital and organized labor proved capable of exerting, historically. Even civil societies which might be considered to be self-organized and sufficiently autonomous from state actors to independently formulate and articulate their own claims commonly lack the political power to translate their agendas into state action. One example is the

Park regime's repression of rural civil societies in Korea. Park proved abundantly capable of quashing civil society resistance to its repressive industrialization agenda, and crushed the resistance movements of rural peasants with a remarkable fervor. There is strong support for such skepticisms in Brazil, as well, where the replacement of a similarly repressive authoritarian regime with formal democratic structures and a constitution in 1988 proved incapable of eradicating clientelistic political cultures and engrained corporatist arrangements in the underlying political economy. Multiple scholars document how *coronelismo*, a related pattern of nearly exclusive control of local governments by landed oligarchs in rural regions (Hagopian 1994), survived the transition to formal democracy intact and continues to define clientelistic politics as usual in the poor Northeast region of Brazil through the mechanisms of vote-buying and turn-out buying (Nichter 2008). Other scholars demonstrate how clientelism continue to defines politics in Southeastern cities like Rio de Janeiro (Gay 1999), while a related pattern of differentiated and unequal citizenships defines the politics of land tenure even in Brazil's largest and most cosmopolitan city, São Paulo (Holston 2008).

In his more recent work, Peter Evans highlights such deficits of an overpowered or co-opted civil society as a major constraint to the rise of "21st century developmental states". Adopting a circumspect and cautious tone, Evans' understanding of prospects for the emergence of a 21st century developmental state begins from this assumption that civil society actors generally prove insufficiently powerful to mobilize state and political party actors around their agendas. He proposes that: "In order to be able to create effective state-society linkages, the state must facilitate the organization of counterparts in 'civil society'" (Evans 2008: 16). Some accounts of Brazilian politics such as the

crystallization of the national HIV/AIDS policy tell just such a story of proactive state actors rallying support for their agendas among a civil society decidedly in need of mobilization (Rich forthcoming). Yet by overlooking the more distant historical processes by which civil society actors transformed the key state structures that propelled such reforms in the first place, these accounts paint the picture of a relatively quiescent civil society in need of mobilization by the state to effectively influence public actions.

I contend that the analytical task of accounting for the role of civil societies in the Brazilian public health sector instead requires a different theoretical understanding of civil society than those embraced or implied within the developmental state, clientelism, and participatory institutions literatures. I instead propose to reconcile my empirical findings with Jeffrey Alexander's theory of the civil sphere (2006), which regards civil society's defining feature not as a deliberative ethos but the production of generalized, society-wide solidarities that Habermas largely under-theorized. This reconciliation begins from the emphasis in Alexander's theory that while some embedded civil society actors wield "civil power" in mobilizing state actors around specific civil society ideologies of state intervention, other civil societies commonly succumb to the co-opting and depoliticizing influences of various noncivil actors. From a sociological standpoint, the theoretical and empirical question that has yet to be satisfactorily answered is how and why the former scenario might occur, when the latter is far more common if not ubiquitous within Brazil, Latin America, and much of the developing world. For example, scholars of state-society politics in both the global North and South have rarely demonstrated direct effects of civil society on redistributive development policies, outcomes, or the state-building processes on which they depend. Nor have they

adequately explained how and why this less structured set of civil society-led politics has unfolded in some political contexts but not in others.

In the recent political sociology of Brazil, where this analytical deficit is quite palpable, explanations suffer as much from inadequate methodological designs as they do from ill-suited sociological theories of civil society and its relationship to state and market actors. Some observers highlight the methodological deficits of recent studies of Brazil participatory institutions (Avritzer 2009) to empirically examine the appropriate counterfactuals required to substantiate such claims (Fung 2011: 866). Other observers allude to a "time of enchantment with democratic possibilities and the Worker's Party" (Baiocchi 2011: 170) that guided such accounts. Indeed, one reading of scholarship that emerged from this time is that it bordered on deducing qualities of actually-existing civil societies from the claims of normative sociological theories of civil society. Whatever the merits of such a deeper and more fundamental critique, few would disagree that the concept of an inherently deliberative civil society, which Habermas most firmly established in the theory of communicative action and subsequent expansions (1984, 1996), became a pivotal theoretical flashpoint in such scholarship.

This chapter embraces the view that the inherently deliberative civil societies posited in such theories must be empirically demonstrated and reconciled with the predictions of alternative theories of civil societies such as those proposed in Alexander's theory of the civil sphere (2006). Alexander's theory contrastingly posits that the defining quality of civil society is an orientation towards producing generalized, society-wide solidarities, not necessarily an orientation towards producing such solidarities through deliberative processes, per se. This leaves open the possibility of multiple, empirical civil

societies, each with its own approach to producing generalized, society-wide solidarities. Further, the theory implies that some civil societies may well adopt political strategies of engagement with "non civil" social institutions like the state and political parties, which are decidedly non-deliberative. In short, civil societies can meet the baseline condition of an underlying, communicative orientation toward publicness, while simultaneously exhibiting the partisan orientations that Mische (2008) documents for the Brazilian youth movement and the pragmatist orientation that I articulate in my account of the sanitarista movement.

The theoretical expansion developed in this dissertation argues for an alternative definition of the kinds of civil societies that – in order to reform the public health sector in meaningful way – proved sufficiently powerful and resistant to co-optation and de-politicization. Further, I propose that not all civil societies embedded themselves within state actors in the same fashion. I argue that the decidedly pragmatist civil societies, which proved most effective in advancing political reforms for universal public health care in urban Brazil after 1988, did not become efficacious in this way because of an inherently deliberative orientation that is commonly ascribed to all civil societies by appropriation of Habermas' theory of communicative action. Rather, I propose that they did so because of a decidedly pragmatist ethos and political strategy of engaging the state through institutional arrangement that I came to think of during my fieldwork as "associational corporatism". Where such efforts were comparatively more successful, sanitaristas proved more effective at re-making the local state to advance their ideology of universalizing access to the most basic forms of health care. Specifically, I show that sanitaristas opportunistically invaded two of what Alexander (2006) calls the regulative

institutions of civil society – namely, political parties and elected office – in ways that advanced a piecemeal set of reforms through an iterative political process that I came to think of as punctuated equilibrium. One intermediate result of these politics is what I define below as a pragmatist regime of state-society politics.

Three Conceptual Building Blocks of State-Society Regimes

To provide a framework for conceptualizing this particular type of state-society regime and differentiating it from several other regimes that had weaker effects on health care reform in urban Brazil over the last twenty-five years, I propose a model of state-society regimes that consists of three continua. First, I focus on the different types of social actors that become most firmly embedded within relevant, local state structures. Second, I differentiate the types of relationships that prevail between key state actors and these embedded social actors. Finally, I bring attention to the different types of political parties that can control key relevant functions of the state and resources for state-building. These three continua – the "type of deeply-embedded social actor," "type of state-society relations," and "party type" axes – ultimately account for a variety of regime types, all of which vary in their public as opposed to private orientations.

Type of Embedded Social Actor

In my conceptualization of embedded social actors, I aim to invert dominant understandings of embeddedeness. While existing literature conceptualizes the particular social actors who compose state-society regimes in terms of their "embeddedness," such accounts typically conceptualize embeddedness as the inclusion of state actors within the networks of social actors, particularly social networks of capitalists (Evans 1995) or those of civil society (Evans 2002, 2010). Thus, broadly speaking, such dominant

conceptualizations understand embeddedness in Polanyan terms as the subsuming of what Alexander would call noncivil spheres (e.g. capitalist production, wage labor, the state) within civil spheres (e.g. civil society). In what follows, I instead adopt a Gramscian perspective in reversing this understanding to conceptualize the embeddedness of both noncivil and civil spheres of actors within local state structures. This perspective instead views the trenches of state structures as vulnerable to the invasions of various social actors that include not just lifetime politicians and bureaucrats, capital, and labor but also civil society actors.

But I depart from a Gramscian perspective in conceptualizing the state as a realm in which civil society can advance not just narrowly individualistic ideologies, but also universalizing ideologies of a more general sort, including the ideology of universal access to publicly provided health care. Alexander usefully articulates the limits that Gramscian theory imposes on our ability to adequately conceptualize such ideologies and their advancement by civil societies, who enter into the trenches of the state to marshal state power in the service of such ideologies.

> "Yet, even while Gramsci challenged the instrumentalism of Marx's thinking about the civil sphere, [he insisted that] within the confines of capitalist market society, there would never be the space for institutionalizing solidarity of a more universalistic and inclusive kind. Gramsci did not associate civil society with democracy. It was a product of class-divided capitalism understood in the broad socio-cultural sense. The values, norms, and institutions of civil society were opposed to the interests of mass humanity, even if they did provide a space for contesting their own legitimacy in a public, counter-hegemonic way. Civil society was inherently capitalist. It was a sphere that could be entered into but not redefined. Its discourse could not be broadened and redirected. It was a sphere that would have to be overthrown" (Alexander 2006: 29).

By instead drawing on Alexander's definition of civil society as "solidary sphere, in which a certain kind of universalizing community comes to be culturally defined and to some degree institutionally enforced," I examine the ways in which a wide range of social actors, including civil societies, become embedded within local state structures and embark upon political projects to harness these structures to universalizing ideologies with broad bases of social solidarity. The most interesting and theoretically path-breaking empirical examples of this distinct definition of embeddedness in urban Brazil are cases of what I call the pragmatist civil society of sanitarista activists, who attempted to leverage their deep embeddedness within the local public health state of Belo Horizonte to advance their longstanding ideology of universal access to the most basic public health services. Before turning to this case in the following chapter, however, I first lay the conceptual building blocks required to construct a more encompassing framework for categorizing other types of regimes in which the most deeply embedded social actors are not pragmatist civil societies but a range of other civil and noncivil actors, who engage key state actors in qualitatively distinct ways.

The first axis of my framework thus arrays several ideal-typical social actors, who become highly embedded within local state structures, according to both the universality and permeability of their ideologies as well as their structural positions within the overarching political economy that they constitute. On one fundamental level, these actors vary in their capacity to produce and propagate normative structures that include ideologies and practices of generalized, society-wide solidarity. On another fundamental level, actors vary in the extent to which their variable structural locations within an overarching political economy differentially condition the penetrability of their own

particular normative structures to those of other actors, who reside in different positions. In short, actors vary in both ideological and material dimensions that tend to reinforce one another and can be measured along a shared parameter.

To account for the variable ways in which these material and ideological qualities define different social actors, I build upon the genealogy of social actors within Jeffrey Alexander's theory of the civil sphere. I specifically focus here on Alexander's typology of "civil" as opposed to "noncivil" actors in society. For Alexander, "the goods they [noncivil actors] produce and the powers they sustain are sectoral not societal, particularistic not universalistic. The hierarchies in these noncivil spheres often interfere with the construction of the wider solidarity that is the sine qua non of civil life" (2006: 7). My approach to conceptualizing how different social actors embed themselves within state structures recognizes that civil and noncivil actors differ from one another, not only in the scope of social actors around which they construct solidary ties, but also in permeability of their particular normative structures to those of other surrounding actors.

On the one hand, Alexander proposes that "the codes and narratives, the institutions, and the interactions that underlay civil solidarity clearly depart from those that regulate the world of economic cooperation and competition, the affectual and intimate relations of family life, and the transcendental and abstract symbolism that form the media of intellectual and religious interaction and exchange" (2006: 33). In particular, civil society is best thought of as "a solidary sphere, in which a certain kind of universalizing community comes to be culturally defined and to some degree institutionally enforced. To the degree that this solidary community exists, it is exhibited and sustained by public opinion, deep cultural codes, distinctive organizations – legal,

journalistic and associational – and such historically specific interactional practices as civility, criticism, and mutual respect" (Alexander 2006: 31). Thus, we might usefully think of civil society as a set of distinctive social actors, whose actions draw heavily on age-old cultural and institutional traditions that sustain society-wide solidary ties of collective obligation. On the other hand, another set of distinctively "noncivil" actors do not so much lack normative traditions altogether[2] as they draw upon, propagate, and practice a set of normative traditions with far narrow social categories as reference points. Following Alexander, I propose that institutions such as the family, religious organizations, and capitalist market relations are all aptly conceptualized as noncivil actors insofar as the normative structures that govern discourse and practice in these spheres tend to be oriented toward more particularistic ideologies and normative structures quite apart from those of a generalized social solidarity.

I also call attention to how the positions of particular actors within a given political economic structure typically reinforce both the variable penetrability of such normative structures as well as the variable scope of social actors with whom such normative structures tend to reproduce solidary ties. Although the differentiated normative structures of "civil" and "noncivil" actors can inter-penetrate one another, some such structures prove more difficult to penetrate than others. Specifically, the normative structures of noncivil spheres such as market relations, religion, and family much more easily penetrate or "invade," to use Alexander's language, civil spheres such as solidary associations. For the purpose of categorizing the full range of social actors, who enter into state-society regimes of politics, the actor type parameter categorizes social actors along a continuum stretching from low to high inter-penetrability and social scope of the

actor's solidary ties structures. Thus, toward the bottom of the actor type axis we find actors, whose distinctive normative structures tend to be, not only less penetrable by those of other actors, but also narrower in the scope of social actors around whom social solidarities tend to crystallize.

I locate state politicians and bureaucrats, who become the most deeply embedded actor within the state, at the bottom of the actor type axis because their distinctive normative structures tend to produce the least penetrable and narrowest solidary ties. On the one hand, the very notions of democratically elected politicians and officers of the state assume that state bureaucracies can "supply political structure to mirror the complexity of social life, developing procedures for coordinating the practical tasks of putting government decisions into play," as Alexander proposes. State bureaucracies "have an Achilles' heel, a structural feature suggesting that state power, while terribly effective as means, can never be an end. As Weber pointed out, every bureaucracy is nonbureaucratic at the top: 'The consequences of bureaucracy depend therefore upon the direction which the powers using the apparatus give to it'" (2006: 108). Thus, the category of politicians and bureaucrats is an internally heterogeneous category in the sense of an inherent variability in the extent to which governing bureaucratic norms of rule-abiding, impersonal, and hierarchically-bounded behavior respond to democratic procedures. Indeed, the very notion of democracy is predicated upon state structures becoming animated by "regulative institutions" of civil society such as "office," "elections," "law," and "parties" (Alexander 2006: 107-132).

Importantly, however, such regulative institutions of civil society commonly fail to penetrate state structures. I aim to recognize such situations by anchoring the "type of

embedded actor" axis with this situation: the axis categorizes bureaucrats and career politicians, who become the most deeply embedded in a given state structure during a particular time and place. At the extreme bottom end of this point on the continuum are situations in which career politicians become not just the most embedded social actor within state structures, but he only such embedded actors. Broadly consistent with totalitarianism, the inability of civil society actors to penetrate state structures through regulative institutions of office, elections, laws, and parties resulted in the brutal forms of repression and genocide that defined the 20th century more than any other single phenomena. If they become sufficiently embedded within the state to systematically exclude self-organized civil societies, whom they cannot crush, state actors become the prime agents within an authoritarian state like the one that dominated Brazilian civil society between 1964 and 1985. It should be obvious that democracy does not exist to the extent that state politicians and bureaucrats become the most embedded actor within such an impersonal, bureaucratic state structure. Ultimately, I place such politicians and bureaucrats, who so thoroughly dominate the landscape of non-democratic states, at the bottom of the actor type axis because the narrow scope and nearly impermeable normative structures prove so severe as to question whether "no social sphere, not even the economic, should be conceived in anti-normative terms"…as completely lacking "immanent moral structures in their own right" (Alexander 2006: 33).

Capitalist actors constitute a second type of noncivil social actor, whose distinctive normative structures can (in the case of democracy) prove somewhat broader in scope and more penetrable by other such structures than those of deeply embedded politicians and bureaucrats. I locate capitalist actors near the bottom of the actor type axis, because

their distinctive normative structures and material positions within the capitalist political economy tend to produce nearly impenetrable and narrow solidary ties. In this sense, capitalist actors constitute something close to the opposite of the most broadly solidaristic civil society actors, whose normative structures are instead more broadly universalistic in their scope, as well as more penetrable by other actors. Still, sociologists have long emphasized that even capitalist relations of production are hardly devoid of solidarity. "As Marx himself was among the first to point out, the complex forms of teamwork and cooperation demanded by productive enterprises can be considered forms of solidarity; persons learn to respect and trust their partners in the civil sphere only after they have learned to do so at work" (Alexander 2006: 206). Yet the solidary ties of capitalist actors tend to remain constrained to an especially narrow set of social referents, particularly fellow partners in exploitation and surplus extraction of labor. In Brazil, as much as in any other developing world democracy, severe economic inequalities, class divisions, poverty, unemployment, and stratification all arose from capitalist relations of production and exchange (Evans 1979) that closely approximate the very antithesis of a generalized social solidarity.

A third type of social actor that is of special relevance in Brazil is organized labor. Cultural theories of civil society like Alexander's categorize organized labor as noncivil spheres because actors in this sphere typically struggle to maintain generalized, society-wide, solidary ties that transcend just workers. The most differentiated institutions of organized labor, the interest-maximizing labor union, is argued to exhibit noncivil tendencies stemming from difficulties in sustaining generalized, society-wide solidary ties beyond just organized workers and the unions that represent their interests (which are

themselves shaped by the overarching political economy). To suggest otherwise would be to ignore that the embeddedness of unions within capitalist market relations requires them to first and foremost pursue particularistic, interest-oriented agendas that belie a more generalized social solidarity.

Yet the permeability of distinctive normative structures that grow up around the central interests of organized labor – especially, the advancement of worker rights in the fact of an inescapable capitalism system of surplus labor extraction – generates undeniable elected affinities between larger, society-wide ideological agendas advanced by civil society actors and the narrower ideological agendas or organized workers. And organized labor in Brazil historically straddled the border between civil and noncivil spheres. For example, Seidman shows that re-democratization in Brazil during the 1980s owed much to union-led patterns of shop-floor militance and organizing that spread into residential communities, where mobilizations evolved into claims-making around more generalized and universalistic ideologies of democratic rights that transcended the initial spark of particularistic worker demands (1994).

But the particular history of mobilizations by organized labor and civil society movements for the right to universal health care in urban Brazil followed something closer to the opposite pattern. I argue that civil society movements for universal health undertook what Alexander would call an "invasion" of noncivil spheres, like labor unions and regulative institutions such as political parties and offices throughout the 1990s. The universalizing civil society ideal of universal public health care is what invaded, transformed, and ultimately expanded narrower, union-specific ideologies, not the reverse. As such, it is both analytically useful and more empirically accurate for

questions surrounding the local institutionalization of Brazil's public health sector to categorize organized labor in Brazil as a non-civil actor. The social scope of ideologies espoused by organized labor tend to be narrower and cluster around the rights and interests of workers exclusively, as opposed to the society-wide scope of ideologies espoused, by activists from the Sanitarista Social Movements, whom I turn to next.

This brings us to a fourth type of actor: civil society. While both regulative and communicative institutions would be equally important to consider for studies in which the central topic of investigation is civil society itself, this dissertation instead examines the place of civil society within state-society regimes of politics, more generally, and studies the effects of divergent regimes on state-building processes and policymaking in the public health sector. As such, I focus attention here on regulative institutions like political parties and state offices because these represent the primary mechanisms through which civil societies influence such regimes and pursue their ideologies through state-building and policymaking. Indeed, I am to show that these regulative institutions constituted the primary channels through which the sanitarista movement in urban Brazil went about translating the universal right to public health care into on the ground realities. This process amounts to an empirical case of Alexander's theory that "those whom civil society has repressed in the name of a restricted and particularistic conception of civil competence" can "save themselves" by wielding such institutions to enforce "universalistic civil against oligarchic power" (Alexander 2006: 233).[3]

The embedded social actor axis further differentiates sub-types of civil society from another by focusing on the various "regulative institutions of civil society" through which such they tend to advance political projects. Although a larger number of ideal-typical

civil societies exist that I lack the space to articulate here, I focus on three: the participatory publics articulated by Avritzer (2002), the partisan publics articulated by Mische (2008), and the pragmatist publics that this project documents. In approaching the conceptualization of these divergent types of civil societies, I emphasize that not all civil societies necessarily embody the deliberative ethos highlighted by Habermas. Currently the dominant conceptualization of civil society on offer in the literature, Habermas instead proposes that a distinctive feature of civil societies is an orientation toward reason-regulated processes of public communication in which the force of the better argument is what guides thought and action. Although I embrace that all civil societies legitimize their ideologies in terms of their public-ness, there are many ways of legitimizing such ideologies, not all of which are deliberative in nature. More importantly for present purposes, I reject that all civil societies advance those ideologies by actively cultivating society-wide deliberations about their validity. Following Alexander, I instead call attention to the "regulative institutions" through which communicative institutions of civil societies – particularly associations – attempt to advance their universalizing ideologies and, in so doing, attempt to generate society-wide solidarities.

I propose three such ways. First, I argue that participatory publics advance their ideologies through the most radically inclusive regulative institutions of civil society, including institutions of Empowered Participatory Governance such as participatory budgeting and other institutions of Redistributive Direct Democracy (RDD) (Baiocchi 2005, Fung and Wright 2003) such as the gram sabha in Indian civic life (Gibson 2012). As the most open-source (Baiocchi 2011) institutional technology of any civil society,

participatory regulative institutions of civil society prove especially permeable to cross-fertilizing, alternative ideologies and bases of generalized, society-wide solidarity.

A second, far less democratic civil society is a pragmatist public, exemplified by the Sanitarista Movement in Brazil. This pragmatist public relies on comparatively narrowly-composed associations of public health care professional and users to reproduce their universalizing ideology of universal public health care. And to advance derivative political projects, they rely heavily upon state office, a far less democratic regulative institution of civil society than the participatory institutions invented by participatory publics. Further, the relatively narrow membership composition of its primary communicative institution (associations of public health professionals and users) almost necessarily precludes the pragmatist public from becoming permeable to the far broader range of ideologies that interpenetrate the ideologies of participatory publics. Yet, pragmatist publics nevertheless pursue a similarly sweeping ideology, in the case of sanitaristas in urban Brazil, the ideology of universalizing access to public health care for all citizens. And because they do so through public offices, a more broadly admissive regulative institution of civil society than the more rarified positions of political party ideologues and strategists, I define the scope and permeability of this pragmatist public's solidary ties as occupying a middle ground between those of participatory publics and the civil society to which I turn next, partisan publics.

A third, perhaps least democratic civil society is the kind of partisan public articulated in Mische (2008). Exemplified by the education reform movement in urban Brazil, this civil society relies heavily on a far more broadly composed association of student associations for reproduction of its universalizing ideology. Ultimately, however,

such partisan publics are less democratic than both participatory and pragmatist publics in the sense that they rely primarily on the civil society regulative institution of political parties, which itself has a narrowing and rigidifying influence on the scope and permeability of these civil societies' solidary ties and ideologies. The end of this chapter sets this model in motion by articulating how these divergent orientations and preferred regulative institutions of participatory versus pragmatist publics condition quite different overarching regime types. For now, however, I merely note that the solidary ties and ideologies of all civil societies are by definition broader and more permeable than those of the noncivil actors articulated above, placing them at points furthest away from the origin of the embedded social actor axis. Next, I turn to the different type of state engagement with both civil and noncivil actor types.

Types of State Engagement with Embedded Social Actors

The second axis that I construct for defining state-society regimes arrays several types of relations that tend to define interactions between state actors and the various social actors who embed themselves within and around key state structures. I focus on six such types of relations that prove especially important for categorizing urban regimes in Brazil: dependence, clientelism, institutionalized devolution, various neo-corporatist arrangements, insulation, and exclusion. I locate these types of engagements along a continuum stretching from the lowest to the highest degrees of state autonomy from embedded social actors. Yet, as will become clearer throughout this discussion, different points along this continuum imply not just differences in the degree of state autonomy, but also differences in the particular qualities of state engagement that particular kinds of autonomy imply.

Nearest to the origin of the state-society engagement axis we find the situation of lowest possible state autonomy from social actors: what I call “dependence”. In the most extreme situations of dependence, social actors not only embed themselves within the state; they effectively absorb all power to direct state action. Commonly associated with rent-seeking capitalism, such engagements typically involve social actors eviscerating the most defining qualities of states: their bureaucratic structures. Indeed, acute situations of state evisceration might at first seem to undermine the very notion of dependent state-society engagements at all because the near absence of fundamental state bureaucratic structures (other than those dedicated to the monopolization of violence) questions whether any relevant state structures remain that one might call dependent on social actors.

As such it should be obvious that the notion of pure state dependence of the state on social actors does more than just preclude a *democratic* state; It calls into question the ability of state bureaucratic structures to survive such an engagement at all. Prime examples of such engagements include Peter Evans discussion of the Zairian “predatory state” of the 1960s and 1970s. For Evans, qualities of the predatory state included an ability to “disorganize[ing] civil society,” an absence of bureaucracy that “made the state rapacious,” and the joining of repressive violence with neo-utilitarian rent-seeking (1995: 43-47). Clearly, however, extreme dependence of state actors on society comprises one sub-set of the larger category of dependent engagements. But for the purposes of this study, these other, less extreme ideal-typical arrangements of dependence are less relevant than other, conceptually-distinct categories that involve not just differences of degree in state autonomy, but also differences of kind in the nature of these engagements.

One such engagement – the second point on the state engagement axis – is what I jointly refer to as clientelism and patronage. Although scholars differ widely in their precise definitions of clientelism, here I borrow from Susan Stokes definition of it as involving more particularistic forms of mobilization than just the forms of vote buying that she associates with the broader category of patronage. Stokes defines clientelism as "involving the proffering of material goods for electoral support, where the criterion of distribution that the patron uses is simply: did you (will you) support me?" (Stokes 2007: 606). Its distinguishing feature is the distributive criterion of electoral support as opposed to materially oriented strategies. In clientelism "a powerful political actor may or may not hold public office, and therefore may or may not be able to credibly promise to secure public resources (as opposed to, say, party resources) for the client." (Stokes 2007: 610) One way that clientelism differs from other materially oriented political strategies such as pork-barrel politics and redistributive politics is that clientelism involves a quid-pro-quo whereby redistribution only become available to clients on the condition that they provide political support.

Clientelism also differs from patronage, which for Stokes is "the proffering of public resources (most typically, public employment) by office-holders in return for electoral support, where the criterion is again the clientelistic one: did you – will you – vote for me?" (Stokes 1997: 609) By contrast, a patron already holds office and distributes state resources. Said slightly differently, clientelism involves an economic monopoly over goods which the patron controls independently of the outcome of the election, whereas patronage involves a political monopoly over goods that she controls only if she stays in power. Because a patron holds a political monopoly, patronage

presents unique collective action problems for voters trying to vote a patron out of office. Even though accomplishing this goal is a common good, individual voters face serious risks of retaliation from the patron for voting against her. Because each individual voter minimizes this risk and maximizes payoffs by simply voting for the patron again, most individuals are likely to vote for the patron, ultimately keeping her in power.

Analysts of Brazilian politics have long argued that clientelism and patronage politics constitute the modal category of state engagement with society since re-democratization (Weyland 1995; Hagopian 1994). In a certain minimalistic sense, the findings of this study do not deny that patronage and clientelism still constitute a central means by which local state actors in the Brazilian public health sector engage various social actors, particularly actors from the private hospital and health insurance industries. Indeed, multiple informants point to such patterns of engagement as a defining feature of health politics in large Brazilian municípios including Rio de Janeiro, Salvador, Fortaleza, and other cities which rank poorly in health service delivery (not coincidentally, I will argue). For analytical purposes, it is important to emphasize that both clientelism and patronage do not only represent comparatively more autonomous forms of state engagement with social actors than relations of outright dependence imply; They also constitute less autonomous modes of engagement than various neo-corporatist, clientelist, and outright exclusive modes, which I turn to shortly. And it is precisely the longstanding dominance of clientelism and patronage politics in local Brazilian politics that renders a newer generation of studies on participatory politics so intriguing.

A third point on the state engagement axis – what I refer to as "institutionalized devolution" – primarily refers to a variety of participatory institutions for public goods

allocation throughout urban Brazil. Perhaps the most carefully chronicled such engagements occurs within the participatory budgeting (PB) institutions for which Brazilian cities like Porto Alegre became renowned (Avritzer 2002; Baiocchi 2003, 2005). Baiocchi, Heller, and Silva define the basic institutional feature of PB as "the creation of submunicipal assemblies of ordinary citizens that discuss and then prioritize budget demands for their areas. The demands are then integrated into the city budget. The most notable feature of PB is that it represents a form of citizen-controlled demand-making that takes places *parallel* to the existing system of party-based representation and as such marks a dramatic break with the patronage-driven politics that have long dominated municipal budgeting in Brazil (2011: 8). Other research points to a variety of relatively new state-society spaces that institutionalize perhaps less participatory but no less consequential engagements such as health councils and city-level master-planning (Abers and Keck 2009; Avritzer 2009; Coelho 2006; Coelho and von Lieres 2010). In contrast to PB, these other spaces might be thought of as quasi-participatory because assumed representatives (Gurza Lavalle and Houtzager 2010) of civil society associations – not lay citizens – participate in these policy-making spaces.

I group both of these participatory and quasi-participatory engagements into the broader category of institutionalized devolution because they both represent substantive efforts by state actors to incorporate social actors – usually (but not exclusively) civil societies – into policy making by devolving them an impressive degree of power to steer state action. Clearly, then, the power relations that various modes of institutionalized devolution cultivate are multiple and depend greatly on the types of social actors to which state actors devolve particular state powers. In my later discussion of the larger regimes

of state-society politics that such engagements partially constitute, I note a range of other such arrangements that diverge quite radically from those of participatory politics in Brazil. For example, the interest group politics that are well-known to the United State federal government could well be thought of as a mode institutionalized devolution in which state actors effectively devolve specific policy making powers to highly cohesive groups of capitalists. The end of this chapter takes up the separate analytical task of parsing the larger differences in regime type that emerge from institutionalized devolution of state action to capitalists (in a capital-driven regimes) as opposed to institutionalized devolution to civil societies (in a participatory democratic regime).

For present purposes, however, I simply define institutionalized devolution as a range of state engagements (with various types of) in which state elites share a strikingly broad set of policy-making powers with social actors through an array of rule-bound and regularized governance procedures. I propose that such engagements tend to produce degrees of state autonomy, which typically exceed those prevalent within clientelist and patronage arrangements, but which typically fall short of the greater levels of autonomy that state actors preserve for themselves through various neo-corporatist arrangements. Thus, I recognize that the broad range of social actors, who may succeed in demanding engagements of institutionalized devolution will generate similarly broad variations in the extent to which resulting institutional arrangements for exerting state action are: a) more versus less transparent and; b) more versus less conducive to the cultivation of traditional notions of the rights-bearing democratic citizen. But for analytical purposes, I offer the broader category of institutionalized devolution as a way to focus attention on state engagements with social actors that can be simultaneously rule bound and regularized

(and therefore not clientelist) as well as highly discretionary in their devolution of greater controls over the state levers to social actors. While many such institutional arrangements (i.e. health councils) may be idiosyncratic to Brazil, others (i.e. participatory budgeting) have traveled the world around and as such warrant closer consideration and more overt comparison to other, longer-standing modes of state engagement with social actors.

Another, distinct grouping of these other modes – what I loosely refer to as neo-corporatism – constitutes a fourth point on the state engagement continuum. My starting point for appropriating and adapting this concept is to draw on the basic definition of Jingjing Huo and John D. Stephens, whose own understanding usefully integrates two different definitions from 1980s literature, "one that emphasized the strength and centralization of employers' organizations and union federations, and one that focused on the tripartite bargaining and policy by these centralized interest associations and the state (Schmitter 1982). Our working definition of corporatism begins with the latter but incorporates the former: In corporatist political economies, peak associations of capital and labor meet with the state to strike bargains over broad social and economic policy including state expenditure, taxation, wage policy, etc" (forthcoming: 3). Although these authors use such definitions primarily to bargaining within such sectors of OECD countries, I propose here to adapt this concept to Brazil and the conceptualization of the health developmental states that this project advances.

Thus, fundamental to my understanding of this concept is that many sub-types of neo-corporatism exist, whose idiosyncrasies owe much both to the type of social actors who embed themselves within state structures, as well as the kinds of ruling political parties in relevant jurisdictions of formally democratic government. I propose that the

most relevant of these sub-types for the study of Brazilian politics and for inductively theorizing state-society relations more broadly is a particular sub-type that I came to think of during my fieldwork as "associational corporatism". I define associational corporatism as a hitherto un-theorized mode of state engagement with embedded civil society associations in which such associations come to exert active and institutionalized policy-making influence through the activist, programmatic agendas they advance as key political party officials and as politically appointed state officials. In my fieldwork, I found that associational corporatism is largely limited to the overarching ideal type of a pragmatist regime in which pragmatist public become deeply embedded within the local state and leftist parties rule local government. As such I discuss this particular sub-type in greater detail below, in my discussion of regime types.

For now, the larger point is that many varieties of neo-corporatism are possible but all such sub-types share the common characteristic that associations of various types – whether civil society, capital, or labor – meet with ruling state officials in a relatively routinized fashion to strike bargains over particular policies. As such, neo-corporatism constitutes a type of engagement in which politicians and bureaucrats exhibit more autonomy from social actors than they do in situations of institutionalized devolution, but less than autonomy than they possess in other types of engagement such as exclusion and insulation, to which I turn next.

A fifth type of state engagement with social actors – what developmental state theorists commonly refer to as "bureaucratic insulation" – constitutes the next point on the axis. Peter Evans' work has done perhaps the most to advance sociological thinking beyond prior understandings, which tended to assume that bureaucratic insulation was

incompatible with the embeddedness of state actor within the networks of social actors, in general, and capital, in particular. Expanding the findings of prior scholarship (Johnson 1982; Wade 1990), Evans' studies of developmental states in Korea (1995) and determinants of development more globally (Evans and Rauch 1999) established bureaucratic insulation from social actors as a key requirement of effective industrial policy. Other state theorists (Chibber 2003) expanded beyond the notion of embedded autonomy to highlight the ways in which bureaucratic insulation constituted a key dimension of state elites' capacity to discipline industrialists in ways that were required for the growth of the manufacturing sector. Evans' subsequent work (2002) helpfully expanded the concept to focus on state-society synergies between politicians and bureaucrats, on the one hand, and a broader range of social actors beyond just capital.

However, it is important to note that – despite examining the same empirical cases – other scholars articulate subtle but theoretically-relevant distinctions in their understandings of the state engagements that some developmental state theorists label as "insulated". For example, in drawing inferences about the Korean developmental state's mode of engagement with capitalists, Atul Kohli (2004) and Vivek Chibber (2003) arrive at quite divergent appraisals from each other and from Evans. The Korean development state for Chibber exhibited, not insulation from capitalists in the manufacturing industry, but a subtle subservience to their imperatives. In this reading, the kinds of state engagements typified by the Korean developmental state resemble (though are not identical to) notions of "relative autonomy" debated by Poulantzas (1976) and his contemporaries. I drew attention to this very real empirical possibility of state engagements with society in the "institutionalized devolution" category of state

engagements that I discussed above. In particular, I conceptualize such subtler, potentially more opaque, but no less institutionalized ways in which state actors devolve development policymaking authorities to capital as helping constitute the more encompassing ideal-type of the industrial developmentalist regime type. Below I discuss in greater detail this ideal-typical regime and the centrist and right-leaning political parties on which they tend to rely in Brazil.

Yet, still other analysts propose that insulation may belie more fundamentally repressive and exclusive state engagements with social actors. In contrast to the argument of Chibber, Kohli (2004) instead crystallizes the concept of a "cohesive-capitalist" state in arguing that the Korean developmental state exhibited a comparatively unadulterated level of autonomy. Indeed Kohli's account articulates not just the bureaucratic insulation of state actors from social actors but something bordering on outright exclusion of them. In this reading, one of several causes of the Korean developmental state' success in promoting industrialization was outright repression of labor, rural peasants, and other social categories that initially opposed its agenda. Another key dimension was the state's ability to impose a modicum of discipline on capital that required a more formidable distance and nearly outright separation from them than the more modest concept of insulation connotes. As such, this reading points to similarities and differences between insulation and the still-stronger types of state (non)engagement with social actors to which I turn next.

Finally, on the engagement continuum, the concept of "exclusion" represents the opposite pole of dependence. Indeed, exclusion connotes such a radical degree of state autonomy from social actors that it begins to altogether undermine the very notion of

state engagement with society. Largely consistent with totalitarianism, the "exclusion" bookend of the axis is theoretically relevant to note here because it undermines the facile notion that the greatest possible state autonomy is always better for social and development policy outcomes. Rather, it allows understandings of state-society relations to highlight the ways in which extreme forms of state autonomy from social actors almost always have deleterious effects on social actors and on social policymaking, in particular. In this respect, while diametrically opposed from the opposite pole of pure dependence of state on social actors, exclusion shares such qualities with extreme dependence.

Outright exclusion was never in evidence during this project's examination of state-society relations in the public health sector. Yet it important to model exclusion within the framework of state-society regimes that I crystallize below because it outlines the limits of state autonomy and the limiting effects that the most extreme form – exclusion – on social relations. Extreme degrees of state autonomy that border on exclusion offer no panacea for resolving trenchant health inequalities. In part, this is because they deprive the state of inputs from civil society actors that can temper state actions and make them less damaging and potentially more conducive to various social actors. Next, I turn to the final axis in the model of state-society regimes.

Range of Political Parties Penetrated

A third and final constituting axis of state-society regimes in urban Brazil captures variation in the number of ruling political parties that relevant social actors penetrated as well as the breadth or narrowness of the social actors with whom such parties tend to ally. I understand the political party in Alexander's terms as a regulative institution of civil society, which is not only susceptible to colonization by noncivil

spheres such as capital and organized labor but also capable of being harnessed in the service of comparatively more universalistic ideologies of particular civil societies. Indeed, the cases of Belo Horizonte and Porto Alegre are cases in which (two distinct types of) civil societies effectively invaded the local party structure of the Workers Party, where they played outsized (but by no means complete) roles in molding its political platforms around their ideologies between the late 1980s and mid-2000s. But since the type of state engagement with embedded social actors and civil societies (namely, the second axis of my model that I reviewed above) already tends to reflect the variably broad or narrow scope of social actors with whom ruling parties ally, I focus in this third axis on the range of political parties that key social actors penetrate.

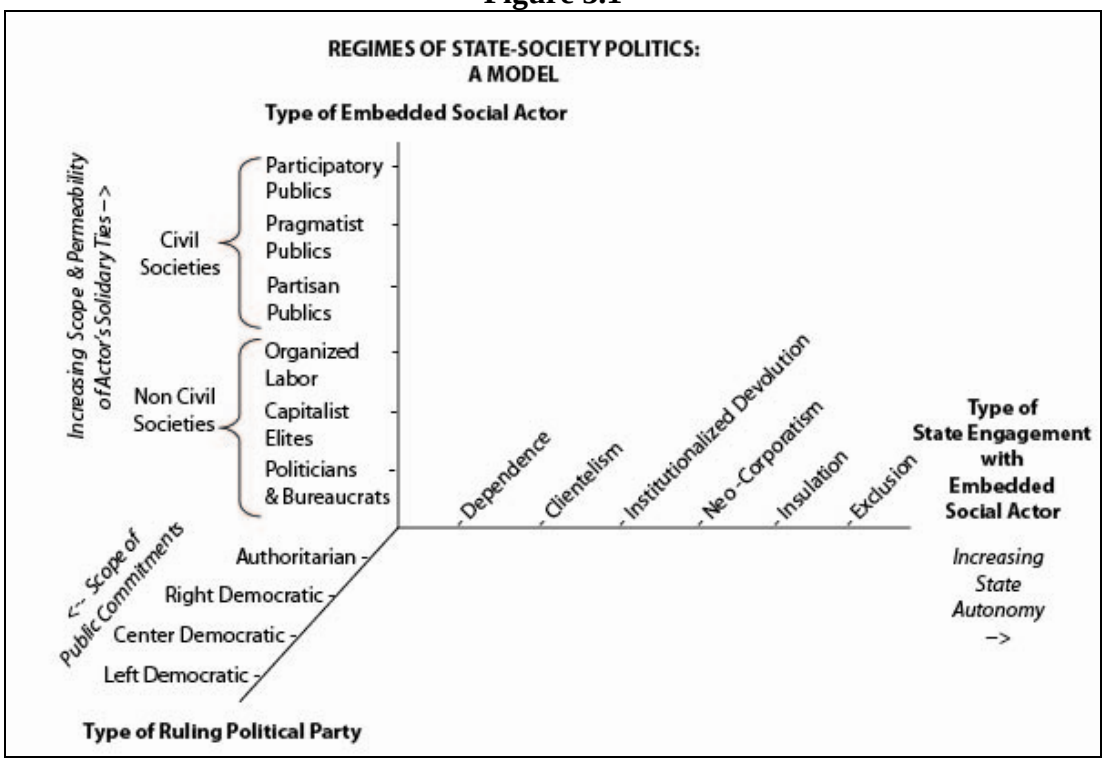
This axis is particularly useful for differentiating participatory and pragmatist regimes from one another. It is clear, for example, that pragmatist civil societies from the Sanitarista Movement in Belo Horizonte penetrated a far broader range of ruling political parties (in the executive and in city council) than was the case for participatory regimes in Porto Alegre, which penetrated the Worker's Party but few other, ruling party structures. Ultimately, this parameter matters because penetrating an especially broad array of ruling political parties can not only pre-empt resistance from opposition parties by diminishing them as potential veto threats to adopted political projects and specific policy proposals; It may also create alignments of otherwise divergent interests in such projects over the long-term. In terms of consolidating local health developmental states in Brazil, this was a crucial variable at which pragmatist regimes excelled because of broad cross-party agreements about the priority of state-building in the sector. By contrast, the comparatively narrower range of parties that both partisan publics and participatory

publics penetrated in other regime types contributed to the difficulty of sustaining state-building commitments over the period extending from the late 1980s into the late 2010s.

A Model of State-Society Regimes in Urban Brazil

I argue that various combinations of points along the three above continua together constitute an array of ideal-typical state-society regimes, which can be located within the three-dimensional conceptual space of Figure 1 (below). Here, I offer the standard qualification that these ideal-types offer a heuristic device, whose correspondence to highly complex on-the-ground realities is certainly inexact. Nevertheless, the model offers one modest tool for differentiating various types of regimes from one another by focusing attention on some of their most theoretically relevant qualities. I focus below on three ideal-types that I observed during my fieldwork: what I call pragmatist, participatory, and clientelist regimes. But I also aim to ground and locate the coming empirical discussions of these regime types and their effects on state-building and service delivery within the existing literature on state-society regimes that I reviewed in previous chapters. To do so, I also briefly address and locate a few other theoretically relevant regime types within the conceptual space of Figure 1, namely industrial developmentalist regimes, labor corporatist regimes, urban growth regimes, totalitarian regimes, and authoritarian regimes.

Figure 3.1



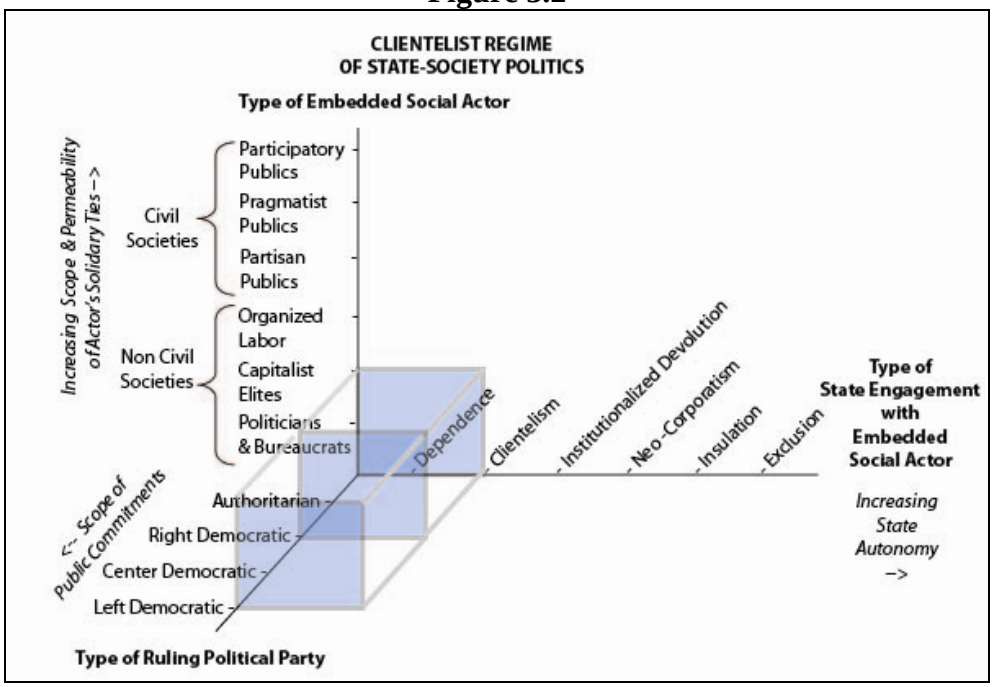
The Clientelist Regime

Perhaps the modal category of state-society politics in urban Brazil until quite recently was what I call the clientelist regime. As such, this regime type serves as an important reference category against which to contrast newer, more democratic, and more developmentally effective regimes such as the participatory and pragmatist regimes that I articulate below. In analytical terms, I define clientelist regimes as involving clientelist modes of state-society engagement in which capitalist elites, entrenched bureaucrats, and lifetime politicians, who successfully embed themselves deeply within relevant state structures, prove effective in extracting rents from their positions from economic and political elites on the local, typically neighborhood level in exchange for what commonly amounts to promises (but not always delivery) of public services, including primary health services. I call these regimes clientelist because, in contrast to participatory,

pragmatist, and even partisan regimes, clientelist regimes typically shield civil societies from meaningful forms of political participation in decision making around public goods provision. Such clientelist regimes occupy the conceptual space outlined below in Figure 2. In later chapters, I ground this ideal-type by demonstrating the ways in which a clientelist regime defined the politics of primary public health care (and other public goods) provision in Rio de Janeiro between the late 1980s and late 2010s.

The work of Weyland (1996) demonstrates that, historically, the nation-state politics of health care provision between 1985 and 1992 roughly approximated this definition of a clientelist regime. As a point of departure for this dissertation, Weyland fundamentally agrees that "leaders of the health reform movement occupied positions inside the public bureaucracy from which they could launch their progressive efforts" and that "members of the movement gained posts in different public agencies" (1700). Yet he argues that they "soon became absorbed into the rampant bureaucratic politics that

Figure 3.2



ravages the Brazilian state" and that "clientelist politicians in the government and in Congress soon offered strong resistance to equity-enhancing change and pressed for the dismissal of members of the health reform movement from the public bureaucracy" [posing] "the most important obstacle to health reform" (1700). While Weyland notes that, "reform-minded public health experts…gained their most powerful support not from society, but from inside the public bureaucracy itself, namely from municipal and state governments…but did not have sufficient influence on policy making," his analysis speaks primary to the period before 1990, when the Integrated Health System was created and local governments received sweeping new powers to institutionalize the health sector at their own pace and to more and less sophisticated degrees. As such, any argument about the existence of more developmentally effective regimes of state-society politics in the Brazilian public health sector must contend with this not-so-distant reality. To be sure, such regimes endure today and continue to impede the expansion of primary public health services in cities as varied as the Northeastern city of Salvador to the former capital of Brazil, Rio de Janeiro.

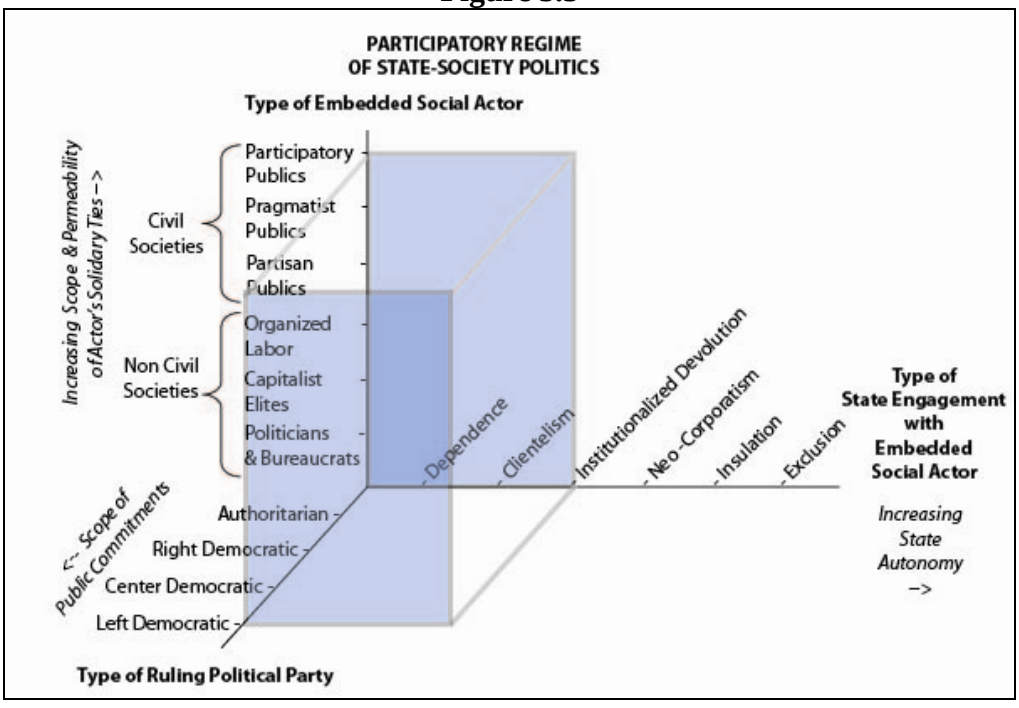
Participatory Regimes

Another theoretically relevant (though empirically quite rare) regime type in local urban Brazilian politics is what I refer to as the participatory regime. In analytical terms, I define participatory regimes as involving a particular form of state-society engagement in which ruling leftist parties orchestrate the decentralization of binding policymaking powers to participatory publics via new modes of institutionalized devolution. Such regimes occupy the conceptual space outlined below in Figure 2. Empirically, later chapters demonstrate the ways in which a participatory regime defined the politics of

primary public health care (and other public goods) provision in Porto Alegre during a materially consequential period stretching from approximately 1989 to 2005. Here, I focus on how the combination of a locally ruling leftist party, a participatory public embedded in the local state, and state-society engagements of institutionalized devolution together constitute the conceptual ideal-type of a participatory regime.

A first, defining quality of such a regime is state engagement with a broad set of civil society actors through a decidedly *participatory mode of institutionalized devolution*. In such participatory modes of institutionalized devolution, a deliberatively-oriented civil society co-generates public goods policies of the local state by adopting decision-making roles that are more typically limited to politicians and bureaucrats. Although the experiences with participatory budgeting that I reviewed above most clearly exemplify such a mode, they are not its only tangible manifestations.[4] But for present

Figure 3.3



purposes I simply highlight that, when not simply imposed in a "mono-cropped" fashion (Evans 2004), participatory budgeting and other, similar institutional technologies may well reflect more encompassing "bottom-up" patterns of state-society interaction. For example, in his path-breaking account of the politics of participatory budgeting in Porto Alegre, Gianpaolo Baiocchi highlights that "[t]he OP [Participatory Budgeting] is part of an empowered participatory regime marked by a high degree of openness to societal demands, few constraints on civil society, and bottom-up empowered participation as a way to process societal demands" (2005: 19). In this sense, participatory regimes out-pace the ability of even the most sophisticated sociological theories of civil society to account for their incumbent modes of state engagement with civil society because participatory publics prove so radically innovative in inventing an entirely new type of democratic institution to involve themselves in the politics of public goods provision. Yet, other analyses refer to this and a separate but related set of Redistributive Direct Democratic (RDD) institutions as a new kind of regulative institution of civil society, in Alexander's terms (Gibson 2012).

A second defining quality of participatory regimes is that they involve a particular sub-set of civil society – namely a participatory public – becoming embedded within the state, typically through the invention of just such participatory institutions. As a result, participatory regimes expose a vast number of citizens in a participatory public to remarkable proximity over the allocation of public goods via these new and more broadly inclusive regulative institutions of civil society. Third, participatory regimes historically have relied upon a surprisingly narrow set of political parties to perpetuate these institutional arrangements. While this commonly proved effective for building some of

the state capacities required to expand basic public health care – particularly, the physical infrastructure of clinics and medical equipment that participatory publics' control over the capital budget allows – it proved less effective for leveraging political pressures to advance arguably the most important piece of state-building in the contemporary era: the ranks of public employees. For reasons that later chapters articulate in more detail, participatory regime's tendency to channel reformist political projects through just one party can result in a loss of momentum for this longer-term, human resource necessity of a health developmental state, not only by reducing the scope of political party advocates for such reforms, but also by expanding the number of veto-points that political parties excluded by the regime tend to erect.

I aim to complement existing accounts of such regimes by drawing attention to the central place that a participatory mode of institutionalized devolution plays in constructing relations between participatory publics and ruling leftist parties within participatory regime. Specifically, I focus on ways in which a defining feature of participatory regimes – the relatively narrow range and sometimes singular left ruling party that orchestrates participatory modes of institutionalized devolution for integrating participatory publics into the politics of public goods provision – may not only distance other civil societies, such as pragmatist publics, from key policymaking roles, but also erect obstacles to enduring patterns of state-building. From the standpoint of deepening and widening civic participation in democracy, this phenomenon is an unquestioned virtue of participatory regimes that is well-documented and shown to improve associational density. However, when considered from the standpoint of their effects on longer-term processes of state-building in particular public goods sectors such as the

primary public health care sector, participatory regimes may also have unintended and potentially detrimental consequences. For example, although the more narrowly-composed civil societies that I call "pragmatist publics" embrace less participatory visions of political involvement than participatory publics do, these pragmatist publics may well prove more adept at advancing sectorally narrower, but financially more expansive state-building and policymaking projects in certain public goods sectors like the primary public health care sector.

Particularly when examined in the comparative light of Belo Horizonte's decidedly less democratic pragmatist regime, several constraints and contributions of Porto Alegre's participatory regime come into fuller relief. On the one hand, existing research clearly establishes that participatory regimes' organization of state-society engagement through particular technologies of institutionalized devolution such as participatory budgeting can not only deepen democracy in a strikingly profound manner (Baiocchi 2005) but also redistribute public goods toward generally poorer city regions (Marquetti, Campos, and Pires 2008). On the other hand, I highlight how participatory regimes may also limit the influence that both participatory and decidedly non-participatory civil societies can exert in matters of state-building. For one, technologies of institutionalized decentralization that are common to participatory regimes often minimize the degrees of freedom that narrower and more centralized "pragmatist publics" might otherwise enjoy in mobilizing broad-based political party support to expand the state itself. Nowhere is this structural deficit of participatory regimes more palpable than in Porto Alegre's public health sector, where proposals to expand the hiring of municipally employed primary health care workers languished during the 2000s. The reasons for this are many and

complex but for comparative purposes of drawing contrasts between participatory regimes and other regimes such as pragmatist regimes, I highlight the comparatively isolated and powerless position in which participatory publics found themselves in their advocacy to expand the size of the municipal public health state (as opposed to simply redistributing its existing resources towards poorer neighborhoods). To be sure, participatory publics accomplished an impressive tour de force in successfully demanding control over state levers for redistributing existing state investments from the capital budget. Yet they also proved generally unable to effectively demand new, expanded investments in the kinds of financially burdensome and politically volatile human resources priorities that were required to universalize and equalize access to primary public health care during the 2000s.

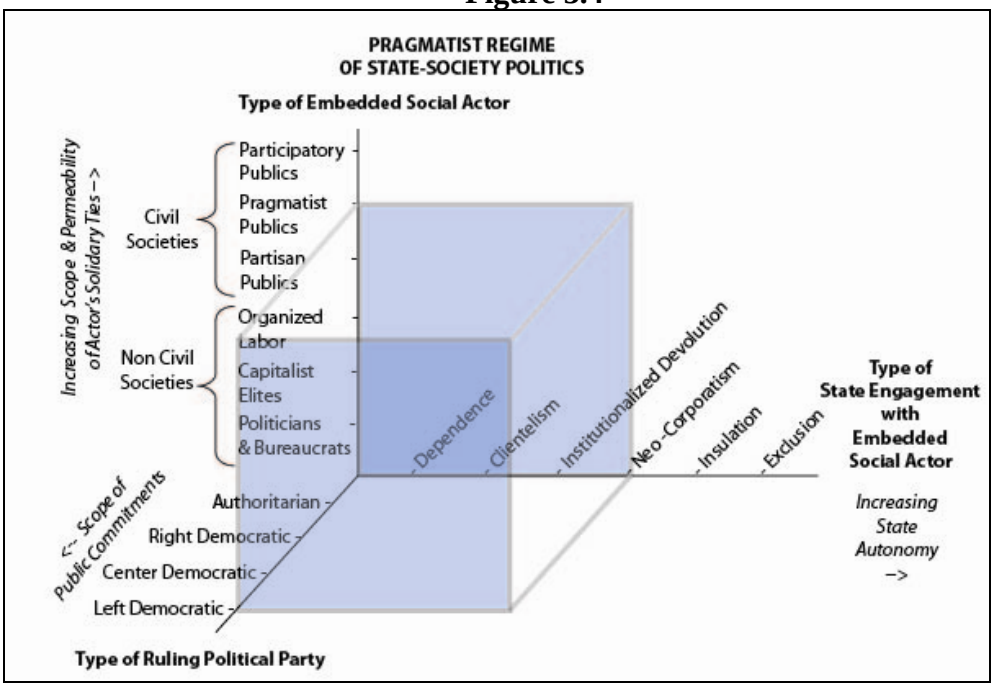
In the coming empirical discussions of both Porto Alegre and in Belo Horizonte, I argue that participatory publics in both cities struggled to mobilize political support for improving what many public health experts argue is the single-most important dimension of a universal health care system: the sizeable numbers of state (municipally)-employed primary health care workers required to deliver such care in sufficient volumes and in locations in which the populations who most need these services reside. For example, the radically democratic technologies of institutionalized devolution that define participatory regimes typically fell short of devolving to participatory publics the kinds of powers for creating cadres of salaried primary public-health professionals to actually provide services. As I come to next, this constitutes a major difference from pragmatist regimes.

Pragmatist Regimes

A third theoretically relevant regime that is of particular relevance to local Brazilian politics is what I refer to as the "pragmatist regime". In analytical terms, I define pragmatist regimes as involving a particular state-society relation in which ruling left or left-center parties engage pragmatist publics through the brand of associational corporatism I introduced above. We can think of pragmatist regimes as occupying the conceptual space outlined below in Figure 3. Empirically, I find these regimes to be slightly more prevalent throughout major Brazilian cities than participatory regimes but far less common than clientelist or left partisan regimes. Upcoming chapters demonstrate the ways in which a pragmatist regime defined the politics of primary public health care provision in Belo Horizonte during a materially consequential period stretching from approximately 1992 to 2008.

A first defining quality of pragmatist regimes is associational corporatism. Recall that associational corporatism is a sub-type of neo-corporatist state engagements with society and may well be endemic to pragmatist regimes. In associational corporatism, ruling left and center parties engage pragmatist publics, not through institutionalized devolution of policymaking powers to deliberative publics, as occurs in participatory regimes, but through something closer to an "involution" of them into what remain fundamentally top-down policymaking processes. In core respects, associational corporatism thus contrasts quite sharply with the institutionalized devolution engagements that partially define participatory regimes. Institutionalized devolution decentralizes the policymaking process by taking it directly to participatory publics through the new regulative institutions of civil society that that they crystallize (e.g. participatory budgeting), in certain respects bypassing traditional state structures and

Figure 3.4



civil society regulative institutions like office and parties. In contrast to institutionalized decentralization, associational corporatism operates in something closer to the opposite manner.

Specifically, while policymaking processes in associational corporatism remain comparatively centralized, pragmatist publics can integrate themselves into these processes by invading state spheres through two regulative institutions – political parties and office. On the one hand, these regulative institutions of parties and office invariably prove to be far less admissive than more novel participatory regulative institutions because the former minimize the roles that can be played by other, non-pragmatist civil societies with far broader memberships and more expansive solidary ties to groups beyond just themselves. On the other hand, when linked to a comparatively broader suite of ruling left and center parties through associational corporatism, pragmatist publics that mobilize through parties – and especially through office – gain perhaps more direct

influence within state-building debates than, for example, participatory publics gain through institutionalized devolution. Crucially, however, two further defining features of pragmatist regimes prevent associational corporatist engagements from descending into outright co-optation or clientelism.

A second defining feature of pragmatist regimes is that pragmatist publics tend to become an especially deeply embedded social actor within relevant local state structures. In this respect, pragmatist regimes differ fundamentally from other regime types, including participatory regimes in which deliberative publics most deeply embed themselves within relevant structures, and clientelist regimes in which rent-seeking actors embed themselves most deeply. In particular, pragmatist publics become deeply embedded within the state by working through regulative institutions such as parties and office, which are more commonly dominated by lifelong politicians in the case of parties and entrenched bureaucrats in the case of office. Unlike these other two actors, however, the ideologies of pragmatist publics originate in and depend upon communicative institutions for their reproduction. Pragmatist regimes rely upon these publics remaining motivated by and dedicated to advancing political projects, which themselves derive from publicly-legitimated civil society ideologies – including the ideology of universal access to public health care – that originate in communicative institutions. The universalizing, publicly-legitimated ideologies that civil societies advance through regulative institutions ultimately rely upon communicative institutions for their reproduction and cultivation within public opinion, law, and democratic associations. But not all civil societies were created equal, in terms of the scope and permeability of the solidary ties that their communicative institutions produce. Important historical differences in the particular

communicative institutions of different civil societies abound that not only affect the scope and permeability of a given public's solidary ties to groups beyond just itself, but also – in the case of associations – the actual membership within this communicative institution.

Indeed, the communicative institutions of pragmatist publics and participatory publics differed historically in decisive ways that differentially molded and distinguished the relational character of the pragmatist and participatory regimes they respectively constituted. The most politically relevant communicative institution for *pragmatist publics* in both Porto Alegre and Belo Horizonte were associations of health care workers, whose memberships numbered in only the hundreds or, at most, thousands. The key communicative institution of Belo Horizonte's sanitaristas, for example, was an association of universal public health care activists that called itself the *Partido Mineiro Sanitarista* or Mineiro Sanitarista Party (MSP). Although upcoming chapters unpack this association in greater detail, two dimensions of this communicative institution stand out for present purposes of articulating how different types of civil societies matter for the overall regime types they constitute. Particularly when compared to the hundreds of thousands of members that participatory publics contrastingly counted among their ranks, the mineiro sanitarista party had a comparatively miniscule membership, mostly of health professionals of various competencies who were in training on university campuses and involved in health care delivery. (The fact that the association called itself a party at all, which it was not, is itself indicative of its comparatively minimal, unofficial membership.)

Yet, a key point is that the small size of the MSP in Belo Horizonte did not preclude it from communicating and propagating an ideology – specifically the ideology of universalizing access to the most basic forms of publicly-provided health care – that ultimately produced and generalized solidary ties of the broadest possible scope and the most permeable of memberships. By contrast, there is no known evidence to suggest that in Porto Alegre anything like a pragmatist public of sanitaristas evolved the sophisticated forms that this civil society developed in Belo Horizonte. It is perhaps not surprising that Porto Alegre's sanitaristas played fleeting roles, but nothing like the consistent, influential roles in producing society-wide solidarities around the ideology of universal health care provision that sanitaristas in Belo Horizonte did.

Communicative and regulative institutions of *pragmatist publics* in Belo Horizonte came to exert far greater political influence than participatory publics in that city. Conversely, the communicative and regulative institutions of *participatory publics* came to exert greater influence than those of pragmatist publics in Porto Alegre. In both cities, the communicative institutions of these participatory publics took the form of umbrella associations of neighborhood organizations, whose massive memberships number in the hundreds of thousands, if not millions. Yet size did not necessarily equate to influence. If anything, the size of the participatory public that advocated participatory budgeting and other mechanisms of institutionalized devolution in Belo Horizonte likely dwarfed that of Porto Alegre, owing in large part to the similar base of this public within the neighborhood associations of what amounts to a larger and denser population in the former versus the latter município. The more relevant consideration is that the ideology of participatory publics in Belo Horizonte's came to be subsumed beneath that of

pragmatist publics for universal health care, who counted among their ranks a much small number of activists.

A third and final quality of pragmatist regimes is that their embedded pragmatist publics occupied a decidedly broader suite of left and center parties than other civil societies such as deliberative publics tended to penetrate and occupy and in the participatory regimes of other major Brazilian cities. Later in this dissertation, I document a prime example in which a pragmatist civil society of sanitarista activists in the município of Belo Horizonte invaded a broad range of left and left-center political party structures that included far more than just the Workers Party (compared to the occupation of Porto Alegre's participatory regime by a deliberative public). The penetration of such a broad cross-section of political parties was far more common during the pro-democracy struggles of the 1970s and 1980s in which civil society activists from the *Diretas Já* movement both colonized a wide array of political parties, many of which they themselves first created as underground, clandestine party organizations. Yet this became a far less frequent phenomenon in local politics during struggles to consolidate democracy in urban Brazil after 1988, as the Workers' Party became the flagship party for nearly all progressive social reforms in the public goods sectors of large Brazilian cities, both nationally and locally. In this respect, both pragmatist publics and the decidedly wider range of left and left-center parties that they permeated in Belo Horizonte's pragmatist regime into the late 2010s fundamentally differ from the narrower range of political parties (typically, only the Workers Party) that other civil societies penetrated in both participatory and partisan regimes.

Other Regime Types

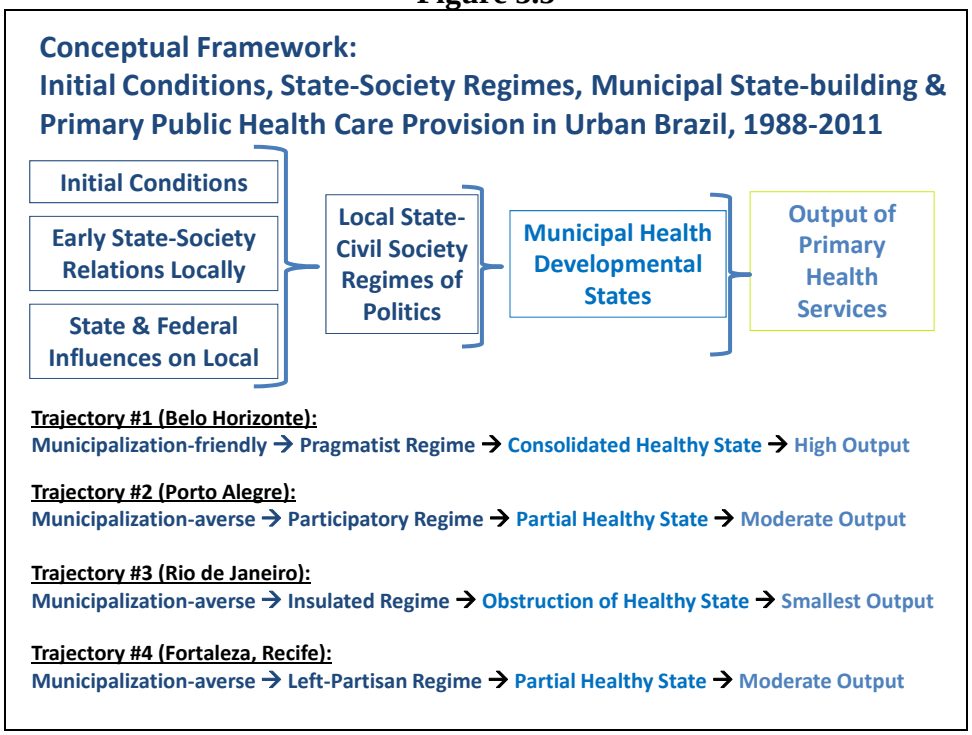
There are many theoretically possible types of state-society regimes that could fit into the conceptual space of Figure 1 (above). I lack the space to articulate these here. But these include what I call the "Industrial Developmental Regime" of the developmental state literature (Chibber 2003; Evans 1995, Kohli 2005) in which state elites adopt an autonomous mode of regulating deeply embedded capitalist elites, typically through a relatively narrow sweep of sometimes authoritarian political parties. Public service provision in an "Authoritarian Regime," which aptly describes the public health sector under the Brazilian regime of national state-society politics between 1964 and 1988, involved predominantly clientelist relations between career politicians from a singular, military-led ruling party and capitalist elites from the private hospital industry (Weyland 1995). "Urban Growth Regimes" (Logan and Molotch 1987) involve either a single of broad suite of political parties, which exchange highly minimal and sometimes non-existent tax revenues from deeply embedded capitalist elites for the approval to maximize the exchange values of public spaces. Neo-Corporatist Regimes (Schmitter 1974, 1985; Kerala: Heller 2000) involve a relatively broad array of left-democratic or center-democratic ruling parties mediating wage-setting and other political economic disputes between highly embedded representative of organized labor and capital.

A Framework of Regimes, State-building & Changes in Primary Public Health Provision

During my fieldwork and research, I observed four distinct trajectories of local institutionalization in the primary public health care sector of urban Brazil after 1988. The chart below summarizes these trajectories. Each trajectory corresponds to one of four regime types: pragmatist, participatory, clientelist, and left partisan. Most fundamentally,

the framework suggests that rates of expansion in primary public health care provision since 1988 are largely traceable to the extent to which these four regime types built, consolidated, or obstructed the rise of local health developmental states. Subsequent chapters describe trajectories of pragmatist, participatory, and clientelist regimes in greater detail, while the conclusion addresses trajectories of left partisan regimes and offers a generalization of the framework beyond just the Brazilian cities examined most extensively in this project.

Figure 3.5



In the following chapter, I document one ultimate outcome of these divergent trajectories: variable rates of change over time in municipal delivery of primary health services since 1988.

Notes:

[1] Although the regimes on which I focus in coming chapters describe politics within Brazil's largest cities during specific period of time ranging from several years to nearly two decades, my aim is to develop a parsimonious and generalizeable framework for categorizing state-society regimes beyond just the contexts of Brazilian cities. I do so by weaving together key findings from my fieldwork with central concepts from the theories I reviewed above. Thus, the model neither pretends to have arisen in a purely inductive fashion from my empirical observations alone, nor does it represent a purely abstract set of concepts deduced from existing the theories I consider. Rather, it constitutes a mixture of these two approaches to theory-building. While some elements of the model offer new conceptualizations that expand upon existing theories by drawing on findings that are specific to Brazil, the three general parameters that I conceptualize speak to questions of democratic governance in social policymaking within other large developing world democracies such as India and Indonesia, as well.

[2] Thus, this notion of market capitalism as having an intimate normative structure of its own differs sharply from much canonical sociological thinking about markets. For example, Polanyi (1944) implies that, unlike the counter-movements against which counter-movement they purportedly arose in a more or less spontaneously reactionary fashion, un-embedded markets lacks normative foundations completely. By contrast, I draw on Alexander in proposing that markets do draw upon normative structural foundations, however, these foundations are fundamentally "noncivil" in the sense that their hierarchies "often interfere with the construction of the wider solidarity that is the sine qua non of civil life" (Alexander 2006: 7).

[3] Among their many achievements, struggles for universal health care in urban Brazil effectively re-defined and expanded the scope of social actors to which the very notion of a citizenship right to public health was thought to pertain. Before the Constitution of 1988's enshrinement of universal rights to public health care, laws and practice of health care administration circumscribed the scope of that right to Vargas-era notions of citizens as formal sector workers.

[4] A suite of other, less directly democratic institutions, including the municipal health councils that Leonardo Avritzer associates with "power-sharing" arrangements (2009), also constitute this sub-type of institutionalized devolution. Such engagements are participatory in their devolution of state authorities to civil society, but narrower than participatory budgeting in the range of civil societies that come to exercise such authorities.

CHAPTER 4

OUTCOMES:
CHANGING SERVICE DELIVERY AND LOCAL STATE CAPACITIES IN THE PRIMARY PUBLIC HEALTH CARE SECTOR

The central outcome explored in this project is post-1988 growth in the performance, role, and state capacities of large, capital-city municípios for delivering primary health care services to populations of exclusive SUS users throughout urban Brazil. This is a theoretically-relevant outcome in part because widespread state delivery of public health services based on universal citizenship rights inscribed in the 1988 Constitution – and guaranteed through a set of additional federal laws that assigned the responsibility for primary care to municipal states – ultimately represents a historic departure from the prior practice of excluding large swaths of the population from access to even the most basic kinds of health services. As discussed in Chapter 2, the country's prior, bureaucratic authoritarian regime systematically excluded all Brazilians except formal sector workers from access to public health care provision, including the most basic forms of primary, preventative care. The few, mostly complex health services that it did provide to formal sector workers were delivered primarily within a network of federally-contracted but privately owned hospitals in large capital city municípios throughout the country's generally wealthier South and Southeastern regions. Indeed, existing research shows that what Brazil's military dictatorship did spend on public health care before re-democratization and the advent of SUS was highly skewed toward

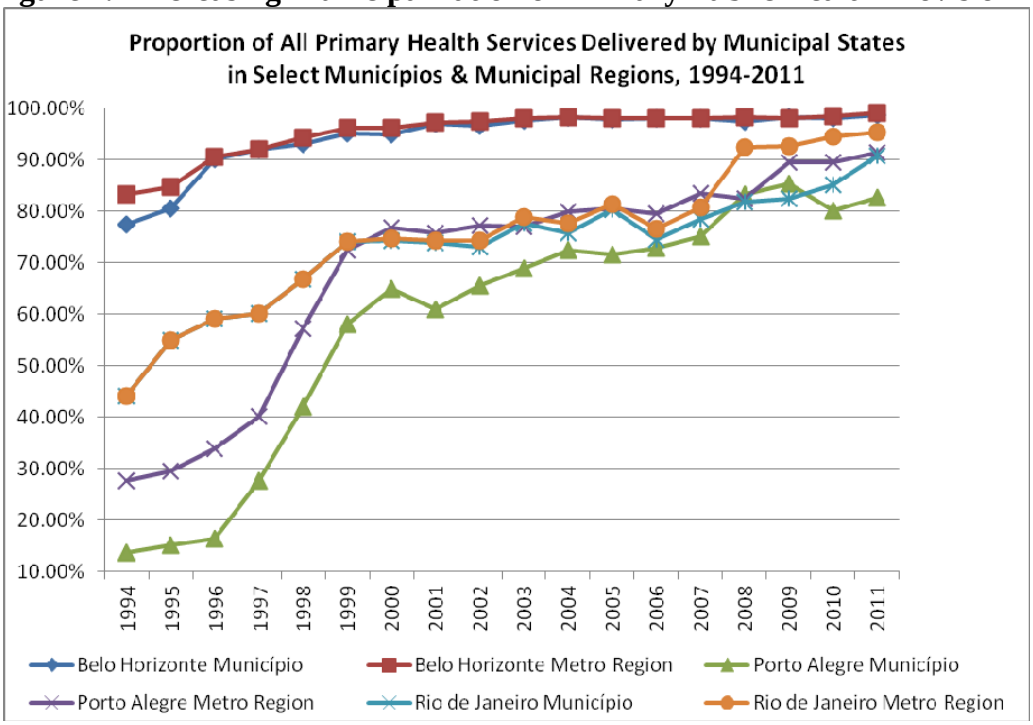
the provision of high complexity services in large South- and Southeastern region cities like those examined in this study (Belo Horizonte, Porto Alegre, Rio de Janeiro) as well as in São Paulo (Akerman 1994; Coelho 1996).

In both comparative, cross-national studies and single case studies, multiple scholars examine how this background played into the national level of Brazil's dramatic expansion in public health provision during the 1990s and 2000s (Falleti 2010; McGuire 2010). Yet, existing work offers few insights into the many dimensions and considerable levels of sub-national variation across urban Brazil. In particular, little is known about sub-national variation in the extent to which municipal states began delivering the most basic health services as a public good accessible to all citizens, particularly those priced out of private health care that is consumed in the country's extensive network of private hospitals and accessed through the associated health insurance industry. In this chapter, I document some of this substantial variation in primary public service provision and the expanding role of the municipal state in providing it across urban Brazil, focusing on variable ending points (by 2011) and trajectories of change over time (between 1994 and 2011) across the municípios of Belo Horizonte, Porto Alegre, Rio de Janeiro.

Probed in greater depth by coming chapters, I begin by highlighting two overarching patterns in the *share* and *magnitude* of primary public health care provision by these cities' municipal states within their respective territories.[1] First, while all municipal states examined in this study eventually assumed the predominant *share* in delivering primary public health services within their respective territories (vis-à-vis the shares accounted for by all other levels of government and the private sector), their trajectories began and ended at different levels and traveled divergent pathways in

between. Figure 4.1 (below) provides an overview of this variation across city and time in these shares of municipal activity in the primary health care sector. In 1994, the first year for which systematic data are available, the municipal state share of all such public service provision within its boundaries was largest in Belo Horizonte (77.44%), smallest in Porto Alegre (13.68%), and at a level in between these two extremes in Rio de Janeiro (44.07%). By 2011, this share had climbed to 98.7% in Belo Horizonte, 82.64% in Porto Alegre (13.68%), and 90.81% in Rio de Janeiro.

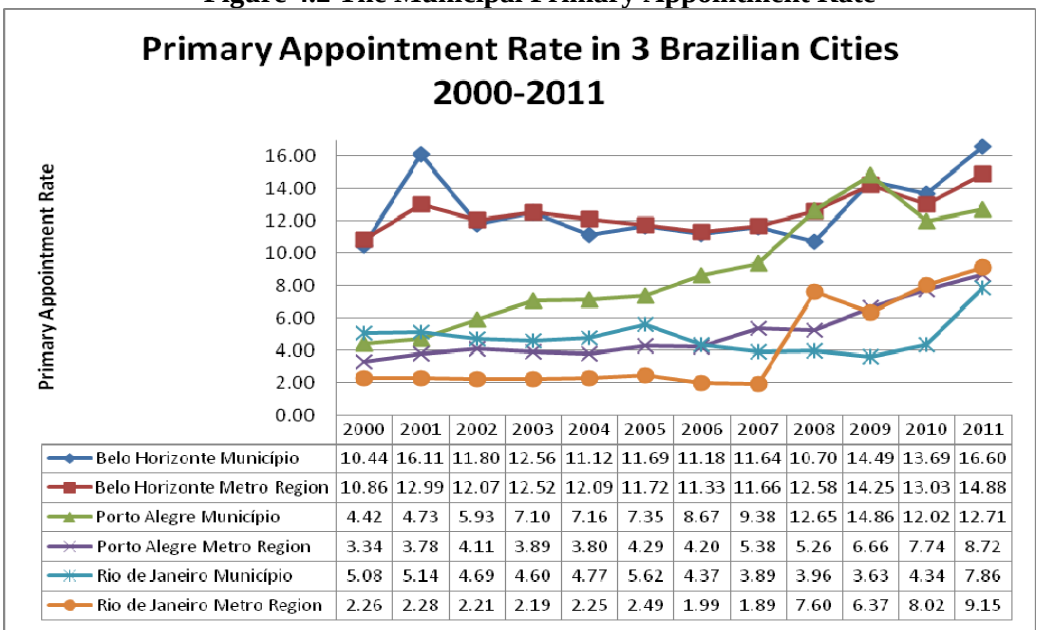
Figure 4.1 Increasing Municipalization of Primary Public Health Provision



Second, municipal states expanded the *magnitude* of their primary health service provision to widely varying levels by 2011 and through diverse trajectories during the 2000s (and probably during the 1990s as well). Here, too, their beginning points, ending points, and pathways travelled in between all varied widely across the municípios I examine. In 2000, the earliest year for which systematic data are available on service

provision, I find that the ratio of all municipally-provided primary health services to exclusive SUS users was 10.44 in Belo Horizonte, 4.42 in Porto Alegre, and 5.08 in Rio de Janeiro.[2] When we instead consider the ratio of primary health services provided to exclusive SUS users, regardless of the identity of the provider,[3] the same ranking of these three cities holds. These cross-city variations are at least partly attributable to the fact that during this year, the município of Belo Horizonte had already become nearly the exclusive provider of such services (94.97%), while Porto Alegre's município provided only 64.87% of those services, and Rio de Janeiro's município provided 74.38%. By 2011, this ratio had grown to 16.60 in Belo Horizonte, 12.71 in Porto Alegre, and 7.86 in Rio de Janeiro. This suggests that while Belo Horizonte continued to be ranked the highest of cities by 2011, Porto Alegre began the decade of the 2000s on par with Rio de Janeiro but dramatically outperformed it afterward to consistently rank second among these cities during nearly all years during the 2000s.

Figure 4.2 The Municipal Primary Appointment Rate



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Belo Horizonte Município	10.44	16.11	11.80	12.56	11.12	11.69	11.18	11.64	10.70	14.49	13.69	16.60
Belo Horizonte Metro Region	10.86	12.99	12.07	12.52	12.09	11.72	11.33	11.66	12.58	14.25	13.03	14.88
Porto Alegre Município	4.42	4.73	5.93	7.10	7.16	7.35	8.67	9.38	12.65	14.86	12.02	12.71
Porto Alegre Metro Region	3.34	3.78	4.11	3.89	3.80	4.29	4.20	5.38	5.26	6.66	7.74	8.72
Rio de Janeiro Município	5.08	5.14	4.69	4.60	4.77	5.62	4.37	3.89	3.96	3.63	4.34	7.86
Rio de Janeiro Metro Region	2.26	2.28	2.21	2.19	2.25	2.49	1.99	1.89	7.60	6.37	8.02	9.15

Further, while the role and performance of município states in primary public health delivery constitute the ultimate outcome explored in this project, this chapter also documents variation in two, key intermediate outcomes related to the capacity of these states for achieving these ultimate outcomes. Município-level states that managed to expand primary service provision during the 1990s and 2000s did so largely by inheriting (from other levels of government) and constructing two especially important kinds of state capacities for delivering these services: primary health care clinics and primary health care professionals.[4] Existing studies highlight how many cities expanded these capacities through the principal federal model of attention for delivering primary, preventative health services: the Family Health Program (PSF). In contrast to prior, more centralized modes of service delivery, the PSF effectively tasked municípios with delivering primary services in the generally poorer, geographically peripheral, and lower (Human Development Index (HDI) regions of cities, where the largest numbers of exclusive SUS users tend to reside (Escorel et al 2009). But the implementation of PSF and the provision of such services more broadly (outside of the PSF platform favored by federal governments since 1994) depended on the capacity of the municipal state for fulfilling these responsibilities. Importantly, such capacity-building processes were heavily tied to more encompassing political processes on municipal and state levels that conditioned the ability of municipal governments to expand the number of municipal primarily health care professionals, including those associated with PSF teams, as well as those delivering primary public health services through attention models other than the PSF. To the extent that this landmark shift in the delivery of public health care to rights-bearing citizens by municipal governments actually transpired within urban contexts

otherwise defined by many entrenched inequalities, the expansion of primary public health care provision constitutes a fruitful topic of inquiry for sociologists of development, citizenship, and politics more generally.

Sub-national Variation in Primary Health Provision via the Family Health Program

The relatively new capacity of municipal states in large Brazilian cities to broadly deliver primary services to poor populations in historically marginalized, geographically peripheral regions of cities is itself an important measure of a Senian notion of development as capability-enhancement. It is also instrumentally important for health outcomes, as epidemiologists have shown by demonstrating that expanded primary health service provision is positively and significantly associated with reductions over time in infant mortality and other indicators of health status. For example, one study shows that across all Brazilian states between 1990 and 2002, a 10% expansion in the populational coverage of the Family Health Program (PSF) was associated with a 4.5% reduction in infant mortality rates, controlling for measures of access to clean water and sanitation, income, female literacy and fertility, physicians and nurses per 10,000 residents, and hospital beds per 1000 residents (Macinko, Guanães, and de Souza 2006). As such, it is important to note that the basic pattern of cross-município variation I find in the expansion of primary care provision through the PSF – an important flashpoint in existing literature on health service delivery in Brazil – largely matches the pattern that I documented above in Figure 4.2 regarding all such provision in the cities I examine. As in my estimate of the more encompassing primary appointment rate, Belo Horizonte ranks first among my cases (and in the country as a whole) in populational coverage

through PSF, while Porto Alegre ranks second, and Rio de Janeiro ranks last for nearly all years.

But expansions of health service delivery are also theoretically important in their own right because they indicate that state bureaucracies of large municípios began penetrating much further downward into peripheral city regions in which residents were previously excluded from the right to health and, as a result, suffered from even greater epidemiological risks than they currently face. This shift represents nothing short of a transformation from the theoretical right to health articulated by the *Sanitarista* and MOS movements to a more fully realized right to health. Service expansions indicate that local states have begun meeting the public demands for primary health care, which these social movements claimed as a universal right of all citizens in the 1988 federal constitution. This shift also represents a counterpoint to the clientelist patterns of service delivery for which Brazilian cities are well-known (Wayland 1996; Gay 1990). Under this more familiar historical pattern, public goods were not only under-provided but were also typically exchanged for votes and other forms of political patronage.

Still, researchers have yet to systematically explain the roots of what amount to substantial cross-city variation in the extent to which Brazil's largest capital city municípios expanded their post-1988 provision of primary health care services.[5] I use several electronic, federal Health Ministry records and statistical records of local governments themselves to calculate changes over time in the number of primary care appointments these local states deliver as well as the rates of these appointments to exclusive SUS users in each city. By highlighting such expansions, I do not intend to minimize the fact that health social movements' project of universalizing access to the

most basic services is very much ongoing, as coverage remains far from universal. Nor should we overlook the fact that accessing primary public health care typically involves substantial delays and uncertain access in the cities I examined. Yet, seen in comparative-historical perspective, the sub-nationally uneven, but overarching pattern of nationwide expansion in primary health care delivery through SUS since 1990 stands out as an impressive achievement, particularly during a period in which Brazil faced the same, formidable neoliberal pressures to shrink social policy that led other countries of the global South away from even attempting to institutionalize anything like a universal right to basic, publicly-provided health care.

Local Implementation of the Federal Family Health Program (PSF)

Although the Family Health Program (PSF) represents the federal government's main platform for delivering wide-ranging array of primary health care across the country, PSF requires substantial levels of municipal commitment, financing, and local state capacity to implement. As part of a larger set of requirements for assuming full control over local institutionalization of public health care provision, municipal governments must first agree to implant PSF teams and embrace this federal program's mode of organizing human resources in the delivery of primary health services. The main intervention of the PSF, which was created by the federal government during the late 1990s, is a team of health professionals that consists of a physician, a nurse, a nurse's assistant, and typically four or more community health workers. Municipal governments then assign each PSF team to a given geographic area over which these assume responsibility for enrolling and monitoring the health status of the resident population, providing that population with primary care services, and referring residents to other

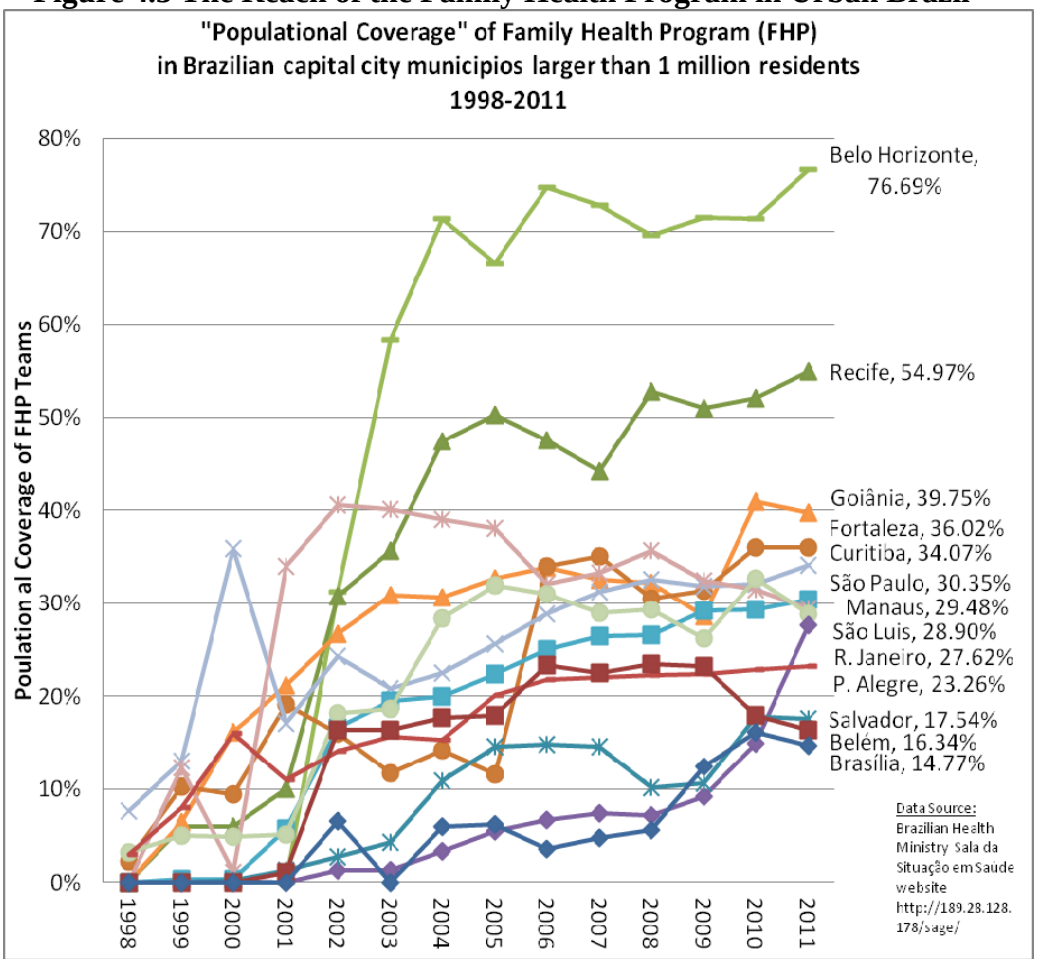
levels of care, as needed. According to federal Health Ministry standards, each team assumes responsibility for 3,450 residents, although this number has varied over recent years and has reached maximums of 4,500 people in the cities I examine. Typically, PSF physicians and nurses deliver primary care services at health facilities located in or near the community to which a team is assigned, while community health agents undertake household visits to identify needs and offer basic health promotion and education consultations.

Based on the federal Health Ministry's assumption that each PSF team reaches 3,450 residents annually, it devised a statistic called "populational coverage," which can be used to measure the reach of a program across a given geographic area. On the level of the município, this statistic is constructed by multiplying the number of teams working in the município by 3,450 and then dividing that product by the total population of the município. On the national level, the Federal Health Ministry reports that the program employed 32,498 teams, which covered approximately 53.41% of Brazil's nearly 191 million residents in 2011. According to this basic metric, the program underwent a massive expansion from its inception in the late 1990s. Indeed, according to these statistics, the PSF reached comparable numbers of Brazilians as the federal government's more commonly noted conditional cash transfer program for combating poverty, *Bolsa Familia*.

Yet, not all municípios implemented the PSF at the same time or expanded the program at the same rate, leading to vast cross-city discrepancies across cities in the populational coverage of PSF. The table below shows that, among Brazilian capital-city municípios with at least 1 million residents (according to Brazil's 2010 Census), the

PSF's populational coverage in 2010 varied from a national high of well over 70% in Belo Horizonte to a low of below 15% in Rio de Janeiro during the same year.

Figure 4.3 The Reach of the Family Health Program in Urban Brazil



By selecting three cases that reflect this full range of variation in the populational coverage of PSF, this project documents and offers a comparative-historical explanation for why and how local governments in major Brazilian cities developed the local state capacities required to implement primary health care programs that include but are not limited to the PSF. Among the three cities that I chose in 2009 for in-depth examination is Belo Horizonte, which then and now is the top-performing large city in Brazil. By 2011, city government in Belo Horizonte employed over 504 PSF teams through which it

reached 76.69% of its nearly 2.4 million residents. As the starkest possible contrast to this effectiveness in implementation, I also chose the lowest performing city – Rio de Janeiro – a second case for further examination. While PSF implementation in Rio de Janeiro improved markedly since the inception of my dissertation research – from by far the lowest coverage rate of any large Brazilian município in 2008 (7.2%) to nearly 28% by 2011 – the município still ranks near the bottom of the distribution. With only 165 PSF teams employed to deliver services in a município of over 6 million residents, Rio de Janeiro constitutes a perhaps more commonplace negative case for understanding the obstacles that clientelism and a general insulation of civil societies from governance processes can pose to the task of expanding primary health care provision in urban Brazil. Third, I also chose the município of Porto Alegre, whose ranking between the median and bottom quartile of this distribution belies its popular reputation for robust public service delivery and its status as a theoretically-relevant anomalous case of public services expansions attributable to participatory democratic politics. While Porto Alegre's moderate primary health care provision vis-à-vis other similarly-sized Brazilian cities reflects its municipal health secretariat's hiring of only 95 PSF teams to deliver these services in a city of nearly 1.5 million residents, this outcome is somewhat perplexing against the backdrop of studies that link the city's pioneering experiences with participatory budgeting to expanded public goods provision in multiple social service sectors (Marquetti, Campos, and Pires 2008). As such, Chapter 6 explores this outcome in greater detail.

For now, however, it is important to note that while state-level factors clearly played an important role in shaping the timing of municipalization and thereby

conditioning the performance of municípios in the primary health sector, the particular performance of the three cases I examine is not merely reducible to such state-level factors. Table 4.1 (below) displays the ten year average of populational coverage between 2002 and 2011 for the three municípios I examine and their encompassing metro regions and states.

Table 4.1. PSF Populational Coverage Rates*, Ten Year (2002-2011) Averages for Three Cities and their Encompassing Metro Areas and States

	Belo Horizonte	Porto Alegre	Rio de Janeiro
Município	70.44%	19.99%	8.45%
Encompassing Metro Area: only metro area municípios over 100,000 residents †	41.55%	21.18%	35.58%
Encompassing Metro Area †	46.44%	15.10%	35.09%
Encompassing State ‡	57.62%	29.18%	28.00%

* Coverage rate data are from the Federal Health Ministry website, Sala da Situação em Saude http://189.28.128.178/sage/.
† According to 2010 census figures. Both metro area coverage rates are weighted by the combined population of the municípios considered.
‡ The encompassing state of Belo Horizonte is Minas Gerais, while Porto Alegre's state is Rio Grande do Sul, and Rio de Janeiro's state is the state of Rio de Janeiro.

The central point to arise from the table is that the exceptional performance of Belo Horizonte's município in populational coverage through the PSF between 2002 and 2011 (70.44%) far exceeded that of the other 34 municípios that comprise its encompassing metro region (only 46.44%). While one might argue that Belo Horizonte's performance during the 2000s was merely an epiphenomena of more aggressive action in the primary health sector by its encompassing state of Minas Gerais, this claim would predict that Belo Horizonte and other large municípios would all be top-performers. Yet this was clearly not the case during the 2000s. While it is true that populational coverage through PSF was generally higher in Minas Gerais (57.62%) than in both Rio Grande do Sul (29.18%) and Rio de Janeiro (28.00%), this generally superior statewide performance of

municípios across Minas Gerais was far less pronounced among the other municípios in Belo Horizonte's encompassing metro region, particularly those over 100,000 residents (41.55%). In short, this suggests that while state-level factors could have played some role in Belo Horizonte's unsurpassed performance, they certainly cannot account for all of the municípios impressive performance in this regard.

A number of additional points arise to further reinforce this interpretation that state-level factors do not determine municipal performance, including the observation that municípios across Porto Alegre's encompassing state of Rio Grande do Sul (29.18%) tended to outperform the município of Porto Alegre (19.99%), as did the other large (over 100,000 residents) municípios within Porto Alegre's encompassing metro region. Thus, on one level, the story of Porto Alegre is one of an under-performing capital city município within a generally under-performing state. The third column in the table exhibits a perhaps more extreme version of this pattern, with the município of Rio de Janeiro grossly under-performing (8.45%) within a generally under-performing state (28.00%) in which other large município within the Rio de Janeiro metro area nevertheless tended to far outperform (35.58%) the município of Rio de Janeiro itself. In short, while state-level factors have some bearing on municipal factors, it is clear that with respect to populational coverage through PSF, municipal factors can matter a great deal in both upward directions, as in the case of Belo Horizonte, as well as in downward directions, as in the case of Porto Alegre.

Limits of Measuring Primary Public Health Care Provision using PSF Coverage

A number of limitations arise when using PSF coverage to estimate municipal delivery of primary public health services. I discovered during fieldwork that in addition

to the many assumptions built into assuming that all PSF teams actually reach the populations to which they are assigned, not all cities relied exclusively on the PSF as their sole programmatic platform for primary health care delivery. The decision to implant PSF locally was one that the municipal health secretariats in early-adopting cities like Porto Alegre experienced major obstacles to implementing effectively after 1998, while other, later-adopting cities like Belo Horizonte implemented the program with relatively few interruptions after 2002. Indeed, Porto Alegre actively resisted the implementation of PSF in the município because of disputes about the work organization of the teams and how health professionals with pre-existing jobs within the local public health bureaucracy would be incorporated into service delivery through the PSF (Scorza 2010). This ill-fated entre of PSF into Porto Alegre led to a consequential backlash against it, which resulted in the PSF comprising a small proportion of primary health care services delivered by the município until as recently as the mid-2000s.

While the manner in which relevant actors resolved this dispute in Porto Alegre was particular to that city's regime, such disputes were hardly unique to Porto Alegre during the period. Indeed, a similar dispute went unresolved for nearly five years in Belo Horizonte, delaying the implantation of PSF teams until 2002. It was not until then that local public health bureaucrats, civil society activists, and organized labor unions reached an agreement, which ultimately proved highly effective for expanding the PSF. In Porto Alegre, the particular solution arrived upon for resolving these disputes initially generate a major backlash against the program that delayed its further expansion. As I develop more fully in Chapter 6, civil society organizations tied to the neighborhood association movement initially succeeded in placing neighborhood association directors in charge of

actual PSF teams when the program was first implemented in the late 1990s, an arrangement that caused a nontrivial uproar among the health professionals who worked on PSF teams.

By contrast, while similar disputes arose in Belo Horizonte, union leaders, neighborhood associations, other civil society organizations, and the local politicians and health bureaucrats responsible for primary health care delivery ultimately accepted and implemented the federal PSF platform in a far more deliberate fashion, which ultimately incurred less resistance than was the case in Porto Alegre (Borges 2010). In Chapter 5, I trace this more seamless entry of the PSF and other home-grown platforms for primary care delivery to a pragmatist regime of state- society politics, which methodically pursued a comparatively deliberate, less democratic, more calculated, and ultimately more effective approach to incorporating of the PSF's new work regime into a pre-existing political economy of health service provision in the city. While the years that these solutions took to crystallize and implement ultimately delayed PSF's entry into Belo Horizonte, they also resulted in the largest expansion of PSF in any large Brazilian city.

Still another contrast can be seen in the slow and limited implementation of PSF in Rio de Janeiro during the same period. Although implementation of the program struggled from similar concerns about the organization of work teams, the clientelist politics that define governance in the city for many analysts (Gay 1999; Weyland 1995) formed a consequential backdrop for the entry of the program there. In response to documented reports of massive and widespread corruption throughout the State of Rio de Janeiro's management of hospitals in 2004, the federal Health Ministry staged an

unprecedented takeover of the entire hospital system from Rio de Janeiro's state government. Against this backdrop, the municipal government's adoption of the PSF played out in a slow and limited fashion with the populational coverage of the program reaching only 7.20% by its 128 teams in 2008.

For present purposes of operationalizing the outcome of change over time in public health care delivery by local governments, this background context presents a number of implications. For one, it implies that analysts would do well to examine statistical records from more than just the Basic Health Information System (SIAB), the federal database for recording services delivered through the PSF platform. By focusing solely on SIAB records of primary care delivery, analysts commonly overlook basic services provided through parallel, complementary delivery platforms. Further, by mistaking município populations as a whole for the actual sub-set of those populations that are exclusive consumers of primary public health services, statistics like populational coverage not only underestimate the nationwide reach of such services to the generally lower classes who use them, but also mask important cross-city differences in overall development levels of cities that affect SUS usership differently in less versus more development cities. Perhaps most troubling is these statistics' conflation of PSF teams' responsibility for reaching a given population with their actually having done so, in practice. Next, I describe my strategy for developing measures that begin accounting for these formidable analytical challenges.

The Municipal Primary Appointment Rate

I operationalize the outcome of changes over time in municipal state provision of primary health care using a measure called the municipal primary appointment rate. The

appointment rate is a ratio of the total number of primary public health services provided by the município to the total number of exclusive SUS users in the município. As I demonstrate below, some municípios expanded this ratio far more than others following re-democratization in 1988. Although the World Health Organization (WHO) had defined the appointment rate in narrow terms as consisting of the ratio of primary care doctor visits to public health system users, the Brazilian Ministry of Health, and municipal health managers in Belo Horizonte, Porto Alegre, and Rio de Janeiro commonly refer to the appointment rate as I defined above. Especially since countries of the global South like Brazil lack the generally larger numbers of trained doctors present in many countries of the global North, the managers whom I interviewed commonly referred to the appointment rate as the number of appointments delivered by a broad range of trained health professionals that includes doctors, nurses, nurse's assistants, and community health workers. These managers generally understand this approach to calculating the appointment rate as it applies to primary care service provision as a widely accepted metric of universality. Further, the appointment rate is a useful measure of service provision because, even though Brazilian municípios vary in the extent to which they achieve this minimum standard in practice, federal and municipal politicians and health bureaucrats often refer to the appointment rate as a performance benchmark for the municipal health secretariat's overall effectiveness in meeting the goals of SUS. To construct this measure, I used four federal databases compiled by the federal Brazilian Institute of Geography and Statistics (IBGE) and DATASUS, the acronym of the data and statistics bureau of Federal Health Ministry (MS).

Estimating an Appointment Rate that Includes PSF and non-PSF Delivery Platforms

I began by using two databases collected by DATASUS – the Outpatient Information System (SIA) and the Basic Attention Information System (SIAB) – to compile the total number of SUS-funded primary health care appointments administered by public health care professionals in each município. This approach contrasts with other comparative analyses that focus more narrowly on doctor visits provided through the federally-funded Family Health Program (PSF), a statistic recorded in the SIAB (Escorel et al 2009). This project embraces the view that only the SIAB and the SIA can together provide a comprehensive record of the total number of SUS-funded primary care appointments delivered in a given município in a particular year because the SIA also captures services primary health care services provided outside of PSF. This especially matters when, for various reasons, municipal mangers resist providing services through the PSF, which has since 1994 been the federal Health Ministry's preferred attention model for delivering primary care.[6] Both information systems exist in part so that the federal health ministry can record the appointments for which municípios claim reimbursement through SUS. As such, both the SIA and the SIAB record the total number and monetary value of primary health care appointments for which each município claims reimbursement from the federal government through SUS. Although both systems also record the value and number of those appointments which the ministry actually approves for reimbursement, I have chosen to use the number of claimed reimbursements because this number represents the total number of appointments each city claims to provide. Even if rejected for reimbursement with federal SUS funds, these claimed appointments are typically reimbursed from public funds of one kind or another,

qualifying them as public health services. Further, the numbers of reimbursed versus claimed appointments typically vary from one another slightly.

In each of the tables in Appendix 1, the column heading "All Basic Procedures" lists the primary health appointment delivered by all three levels of government and the private sector within both the municipal boundaries and the metro region boundaries of Belo Horizonte, Porto Alegre, and Rio de Janeiro. The appendix lists all years between 1988 and 2011 for which data were available. The sum of all these appointments in a given year appears in the "Total" sub-column. For purposes of calculating the municipal appointment rate, however, I use the sum of values in two columns – the "Municipal: PSF" and "Municipal: Non-PSF" sub-columns – as the numerator for this ratio. The main reason for this choice is that this project is primarily interested in documenting and explaining the state capacity of municipal (not provincial or federal) states to deliver primary health care. More substantively, we should be especially interested in the primary service production by municípios since they not only hold primary responsibility for doing so in Brazil, but also because they increasingly played this role in practice, as the data from 1994 to 2011 attest for all three municípios and their encompassing metro regions.[7] Thus, three other categories of basic health procedures – those provided by contracted private sector providers, state government, and federal government – are not included in the numerator of the appointment rate.

Next, to develop a denominator with which to calculate the appointment rate, I devised a way of estimating the number of exclusive SUS users in each city, as opposed to simply using measures of the municipal population as a whole.[8] Obviously, however, this rate varies by city. The first step in this process was estimating the portion of the

municipal population that is not covered by private health insurance plans, all of which provide privately-consumed primary health care. Private sector health plans (*planos de saúde*) are health insurance plans that can be bought on the open market by individuals or families or may sometimes be provided through formal employment. Although ranging widely in the full range of services they cover, nearly all health plans cover basic primary health care through networks of private (non-SUS) providers. As such, it is a safe assumption that private health plan holders are highly unlikely to seek primary care from SUS. Thus, the proportion of a population with no coverage by a private health plan is a reasonable proxy for the proportion that relies exclusively on SUS for primary health care.

Although scholars commonly use PNAD data for estimating the non-coverage rate,[9] I instead chose the alternative approach of using data on health plan coverage produced by Brazil's National Agency of Supplementary Health (ANS). This body of the federal government is the primary agency in charge of regulating the private sector health insurance industry and receives its data annually on the populations that these companies directly insurers. Companies are required to report these data annually. By multiplying the proportion of residents in a city with no coverage by the total município population, I estimated the population of exclusive SUS users in all cities examined for every year between 2000 and 2011. See Appendix 1 for these estimates and the estimated non-coverage rates and total resident population figures on which they were based. Ultimately, I found that the un-insured population of exclusive SUS users varied by city, metro region, and year. For example, the population of exclusive SUS users in the município of Belo Horizonte was about 1,063,995 (44.6% of all residents) in 2011, while

this number was about 713,612 (50.5%) in the município of Porto Alegre, and 2,815,685 (44.3%) of the município of Rio de Janeiro.[10] Further, these estimates of the SUS-using population are likely to underestimate users since the public health care network of capital-city municípios like Belo Horizonte, Porto Alegre, and Rio de Janeiro often attract residents of neighboring municípios.[11]

It is worth noting here that the general pattern in all three cities and their encompassing metro regions was one of consistently declining non-coverage rates during the 2000s, and likely during the 1990s as well (although figures are not available for that period). This pattern of increasing participation in the private insurance health market likely has as much to do with the general pattern of nationwide economic growth during this period as any other single factor, although no known studies systematically address this question. Thus, while it is clearly true – based on the public service provision figures for primary care in Appendix 1 – that the public system now reaches more Brazilians than at any other time during the sequence under consideration, this would not seem to be causing any downward trend in consumer participation in the private health insurance market; Indeed, usership of private insurance has consistently grown during the 2000s and likely before that, as well. If anything, the generally declining population of exclusive SUS-users could also be related to the stereotypical image of SUS propagated in Brazilian media, which generally frames SUS-funded primary care services as low-quality and difficult to access without substantial delays and inconveniences.

Finally, to arrive at my estimate of the SUS-using population (the denominator in the appointment rate), I multiplied this non-coverage rate for each município by the yearly estimate of the municipal resident population calculated by a federal agency

(*Tribunal de Contas de União, TCU*) responsible for determining the population basis for the federal government's per-capita transfers of Municipal Participation Funds (FPM) to municípios. The Health Ministry (MS) itself uses these yearly population estimates of the TCU when calculating the per-capita based transfers that it makes to municípios for primary health care provision, a transfer that it calls the "Fixed Basic Attention Baseline" fund (*Piso Atenção Básica Fixo, PAB Fixo*). To arrive upon the municipal primary appointment rate, I simply divided the total number of municipally-provided primary care appointments by this estimate of the exclusive SUS-using population for a given year. These ratios are displayed in Figure 4.2 above.

Here, I note a caveat about the municipal primary appointment rate, as I have calculated it. Systematic data on service provision are not available in a consistent and comparable format for all the necessary cases to calculate this rate before 1994. While the project is primary concerned with changes between the initial moment of re-democratization in 1988, I have instead defined the starting point of the service provision trajectories under consideration here as 1994. Thus, I refrain from assuming that the municipal health state in these cities provided no primary care services during 1988 in order to extrapolate the extent of change over time in the trajectory of any given município. Rather, by using 1994 as a beginning point during which all the municípios I examine provided some level of primary care, I model the different starting points of each.

Before moving to a discussion of the key intermediate outcomes that factor into these cities' respective service provision records, it is worth reiterating the many finding that this approach to calculating the municipal appointment rate revealed: namely, that

nearly identical rankings for Belo Horizonte (1st), Porto Alegre (2nd), and Rio de Janeiro (3rd) emerge for the vast majority of years examined, even when using two different ways of estimating service (first, using the commonly applied indicator of populational coverage through PSF; and secondly, calculating a more encompassing municipal appointment rate that accounts for all primary public health services, including PSF and other attention models). When using the measure of PSF populational coverage rates within these municípios, Belo Horizonte ranks first among all Brazilian municípios in the ending level (in 2011) and growth (between 1994 and 2011) of its appointment rate, while Rio de Janeiro ranked near the bottom of the bottom quartile, and Porto Alegre ranked near the median in this regard. As demonstrated above in the Figure 4.2, Belo Horizonte, Porto Alegre, and Rio de Janeiro also ranked first, second, and last, respectively, in the extent to which their respective municipal states produced primary care services within the more encompassing set of clinics, some of which are designated as PSF clinics and some of which are not.

Intermediate Outcomes: State Capacities for Service Delivery

Although the primary appointment rate constitutes the central outcome under investigation in this project, it is an outcome that is indelibly linked to at least three intermediate outcomes the case-based analyses in coming chapters examines in more detail. These include the municipally-employed or contracted health care professionals who provide primary care, the clinics in which they provide these services, and an array of technical planning capacities that municipal governments require to allocate clinics and health professionals toward pressing epidemiological risks that vary widely across regions within the same município. Coming chapters provide more detailed discussions

of the intermediate outcomes and articulate how they together comprise what I conceptualize as local health developmental states. For present purposes, I merely aim here to demonstrate that these capacities vary widely across urban Brazil and the case selections adopted in this project capture much of this variation.

Clinics for Primary Service Provision through SUS

One measure of this intermediate outcome of state capacity for primary health care provision can be seen in the number of SUS facilities that provide primary health care within each city, specifically Basic Health Units (UBS), as well as the ratio of total SUS users to Basic Health Units (UBS). I have chosen these measures because they capture municipal health secretariats' state capacities to meet the SUS goal of universal provision of primary care. UBSs are a crucial piece of physical infrastructure for primary service provision because they house medical teams organized through the two most central SUS-funded primary health care programs in Brazil: the Family Health Program (PSF) and Community Agents Program (PACS). As such, UBS quite literally constitute the doorway to SUS and as such constitute the single most important piece of physical infrastructure for assessing state capacity for primary service provision.

During the late 1990s and early 2000s, some município*s* began confronting low magnitudes and unequal spatial distributions of primary health care facilities by investing in new construction of UBSs in peripheral regions of cities. For example, Coelho (2010) show that after 2000, the município of São Paulo began a major expansion of new Basic Health Units (UBS) as well as Medical Assistance Units (AMAs) in peripheral *sub*-município*s*. Between 2005 and 2008 the number of AMAs expanded from 10 to 116. Although this meteoric rise is somewhat misleading since many pre-existing UBS were

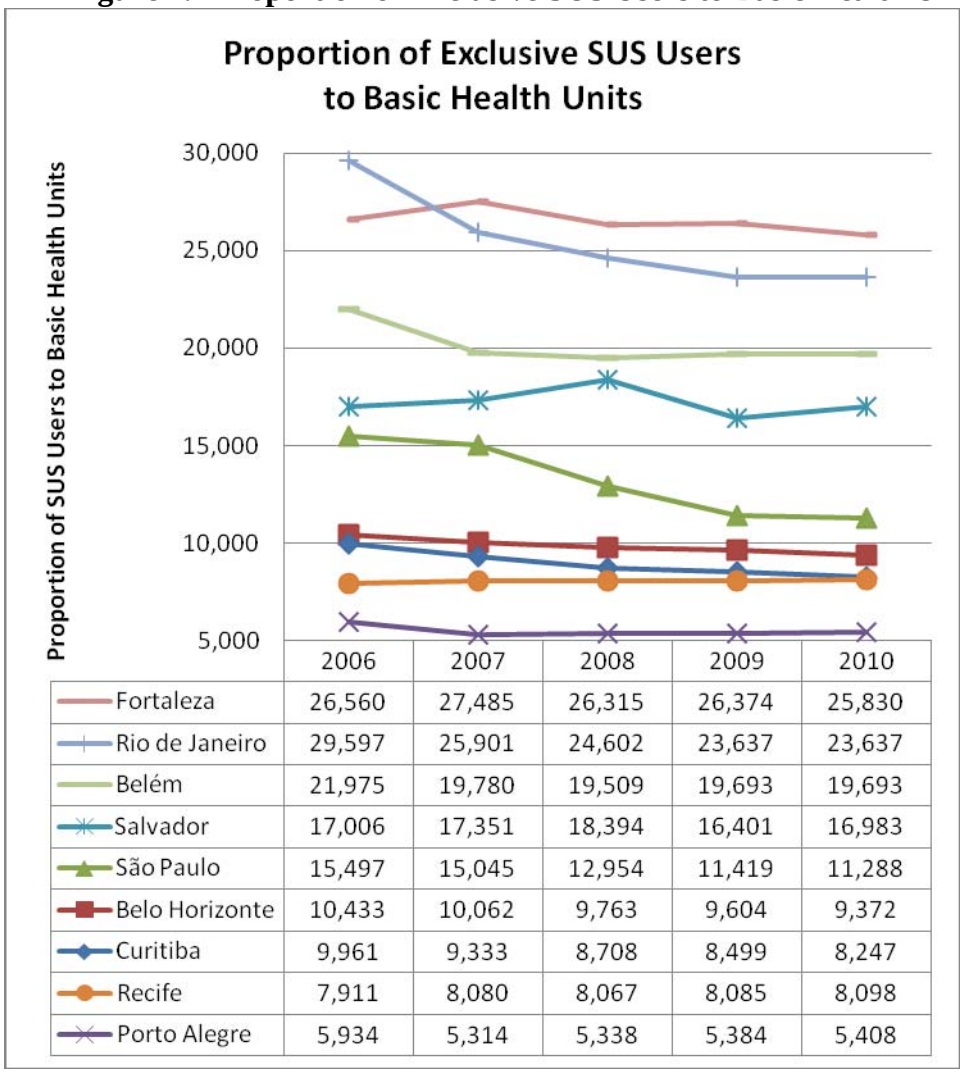
converted into AMAs, the overall trend of expansion is clear. Similarly, the number of UBS more than tripled from 135 in 2000 to 416 in 2008. Although some of the new UBS were also previously healthcare centers or medical service centers of a different designation, few would deny that this represents a major expansion in São Paulo's physical infrastructure for primary health care provision.

This expansion also appears below in my estimate of the proportion of SUS users to Basic Health Units (UBS) for major capital city municípios since 2006. To generate these estimates, I acquired the data on number of UBS from the federal health ministry's electronic information system for registering SUS facilities. I then divided this number by the estimates of the SUS using population discussed above. Again, the overarching picture is that the largest Brazilian municípios vary widely in this measure of state capacity to provide universal care. A minimum condition of providing care – constructing the physical infrastructure in which health professionals can deliver actual care – is another measure of state capacity at which some large Brazilian capital city municípios excel, relative to others. As with the first measure of the primary appointment rate, five municípios far outperform all others: Porto Alegre, Recife, Curitiba, Belo Horizonte, and São Paulo. And between these cities alone, we observe substantial variation with cities such as São Paulo registering nearly double the proportion of SUS users to UBS as is estimated for Porto Alegre.

When considered in the light of rankings of the primary appointment rate, the table also demonstrates that urban Brazil's top performers in actual service provision were not necessarily those with the lowest possible proportion of exclusive SUS users to clinics. For example, while Belo Horizonte exhibited a low user-to-clinic ratio during the

last half of the 2000s, it was not the top performer in this regard. Rather, its ratio of 9340 users per clinic, on average, is still nearly double that of the highest-ranking city, Porto Alegre (which I examine in Chapter 6). By 2010, Belo Horizonte operated 147 basic health units, in which doctors provided over 4 million of the approximately 80 types of services and procedures that are classified as "basic health services" by the federal Health Ministry (MS). While other cities like São Paulo during this

Figure 4.4 Proportion of Exclusive SUS Users to Basic Health Units



	2006	2007	2008	2009	2010
Fortaleza	26,560	27,485	26,315	26,374	25,830
Rio de Janeiro	29,597	25,901	24,602	23,637	23,637
Belém	21,975	19,780	19,509	19,693	19,693
Salvador	17,006	17,351	18,394	16,401	16,983
São Paulo	15,497	15,045	12,954	11,419	11,288
Belo Horizonte	10,433	10,062	9,763	9,604	9,372
Curitiba	9,961	9,333	8,708	8,499	8,247
Recife	7,911	8,080	8,067	8,085	8,098
Porto Alegre	5,934	5,314	5,338	5,384	5,408

Sources: DATASUS (2006-2010); PNAD (2003, 2008); IBGE (2006-2009)

period invested heavily in the construction of new clinics in order to bring this ratio further below the minimum standard of 20,000 recommended by MS and closer to the ratios of Brazil's leading cities, both Belo Horizonte and Porto Alegre had by 2006 already built a formidable number of basic health clinics, relative to other cities in the sample.

It important to note here that – while this head-start goes far further back into recent history than just 2006 and can be seen partially as a path-dependent legacy of a pattern of regional inequality in Brazil by which relatively wealthier South and Southeastern cities like Porto Alegre, Curitiba, Belo Horizonte, and São Paulo generally out-performed less developed Northeastern cities like Salvador and Fortaleza in user-to-clinic ratios – important outliers demand explanation. For example, Recife, the comparatively less developed Northeastern city infamous for having among Brazil's highest infant mortality rates until the early 1990s, stands out as a city whose beginning point in terms of primary health clinics was far less endowed but which managed to build sufficient clinics to outrank all major Brazilian municípios in this respect, except for Porto Alegre. Conversely, the relatively wealthy Southeastern city of Rio de Janeiro ranks last among all major Brazilian municípios in this ratio, dispelling any facile prediction that economic development levels alone predict the state capacity required to build sufficient numbers of clinics for exclusive SUS-using populations.

Further, while low ratios of users to clinics appear to be necessary for the most sizable expansions in primary care provision in urban Brazil, they would not appear to be sufficient. Outliers like Recife, Rio de Janeiro, and Belo Horizonte's generally over-achieving and higher appointment rate vis-à-vis a city like Porto Alegre, with by far the

lowest user-clinic ratio among large Brazilian cities suggests that other factors must be at work, as well. In the case-based analyses of subsequent chapters, cross-city differences in technical planning capacity of municipal states and both the city-wide magnitude and intra-city spatial distribution of clinics and municipally-employed primary health care workers both emerge as important intermediate outcomes that vary across cities as well.

Human Resources for Primary Service Provision through SUS

If basic health clinics constitute one key state capacity required for primary health care delivery, trained primary health care professionals are another. Here, too, considerable variations exist, even between the three cities examined in upcoming chapters. The three columns on the right side of Table 1 (below) display the total number of Family Health Program (PSF) teams in each município between the inception of PSF on a nationwide basis in 1994 and 2011.

Table 4.2. Ratio of Exclusive SUS Users to Family Health Program Teams (PSF)

Year	Ratio of Users to Teams			Number of Teams		
	Belo Horizonte	Porto Alegre	Rio de Janeiro	Belo Horizonte	Porto Alegre	Rio de Janeiro
2011	2015	7512	5565	528	95	506
2010	2206	7539	10768	504	95	266
2009	2574	8478	17885	504	93	165
2008	2675	8950	23826	497	93	128
2007	2817	9389	23630	484	92	131
2006	2831	10215	25119	501	90	118
2005	2847	11569	31106	504	82	96
2004	3201	15260	53507	445	62	57
2003	3682	15733	146235	382	63	23
2002	2840	18133	145075	473	56	23
2001	3412	24177	0	382	43	0
2000	62363	16838	0	20	61	0
1999	0	NA	0	0	30	0
1998	0	NA	0	0	11	0
1997	0	NA	0	0	30	0
1996	0	NA	0	0	24	0
1995	0	0	0	0	0	0
1994	0	0	0	0	0	0

In order to provide a more comparable statistics across cases, the columns on the left side of the table display the ratio of exclusive SUS users to teams. Here again, Belo Horizonte far outranks both other cities during every year of the sequence (except for 2000 when it ran a small, pilot experiment with PSF). As will become clear in the following chapter, municipal politicians and health managers in the city delayed the implementation of PSF until 2000, due in part to protracted disputes over the organization, composition, and management of the teams. While these same disputes percolated throughout Porto Alegre, too, the solution reached for managing teams there differed quite dramatically and ultimately contributed to unwillingness on the part of its municipal politicians and bureaucrats to appreciably expand PSF as its primary attention model for delivering basic care. The case of Rio de Janeiro is one in which the municipal politicians and bureaucrats resisted the program mightily until 2002, when pressure from the country's federal government succeeded in inducing its government to adopt an almost trivial number of teams for a city of its size.

Trends and Implications for Explanatory Analysis

In comparative perspective, several patterns emerge from these descriptive analyses of changing primary appointment rates in the three cases examined. First, in terms of the municipal primary appointment rate by 2011, the highest *level* was reached in a município defined by a pragmatist regime (Belo Horizonte), while the lowest level was reached in a município defined by a clientelist regime (Rio de Janeiro), and a comparatively moderate level was reached in a município defined by a participatory regime (Porto Alegre). The analysis of intermediate outcomes further suggested that this

variation in the level of the appointment rate by 2011 was positively correlated with the construction of primary health care clinics and health professionals.

Secondly, a central story that emerges from the data regarding *trajectories of change* in the appointment ratio is that that not all cities exhibited equal starting points, when we use 2000 as a beginning point. Indeed, as emphasized above, this ratio for Belo Horizonte in 2000 was more than double that of both Porto Alegre and Rio de Janeiro, suggesting that it had already diverged substantially from these other two cities during an earlier period. Although calculated using the less-than-ideal technique of proxying the 2000 non-coverage rate for the 1994 coverage rate in all three cities, the appointment rate in 1994 exhibits even greater divergence with Belo Horizonte registering a ratio more than three times as large as both other cities. Even if we dismiss these apparent 1994 differences based on the inferential problems associated with interpolating the non-coverage rate backward into time, the clear picture still remains of Belo Horizonte's município as far more productive in its primary care delivery as early as 2000 and, quite likely well before that. Indeed, when we consider only the rate of change between 2000 and 2011, the primary appointment rate of Porto Alegre's município grew by far the most (187%), while Belo Horizonte grew by only 59%, and Rio de Janeiro grew by 55%. In large part, this speaks to the dramatically lower share (only 65% in 2000 and only 13% in 1994) of all primary service provision that Porto Alegre's município produced during the pre-2001 period, compared to both Belo Horizonte (95% in 2000; 77% in 1994) and Rio de Janeiro (74% in 2000; 44% in 1994). In part, this suggests Porto Alegre's município had far more room for expansion, by assuming service provision roles that the federal government fulfilled during this earlier period.[12]

Third, it is also clear from the data that – in terms of their rates of municipalization in the primary public health sector (Figure 4.1, above) – the three municípios examined in this study tended to progress at nearly identical rates and to nearly identical levels as their encompassing metropolitan regions. Some of this symmetry is clearly an artifact of these three municípios constituting a sizeable share of all primary services provided in their encompassing municipal regions (about 41% in Belo Horizonte, 47% in Porto Alegre, and 80% in Rio de Janeiro, on average between 1994 and 2011).[13] Yet, it is also likely that the distinct relationship of each of these three municípios to the federal government and to their encompassing state government mattered for their service provision records – and mattered in different directions and ways for each of the three municípios I consider. As upcoming chapters discuss, one such way is that the relationship of each município to its encompassing state government – and the willingness or hesitancy of the state government to support health sector municipalization during an initial moment – played a clear role in the timing of municipalization. But disjunctures between the municipal appointment rate trends in Figure 4.2 (above) and the municipalization trends in Figure 4.1 (above) together suggest that the former does not necessarily explain the latter. Thus, while a município's relationship to its encompassing state government may have conditioned the timing of municipalization in direct, clear ways, these relationships would not appear to have affected these município's appointment rates in as clear of ways, after the initial moment of municipalization. In the following chapter on Belo Horizonte, I consider how these relationships influenced local regimes of state-society politics and other factors that help explain the outcomes delineated above.

Notes:

[1] Appendix 1, located at the end of this dissertation, provides a more detailed overview of all basic attention procedures provided that different levels of government and the private sector provide within these municípios and their encompassing metro regions between 1994 and 2011.

[2] Due to the lack of systematic data on the pre-2000 percentage of un-insured municipal residents required for reliably estimating the appointment rate, 2000 is the earliest year for which I have calculated the rate. However, when we extrapolate the 1994 un-insured population based on the last observed year (2000) for each city, the appointment rate is 7.69 in Belo Horizonte, 0.76 in Porto Alegre, and 1.58 in Rio de Janeiro. Ultimately, these calculations cannot be relied upon due to likely cross-município differences in the non-coverage rate for each year between 1994 and 2000. Nevertheless, the differences between Belo Horizonte and the other cities might lead one to plausibly speculate that Belo Horizonte's clear, early start on municipalization by 2000 actually extended at least as far back as 1994, and likely well before that.

[3] This ratio is 11.00 in Belo Horizonte, 6.82 in Porto Alegre, and 6.83 in Rio de Janeiro.

[4] The technical capacity for targeting both of these capacities toward the greatest epidemiological risks within municipal boundaries constitutes a third kind of state capacity that I explore in Chapters 5, 6, and 7.

[5] A notable exception is the comparative study that Sarah Escorel and colleagues (2009) undertook on the implementation of the PSF by four capital city municípios: Aracaju, Florianópolis, Belo Horizonte, and Vitória.

[6] For example, municipal health councilors and managers in Porto Alegre were particularly emphatic that – precisely because politicians and health bureaucrats in the município resisted full implementation of the PSF model for much of the period between the mid-1990s and mid-2000s – the analytical strategy of focusing exclusively on SIAB records would provide a downwardly biased assessment of the município's record in this regard. Indeed, one notes that 2006, 2007, and 2009 were the only years between 1994 and 2011 in which primary service provision through PSF outnumbers primary service provision through non-PSF models of attentions. (See Table 3 in Appendix 1 for more detailed statistics in this regard.)

[7] Although subsequent chapters develop this observation in greater detail, it is worth noting immediately that, compared to all other municípios and metropolitan regions in Tables 1 through 6 of the appendix, the município of Porto Alegre was the territory in which the municipal state accounted for the lowest average share of all such primary health services in 2011 (82.64% compared to 98.79% in Belo Horizonte and 90.81% in Rio de Janeiro).

[8] The National Household Survey (PNAD) estimated that nationwide, the percentage of the total population that was not covered by a health plan – the "non-coverage rate" – was 75.53% in 2003 and 74.11% in 2008.

[9] For example, Coelho et al (2010) use raw data from the PNAD (2008) to calculate the non-coverage rate in the município of São Paulo as 48%. Based on this method, one can use responses from a question in the IBGE's national household survey (PNAD 2003, 2008) for 2003 and 2008, which asks a município-representative sample of respondents whether or not household residents have a private sector health insurance plan. Yet the infrequent fielding of this survey module and the rapid year-to-year changes in rates of insurance coverage make this a less than ideal way of estimating exclusive users of primary public health services provided through SUS. Mitigating for the absence of data between years can be managed through interpolations based on extrapolating from the rate of change observed between two years for which there are data. Yet interpolation is not advisable for interpolating backward toward prior years for which no data anchor in preceding years is available. Perhaps the bigger constraint I encountered in using this method was that I was unable to acquire PNAD estimates disaggregated to the required level of the município for the cities I examine. Although these estimates are available for the encompassing metro regions of the municípios, I ultimately decided that the perils of estimating the former from the latter were too great and

instead chose to use ANS estimates. In particular, upwardly-biased estimates of the exclusive SUS-using public are likely to arise when imputing the município-level coverage rate from the rate for the encompassing metropolitan region of which each município is the most central part. This is largely due to the center-periphery pattern of inequality in which far greater numbers of economically poor resident (who are priced out of the private insurance market) live in city peripheries and vice-versa.

[10] According to PNAD data, non-coverage in the metro area of Belo Horizonte was 65.90% in 2003 and 58.95% in 2008, the two years during the first decade of the 2000s in which the survey was conducted. In Porto Alegre, the proportion was 60.93% in 2003 and 62.33% in 2008, while in Rio de Janeiro, the proportion was 68.14% in 2003 and 63.89% in 2008 (PNAD 2003, 2008).

[11] This is perhaps more commonplace for higher complexity procedures than the basic health services examined in this project. Depending on the year under consideration, the surrounding metro area of Rio de Janeiro constitutes at least an additional 4 million residents, while that of Belo Horizonte is about an additional 3 million, and that of Porto Alegre is an additional 2 million. See Appendix 1 for more precise figures for a given year.

[12] More disaggregated data show that much of the federal production during this period occurred in federal university hospitals.

[13] This is especially plausible for Rio during most of its trajectory. During all pre-2006 years of Rio's trajectory, the primary public health services that Rio's município delivered account for over 90% of all such municipally-provided services throughout its metro region as a whole. This is remarkable considering that for most years, the combined population of the surrounding municípios in Rio's metro area were nearly as populous as Rio's município.This suggests that, while the underperformance of Rio's município may seem extreme throughout most of its trajectory, this pales when compared to the almost non-existent record of primary service delivery by its surrounding municípios like Duque de Caxias and others that comprise the Rio metro area.

CHAPTER 5

MUNICIPALIZATION-FRIENDLY CONDITIONS, PRAGMATIST REGIMES, AND A CONSOLIDATED HEALTH DEVELOPMENTAL STATE IN BELO HORIZONTE

After 1988, when access to public health care became a constitutionally-mandated social right in Brazil, state reformers in the 2.5 million person município of Belo Horizonte undertook one of the largest per capita expansions of primary health care provision witnessed in any large Brazilian city. Although epidemiologists isolate the expansion of such services as a central cause of the country's dramatic, nationwide improvements in development indicators like reduced infant mortality (Macinko et al 2006), little is known about the origins of the local state structures that increasingly served as the institutional foundations of these service expansions. Following the creation of the federal Integrated Health System (SUS) in 1990, Belo Horizonte experienced a level of growth in the size, capacities, and infrastructural power (Mann 1986) of its public health state for which there was little prior precedent in Brazil or in much of the global South. By 2010, for example, Belo Horizonte's municipal government spent nearly 22% of its total budget on health care and had evolved from a bureaucracy that possessed four 386 computers and a few hundred employees in 1993 to the single largest bureaucracy within the municipal state with an approximately $1.3 billion real (US$775 million) budget, nearly 20,000 directly employed health professionals, thousands of other

contracted employees, and a network of nearly 150 municipally-owned and run primary health care clinics that delivered over 4 million primary health care doctor appointments and millions more basic health care services by nurses and other health professionals. In what follows, I argue that by 2010, Belo Horizonte had evolved a full-blown developmental state in the public health sector that proactively targeted its delivery of basic health services to geographically peripheral city regions, where large populations not only suffer from abnormally high health risks but also remained excluded from access to public health care until quite recently.

On the one hand, Belo Horizonte's impressive record of increasing its output and allocation of basic health services within the município may not strike today's casual observer as especially surprising, given the current ascendant moment of redistributive politics in the country. Between 1993 and 2008, Belo Horizonte's city hall played host to mayors from two leftist political parties, including the local branch of the same Workers Party (PT) apparatus that held the country's presidency under the iconic 2003 to 2010 rule of Luiz Inácio Lula da Silva, whose 80% approval ratings by the end of his 2 4-year terms established him as the country's most popular president ever. These mayors were relatively quick to take note of the fact that, as in other large municípios such as Rio de Janeiro and São Paulo during the early and mid-1990s, *horizontinos* (residents of the city of Belo Horizonte) consistently named access to health care as their single top public concern when surveyed (Folha de São Paulo 1995), beating out even urban violence, the social ill for which Brazil was and is perhaps best known internationally. All three mayors of Belo Horizonte between 1993 and 2008 declared public health care provision to be the top political priority of their administrations, at various points (Folha de São

Paulo 1995, 1997; Estado de Minas 2003). And although the reputations of the city and its progressive mayors during this period never rivaled that of other municípios examined in this dissertation such as Porto Alegre, which garnered international recognition for initiating the Participatory Budgeting institutions that some Brazilian observers argue have delivered even more public goods in Belo Horizonte since its adoption there in 1993, Belo Horizonte gained some measure of acclaim within Brazil for the health service provision achievements of its famously pragmatic mayoral administrations (Avritzer 2009; Escorel et al 2009; Folha de São Paulo 1994).

But on the other hand, despite an evident political will for health care reform, few observers could have predicted in 1990, when the Brazilian federal government created a new federally-financed health system (SUS) to implement the constitutional right to universal health care, that by 2010 Belo Horizonte would have undertaken the single largest expansion in public health care provision of any large city in Brazil during the 2000s. Even though Belo Horizonte's pragmatic state reformers were on the leading edge of institutionalizing SUS locally, the first mayoral administration to effectively implement SUS locally – the PT administration of Mayor Patrus Ananias between 1993 and 1996 – faced a nearly comical absence of state capacity to administer a universal health care system, in term of financial, human, and physical resources. Upon entering office in 1993, Patrus (as he is commonly referred to in Brazilian politics and media) appointed Lídia Tonón, a PT founder, doctor, medical sciences professor at the Federal University of Minas Gerais (UFMG) in Belo Horizonte, and longtime organizer in the local and national *Sanitarista* Movement to become the high-level political appointee (*cargo de confiança*) in charge of transforming the município's Health Secretariat (SMS-

BH) into a bureaucracy capable of institutionalizing SUS's goals of universality and equality in service provision. Tonón described the deficits in the capacity of the local state upon entering office in 1993 with a certain measure of incredulity.

> "When the PT entered office, Brazil was in a major economic crisis that seriously affected what we could with our already limited capacities...The kids that work here [in the Health Secretariat] today don't know what it is to live with 30%, 40%, 100% inflation per month. At home, everybody had a freezer that you filled up with a stock of meat, a stock of food, on the day you got paid because your money became worthless by the end of the day… Can you imagine running a public health system under such conditions? You faced huge pressures and the expectation that basic health clinics would be built. But when I started in 1993, we had four 386 computers and that was it. I came from the university, where we had modern computers and at least a fax machine. It was a city administration that resembled a third world country and it was horrific!" – Interview with Lidia Tonón

Even though the creation of SUS effectively gave *municípios* the primary responsibility for providing universal access to public health care, Belo Horizonte mirrored nearly all other large capital city municípios at the time in its almost complete lack of funding and near total absence of pre-existing state capacities to deliver on grandiose promises of universal health care provision.

But despite these early constraints, state reformers in the health secretariat managed to achieve some impressive, short term gains after only four years of holding local government reigns, including reducing the infant mortality rate in the município from 39.2 deaths per 1000 live births the year before this first PT administration took office in 1993 to about 23 deaths per 1000 at its conclusion in 1997. (By 2010, IMR in Belo Horizonte hovered around 12 deaths per 1000 live births.) A recurring pattern in my discussions with Belo Horizonte's health care activists and state managers who reflected on this nascent phase in the formation of its public health state, the roots of such early

improvements were fundamentally pragmatic in the Deweyan sense of involving the privileging of innovative, often improvised problem-solving, typically with few resources other than a health practitioner's knowledge of basic health care needs and a lay-person's willingness to learn while gerry-rigging solutions.

> We functioned in a totally informal manner. We invented jobs among us that didn't exist. Somebody would say 'Oh I think we should create an epidemiological unit.' And then you would get to work on it, but the computer or the phone wouldn't work…So many things didn't work. But we had nothing in the way of the most important services, including a neo-natal program. And so we started to address the question of uptake [in health clinics] and evened out the distribution of our personnel and clientele [across existing clinics]. We made up a pre-natal and neo-natal program because it was possible and because it had to be done: we had an infant mortality rate of 33 or 34 per 1000 [live births in 1993]. And we lowered it to 20 [in only 4 years.]." – Interview with Tonón

Among the immediate changes initiated by Patrus, Tonón, and Cézar Campos – the venerated (now deceased) activist from the Sanitarista Social Movement, who served as health secretary during Patrus's first term – was a public health-focused, geo-spatial application of the more general ideology of "inverting priorities" that *petistas* (members of the PT) rode to electoral success in município politics across South and Southeastern Brazil during the late 1980s and early 1990s, including Patrus in 1992. It is notable that the first such mini-inversion of priorities to be orchestrated in Belo Horizonte's public health sector – the on-the-fly organization of its pre- and neo-natal programs – did not require access to the relatively substantial amounts of federal financing that later became available to health secretariats like Belo Horizonte's during the mid-1990s. Instead, it relied more heavily on the reallocation of existing human resources. A first decisive stage in Belo Horizonte's "municipalization" of what was previously a federally-administered health system involved assuming administration of the doctors, nurses, physicians

assistants, and other health professionals who had previously worked as federal employees in federal hospitals located in the city's center. Campos and Tonón re-allocated many of these health professionals away from hospitals and clinics located in wealthier, central regions of the city that feature relatively low health risks and toward clinics located in generally poorer, outlying regions with much higher health risks and development indicators such as infant mortality rates. As these health professionals were converted into municipal from federal or provincial employees, they increasingly delivered pre-natal services in the modest network of primary health clinics that dotted the periphery of the city, where infant mortality was most heavily concentrated. Tonón and epidemiologists in Belo Horizonte's health ministry attribute the dramatic 1993 to 1997 reductions in infant mortality to contemporaneous increases in the number of live births occurring in hospitals, particularly the pre-natal care program that they had created by "changing all four tires on the car while driving it" so that it could begin reaching previously excluded women living in the poor, urban periphery.

This chapter examines how, like this shorter-term improvisation of Belo Horizonte's programs for lowering infant mortality, more fundamental and longer-terms expansions and equalizations of health care provision between 1993 and 2007 emerged from similar political dynamics, as civil society activists from the Sanitarista Social Movement acquired the political power to adapt and transform the generic ideology of "inverting priorities" into new, tangible state capacities to deliver basic health services in poor urban peripheries defined by high health risks. The chapter proceeds as follows. First, I set the stage for examining this major transformation by describing the defining context that state reformers faced upon taking power of the local state in 1993: an

entrenched, center-periphery pattern of spatial inequality in which residents of Belo Horizonte's peripheral city regions faced disproportionately larger health risks than residents in central city regions. Perhaps more importantly, I demonstrate how state-level factors played a major role by turning over a large network of pre-existing health clinics to the city and expediting its municipalization process. Next, I conceptualize the proximate cause of the equalizing expansions in Belo Horizonte delineated in Chapter 3: the construction of Belo Horizonte's health developmental state. The defining features of Belo Horizonte's healthy state were increased numbers of primary health care clinics, permanent municipal health professionals, and new technical capacities to target clinics and professionals to the highest health risks, typically in peripheral city regions.

Then, I conceptualize the ultimate driver, not only of Belo Horizonte's equalizing expansions but also of the healthy state that executed them: what I call the city's "pragmatist regime" of state-society politics in the public health sector. I argue that this regime consisted of 5 types of sociologically distinct actors (namely, civil society, organized labor, political parties, capital, and the state), each of which came to occupy dominant, submissive, or acquiescent positions within the regime. I argue that what ultimately generated the political power of Belo Horizonte's "pragmatist" regime to mold the local public health state in the image of sanitarista ideals was a configuration in which civil society actors from the Sanitarista Movement, three organized labor unions, and multiple state reformers shared dominance of the regime, while political party ideologues occupied a submissive position (that will not surprise students of Brazil's fragmented, multi-party system), and capitalists from the private sector hospital and health insurance industries adopted a relatively acquiescent position.

Municipalization-friendly Conditions of State and Federal Health Politics

In comparison to other cases examined in this study, it is clear that Belo Horizonte's civil society advocates for SUS and the universalization of primary public health care enjoyed a pre-existing environment that was largely conducive to its municipalization of the health sector as a whole. Even before the advent of SUS in Belo Horizonte, sanitaristas from Minas Gerais cultivated experiments with primary health care provision by working through state government programs to build the capacity of rural municípios for delivering these services. During the early 1970s, the state government of Minas Gerais, whose Health Office was then directed by Fernando Megre Veloso, sought to expand the reach of healthcare by sending trained health care workers into the state's lower-HDI, Northern region through a program called the Integrated Health Service Provision System of Northern Minas (*Sistema Integrado de Prestação de Serviços de Saúde do Norte de Minas, SIPSSNM)*. These health care workers founded a research institute in the Northern Minas city of Montes Claros, called the Training and Research Institute for the Development of Rural Sanitary Care (*Instituto de Preparo e Pesquisas para o Desenolvimento da Assistência Sanitária Rural, IPEDASAR*). What proved far more enduring than the SIPSSNM program were the social networks fortified through what sanitaristas now call the "Montes Claros Project" (Escorel and Teixeira 2008).

If IPEDASAR served as a nexus for the crystallization and dissemination of sanitarista thought (before its subsequent decommissioning), the enduring ideologies of primary care provision and the social ties that sanitaristas formed and solidified in Montes Claros continue to link a generation of these influential activists, not just from

Minas Gerais, but also from Rio Grande do Sul, Rio de Janeiro, and São Paulo, among other states. While Minas Gerais' state government was an early mover among Brazilian states in expanding primary public health care provision to far-flung, rural corners of the state, other state governments include that of Rio Grande do Sul adopted a similar emphasis during the 1990s and before. But multiple interviews confirmed that the dense associational ties amongst the Minas' sanitaristas, their active involvement in local government, and the early experiences of sanitaristas in leading the experiments of state government in promoting primary health care provision throughout rural regions of the state also mattered for the pace and form of Belo Horizonte's own process of health sector municipalization.

Pre-SUS Health Politics and Municipalization in Belo Horizonte

Although it was not until much later that the municipal state of Belo Horizonte would become a much larger provider of primary, preventative health care, these later institutions and the sanitaristas who would manage them had nontrivial historical antecedents. Founded in 1948, an early, municipally-run health care institution in Belo Horizonte was the Department of Health Assistance (DAS), whose functions included providing both health services and social welfare. In terms of health services, DAS operated through a municipal hospital which provided inpatient services as well as dentistry, and preventative medicine to indigent populations, municipal employees, their families, and other affiliated state institutions (Veloso and Matos 1998). It was not until 1983, as the military regime began to lose its grip on national power that significant changes arose in the structure of Belo Horizonte's municipal health bureaucracy.

During that year, the Municipal Health Secretariat (SMS-BH) became its own, standalone entity, formally shedding its former role of also administering social welfare schemes. A medical doctor and faculty member in the Federal University of Minas Gerais's (UFMG) School of Medicine, its first Secretary was Dr. José Maria Borges, a prominent sanitarista activist and former militant in the then clandestine Communist Party of Brazil (PC do B). At that moment, the State Health Secretary was Dr. Francisco de Assis "Chicão" Machado, Borges's fellow sanitarista, doctor, friend, and colleague in the UFMG Medical School. During the 1970s, Dr. Machado was an active participant in the Montes Claros Project in Northern Minas Gerais, perhaps the most pivotal experiment with the model of integrated health service provision by municípios that would later be crystallized into a central tenet of SUS. In 1984, under the joint leadership of Machado and Borges, SES-MG partnered with SMS-BH to sign one of the country's first Integrated Health Actions (AIS) contracts with the Ministry of Health (MS). Through its movement toward limited decentralization of some formal responsibilities for service provision municípios through the signing of AIS contracts with their encompassing states on a case-by-case basis, Figeueiredo's national regime sought to address a steadily deepening economic and budgetary crisis by enlisting other levels of government to sharing the burden of providing services. Yet, the adoption of AIS depended on health bureaucrats and politicians on state and municipal levels, who were proactive in their willing to adopt these new responsibilities, typically with few new sources of financing for doing so.

Thus, health sector municipalization got off to an early start in Belo Horizonte during 1984, in large part due to the fact that two sanitaristas – each with a foot in both

the health professional and academia camps of the movement – held both of the crucial positions – State Health Secretary of Minas Gerais and Municipal Health Secretary of Belo Horizonte. It is, of course, notable that the mayors and governors who appointed Borges and Machado were, at the time, defenders of the military 1964 coup. As mayor of Belo Horizonte during 1984 and 1985, it was Rui Lage who appointed Borges as health secretary. But at a time in which sanitaristas began aggressively pursuing their new political strategy of occupying the trenches of the public health state on the national level, mineiro sanitaristas were particularly precocious (and effective) in doing the same on both the state and municipal levels. Increasingly sensing that the military regime was on its last legs, Borges and others capitalized on their reputations as political centrists to make their way into such key positions. Further, in referring to his appointment by Lage, Borges notes that "in no moment did he question the fact that we were discussing a new model or fail to approve resources that so that this model could be put into motion; on the contrary, he gave substantial support for this" (interview with Borges: 7). Furthermore, this pattern of sanitaristas occupying the top health posts in both SES-MG and SMA-BH endured throughout the remainder of the 1980s and almost entirely throughout the 1990s.

During 1991, José Saraiva Felipe, a sanitarista and student of Machado's from UFMG Med School, occupied the post of health secretary on the state level. An appointee of the centrist PMDB party governor Hélio Garcia, Saraiva had also participated in the Montes Carlos project and considered himself party of what this group of former managers call the "sanitarista political party," which was not a political party but did aggressively pursue the nationwide strategy of occupying key health offices on all levels of government. As secretary, he began actively pushing an agenda to municipalize the

health sector across the state. With Borges again in the post of municipal health secretary in 1989, having been appointed by the PSDB party mayor João Pimenta da Veiga, the stage was set in Belo Horizonte for one of the country's earliest health sector municipalizations.

One of the results of this collaboration and symmetry between sanitaristas in SES and SMS was a very early and large pattern of the município assuming pre-existing basic health units from the state. Table 5.1 (below) demonstrates that during 1992, the year in which Belo Horizonte municipalized the health sector under the "full management" status created by NOB 1991, it received a rather large number of facilities, many of which came to it from the state government. The vast majority – 112 of 123 – of the facilities it managed by 1992 were fairly basic health clinics. This stands in sharp contrast to the hospital sector, which remained dominated by the private sector, which owned 71 of 86 hospitals in the region.

Table 5.1 Health Facilities in the Município of Belo Horizonte, 1992 and 1999

Year	1992					1999				
Type	Fed.	St.	Mun.	Priv.	All	Fed.	Sta.	Mun.	Priv.	All
Health Post	-	1	-	-	1	NA	NA	NA	NA	NA
Health Center	-	3	112	2	117	NA	NA	NA	NA	NA
Hospital	2	12	1	71	86	NA	NA	NA	NA	NA
Clinic	5	5	10	168	188	NA	NA	NA	NA	NA
Diagnostic	2	1	-	259	262	NA	NA	NA	NA	NA
TOTAL	**9**	**22**	**123**	**500**	**654**	**9**	**19**	**150**	**666**	**840**
Source: IBGE (2002)										

A number of implications for our understanding of the efficacy of Belo Horizonte's pragmatist regimes emerge from these findings. First, it is clear that its município not

only enjoyed an early start on municipalization. Second, it also received a large inheritance of pre-existing basic health clinics from the state of Minas Gerais. Further, in contrast to other municípios like Rio de Janeiro, which managed a large number (13) of hospitals as early as 1992, Belo Horizonte managed only one hospital during this period. In part, this was because the there were few state hospitals that it could inherit because the state of Minas Gerais had already spun of a network of hospitals (many of which were located within the município's territory) to state-owned company (*autarquía*) called FHEMIG. Thus, Belo Horizonte's município was not immediately burdened with managing an expensive and complex network of hospitals, allowing sanitaristas who held key health posts at the time, to focus more squarely on advancing their ideology of expanding access to the basic services and designing pre-natal and neo-natal programs like the ones that Tonón took on as municipal secretary in 1993. Ultimately, however, it is important to recognize that state-level actions and a generally more programmatically-oriented state health secretariat in Minas Gerais played a major role in opening up such spaces for agency on the municipal level.

Spatial and Political Contexts of Public Health in Belo Horizonte

Like other large Brazilian cities examined in this dissertation, Belo Horizonte in 1993 was a highly unequal city in terms of the spatial distribution of health risks faced by its population. Using a health risk index calculated from Year 2000 census data for all for all 2563 census tracts in the city, Map 1 (located in Appendix 2 at the end of this dissertation) demonstrates that as recently as 2000, the Municipal Health Secretariat of Belo Horizonte (SMS-BH) classified over 800 – or over 31% - of Belo Horizonte's census tracts and about 50% of its overall population as suffering from "elevated" or

"very elevated" health risks. This index is a weighted average of 13 measures of five general concepts capturing exposure to health risk: sanitation, housing conditions, education levels, earnings, and health status. For each census tract, sanitation is measured by the percentage of households with inadequate or non-existent sewage, running water, and trash disposal; Risk from housing informality is measured by the percentage of improvised households and overcrowding; education is measured by the percentage of illiterate households and the percentage of household heads with four or fewer years of education; Earnings are measured by the percentage of households earning less than 2 minimum salaries, and the inverse of the average household earnings; Health status is measured by the percentage of cardiovascular deaths among 30 to 59 year-olds, the mortality rate for residents under 70 years old and children 5 and younger, and the proportion of household heads between 10 and 19 years old.

In Map 1, the black-shaded areas of "elevated" and "very elevated" health risk clustered primarily around the periphery of the city – and the white-shaded areas of low health risk clustered in the city's central regions – together demonstrate that there is a clear, center-periphery spatial pattern to health vulnerability in Belo Horizonte. Furthermore, simple descriptive statistical tests of relationships between census tracts reveal that this clustering is not random. Using a geographic analysis program called Geoda, I calculated the Global Moran's I, which measures the extent of spatial association between units of analysis on a particular variable, as .71 on a scale from 0 to 1. This suggests that the distribution of health risk values on the map diverge substantially from spatial randomness. In other words the health risks faced by populations in many census tracts of the city were heavily dependent on the risks faced

by populations in the immediately neighboring census tracts. In substantive terms, this suggests that, similar to how poverty traps have been show to be geographically clustered within cities, something like health status traps characterized much of Belo Horizonte in 1993, with clusters of high health risk located in the poor, urban periphery and clusters of relatively low risks located in the wealthier center of the city.

Map 2 uses the same health risk variable to display Local Indices of Spatial Association (LISA), a descriptive analysis which supplements this finding by identifying four types of statistically significant “hot spots” or clusters of health risk in Belo Horizonte: 1) areas with high values of a variable surrounded by other areas with high values, representing a cluster of units; 2) high values surrounded by low values, representing an isolated unit; 3) low values surrounded by high values, also showing isolation; and 4) low values surrounded by low values, indicating a cluster that is the opposite of the high/high type (Logan, Alba, and Zhang, 2002). Multiple permutations of local Moran’s Indices allow for significance testing by producing a distribution to which values can be compared. Specifying weights for both equations involves deciding what constitutes a contiguous or nearby neighbor area; for this paper, I use one order of rook contiguity, specifying as neighbors areas that share an arc with the reference area. I used GeoDa to calculate local Moran’s I. LISA Clusters are a widely used method for examining univariate spatial association at the local level (Anselin 1995).

In effect, this measures how census tracts are positioned with respect to their neighbors, in order to approach a spatial understanding of the composition and distribution of health risk in Belo Horizonte. LISA analysis allows for identification of non-random clusters of varying types. Three large clusters of the high/high type show

statistically what proportional visualization in Map 1 showed: that residents of many outlying city regions would have had to live substantially closer to the city center in order to suffer fewer health risks. Substantively what this shows is that after 1993, Belo Horizonte's mayors and the state reformers they appointed in the município's health secretariat faced entrenched, spatial concentrations of high health risk in the most of the city's poor, geographically peripheral outskirts.

In terms of the political context into which state reformers entered in 1993, the general political climate of the time provided momentum (if not immediately funding or other resources) for reforms in the health sector. But this was not only because public opinion surveys pointed to health care as the most pressing social need but also because relatively intense electoral competition defined races for mayor as well as for seats on City Council (*Câmara de Vereadores*). In 1988, for example, when Pimenta da Veiga, a centrist candidate from the Brazilian Social Democratic Party (PSDB), the party of future President Fernando Henrique Cardoso, won the mayorship, he did so by a thin margin of only 28,000 votes in a município of over 2 million residents. City council was nearly deadlocked, too, with the PSDB and PT constituting the two top seat holders and the PT holding a narrow advantage in seats. During this period, national and local PT strategists increasingly came to see the expansion of health care as good electoral politics, pure and simple, with poor populations – excluded from access to public health care by virtue of living in peripheral regions of Belo Horizonte – looking more and more like voting blocks for Lula's (ultimately failed) presidential bid in 1994. Thus, it is undeniable that at least three major key events in national politics – first, the passage of the federal constitution in 1988, which deemed universal public health care a right of all citizens and

second, the 1990 creation of SUS to deliver on that promise, and third, Lula's presidential run in 1994 – were consequential for Patrus, who swept into office in 1993 with a clear mandate and political will to reform the health care sector and expand service provision.

Yet, in urban Brazil during the last twenty years, political will for health care reforms has rarely been sufficient for meaningful changes to occur, in terms of state provision of actual services. Beyond Belo Horizonte, two especially notable cases in Brazil – first, the case of failed health reforms under the PT mayors of Fortaleza (Brazil's 6th most populous city) since 2005, and secondly, the case of shrinking health service provision under Porto Alegre's PT mayors between 2000 and 2004 – both show that the political will of a PT administration to reform the health sector is hardly sufficient to create lasting changes in this regard. In Belo Horizonte, too, neither PT administrations, nor the concerted political will of state reformers was sufficient to launch the sustained processes of state transformation that were required to actually deliver health service expansions and reductions in inequality. The Patrus mayorship of 1993 to 1996, the Brazilian Socialist Party (PSB) mayorship of Célio de Castro between 1997 and 2001, and (to a lesser extent) the later PT mayorship of Fernando Pimentel between 2002 and 2008 all found their loudly articulated political will to expand health service provision butted up against an entrenched, center-periphery pattern of spatial inequality in service provision defined by two qualities: first, a relative dearth of health clinics and health professionals in the peripheral regions of the city where health risks were highest; and secondly, a relative plethora of clinics and workers in central regions with generally lower health risks.

Belo Horizonte's Health Developmental State

Between 2000 and 2007, the município of Belo Horizonte went from being one of the most underperforming providers of basic health services per capita to nearly the highest performer of any large Brazilian capital city município. Furthermore, Belo Horizonte made impressive strides in targeting the geographic distribution of those services toward epidemiological risk. The lack of a sufficiently disaggregated (to the level of the município region) baseline measure of the number of primary health services delivered in health clinics during years before 2004 precludes the same temporal comparison between 1993 and 2007 that is possible for human resources and clinics. Yet Maps 3 and 4 from 2004 and 2009, respectively, demonstrate that by the mid 2000s, primary health care services were provided most heavily in clinics located in the periphery of Belo Horizonte. (Due to data management issues, the variables visualized in both Map 3 and 4 represent only those primary care doctor appointments provided through the Family Health Program or "PSF" rather than the full number of such appointments, which is reflected in the município's appointment rate for example.) And when we consider two facts – first, that only 96 of the 147 clinics that existed in 2009 had already existed in 1993, and secondly, that these clinics were woefully understaffed in 1993, compared to clinics and hospitals in the central regions – it is safe to assume that the substantial concentrations of services provided in the peripheral city regions by 2009 evolved during the 1990s and 2000s.

Qualitative interviews of high ranking political appointees working in the health secretariat during this period all converge on the fact that the concentration of service provision visible in peripheral city regions as early as 2004 in fact represented a major

new expansion, one that began as Belo Horizonte became the single most prolific provider of primary health care services provided through the federal Family Healthy Program in all of Brazil. As PT Mayor Fernando Pimentel entered mayoral power in 2002 and Lula entered the presidency at the same time, a political decision was made to make Belo Horizonte a poster-child for how PSF could work in major urban areas of Southern, Southeastern, and Center-West cities, not just the Northeastern cities and rural areas for which the program had grown a reputation for serving.

To what can we attribute Belo Horizonte's equalizing expansions and the record of its local state in expanding primary health care provision more than in any other large, Brazilian capital-city município during the 2000s? In this section, I argue that these equalizing expansions depended on the construction of three key state capacities in Belo Horizonte, which together comprise the central features of its health developmental state, or "healthy state" (for short). On the most basic level, its equalizing expansions not only depended on the construction of new primary health care *clinics* in the most epidemiologically vulnerable, geographically peripheral regions of the city, but also on waves of newly-hired municipal, public health *professionals* to staff them and physically deliver services. As was the case in the above discussion of the actual services provided, both the absolute *magnitudes* as well as the geographic *targeting* of clinics and professionals became essential features of Belo Horizonte's healthy state. Developing these twin capacities constituted a major political victory for state reformers who entered into an ongoing debate over the size of the local public health state in Belo Horizonte, beginning in 1993. But applying them also required a third capacity: the technical ability to identify and target município regions that were most in need of the first two capacities

(workers and clinics). I show in other chapters of the dissertation that neither this political victory nor these technical capacities arose in other large Brazilian municípios like Rio de Janeiro, where basic service provision actually retrenched during the 2000s. Next, however, I merely demonstrate the two main state capacities of Belo Horizonte's healthy state that allowed state reformers to exert the infrastructural power (Mann 1986) required to penetrate regions of the city previously excluded from service delivery: primary care clinics and health professionals that were geographically targeted to peripheral regions with high health risks.

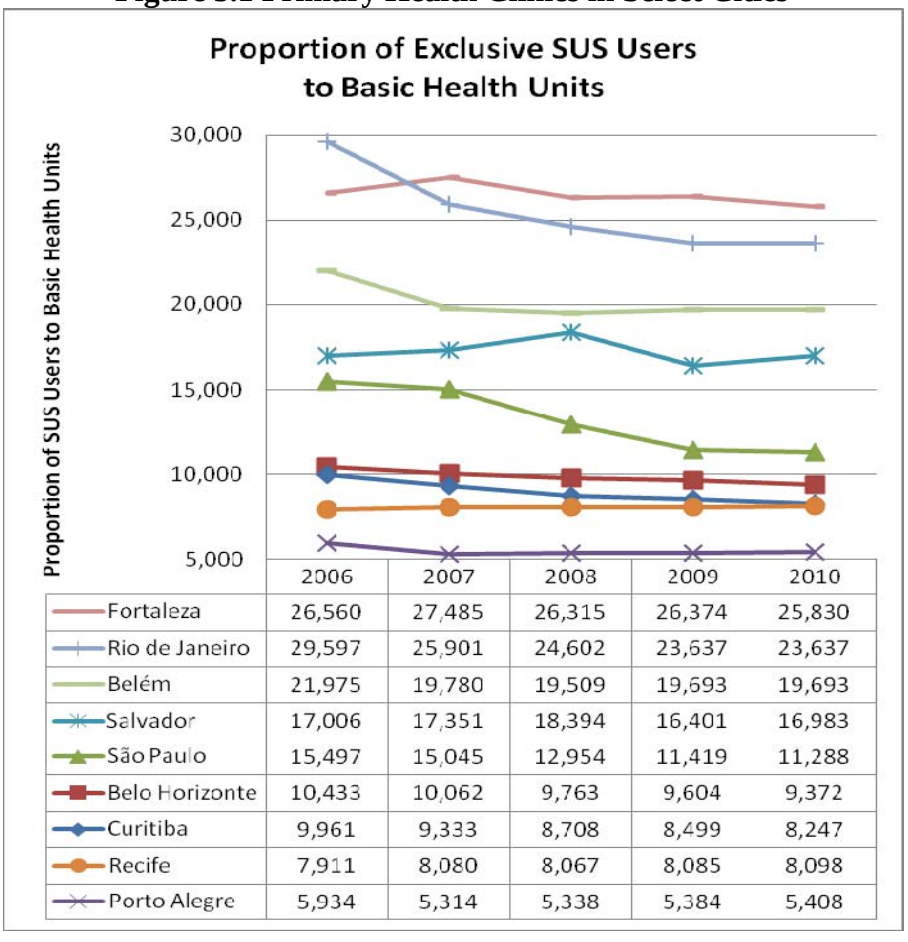
Expanding Numbers of Municipal Public Health Workers and Clinics

In Figure 5.1 (below), we can see that, among Brazil's largest capital city municípios, Belo Horizonte's ratio of SUS users to municipally-run primary care health clinics during the last half of the 2000s was among the lowest in Brazil but was still nearly double that of the highest-ranking city, Porto Alegre (which I examine in the following chapter). By 2010, Belo Horizonte operated 147 basic health units, in which doctors provided over 4 million of the approximately 80 types of services and procedures that are classified as "basic health services" by the federal Health Ministry (MS). While other cities like São Paulo during this period invested heavily in the construction of new clinics in order to bring this ratio further below the minimum standard of 20,000 recommended by MS and closer to the ratios of Brazil's leading cities, Belo Horizonte by 2006 had already built a formidable number of basic health clinics, relative to other cities in the sample. During the end of Mayor Pimentel's administration, additional expansions in primary care clinics continued to occur under the 2003 to 2008 tenure of Municipal Health Secretary Helvécio Miranda Magalhães Júnior, a nationally-recognized leader of

the Sanitarista Movement and the President of the national Council of Municipal Health Secretary's (CONASEMS), which has actively lobbied federal policymakers to expand and preserve the public dimensions of SUS since the 1980s.

Perhaps more importantly than the relatively smaller expansion visible in Table 2 (next page) during the mid 2000s under Magalhães and its tapering off during the more centrist administration of Brazilian Socialist Party (PSB) Mayor Márcio Araújo Lacerda after 2009 is the fact that cities such as Porto Alegre, Curitiba, and especially Belo Horizonte had something of a head start in the number of basic clinics they already managed well before 2006, when it operated 142 clinics.

Figure 5.1 Primary Health Clinics in Select Cities



	2006	2007	2008	2009	2010
Fortaleza	26,560	27,485	26,315	26,374	25,830
Rio de Janeiro	29,597	25,901	24,602	23,637	23,637
Belém	21,975	19,780	19,509	19,693	19,693
Salvador	17,006	17,351	18,394	16,401	16,983
São Paulo	15,497	15,045	12,954	11,419	11,288
Belo Horizonte	10,433	10,062	9,763	9,604	9,372
Curitiba	9,961	9,333	8,708	8,499	8,247
Recife	7,911	8,080	8,067	8,085	8,098
Porto Alegre	5,934	5,314	5,338	5,384	5,408

When asked about the roots of Belo Horizonte's effectiveness in expanding primary care provision during the 2000s, nearly all informants described the single most important factor as a longstanding emphasis on basic attention in the município, which itself emerged from sustained pressures by Sanitarista Social Movement activists beginning during the 1980s. Magalhães himself emphasized that "Belo Horizonte has a tradition of basic attention that began during the 1980s, which preceded the creation of SUS and emphasized locally professionalized management districts that existed nowhere else in Brazil, except for maybe São Paulo. In 1984, we already had a structure with technical managers, who were mid-level, politically-appointed technical experts (*gerentes técnicos de nível superior*) [of the provincial government] and whose emphasis was primary attention". But if one legacy of this tradition was a state structure that "saw" more central city regions as presenting higher political priorities to such managers and the politicians who appointed them, another legacy was the relatively large number of health units that already existed in the city. In 1992, when Belo Horizonte became the first large município in Brazil to "municipalize" the pre-existing network of federally-managed health clinics and health professionals that were located inside the boundaries of the município, the municipal Health Secretariat became the manager of 123 health clinics, hospitals, and other facilities (IBGE 1992), approximately 97 of which were estimated by a manager at the time to have provided exclusively basic health services in 1992. By 2010, the number of basic health units had increased to approximately 147.

The question of the number of health professionals actually working in Belo Horizonte's clinics, however, was and is an altogether different story, even leaving aside the complicated matter of absenteeism (which I attempt to control for above in estimating

service delivery using statistics on health services rendered, not appointments scheduled). Compared to health clinics, health professionals represent a state capacity that proved more difficult to construct, not only prior to the late 1990s and 2000s when hiring was a more ad-hoc process that was severely constrained by lack of funding, but also during the 1990s and 2000s, when far more funding existed to hire new municipal employees but the process of doing so came to involve an elaborate, bureaucratic process in which the mayor was required to gain the approval of City Council for the Health Secretariat to conduct a competitive, testing-based process of hiring salaried, municipal employees (*abrir concursos*) as doctors, nurses, and other health professionals. Between 2003 and 2008 alone, however, Magalhães and Pimentel succeeded in opening 5 such *concursos*, which helped increase the number of municipal health professional from 14,145 employees in 2002 to a total of approximately 16,908 in 2008.

Yet what is perhaps more striking is the meteoric, nearly ten-fold increase in the number of municipal health professionals from the approximately 1500 employees that I estimate in 1993 based on official documents (SMS-BH 2008: 38) and interviews to the 14,145 employees in 2003. This initial period of uptake in hiring happened earlier (in 1993) and more steadily in Belo Horizonte than in other high-performing cities such as São Paulo, where the process of state-expansion was interrupted by the conservative, *Malufismo* phase of município politics between 1995 and 2000. Equally impressive is that rates of unionization amongst these employees remained remarkably high with the two major labor unions for health employees (SINDIBEL; SINDSAÙDE) boasting high membership rates. This represents an even stronger contrast with other, poorly performing cities like Rio de Janeiro, where municipal health administration was so

corrupt and inefficient that the federal Health Ministry (MS) took over management of the city's hospitals (Folha de São Paulo 2005), leaving the município with even fewer unionized, municipal health care professionals than the already small numbers it had. Belo Horizonte's large number of unionized, health professionals – many of whom counted within the ranks of Brazil's ascending middle class – constituted a key voice for maintaining the public system in the face of the private hospital and health insurance industries that increasing lobbied to siphon away public SUS funds into private pockets as outsources, service providers.

Diminishing Spatial Inequality of Municipal Health Workers and Clinics

Belo Horizonte's effectiveness in rolling out primary health care, however, was not only a function of increased numbers of health clinics and unionized health professionals, who in addition to becoming a force to be reckoned with in municipal politics of health as early as the mid-1990s, constituted a major logistical tool of the state for expanding service provision. In addition to this, the capacity of state reformers to geographically target these two capacities toward city regions with high health risks represented a substantial advance over other município's application of federal SUS funds, which are distributed to municípios on a per-capita basis but with no explicit requirements for geographic targeting according to health risk.

Map 5 shows the spatial distributions of two variables during 1993. First, the shaded regions represent the per capita number of municipal health professionals, who were working in clinics within the borders of the 9 city regions that were established for planning purposes. For ease of explanation, I call this variable "worker density". Second, the blue-colored "H"s denote the location of an outpatient health clinic. What Map 5

shows is that in 1993, when we can safely assume that the same spatially unequal, center-periphery pattern of health risk we observed in Maps 1 and 2 already existed (if not to an even more pronounced degree), the município's health worker density and its health clinics tended to be disproportionately located in central regions of the city, which (we know from Maps 1 and 2) exhibited lower health risks. In other words, municipal health workers and primary care clinics were not very well targeted to the regions of the city with the highest health risk.

By 2007, major changes had occurred in this previous, spatially unequal pattern of poorly targeted workers and clinics. In the next section, I show how Belo Horizonte's prefeitura during the 1990s and 2000s began applying a doctrine of "inverting priorities," a doctrine whose specific application to the public health sector drew on the longstanding sanitarista ideology of extending provision of basic health care to citizens in the urban periphery. But in Map 6, we see some evidence of the tangible product of this political shift, as evidenced by a near reversal in the geographic distribution of public health care provision within the município. Map 6 presents the same descriptive visualization in Map 5's analysis of clinics and health worker density within the 9 major regions of the municipal basic health network, only in Map 6 we see value for the year 2007 instead of 1993. We can observe that during the 14 year period in between, the health secretariat constructed new health clinics and distributed a majority of its by now, nearly 18,000 health workers predominantly in outlying city regions. For example, the Central-South region, which is the only region in Map 5's 1993 analysis to be shaded completely black (because of its city-high ratio of 24.15 health workers per 10,000 residents) had, by 2007, become the only city region to be shaded white in Map 6, suggesting that it had become

the region with the lowest health worker density in the entire city. This is just one indication that the municipal state had begun to implement the kind of inversion of priorities advocated by sanitaristas in the city on a fairly consistent basis over the 14 years between 1993 and 2007.

Conversely, we also see evidence of this inversion of priorities in the following sense: a majority of every outlying city region was shaded lighter in Map 6's 2007 analysis than it was in Map 5's 1993 analysis. This suggests that the positional ranking of each of the outlying regions' health worker density, relative to the city-wide average, was higher in 2007 than it was in 1993. In addition to these *relative* measures of health worker density that are denoted by each region's shading, we can also see that the *absolute* magnitude of worker density for every single city region is far greater in 2007 than it was in 1993. In other words, every region witnessed a substantial increase between 1993 and 2007 in the *absolute* level of health worker density. Further, poorer, outlying regions with greater health risks experienced the largest such increases. A similarly clear, outward geographic shift is observable in the disproportionately greater expansion in the absolute number of health clinics located in outlying city regions.

Growing Technical Capacities to Target Services toward Epidemiological Risk

Although it may be regarded as commonplace in the technocratically sophisticated bureaucracies of Northern welfare states with universal health systems, the local state capacity to target the roll-out of health professionals, clinics, and ultimately services within city regions with the greatest epidemiological risks was hardly a given in Belo Horizonte, even as late as 2001. Although the funding for basic health care provision that the município received from the federal Health Ministry was allocated on a per-capita

basis, this funding did not arrive into the coffers of the local health secretariat (SMS-BH) with explicit criteria for how to allocate the funding toward service roll-out. Indeed, up until the mid-1990s, such funding was not even necessarily reserved for primary care provision at all; Instead, it was not uncommon for mayors to tap into the Municipal Health Fund, where federal funding was deposited for SUS expenditures, and use these funds for other purposes unrelated to health. Further, up until 2001, no formal bureaucratic mechanism existed for allocating the new health professionals and basic care clinics that were slated to be built with newly expanded amounts of funding.

While the former doctor, doctor's union president and PSB mayor Célio de Castro, who became known in the city as "Doctor BH," was serving his last months in office before having to resign due to his own failing health in late 2001, his health secretary, Dr. Evilázio Teubner Ferreira created a new branch of SMS-BH called the Division of Planning and Development (GPLD). Among its other responsibilities, which included authoring proposed annual budgetary reports for the upcoming year, spending summaries for the prior year, and 4-year strategic plans for all of the secretariat's new infrastructure construction and service provision plans, GPLD was tasked with developing technical capacities to geographically target these service and infrastructure expansions according to the perquisites of the secretary and mayor. Teubner, a former activist in the doctor's union (SINDMÉD), hired a psychologist, former Brazilian Communist Party (PC do B) militant, and municipally-tenured employee named Paulo César Machado Pereira to head GPLD. By 2002, Pereira had hired the staff and built the technical capacity of the division to create estimates of health risk in every census tract in the city, based on Year 2000 census data. In addition to providing an empirically founded snapshot of the

variable severity of health risk within the city, Map 1 (see Appendix 2) also represents GPLD's first geo-referenced planning tool for targeting the new clinics and health professionals that it planned to begin rolling out in 2002 on a relatively massive scale.

As Belo Horizonte's mayor became Workers Party-leader Fernando Pimentel in late 2001, GPLD evolved into the lead division within SMS-BH for planning a massive new roll-out of the federal family health program (PSF). PSF is a federally funded program that provides municípios with approximately half of the new funds to hire roving teams of doctors, nurses, physician's assistants, and other health professionals, who work out of one of the 147 neighborhood-based primary health clinics, and register approximately 1500 residents in the surrounding neighborhood. Teams document health problems of household residents, provided in-home care, and raise awareness about the availability of primary, preventative care and medication in these clinics. When the question arose of where to implant the approximately 382 such teams that SMS-BH implanted between 2001 and 2002 – as well as subsequent expansions of over 120 additional PSF teams between 2003 and 2008 – GPLD provided the geographic tools for making these allocative decisions. These GPLD tools became a central means of deciding the service- and infrastructure roll-out strategies outlined in the Municipal Health Plan for 2001 to 2004 (SMS-BH 2001a) and for 2005 to 2008 (SMS-BH 2005a). They also became an important means of assessing effectiveness in the execution of these strategies is various reporting documents that the secretariat must present to City Council and the Municipal Health Council for its approval. Under the directorship of Pereira, GPLD presented detailed management reports not just for the first concerted year of PSF in Belo Horizonte but also for the entire network of municipally run health care facilities and

service provided during every year after 2001 (SMS-BH 2001b, 2002, 2003, 2004, 2005, 2006, 2007, 2008). GPLD had also become an active collaborator with epidemiological units with SMS-BH that tracked vital statistics like infant mortality within the city (SMS-BH 2010).

In sum, by 2002, SMS-BH had evolved the technical tools within GPLD to allocate health clinics and professionals within the city according to the most serious health risks. Below, I trace the development of these three main elements of Belo Horizonte's healthy state – its targeting capacities, and expanded numbers and risk-targeted clinics and health professionals – to the pragmatist regime of state-society politics that propelled state action in the public health sector between 1993 and 2008.

Belo Horizonte's Pragmatist Regime

In what follows, I offer an explanation for how and why this regime succeeded in constructing the health developmental state that equalized and expanded primary health care provision in Belo Horizonte after 1993. Contemporary politics of public health Belo Horizonte offer a more detailed picture of what I mean by a pragmatist regime insofar as they elucidate the historical and relational dynamics by which these diverse actors occupied the three positions within the regime during key moments of state transformation. First, because civil society activists from the Sanitarista Social Movement so completely permeated four other spheres of social life beyond civil society – namely, 1) relevant labor unions (SINDIBEL, SINDSAÚDE, SINDMED); 2) leftist and centrist political parties (PT, PCdoB, PSB, PMDB, PSDB); and 3) eventually the state itself (especially the mayorship, health secretariat, and other key politically-appointed positions) – they were able to build support for a political agenda of basic health care

expansion and a campaign of state expansion for achieving that goal, the principle components of which were the hiring of municipal employees and the construction of clinics required to expand services. Civil society's permeation – or in Alexander's terms, its "colonization" (2006) – of these other spheres in Belo Horizonte, amounted to a position of dominance within the regime for sanitaristas, who effectively relegated political party ideologues from the five main political parties that were active in public health politics locally to relatively submissive positions. (This dynamic contrasts sharply with other cities with similar political party configurations, such as Porto Alegre, in which party ideologues nevertheless colonized the civil society sphere of sanitaristas to the extent that sanitarista ideologies and actors came to occupy acquiescent positions within what I call that city's "participatory regime.")

A second, defining quality of Belo Horizonte's "pragmatist regime" was the occupation of key political and bureaucratic positions within the local state by sanitaristas during an extended period stretching from 1993 to 2008. Perhaps the crowning achievement of Sanitarista Movement activists in Belo Horizonte was the near hegemony that its ideology of prioritizing primary preventative care achieved among three successive mayors during this period: PT mayor Patrus Ananias from 1993 to 1996; the former Doctor's Union (SINMED) President, former PC do B activist and PSB mayor, Célio de Castro from 1997 to 2001; and PT mayor Fernando Pimentel from 2002 to 2008. Although sanitaristas had long advocated their agendas from more subsidiary roles, they themselves began "civilizing the state" by became important state actors during the period after 1993. Although part of a more leftist tendency within the PT that advocated a society-wide "inversion of priorities," Patrus ultimately proved to be fundamentally

pragmatist in the sense of not turning over the reins of health care policy to a minority of dogmatic party ideologues within the local PT, who advocated the same *etatist* program on the local level that was defeated on the national level during the Constitutional Assembly in 1988, a program that advocated a outlawing the private sector health care hospital and insurance industries altogether. Rather, Patrus appointed Cézar Campos and Lídia Tonón, who described herself as having "run in a Trotskyite, Mandelist current of opinion within the PT" and having organized "in the health union movement in what became the Health Workers Union (SINDSAÚDE), but not in the Doctors Union (SINDMÈD) Movement." Tonón contrasted her chosen path within the precursors of SINDSAÚDE to the current and prior incarnations of SINDMÈD, which she described as exhibiting far more Leninist tendencies and advocating an ideology of institutionalizing SUS in such a way as to promote the structural interests of doctors (as workers) while minimizing the more universalizing ideals of sanitaristas (*reforma sanitarista*). Mayor Pimentel made the similar choice of appointing Magalhães as a well-known sanitarista to the post of Health Secretary between between 2002 and 2008. It is perhaps not surprising, then, that during these two golden periods of *reforma sanitária* in Belo Horizonte, expansions in basic health care expanded substantially as did the construction of new basic health clinics and the hiring of a broad range of health professionals beyond just doctors. Even during the more SINDMÉD-influenced mayorship of PSB leader Célio de Castro between 1997 and 2001, who appointed a string of several former SINDMÉD activists as Health Secretary, these expansions in the public health state initially slowed but never stopped completely (Estado de Minas 1999). All in all, sanitaristas achieved a relatively continuous presence as political and bureaucratic managers of the local state

between 1993 and 2008, a presence that was unsurpassed in other large Brazilian capital city municípios.

A third quality of Belo Horizonte's pragmatist regime is that sanitaristas relegated non-sanitarista ideologues from several political parties to submissive roles within the regime. In particular, ideologues from the Workers Party (PT), the Brazilian Socialist Party (PSB), the Communist Party of Brazil (PC do B), the Brazilian Social Democratic Party (PSDB), and the Brazilian Democratic Movement Party (PMDB) were effectively forced to cede control of agenda-setting over public health care provision because sanitaristas' ideas about how to institutionalize universal health care had long dominated each of these parties' respective platforms and planks around public health policy, long before any of these parties were even formally legalized in the mid 1980s. As I demonstrate below in my discussion of what activists called "the Mineiro Sanitarista Political Party" during the 1970s and 1980s, this historical development owes much to a particularly broad pattern of politicization of sanitaristas according to which prominent sanitaristas from pre-union and pre-party organizations did not congregate around just one political party, as sanitaristas did around the PT in Porto Alegre during the same phase. Rather, their broad penetration of all these parties during early stages led a near full saturation of party agendas by the sanitarista ideal of providing universal access to primary, preventative health care. In Belo Horizonte's political context, those party ideologues, who advocated more sweeping reforms that would eliminate the private sector completely as a provider of health services, resided in minority positions within each of their respective parties, and within the overall regime as a whole.

Fourth, capital – namely, the health insurance industry and especially the private hospital industry – adopted an acquiescent position within Belo Horizonte's regime in part because, as Magalhães himself put it, "primary preventative health care itself does not disrupt [*não incomoda*] capital…because it is relatively cheap to provide and it is what allows you to coordinate care well, even for a private sector hospital…Private hospitals want to maximize profit and they do that by providing expensive, high complexity procedures like elective surgeries". Running a primary health program does not necessarily diminish the prospects of profit-making for capitalists in the private hospital and health insurance industries; Indeed, challenges to capital more typically come when municípios get into the business of competing for federal SUS dollars with private and philanthropic hospitals that provide so called high- and medium-complexity services like surgeries and in-patient procedures. Unlike in Porto Alegre, for example, where the município challenged capital during the late 1990s by maintaining municipally-run hospitals that "compete" with private and philanthropic hospitals to milk this cash-cow of high complexity services, the município of Belo Horizonte does not manage such hospitals itself. This divergent historical development in Belo Horizonte left capital relatively well accommodated because even as the municipal state spent comparatively large proportions of its overall health budget on lower complexity, cheaper, primary care services, private and philanthropic hospitals as well as the health insurance companies that profit from the middle and upper-classes who use them, ultimately faced no competition from the kinds of public hospitals that in Porto Alegre drive a wedge into private sector profiteering from more lucrative and complex service provision.

The Pragmatist Regime at Work

In Belo Horizonte after 1993, sanitaristas successfully advocated a pragmatic agenda of policy reform in the public health sector that not only prioritized equalizing expansions of primary, preventative health care into the most epidemiologically vulnerable regions of the city but also construct the key pieces of the local state that were required to do so. Specifically, this agenda emphasized building new local state capacities to: 1) expand primary care provision within a pre-existing federal network of outpatient health facilities; 2) regulate private sector providers of public health services; 3) build and staff new public health care facilities; and 4) geographically target such expansions toward high-risk epidemiological regions of the city. Although the content of this activist reform agenda shared key features with other PT-ruled cities such as Porto Alegre, its implementation in Belo Horizonte responded to more systematic preparations, unfolded over a much more continuous period of time stretching into the mid-2000s, and ultimately suffered fewer major political defeats. Witnessing surprisingly few major interruptions, implementation of Belo Horizonte's reformist agenda experienced two decisive phases of full-blown implementation – first during the administration of Workers Party (PT) Mayor Patrus Ananias Souza from 1993 to 1996 and then again during the PT administration of Mayor Fernando Pimentel from late 2001 until 2008. Although a weakening of the pragmatist regime by organized doctors unions during the mayoral administration of Célio de Castro from 1997 to late 2001 temporarily reduced the momentum and size of these state-building efforts, they never seriously derailed the pursuit of sanitaristas' reform agenda.

Although less sweeping in its ambitions than a more radical reform program that failed over time in Porto Alegre, and aborted attempts for reform in Rio de Janeiro and even in other large cities like Fortaleza, which has been governed by PT mayors since 2005, the "pragmatist" reform program that was successfully implemented in Belo Horizonte succeeded in reducing inequality of access to basic forms of health care. In some respects, Belo Horizonte's reformist strategy shared important features with more radical reforms pursued in Porto Alegre and the more minimalist reforms pursued in Recife and Rio de Janeiro. In response to the at-first unfunded federal mandate of providing universal access to primary health care, state reformers in all four cities attempted not only to build new state capacities required to expand infrastructure, staffing, services and their targeting. They also began defining the relationship of the municipal state to the private sector health industry, although in fundamentally different ways. Key differences in political ideology of state reformers – particularly an uncompromising refusal to recognize any legitimate role for the private sector health industry as a provider of public health services in Porto Alegre – ironically led reformers in that city to largely forego regulating private sector health providers altogether. In Belo Horizonte, however, a more centrist stance on the part of sanitaristas in local power ultimately led to less conflictual relations with the same key private sector health industry actors, who in these other cities resisted efforts by expand the local public health state.

Ultimately, much of this variation in the content and fate of public health reform proposals in these cities can be traced to local variations in the Sanitarista Movement, especially the extent to which its members broadly penetrated what, during the 1980s and early 1990s, were the most politically powerful leftist institutions: labor unions and

political parties. In Belo Horizonte, sanitaristas penetrated all of the five most active leftist political parties in city politics: the Workers Party (PT), the Brazilian Socialist Party (PSB), the Communist Party of Brazil (PC do B), the Brazilian Social Democratic Party (PSDB), and the Brazilian Democratic Movement Party (PMDB). They also enjoyed wide representation within the three most active health and municipal labor unions including the Doctors Union of Minas Gerais (SINDMÉD-MG), the Health Workers Union of Minas Gerais (SINSAÚDE-MG), and the Municipal Public Servants Union of Belo Horizonte (SINDIBEL-BH). Sanitarista occupation of these institutions, which themselves emerged from clandestine proto-party and proto–union organizing by medical and other students on the campus of the Federal University of Minas Gerais (UFMG) in Belo Horizonte during the height of the military dictatorship, was crucial because it lent key sanitaristas the political clout to promote core tenets of the Sanitarista Reform ideology during major struggles over the scope of the local public health state. Ultimately, then, this broad penetration of key spheres in Belo Horizonte enabled sanitaristas to effectively advocate an earlier, more continuous, and comprehensive program of policy change and institutional transformation than occurred in Porto Alegre, Recife, and Rio de Janeiro during the same period.

By 2007, the result of this trajectory was that, in comparison to these other cities, Belo Horizonte's municipal state had hired proportionally larger numbers of public sector health workers and had proactively crafted and enforced new regulative systems for integrating and defining the relationship of the private sector health industry to the public system. Additionally, it had created new information systems and human resources for identifying the most epidemiologically vulnerable populations within the city. Putting

these new capacities to work as early as the mid-1990s, the municipal health secretariat in Belo Horizonte began expanding primary health service provision and infrastructure roll-out in those regions. In short, state reformers in Belo Horizonte had begun evolving a health developmental state that would prove decisive in their effectiveness in reducing health service inequalities. Yet the origins of these achievements lay in the nature of the sanitarista movement in Belo Horizonte as early as the 1970s, which I turn to next.

Civil Society Origins of Pragmatist Regimes: The Sanitarista "Political Party" of Minas Gerais

In Belo Horizonte's recent history of public health politics and in its political history more broadly, generations of its most influential civil society activists, union leaders, state bureaucrats, political party leaders, and elected politicians first became active as students and militants during the 1970s and 1980s. Indeed it is the rare educated, leftist, *horizontino* (resident of Belo Horizonte) politician or health activist over the age of 45, who cannot trace her involvement in politics to an introductory moment of student militancy in pro-democracy struggles. During the late stages of the dictatorship, the campus of the Federal University of Minas Gerais (UFMG) in Belo Horizonte was a hot-bed of clandestine student organizing – not just for the pro-democracy struggles that would ultimately unseat the dictatorship and pave the way for the return of formal democracy to Brazil in 1985, but also for the health movement. Many respondents who led Belo Horizonte's municipal health secretariat trace their pedigree to what they call "the mineiro sanitarista party," which was not a party but contained sanitaristas who sought political vehicles for translating the reform ideas of sanitaristas into practical realities through the practice of primary, preventative, and publicly accessible health care.

The sanitarista party actively linked its pursuit of these ideals to the pro-democracy struggles of the 1970s and 1980s. Indeed, sanitaristas attribute the successfully codification of a constitutional right to health, the creation of the Integrated Health System (SUS), and the circulation of both these ideas in the 7th National Public Health Conference to the mineiro sanitarista party.

And while this is also the case in other large Southern and Southeastern Brazilian cities like Porto Alegre, São Paulo, and Rio de Janeiro, one key factor that differentiates Belo Horizonte's history of militancy from these other cities is that sanitaristas carried these ideas with them as they permeated an unusually broad set of proto-union and pro-party organizations. This phenomenon emerged in part from the fact that the Medical Sciences School of UFMG constituted one of the largest, most prestigious, and venerable medical schools in Brazil during this period, as it is today. Yet peculiarities in the military dictatorship's management of the UFMG Medical Sciences curriculum and its enrollment during the late 1970s played an understated role in radicalizing its students, not just around the general movement for democracy, but also around more specific public health agendas. Decisions regarding enrollment and curriculum served to mobilized medical students during the 1980s around a more programmatic set of proposals for educating medical students to serve city regions with the poorest and most at-risk residents, a proposal which many students of the time felt was constructed to prevent students from building solidarities with the "the poor masses," which could undermine the dictatorship. Not surprisingly, this only radicalized more students around just such a goal.

Nearly a decade later, when sanitaristas began working in the Municipal Health Secretariat under the first Workers Party mayor of Belo Horizonte, Patrus Ananias between 1993-1996, the combination of virtually no pre-existing state capacities, a start up atmosphere, and new sources of municipal funding for health programs, which were difficult to spend at the time because of lacking capacity, all aided in opening a space in which the venerable sanitarista ideal of primary, preventative health care for epidemiologically vulnerable populations began making its way into policy shifts. When in 1992 the city municipalized all pre-existing federal primary care clinics from the federal government, sanitaristas in power began actively pursuing major human resource expansions to staff these centers, better equip them, and in some cases renovate them completely. In short, municipalization marked the launch of sanitarista ideals making their way into tangible policies of the local state as well as its material actions.

Ultimately, the pragmatist reform agenda that these actors began pursuing in 1993 had three defining features. First, during an earlier period known as municipalization, state reformers in Belo Horizonte precociously took control of a pre-existing federal network of health care clinics and workers. Second, reformers also pursued a more ambitious program for regulating the private sector health industry than witnessed in other cities such as Porto Alegre, allowing them to exercise greater control over the role that private health care providers would come to play in the provision of publicly-financed health services. Lastly, Belo Horizonte's state reformers substantially expanded the size of the public health state by adding scores of new health care workers to the municipal payroll, building new outpatient clinics that the município managed, negotiating agreements with private hospitals to perform public services, and crafting

new state capacities that were required to manage this process of expansion. Although the ways in which this proposal were tangibly pursued by the municipal health secretariat between 1993 and 2000, I these interventions were never seriously derailed.

Conclusion

In this chapter, I first drew on descriptive spatial analyses and qualitative evidence to argue that equalizing expansions in the provision of basic public health care services in Belo Horizonte occurred during the 2000s, primarily because state reformers between 1993 and 2007 constructed a developmental state for the public health sector. This construction of Belo Horizonte's healthy state involved building the technical capacities required to execute state reformers' reform program of reversing a pre-existing spatial pattern in which concentrations of municipal health professionals and municipal health clinics were (mis)allocated in wealthier, geographically central city regions with generally lower health risks. As early as 1993, state reformers had effectively begun re-allocating existing health professionals in poorer, geographically peripheral city regions that exhibited generally higher health risks, with impressive immediate reductions of infant mortality rates from nearly 40 deaths per 1000 live births in 1992 to only 23 deaths in 1997. But as increasing amounts of federal funding for primary care provision began arriving in the late 1990s, these reformers also undertook more fundamental transformations and expansions of the município's public health state. Three transformations were especially crucial: 1) expanded numbers, and 2) improved allocation of basic health care clinics and health professionals within the município, as well as 3) the technical capacity to target these new state capacities within city regions, where health risks of resident populations were relatively severe by município standards.

The evolution of these three qualities of Belo Horizonte's healthy state had the ultimate effect of expanding município-wide service provision and substantially reducing pre-existing spatial inequalities of access to basic public health care provision within the município during by 2009.

In later portions of the chapter, I drew on my qualitative findings from fieldwork to trace these equalizing expansions in Belo Horizonte – and the construction of the município's "healthy state" – to the dominant position of civil society activists from the Sanitarista Social Movement within a regime of state state-society politics, comprised of five types of actors that influenced state action in the public health sector from their vantage points within their dominant, submissive, or acquiescent positions within the regime. Specifically, I argue that civil society actors from the Sanitarista Social Movement came to occupy the dominant position within the regime alongside actors from organized labor by colonizing the three key labor unions and five major left and left-center political parties that influenced debates about state expansion in the public health sector. Because of their seminal role in forming nearly all of the local and sometimes also the national organizations of the five most active leftist political parties in Belo Horizonte's politics – the Workers Party (PT), the Brazilian Socialist Party (PSB), the Communist Party of Brazil (PC do B), the Brazilian Social Democratic Party (PSDB), and the Brazilian Democratic Movement Party (PMDB) – sanitaristas in Belo Horizonte faced few fatal threats to their agenda of "inverting priorities" in the public health sector by expanding primary health care provision in city peripheries exhibiting high health risks. For similar reasons stemming from their involvement in the founding of the Doctors Union of Minas Gerais (SINDMÉD-MG), the Health Workers Union of Minas

Gerais (SINSAÚDE-MG), and the Municipal Public Servants Union of Belo Horizonte (SINDIBEL-BH), sanitaristas also faced few serious setbacks at the hands of these actors, even when the more centrist mayor and former SINMÉD President, Mayor Célio de Castro, held power between 1997 and 2001..

Ultimately, then, this historically broad penetration of key leftist institutions spheres in Belo Horizonte – and the lack of any singular dependence on the Workers Party to push reform agendas – enabled civil society actors to effectively occupy a dominant position within the município's regime of state-society politics in the health sector. From this position, sanitaristas advocated an earlier, more continuous, and more universalizing program of policy change and institutional transformation than occurred during the same period in other municípios examined in this dissertation such as Porto Alegre or Rio de Janeiro. The tangible result of these state-society politics in the city was a reduction of health service inequalities that was unsurpassed among Brazilian cities over the past twenty years. In the following chapter I provide a similar analysis of the different circumstances of changing health service inequalities in Porto Alegre.

CHAPTER 6

MUNICIPALIZATION-AVERSE CONDITIONS, PARTICIPATORY REGIMES, AND AN UNCONSOLIDATED HEALTH DEVELOPMENTAL STATE IN PORTO ALEGRE

Chapter 4 demonstrated that the município of Porto Alegre exhibited comparatively moderate levels of primary public health provision throughout the município during the 2000s and the last half of the 1990s. During a period in which Belo Horizonte undertook dramatic expansions and Rio de Janeiro hardly expanded at all, Porto Alegre hovered near the median of large Brazilian cities, both in the populational coverage it achieved through the Family Health Program as well as its primary care appointment rate, more generally. This chapter argues that this somewhat counterintuitive outcome occurred in Porto Alegre because of a mixture of inherited institutional legacies in the health sector and a pattern of political mobilization in which sanitaristas periodically occupied key top-level health offices in municipal government, but proved too weak and narrowly tied to one political party to affect state-level health politics that were crucial in the initiation of municipalization. Ultimately, the participatory regime of state-society politics that molded local health policymaking and state-building efforts in the local public health sector struggled to meet the organizational challenge of building sufficient human resources on the large scale that defined the rise and consolidation of more formidable health developmental states in otherwise similar cities like Belo Horizonte.

Yet one cannot understate the importance of the very different state-level context in which Porto Alegre's sanitaristas and other activists for universal health care found themselves. In stark contrast to the more conducive circumstances throughout Belo Horizonte's encompassing state of Minas Gerais, state government in Rio Grande do Sul almost uniformally opposed municipalization of the health sector in Porto Alegre. While sanitaristas made proposals to state government for municipalizing the sector as early as 1989, state-level officials rejected these proposals, leading to a comparatively later starting point for primary service provision by local government in the city. Further, even after the onset of municipalization in Porto Alegre, state government not only suffered through an extended budget crisis that narrowed its degrees for freedom, but also focused the few resources it did have on fostering the capacity of rural municipalities to deliver basic health care. In short, this state-level context made it difficult for local sanitaristas and state reformers to actively build new state capacities for universalizing health care throughout the city. None of this is to say that other civil society actors remained similarly weak and disconnected from the politics of public goods provision.

On the contrary, between 1989 and 2004, locally ruling Workers Party politicians and bureaucrats developed sophisticated modes of engaging previously disconnected and unorganized members of civil society through Participatory Budgeting, a prime example of the "institutionalized decentralization" mode outlined in previous chapters. Institutionalized decentralization in Porto Alegre radically democratized decision making over the município's capital investments through Participatory Budgeting (OP), including the construction of primary health clinics. Somewhat overshadowed by this approach to engaging civil society, the city's relatively weaker sanitaristas proved unable to advance

their agenda of universalizing basic service provision, as they did in other cities. Indeed, they remained comparatively sheltered form equally important decision making processes about the hiring of primary health care professionals from civil society demand-making. The combined result of these politics within the municipal state was a substantial number of primary care clinics but a dearth of publicly-employed primary care workers to staff them and an absence of systematic targeting of these workers and clinics toward geographic regions characterized by the most severe epidemiological risks.

Unlike in other cities like Belo Horizonte where a pragmatist regime built a formidable public health state for providing basic health services but surrendered administration of more lucrative high and medium complexity services to capitalist actors from the private hospital industry, Porto Alegre's "participatory" regime challenged capital by unsuccessfully pursuing a fully etatist system for providing *all* types of health service, including more complex services. This had the effect of subsuming the longstanding Sanitarista emphasis on universalizing provision of basic health services beneath the separate proposal of popular movements and neighborhood associations for promoting participation in public goods allocation, including public provision of health care. But above all, the regime's lack of focus on institutionalizing the health sector locally comes through in the voices of those who waged these politics. One local PT founder, doctor, and former Municipal Health Secretary traced the município's stagnant primary health care provision during the 2000s to the fact that "health policy, in general, was never taken on or understood by the [Workers] Party, as such" (Kliemann 2010: 3-4). Dr. Lúcio Barcellos, another former Municipal Health Secretary, prominent Sanitarista, and PT founder who later migrated to the more progressive PSOL, offered a slightly

more precise formulation. He points, for example, to what he calls a "crazy arrangement" that the município pursued between 1995 and 1998 of placing neighborhood associations across the city in charge of managing and overseeing the work of public health care professionals (Barcellos 2010: 6). Its many other virtues aside, the ultimately failed pursuit of an etatist public health care system, together with the low political priority that key regime actors assigned to the health sector, not only relegated sanitarista ideologies for institutionalizing primary public health care provision to peripheral importance, contributing to comparatively stagnant state capacities for providing these services in the município during the 2000s. Thus a central finding is that actors from the sanitarista movement, who advocated for these two specific forms of state building most forcefully, exerted little influence within Porto Alegre's participatory regime and proved unable to transform their proposals into executed actions of the local state.

Porto Alegre's Participatory Regime: Actors, Roles & Origins

Between 1989 and 2004 in Porto Alegre, public health policymaking responded to the local politics of what I call a participatory state-society regime. I define the relations internal to this regime in Porto Alegre as participatory ones because a deliberatively-oriented civil society allied with political society actors in advancing a comparatively progressive and more democratic ideology for institutionalizing civil society control over a broader scope of public service provision than a more narrowly circumscribed, pragmatist civil society pursued in Belo Horizonte's public health sector. Led by the Workers Party (PT) and civil society activists from the popular and neighborhood association movements, sanitaristas occupied more of an ancillary role in this regime and remained largely shielded from key channels beyond participatory budgeting that were

crucial for building the capacity of the municipal health state in other cities like Belo Horizonte.

As has been well-documented in existing literature (Abers 2000; Baiocchi 2005), Workers Party (PT) mayors governed the município of Porto Alegre for five consecutive terms between 1989 and 2005. These mayors generally represented two competing tendencies within the party, tendencies which loosely fit the classic ideal typical struggle between more leftist versus more centrist currents. Generally speaking, the mayorships of Olívio Dutra between 1989 and 1993 and Raul Pont between 1997 and 2000 exhibited more leftist tendencies, while the two terms of Tarso Genro between 1994 and 1996 and between 2001 and 2002 exhibited more centrist tendencies. After Genro left the mayorship to run for governor in late 2002, the vice-mayor who became mayor between 2003 and 2004, João Verle, drifted further to the center than any other PT administration. Two factors – first, the fact of health care policy came to occupy a low priority within dominant party agendas and second, the fact that the health policy goals that these two divergent tendencies did pursue varied depending on the PT administrations in power – ultimately stunted the evolution of state capacities to provide basic health care.

It is far beyond the scope of this chapter to analyze the many, intricate ideological tendencies within Porto Alegre's PT. In the overall comparative argument of the dissertation, what is instead important is the fact that the municipal state never pursued one continuous public health policy, much less a policy that prioritized basic public health care provision to the poor, as was the case in Belo Horizonte. All of the município's PT mayors from 1989 to 2005 faced fierce internal ideological dialogues within the party, which made pragmatist courses of policy action more difficult to pursue

(with the one exception of Participatory Budgeting). Former mayor Raul Pont traced this tendency to the historical construction of the city's PT, which he argues was more radically democratic in both its process of debate and outcome in terms of party structure, than PT counterparts in other states.

> "I think the PT was born firmly (*nasceu sólido*). It's origins are not much different than in the rest of Brazil: the union movement, the left that emerged from universities, secret organizing during the dictatorship (*clandestinidade*), the church movement…it had an ability to unite everyone. But it [Rio Grande do Sul] is the only state I know of in which the right of proportional representation in the Executive was respected by the Provisional Commission. And this made [PT organizations in] many other states lose people over the long term, because they reproduced a very monolithic style in their direction and became more sectarian than other experiences…The other important fact is that the PT here, as distinct from other places, never subordinated its construction to electoral alliances or pragmatic alliances that, in an initial moment, may have appeared favorable but at later points gave way to tragedies" (Ferreira and Fortes 2008: 225; my translation).

Scholars commonly highlight the ways in which this brand of internal party democracy proved fruitful for local democracy more generally. Pont also highlights another factor that impeded this pursuit: the PT's refusal to assemble multi-party tickets, in this case, the practice its refusal to pair mayoral candidates from the PT with vice-mayor candidates from other parties.[1] In contrast to Belo Horizonte, where sanitaristas exerted in outsized role in defining health policies, passing the kinds of legislation required to undertake health sector expansion in Belo Horizonte provide more difficult. In part this was due to the wider-reaching alliances and multiple party tickets that Belo Horizonte's pragmatic PT governments forged while in and out of mayoral power between 1993 and 2008.

Such difficulties are especially palpable in the politics of gaining political support to create new slots for the hiring of additional municipal employees, a process known as the opening of *concursos*. Opening concursos is almost always a challenging political

undertaking for a sitting mayoral administration in local Brazilian politics because political opponents in City Council (*Câmara de Vereadores*) tend to avoid approving their opening. Opponents avoid opening concursos because doing so is generally understood by party strategists and authorities to give the party in mayoral power a powerful material resource that it can allocate to political supporters of one kind or another: namely, a public job with guaranteed tenure and retirement benefits that include a pension in the amount of 100% of the monthly salary earned while publicly employed. Overcoming this resistance typically proves difficult politically, but is all the more challenging when the party of a sitting mayor constitutes a minority on City Council, as was almost always the case for sitting PT mayors in Porto Alegre between 1989 and 2004. If opening concursos for public health workers already required sizeable amounts of political capital that Porto Alegre's mayors generally lacked during this period, doing so became even more of an uphill struggle because the PT systematically eschewed running multi-party tickets for Porto Alegre's mayorship. This eschewal further narrowed the already slim political basis for log-rolling, which mayors typically rely upon to overcome such resistance.

Participatory and Pragmatic Civil Societies

Both sanitaristas and advocates for participatory democracy both offer prime examples of Alexander's definition of civil society as "a solidary sphere in which a certain kind of universalizing community comes to be culturally defined and to some degree institutionally enforced" (2006: 31). On one level, in order for civil society to acquire the political power required for effectively propagating their particular notions of universalizing community, they orchestrate hegemonic relationships with other, non-civil

society actors. These hegemonic relations are fundamentally Gramscian in the sense of one bloc within civil society successfully presenting its own ideals as those of multiple blocs (Gramsci 1973: 273). In Porto Alegre, popular movement activists succeeded in presenting their own ideal of participatory democracy as one which other dominant actors in the regime (namely governing PT elites) ultimately accepted as their own. By contrast, Porto Alegre's sanitaristas attempted but ultimately failed to construct a similar set of relations.[2] In this sense, Porto Alegre differs from Belo Horizonte, where sanitaristas effectively won a war of maneuver through which they became dominant within the regime by constructing hegemonic relations with a sweeping set of labor unions and political parties.

Their hegemonic aspirations aside, actors in both movements in both cities qualify as civil society actors, in the Alexandrian sense, because both were firmly rooted in "communicative institutions of civil society". While these were primarily neighborhood associations for OP activists, sanitarista activists were rooted in a different communicative institution: namely, dozens of clinic- and hospital-level health councils (*conselhos das unidades*) that united health professionals and patients and were pre-figurative of, but not reducible to health care workers unions and public employees unions. Leaders in both movements in both cities qualify as Alexandrian civil society actors in two respects. First, sanitaristas and *opistas* (popular movement advocates of OP, or Participatory Budgeting) drew on their roots in (different) communicative institutions to cultivate two (different) solidary ethea. The ethos of each emerged, not only from a different set of ideals around which to construct these solidary relations, but also from a different set of subjects with whom they set out to construct that solidarity. As health-

center based leaders of professional associations based in health care centers and hospitals, sanitaristas cultivated among their patients a specific notion of universalizing community that is based in the constitutionally inscribed, universal right to public health care. As neighborhood-based leaders of the popular movement, neighborhood association presidents and opistas instead propagated among residents a notion of universalizing community based in the right to participate in allocating the state's public goods through OP. Second, sanitaristas and *opistas* both acquired and used ideological tools for accumulating political power. As civil society actors, they lacked the sources of political power for influencing state action, which are common to other non-civil society spheres.[3] Instead, they relied on the construction and exertion of ideological and organizational resources. In sum, actors from the separate social movements for participation and public health in urban Brazil are Alexandrian in their propagation of solidaristic, universalizing ideals of community, but Gramscian in the sense that they sought out the political power required for advancing these ideals (with varying degrees of success) by orchestrating hegemonic relations with non-civil society actors.

After 1989, the popular participation and neighborhood movements played a key role within Porto Alegre's regime of state-society politics, while sanitartistas played an acquiescent role. Specifically, the popular movement offered and won PT and broader social support for the specific idea that a broad array of civil society actors should have direct forms of institutionalized control over the local state's public goods provision. The creation of Participatory Budgeting (OP) was one tangible institutional form that these actors successfully proposed for actualizing this idea. A preponderance of existing evidence shows how, early on in the regime's history (the late 1980s), these popular

movement actors became the regime's hegemonic civil society actor par excellence by proposing and winning widespread support for their ideal of realizing participatory democracy through Participatory Budgeting's set of procedures for directing a small portion of the state's investment into areas chosen by civil society (Baiocchi 2005; Baierle 1998). By contrast, another set of civil society actors from the sanitarista movement largely failed to widely propagate their ideology of expanding the local public health state in ways required to broaden access to primary public health care in the city. A central historical reason for this failure is that sanitarista activists in Porto Alegre never permeated the full array of leftist institutions and political parties as their counterparts in Belo Horizonte did (See Chapter 5). In short, Porto Alegre's sanitaristas never elevated their ideas about the social importance of primary public health care provision to the hegemonic level they achieved in Belo Horizonte, nor did this ideal ever seriously rival the ideal of participatory democracy that Porto Alegre's popular movement activists advanced.

In something as simple as the creation of the PT's early governments, we can see the unfolding of this particular power dynamic and better understand how some social movements acquire more political power than others. The variable political power resources that different civil society actors acquire are observable through the imperfect lens of the social movement pedigrees and backgrounds of the top-level political appointees, whom PT mayors select to occupy top-level positions (*cargos de confiança*) during crucial moments. The most relevant of these appointments for questions of public health policy is the position of Municipal Health Secretary. When Olívio Dutra became the city's first PT mayor in 1989, he appointed the sociology professor and popular

movement activist, Maria Luiza Jaeger, as Municipal Health Secretary. In her rendition of the internal party dispute that led to her being appointed, Jaeger describes the party's decision as owing much to her lack of alignment with certain tendencies within the state's PT and her close relationship with Dutra.

> "So, Olívio is the mayor and Tarso Genro is named his vice-mayor. The [creation] of the government is entirely a process of negotiation between various tendencies of the PT and I am not of any tendency and never was. The name that they arrived at was [Dr. Rogério] Amoretti, who is [a manager] of GHC [the federally-owned Conceição Group of Public Hospitals] and a person connected to Tarso. There was a meeting of the directorate in which Olívio presents his name and Amoretti goes home to celebrate his having become Secretary. Only the meeting continues, and people who came more from the health and union movements propose my name and Olívio ends up accepting it because Olívio knew me since the days of the union movement. He was involved in the union movement at the same time, when I was president of the Sociologists Union and he was president of the Bank Employee's Union, so we had known each other for a long while through the PT, the CUT, etc." – Interview with Jaeger

Although Jaeger first describes herself as representing no tendency at all, she later indicates that the health and union movements suggested her name and supported her appointment. On one level, her roots as a university professor and her former activism with the Sociologists Union plant her firmly in a tendency within the PT that grew out of clandestine student and faculty organizing on the campus of the Federal University of Rio Grande do Sul (UFRGS) throughout the 1970s and 1980s. Lacking the union organizations that served as institutionalized vehicles for making demands on the state, the student movement that grew out of UFRGS allied with neighborhood association activists around proposals to create new institutions like Participatory Budgeting.

But in another sense, Jaeger alludes to the fact that the party apparatus approved her nomination over that of a prominent doctor and doctor's union member, who was a federally employed manager of the Conceição Hospital Group (GHC). In light of this, the

fact that Jaeger's activism straddled the labor, sanitarista, and popular movements likely contributed to the PT appointing her to this role. For example, in 1988, Jaeger was one of the activists in the CUT, the largest confederation of labor unions in Brazil at the time, who helped write the universal right to public health care into the constitution. This dimension of her activist pedigree is insightful because the CUT was one of the most strident defenders of an etatist public health system. During two years of intensive meetings leading up to the writing of the constitution during the Constitutional Assembly of 1988, members the National Commission of *Reforma Sanitária* convened an important set of negotiations about whether Brazil should have an etatist public health system in which the state provided all services, as opposed to an integrated health system in which both the state and the private sector provided public health services. Immediately after this etatist proposal lost out in the Constitutional Assembly of 1988, many of its strongest advocates from the commission fanned out across the country, shifting the terrain of this struggle to municipal and state governments, where they continued advocating a complete moratorium on private sector provision of publicly-financed health services. In 1989, Jaeger was one of the strongest proponents of this position in Porto Alegre's newly formed government.

Thus, three key elements of Jaeger's background played a pivotal role in her becoming health secretary in 1989. First was the post-1970s union organizing background she shared with other labor and pro-democracy activists like Dutra, who eventually became a key locally elected PT officials and remains one if its chief power brokers. Second is what she alludes to in saying that she was not aligned with any tendency in the PT. This can be interpreted as meaning emphasizing that she had no

strong ties to the extremely powerful statewide doctors union (SIMERS, *Sindicato Médico do Rio Grande do Sul*) or the regional council of medicine (CREMERS, *Conselho Regional de Medicina do Estado do Rio Grande do Sul*), in sharp contrast to the rejected nomination of Amoretti, who featured prominently in both. This ties into a third element of her background – namely, her activism in the CUT for an etatist public health system. This was a position that SIMERS, CREMERS, and Amoretti, whose nomination was rejected, all opposed at the time. In short, what Dutra's first health secretary appointment shows is that in the initial moment of the PT's ascendance to state power, it was not the sanitarista or labor movements, but the popular movement, which the party and its first mayor placed in charge of formulating health policy.

Labor and Capital

It should be noted that in Porto Alegre, sanitaristas did not colonize the broad area of labor unions in Porto Alegre that they do in Belo Horizonte. This led to unions acting more like unions in the sense that they primarily defended the interests of the categories they represent. The Sanitarista Movement's inability to succeed in expanding local state hiring of municipal health care workers in an initial moment (1989 to 1998) resulted in a missing agent for further reform. When Helath Secretary Barcellos attempted to expand public health care workers in 1998 to 2000, public health care workers unions were still relatively small and insignificant at this moment, particularly in comparison to the statewide doctors union, which adopted a much less consistent position and generally more unfavorable position regarding the expansion of state capacities for primary preventative health care provision. One example of this was the fact that Dr. Amoretti, was not strongly in favor of early municipalization and instead favored

expanding the município's regulation of private hospitals in the city. This contrasts with Belo Horizonte, where sanitaristas supported primary health care provision and actively tried to cultivate public health care workers as a political agent that would support the agenda. BH's Sanitaristas wagered that expanding this agent by opening concursos would generate political support for future expansions of basic health care provision.

During the 1990s and first decade of the 2000s, owners and managers of Porto Alegre's private hospitals[4] constituted the most relevant capitalist actor within the city's state-society regime of public health politics.[5] On the crudest level, the existence of this private sector hospital industry can be viewed as an institutional legacy of Brazil's authoritarian regime. The authoritarian regime actively cultivated the development of the industry between the mid-1960s and mid-1980s as part of a national health policy that provided curative, state-provided health care services to formal sector workers only. Multiple authors have demonstrated how the military regime nurtured the industry, in part to shore up its support among urban upper classes by building hospitals in the geographic centers of Brazil's largest capital cities, where these classes increasingly lived (Escorel 2008). In 1974, the dictatorship created a health bureaucracy known as INAMPS (*Instituto Nacional de Assintência e Previdência Social*), which accelerated the growth of the private hospital industry. After this period, the industry increasingly provided upper class Brazilians and other formally employed citizens with expensive, high and medium complexity health services intended to cure ailments (as opposed to preventing their emergence in the first place through primary, preventative health care).

On the one hand, this industry's exclusion of informally employed, poor dwellers of the urban periphery from publicly financed health services became a major rallying cry

for the civil society activists who successfully inscribed health care into the 1988 Constitution as a universal right of all citizens. On the other hand, as described in the introduction of this dissertation, the public health system (SUS) and bureaucracy that emerged to realize this right was one in which the state was not the sole provider of health services. Rather, SUS reinforced a key dimension of INAMPS in its preservation of a central role for private hospitals as providers of publically financed services. Furthermore, pre-existing sources of bureaucratic fragmentation in the military regime's administration of health care persisted in the form of divided responsibilities between two separate federal ministries for overseeing and managing hospitals. Although analysts commonly refer to the Health Ministry as the primary federal bureaucracy for administering public health care in Brazil, the federal Education Ministry plays an overlooked role because it oversees most clinical hospitals that are associated with medical schools in large Brazilian capital cities. And if the reform ambitions of SUS proponents were slow to permeate through the Health Ministry, the same is true in spades for the Education Ministry's administration of federally-owned and operated research hospitals. In short, legacies of the military regime persevere today in the tangible institutional form of a private hospital industry it helped create.[6] Furthermore, because municipal governments like Porto Alegre's struggled to assume their new role for regulating private hospitals during the 1990s, some informed observers argued that the industry's continued extraction of profit and exploitation from governments has continued in a relatively unabated fashion that closely resembles authoritarian era levels (Barcellos 2010).[7]

In a Marxian lens, the private hospital industry in Porto Alegre possesses especially formidable structural power by virtue of its favored location within the productive apparatus of health service provision. Private hospitals own several crucial means of production, including, for example, approximately 80% of all hospital beds in the state of Rio Grande do Sul and about the same proportion in the município of Porto Alegre itself. Furthermore, while the industry competes with the state for ownership and operation of the hospitals located in Porto Alegre, it dominates these competitors, providing about 80% of all SUS-financed health procedures administered in the city during most years of 2000s and about 65% by 2011 (GHC 2011). Private hospital managers note that their provision of so many publicly financed services makes them financially very dependent on government for the SUS reimbursements various levels of government provide (Leite 2010: 140). But this relationship also gives hospitals substantial bargaining power in negotiations with the federal health ministry and the município, for example in setting the agreed-upon prices that these states allow private hospitals to charge the federal government as reimbursements for the hundreds of different medical procedures they provide to SUS users monthly.

Thus, the private hospital industry continues to thrive in Porto Alegre (and across Brazil) today, long after the demise of the military authoritarian regime that helped create and expand it. In large capital cities including Porto Alegre, these hospitals provide patients primarily medium and high complexity services, including the growing variety of highly profitable, elective surgeries that helped make Brazil an internationally recognized haven for medical tourism, especially plastic surgery, during the last decade (Edmonds 2010). In this sense, important dimensions of the highly profitable relationship that

private sector hospitals developed with INAMPS during Brazil's dictatorship endure to this day in these hospital's relationships, not only with the federal Health Ministry, but also with município governments such as Porto Alegre's. By the year 2000, for example, Porto Alegre's Municipal Health Secretariat spent well over half of its total budget on its Health Service Division's (GRSS or *Gerência de Regulação de Serviços de Saúde*) reimbursements to private and philanthropic hospitals for the services they provide SUS users (Kliemann quoted in Leite 2010: 141). And in one respect, the industry's formidable structural power as a major producer of public services in Porto Alegre has leant it a certain undeniable political relevance in the crystallization of key municipal health policies.

But in another respect, PT administrations between 1989 and 2000 forced the private hospital industry to occupy something of a submissive position within Porto Alegre's state-society regime of public health politics. Recent research documents how Porto Alegre's mayor, health secretary, and other top-level health bureaucrats excluded the private hospital industry from discussions during this period about how it would be regulated (Leite 2010). Furthermore, although it ultimately failed to do so, the município's first PT mayor, Olívio Dutra, briefly attempted to municipalize the largest group of publicly-owned hospitals from the federal Health Ministry.

> "Olívio didn't have this preoccupation about finances, so much so that he wanted to get [municipalize] GHC [Grupo Hospitalar Conceição][8], which would have been absolute madness for us. When I went to him with this proposal, I thought "There is no way he will accept this." He accepted it…Our [first] proposal for municipalization [in 1989] was to get everything, hospitals included. It was very much like, 'Let's go, let's do this.' (*Vamos lá. Vamo que vamo.*) And the secretariat that would have been left to do everything was a tiny thing. But the agreement was, 'Let's do this now and see how it turns out later (*Vamos e depois ver como faz*)'" – Interview with Jaeger

Jaeger and others describe this early move of Dutra as something of a shot across the bow of the industry in Porto Alegre, which was intended to convey the PT government's continued support for local etatization of public health care provision (Jaeger 2010; Barcellos 2010). In this sense, the position of Porto Alegre's PT in 1989 closely mirrored the position with which the national-level PT began the Constitutional Assembly just a year earlier in 1988, but begrudgingly abandoned by the end of the Assembly for the compromise, "integrated" system eventually that the framers eventually agreed upon.

Although the local PT's etatist stance abated somewhat between 1993 and 1996 during the more centrist PT administration of Tarso Genro, who appointed the federal hospital manager Dr. Luis Henrique Mota as Municipal Health Secretary, it resurfaced again in 1998, when many actors from the more left-leaning tendency that governed health policy from 1989 to 1993 returned to power in the administration of Raul Pont and his health secretary, Dr. Lúcio Barcellos. Indeed, during this period, Pont and Barcellos succeeded in municipalizing President Vargas Children's Hospital from the federal government by striking an unusual deal with the federal Health Ministry (MS) in which it absorbed all of the hospital' personnel and pension costs in perpetuity, while surrendering management control to the município. Although they became adept at updating "inampista" practices to evade regulation and continue maximizing profit from the services it provides to health bureaucracies from all three levels of government (município, state, and federal), private sector industry actors played no role in these negotiations.

Public Health Sector Municipalization & Policymaking

When the federal government's Family Health Program (PSF)[9] first arrived Porto Alegre in 1996, it came to be directly overseen not by elected politicians or appointed bureaucrats of the local state, but by neighborhood associations. Instead of the Municipal Health Secretariat overseeing its implementation, as was the case in Belo Horizonte where the program expanded exponentially after the late 1990s, Porto Alegre's neighborhood associations became de facto managers of PSF's teams of health care professionals across the city. The question of why and how this occurred offers a window into the internal power dynamics that defined the city's regime of state-society politics in the public health sector. Specifically, it demonstrates the formidable influence that the social movement for popular population achieved in city politics. Though loosely allied with the Sanitarista Movement in the city, neighborhood and popular movement actors during the 1990s exerted far greater influence than Sanitarista actors within key debates about whether, how, and how much to build new state capacities for providing basic public health care in a geographically-decentralized and epidemiologically-target fashion throughout the city.

Primary Health Care Plays Second Fiddle to Participatory Democracy, 1995-97

Given this background, it is perhaps not surprising that the federal government's programmatic platform for pushing municípios to expand their primary public health care provision – the Family Health Program (PSF) suffered from an inauspicious beginning in Porto Alegre. The entry of the program generated substantial conflicts between Sanitaristas, UAMPA and neighborhood association activists, and PT strategists. Dr. Lúcio Barcellos, a prominent sanitarista activist, co-founder of the PT in Porto Alegre,

and Municipal Health Secretary from 1998 to 2000, described the way in which PSF was first implemented in the city, using the example of its administration in the traditional PT regional redoubt of Partenon/Lomba do Pinheiro.

> "So, the neighborhood association there in Lomba do Pinheiro employed the PSF teams that worked in Lomba do Pinheiro. And the município had a contract with the association. It passed funds to the association and the association hired the teams. So the president of the association was the employer of the PSF team. If you think about it, this was a crazy arrangement (*um negocio maluco*)! For better or worse, the guy who was president of the association, he thought he was the owner of all the equipment, but not everyone, not every community leader has his head on straight (*tem uma boa cabeza*). These guys thought they were the boss and that they could fire workers and order the team around. So this created a tense situation. – Interview with Barcellos

This practice exemplifies the impressive level of decentralized control of state service provision for which Porto Alegre's politics became well known during the last twenty years.

The city government's initial practice of assigning neighborhood association heads as *de facto* managers of PSF teams exemplifies how more technically oriented proposals for expanding primary held far less sway than participatory budgeting. More specifically, the story of PSF's initial, unorthodox implementation exposes how these strategists subsumed the institutional requirements of adequately municipalizing the health sector beneath the separate political project of continuing to propagate the PT as the party of popular participation. By 1995, neighborhood association leaders were demanding new and additional forms of control over state actions of many kinds, including control over health care provision, in general, and PSF in particular (Interview with Dr. Scorza)[10]. At this time, Porto Alegre mirrored the other large Brazilian capital cities examined in this study to the extent that health constituted the single greatest social concern in 1995, according to a Datafolha survey (Folha de São Paulo 06/22/1995). Dr.

Humberto Scorza, a longtime petista, sanitarista, and the first non-municipal health secretary to become coordinator of Porto Alegre's Municipal Health Council,[11] described this moment as one in which the initial buzz and novelty of Participatory Budgeting was beginning to wear off.

> "When people started to participate, the novelty (*novidade*) of Participatory Budgeting was that they felt, to a certain point, validated in their efforts (*se sentiam compensadas nas exigências*). With the passage of time and with all that kept disturbing the process – people started to encounter delayed projects, projects that never actually arrived, you know – people started to, in quotes, I won't say tire, but to not participate as effectively. Why? First of all, because sometimes people have a vision of our turf and we forget the macro-vision. Because if this vision is promised that [the state] will resolve this micro-issue and it doesn't get resolved, it bothers you (*tu fica atrapalhado*) And it incites enemies to say 'Look, can't you see that you're not advancing anything with what you're doing?'" – Interview with Scorza

In short, a palpable sense emerged among popular movement activists from neighborhood associations that decentralized control of public goods provision through OP was proving less effective than originally thought and was falling short of the vision of civil society control over the state that led participants to support OP in the first place.

The handing over of management of PSF to neighborhood associations may well have responded to palpable frustrations that OP offers participants no opportunity to set larger policy agendas in the ways they might have hoped. For example, Heverson da Cunha, another longtime popular movement and health activists who now sits on the city's Municipal Health Council, bluntly pointed out that OP offers participants no control over what he views as the most fundamental organizational problem of effective health service delivery: the ability to hire new health professionals to work in clinics.[12] "Whenever citizens begin to make more fundamental critiques of the government's provision of, say, primary health services in Health Posts, the reply is always the same:

go to participatory budgeting to make your claim. But in participatory budgeting, you can advocate for a health post to be built where you live, but it doesn't work for solving (*não da pra resolver*) more complex problems like opening concursos for the doctors and nurses who work in the health post, you know, making sure there are actual professionals working in clinics" (Interview with da Cunha). Other former popular movement activists like Heverson, who were once more concerned with promoting widespread civil society control over state action through participatory mechanisms like OP, eventually gravitated to what they view as less participatory but more direct institutional channels like the Municipal Health Council (CMS) and within the Municipal Health Secretariat itself for influencing these more fundamental issues (Interviews with Jaeger and Carvalho).

Heverson described the major reason for his shifting activism as the fact that he lives in the southern city region of Restinga, a less densely populated and more geographically peripheral city region, which PT strategists long viewed as an ancillary terrain of struggle for electoral hegemony in the city. Geographically and politically peripheral regions like Restinga suffer from particularly under-staffed clinics and a deficit of basic health service provision. This is due to many factors beyond just being viewed as a peripheral terrain of electoral struggle. The predominantly middle class of health care professionals (and upper class of doctors), whom the município employs to work in geographically peripheral regions like Restinga, generally consider these places to be undesirable workplaces. Health workers often eschew assignments to work in such city regions, which they view as particularly undesirable workplaces. This is partly because simply commuting to Restinga and other outlying município regions from the city center can take upwards of two hours to reach by car and longer by bus, depending

on traffic. Heverson also highlights that OP participants play no direct role in influencing perhaps the largest of these state capacity-building challenges to institutionalizing SUS in the city: that of building adequate human resources. Indeed, these more fundamental institution-building tasks were instead left to an antiquated and institutionally retrograde municipal health secretariat, which governing elites viewed as an, at best, peripheral terrain of struggle within their larger stratagem for orchestrating electoral hegemony.

Relative to other cities like Belo Horizonte, where the PT administration in 1992 began municipalization by hiring large numbers of new public health employees to provide these basic services, official municipalization was delayed significantly in Porto Alegre and was defined by an unwillingness to expand human resources in to this extent. Porto Alegre's lagging human resources emerged from sporadic, multi-year negotiations about whether and how to undertake this process. These negotiations only produced the first decision about the institutional contours that SUS's local institutionalization would take began to materialize 1996. And health care worker unions quickly rejected this highly improvised and unstable arrangement, sparking further debates that resurfaced in 1998 and consistently in the city since then.[13]

Municipalizing the Public Health Sector

The generic process of health sector municipalization across large Brazilian capital cities during the 1990s and early 2000s was one in which mayors and municipal health secretaries would "negotiate with the [federal Health] Ministry and with the state, create and sign a contract (*termo de compromiso*), take control of (*assume*) pre-existing facilities and employees, but receive no assistance (*contrapartida*) from the point of view of financing personnel. So in this way, the município over the long term, over ten or

fifteen years, assumes a great burden (*ônus*), in terms of cost" (Borges: 4). While mayors gain control over pre-existing facilities by taking over from the federal Health Ministry the responsibility of installing their own political appointee as the director of the Heatlh Clinic, an even more consequential responsibility is the matter of staffing clinics. Debates about how to minimize this particular cost of health sector municipalization in Porto Alegre were especially long and drawn out, taking approximately six years to generate the city's first actions in this regard, namely the above-mentioned contracting of neighborhood associations as administrators of PSF. And even this arrangement proved to be an unstable outcome, which generated continuing debates and subsequent shifts in Porto Alegre's financing and administration of primary public health care workers.

As in most other large Brazilian capitals, these shifts mirrored the variable political will of mayoral administrations to assume the financial and political burdens of opening new slots for public health employees. In Porto Alegre, as elsewhere, the actions of these administrations typically emerged from the agendas of dominant actors within local state-society regimes. The particular shape of municipalization in the city emerged – more than any other single factor – from PT strategists' steadfast unwillingness to prioritize the hiring of new public health employees. These strategists, who controlled city government and dominated the município's regime of public health politics during this period, consistently saw such a commitment as a financially and politically costly project with few potential benefits electorally. Dr. Lúcio Barcellos, a sanitarista, PT founder (and subsequent defector for the PSOL), and Municipal Health Secretary in Porto Alegre from 1998 to 2000 described this dominant attitude of the PT toward public health as follows. "There was always a strong tendency to not want to open public *concursos*.

This was true of Tarso, before and after my administration [e.g. during Tarso Genro's administration from 1993-96 and from 2001-2002], and true of João Verle's administration [from 2003 to 2004]" (Barcellos: 6).

On a superficial level, the município's 1996 to 1999 arrangement of contracting neighborhood associations to manage PSF teams simply responded to the undeniably steep financial costs of adding new employees. It reduced the long-term financial onus that would otherwise have been placed on the município had it hired the new health professionals who staffed PSF *as municipal employees*. Hiring new public employees of any kind is generally a costly proposition for município governments in the long term because Brazilian laws require that such public employees receive, in perpetuity, retirement pensions that are nearly equal to pre-retirement earnings. Genro's second administration, under the oversight of his health secretary, Dr. Luis Henrique Motta, instead contracting neighborhood associations to hire and administer PSF employees and other health professionals on a temporary basis, using an "emergency" contracting procedure that shielded the city and the associations they contracted from paying retirement costs. In this sense, the PT's administration in Porto Alegre appears to have succumbed to some of the neoliberal influences for cost-savings that analysts commonly claim it resisted during this period through its commitment to popular participation. Such decisions demonstrate that even during what many view as the halcyon days of PT administration in Porto Alegre, the city's management of public health care more closely acquiesced with neoliberal influences that other analysts show were also central to the crystallization of the federal HIV/AIDS policy at about the same time (Biehl 2004, 2009).

On a more fundamental level, however, this improvised arrangement eliminated the political costs that would have been required to secure legislative support for creating and filling new positions for município employees (*concursos*) as public health professionals. This effectively obviated the need to expend scarce political capital on garnering support for what, in any case, amounted to a tertiary policy priority for petistas. Common knowledge among politicians from competing political parties, analysts of contemporary Brazilian politics consistently document how the opening of *concursos* by a sitting government offers elected politicians in that government a resource that can be distributed to supporters through patronage politics (Hagopian 2004). As such, political opponents – and there were many in a City Council (*Câmara de Vereadores*) that was nearly equally split between PT-aligned parties and opponents during this period – tend to vociferously oppose the creation of new concursos. Overcoming this resistance would have required an exertion of political will and political capital by dominant petistas in Porto Alegre's state-soceity regime of the 2000s, which was generally absent. By contrast, in other Brazilian cities such as Belo Horizonte, Sanitaristas effectively generated the political will to open such concursos in spades.

As the dominant actor in the regime, Workers Party (PT) strategists generally understood health policy to be a relatively low political priority. Joaquim Klinsmann, a sanitarista, PT founder, and Municipal Health Secretary from 2000 to 2003, described this lack of political will for basic health care expansion as a persistent feature of Porto Alegre's PT administrations.

> "Health policy, in general, was never taken on (*assumida*) or understood (entendida) by the party, as such. It was raised [in an ad hoc fashion] by a group connected to health, by health professionals who worked in the public system and were connected to the party. We didn't have a platform (*postura*). We had a

> defense of SUS, but it was something very much like, 'Oh, we are in favor of SUS, holistic (*integral*) for everyone, public provision (*atendimento*), against payment for anything,' things like that. Now, the project of health as a social priority, really, [within] the party, well that was another story. The government and its secratariats always placed health in a different category. Health was another story. It didn't integrate well into the party, and for a logical reason: because health, weather you like it or not, follows the rules of SUS and the rules of SUS are not always the rules that that *prefeitura* wanted us to follow. Health here has to be theoretically the same as in Belo Horizonte, Curitiba, and wherever else because those are the rules of SUS. But it doesn't always work out like that. Many times, local visions vary. And those of the party were different [than those of SUS], that's for sure. – Interview with Kliemann

But if limited political prioritization of basic public health care provision generally characterized the enacted platforms of PT administration from 1989 to 2004, important anomalies during this period were consequential for service provision outcomes.

The Rise and Fall of State Building for Primary Health Care Provision, 1998-2000

The period between 1998 and 2000 witnessed a momentary interruption in the hold on public health care policymaking by the dominant alliance between neighborhood associations and PT electoral strategists. The brevity of this interruption is especially telling because it demonstrates the inability of sanitaristas to alter the pre-existing trajectory of health sector municipalization that was at work between 1989 and 1997. Nevertheless, the isolated state-building achievements of the 1998 to 2000 period hold a stand-alone explanatory importance for understanding the stagnancy in primary health care provision during the 2000s because the period witnessed much of Porto Alegre's relatively limited expansion in health workers in the city. During this period, the city municipalized a major hospital from the federal government and converted approximately 800 health care workers, who were previously hired as "emergency" employees using temporary, 6-month contracts, into permanent municipal employees. The politics of why and how these somewhat anomalous events in the city's history occurred ultimately

inform more than just our substantive understanding of where Porto Alegre's state capacities for health service provision came from and how they contrast with those of other large Brazilian cities. They also deepen our theoretical understanding of the very constraints that state-society regimes imposed on the agency of autonomous, well-organized civil society actors from the Sanitarista Movement, whose expansion of state capacity to provide basic public health care was unusual in Porto Alegre's recent history.

The two-year tenure of Dr. Lúcio Barcellos as municipal health secretary of Porto Alegre witnessed the single largest expansion of tenured municipal public health employees of any other single two-year period in the city's history. At the beginning of 1999, before he effectively mobilized the mayor and city council to add 800 new public health employees, SMS-PoA employed a total of only 4119 workers, only 1995 were município-employed health professionals working in the decentralized network of primary care clinics scattered across city districts[14] (CMS 1999#08). By the end of 1999, after Barcellos' intervention, around 2795 municipal employees worked in the regionally decentralized primary care network of facilities. In 2010, SMS-PoA employed 5250 total workers, representing only a 27% expansion of 1131 employees over the eleven years since 1999. Thus, over 70% of these new hires occurred in just one year of Barcellos' tenure. In short, Barcellos was unsurpassed in his tangible record of expanding municipal public health care employees in Porto Alegre.[15]

But this brief expansion during Barcellos' administration was the product of interactive, intensive conflicts and negotiations during 1998 and 1999 between Sanitaristas like Barcellos, neighborhood association leaders of UAMPA, and PT electoral strategists in the Central Administration of the party's state organization. The

Central Administration was then controlled by figures such as Raul Pont, Porto Alegre's mayor at the time; Tarso Genro, its president; and Olívio Dutra, the party's eventual candidate for governor in the 2000 election. During the first phase of negotiations, when Barcellos began his tenure as municipal health secretary in early 1998, he first tried and failed to convert all PSF workers, then under the control of neighborhood associations and precariously employed with temporary 6-month contracts, into municipal employees.

> When I entered, there was this widespread commotion (*fuzuê generalizada*) and an ongoing battle (*briga montada*) between [the PSF] teams and the neighborhood associations. Some had a good relationship but most were in serious disarray (*uma confusão danada*). So what did I do? There was a political discussion. I tried to negotiate with the Secretary of *Fazenda* for us to employ all the PSF team workers. But despite also being PT, the guy only thinks about money (*o cara só pensa em grana*). So he arrived at the following conclusion: 'Listen, we can't hire everyone, since this will create a very large expense for the município when these people retire as municipal employees and the município will have to continue paying them a full salary. So, no, we can't hire them.' The alternative I found was to remove all of these workers from their linkages to the neighborhood associations and to negotiate with FAURGS, the University Foundation of the State of Rio Grande do Sul, to become their employer. So instead of remaining with that scattered arrangement of having these ten teams here contracted by the association [where they work], we negotiated and made a contract with FAURGS, passed them the resources, and they started to employ everyone according to CLT requirements.[16] This happened because there was a political decision of the município to not burden the payroll (*para não onerar a folha de pagamento*) by opening concursos, more generally [beyond just the health sector]. – Interview with Barcellos

This inability of Barcellos to overcome PT strategists' unwavering resistance to expanding the number of public employees in the city contrasts sharply with developments in Belo Horizonte's municipal public health sector that unfolded only a few years earlier.

In Belo Horizonte, the PT administration in power instead decided to open massive numbers of concursos for hiring municipal public health workers to staff primary

care clinics scattered across the city. The failure of Barcellos to secure political support from PT strategists for pursuing the same course in Porto Alegre reveals important differences in the state-society regime underlying these two cities' politics. In Belo Horizonte, sanitarista proposals for expanding employment of public health care workers had not only become the hegemonic party stance by 1992, continuing as such to this day. They also became enacted municipal policy during this period. In Porto Alegre, PT electoral strategists roundly rejected this same proposal when Barcellos advocated for it most forcefully in 1998. At that time, the human resource demands of municipalizing the public health sector imposed themselves in earnest on Porto Alegre's regime actors for the first time. And their response could not have been more divergent than that of the different state-society regime in Belo Horizonte, where the same party apparatus instead adopted a nearly opposite position.

These contrasts with Belo Horizonte aside, Barcellos still managed in 1999 to successfully hire about 800 municipal health care workers, who were previously contracted on a precarious, "emergency" basis.[17] Yet he was only able to do so by negotiating an agreement with the federal Health Ministry, according to which the ministry agreed to pay all of the retirement expenses for these 800 new municipal employees in perpetuity. Barcellos himself described this arrangement as the only such arrangement he knows of in all of Brazil. Some of these newly municipalized health workers were primary care workers. Many were still employed under the various work regimes that the federal-level Health Ministry and state-level Health Secretariat of Rio Grande do Sul still used to administer their employees. Begun in 1996 under the first Genro administration and on the watch of Dr. Luis Henrique Mota, the Municipal Health

Secretary he appointed, these "emergency" contracts came to be routinely abused and applied in far less than emergency purposes.

> When I entered the secretariat, there were practically 800 workers, who were not PSF workers, but other who worked in Emergency Rooms and in the general network of facilities, who were contracted through an arrangement called an "emergency contract" (*contrato emergencial ou carta contrato*), which is an invention (*figura*) here that the município created, which means the following: you are contracted for six months. It's just that here you had people who were contracted on an emergency basis four years ago [and were still working under that status]. So where's the emergency? … This was the policy, a policy that should never have been made by the PT, no? But it was the policy that the Central Administration of the state level PT applied in that era. – Interview with Barcellos

Reversing this somewhat surprising abuse of emergency contracts during the short-lived administrations of Mota in 1996 and his successor, Dr. Henrique Fontana in 1997 involved an elaborate political struggle in which Barcellos raised the contracts as a potential electoral liability in the 1998 state governor election, which the PT hoped to capture for the first time ever in the state.

Barcellos describes the process of regularizing these workers as owing much to luck, timing, and a sense that the emergency contracts could become a political liability in the 1998 election for governor, in which the PT eventually ran (successfully) Porto Alegre's first PT mayor, Olívio Dutra.

> In truth, during my administration, we were able to [hire the 800 workers as permanent employees] because of a political interference (*ingerência political*) that occurred, not naturally (*por uma questão de natureza*) or due to conviction, but because when I was [Health] Secretary there was an election for state governor and the PT's candidate was Olívio Dutra. So, I negotiated with the Secretary of *Fazenda*, which was also ours [held by the PT], and said 'Look, my friend, let's do the following: let's nominate these 700, 800 precariously employed guys (*esses 700, 800 caras que estão em regime precário*). Let's open *concursos* and nominate them, because we can use this as a campaign tool, right, you know, saying we are going to hire doctors, nurses, psychologists, audiologists, blah, blah, blah'. So because of this specific situation, which involved a state election in which we could use it as a campaign tool, we nominated and wiped the slate clean of the emergency

> contracts [*limpamos e acabamos com os contratos emergenciais]* in the health sector during that period." Interview with Barcellos

On the one hand, this episode shows that hiring public sector health workers had a certain appeal, if only a very limited and ephemeral appeal to the PT operatives responsible for determining electoral strategies during that particular election. And Dutra won the 1998 election, becoming the first ever PT governor in Rio Grande do Sul. But this was due to a number of complicated factors other than simply regularizing the employment status of 800 public health workers. And, on the other hand, the more salient fact is that this is the only known occurrence in which hiring permanent public health workers ever entered into the PT's electoral calculus in a significant fashion at all in Porto Alegre. Just how anomalous this one episode was becomes clearer in light of the contrast with Belo Horizonte, where this became a central, persistent tenet of the strategy that delivered the PT electoral dominance between 1992 and 2004.

Further, during the only other incidence in which state capacity building for the public health sector momentarily rose to the level of electoral significance, PT strategists insisted on deals that (somewhat paradoxically) externalized the typical human resource costs of municipalization onto the federal government. Specifically, during another, similar episode in 1999 and 2000, Barcellos succeeded in negotiating another unorthodox arrangement with the federal Health Ministry to municipalize a large formerly federal hospital in Porto Alegre, known at President Vargas Children's Hospital. He did so by brokering an agreement in which the health ministry absorbed all of the human resource costs typically assumed by municípios when they municipalize formerly federal or state health care facilities, describing the agreement as follows.

> In 1999 and 2000, we municipalized a hospital in Porto Alegre called President Vargas Children's Hospital, which was a federal hospital. In the negotiation with the union [federal government], we succeeded in placing the following condition (*clausula de negociação*): for each federal employee that will retire, be dismissed, or die, the union must annually transfer from the national health fund to the municipal health fund the equivalent value of this citizen's salary. It's the only contract between município and union that I know of in Brazil, which requires the union to do this…So the onus is not on the município; it assumes none of these costs. If I wanted to open a *concurso* to replace (*repor*) President Vargas' employees who leave, I can do so and the union pays me [as the município, the amount of the new employee's salary]. - Interview with Barcellos

In short, Barcellos negotiated a deal which allowed the município to have its cake and eat it, too. The município got to gradually convert the hospital's workers from federal to municipal employees and it got to send the federal government the entire bill for the conversion. Yet such deals were as rare and they were antithetical to the very nature of municipalization.

What these two episodes indicate is just how different Porto Alegre's regime of state-society politics of public health was from otherwise similar cities during the 2000s such as Belo Horizonte and Recife, which experienced starkly divergent (upwardly trending) service provision outcomes, and Rio de Janeiro, who whose service provision record declined during the same period. Chapter 5 demonstrated that as early as 1991, a coalition of Sanitarista activists and public sector health workers unions in Belo Horizonte became dominant in that city's regime and ultimately succeeded in convincing pragmatic electoral strategists from the PCdoB, PSB, and the PT to make the expansion of public sector health care workers a central tenet in what ultimately became a wildly successful plot for achieving electoral hegemony in the city. By contrast, in Porto Alegre, similar proposals by Sanitaristas like Barcellos failed to gain anything close to the traction they achieved in Belo Horizonte. Indeed, their ephemeral rise to prominence in

1998 and 1999 only amplifies their conspicuous absence between 1989 to 1997 and between 2001 and 2004, when PT administrations opened precious few *concursos* for public health employees of any kind, much less primary public health care workers to staff outpatient health clinics scattered throughout the city' poor, geographic periphery. By 2004, the politics describe above had yielded a municipal public health state with far fewer state capacities for providing basic public health care than other similarly-sized cities like Belo Horizonte, Curitiba, and Brazil's one true mega-city, São Paulo.

Notes:

[1] For the PT and other Brazilian political parties, creating multi-party tickets is a common practice for expanding voting pools in campaigns for mayor, state governor, and president. For example, both of President Lula's running mates and eventual vice-presidents hailed from parties other than the PT, as does current President Dilma Rousseff's Vice President Michel Temer (PMDB).

[2] In urban Brazil, non-civil society actors more commonly come to dominate the ideas and actions of a state-society regime in other ways than by becoming hegemonic in this sense. (See Chapter 6 on Rio de Janeiro). For example, state actors may elicit consent through violence or its threat, organized workers may withdraw labor power or credibly threaten to do so, while capitalists commonly leverage their ownership over means of production and the inherently self-organizing capacity or capital to undertake coordinated action through market action that can both induce and supersede state action.

[3] For Alexander, for example, civil societies rely on their ability to fashion discursive codes into solidary ties that hold wide appeal across society. Doing so relies on the ability of actors in communicative institutions like associations and public opinion to undertake "civic translations" according to which they effectively counter-colonize non-civil spheres like labor unions, political parties, and state institutions such as elected office and elections (2006).

[4] The four largest of these are UFGRS's Clinical Hospital, the Catholic Pontificate Hospital (PUC), Santa Casa, and the Group of Conceição Hospitals (GHC).

[5] Here, I do not discuss another formidable capitalist actor – the private health insurance industry – because the federal government – not the município – holds chief responsibility for regulating it. This fact minimizes cross-município variation in the industry's influence, which is considerable and growing at the national level. Chapter 2, However, discusses how I use PNAD data to systematically account for how variable rates of participation in the private insurance market differentially affect the numbers of residents in each city, who depend solely on SUS.

[6] In cities like Porto Alegre, this industry receives reimbursements of federal dollars for each service provided, based on predetermined fees, which vary widely according to the level of complexity a particular service involves. The industry provides the vast majority of all publicly financed health services, not only in terms of the number of services, but also in terms of the dollar value of these services as a proportion of

all publicly provided health services.[6] Further, the federal Health Ministry, the bureaucracy tasked with regulating these hospitals, commonly struggles to effectively regulate its provision of services, a task which it only began to take on in earnest during the early to mid 2000s by issuing Basic Operating Norms (NBOs).

[7] The continuing legacy of INAMPS in current day relations between private hospitals and various levels of SUS-funded government agencies (including the município) is so palpable that it has literally entered the lexicon of politicians, health care activists, and professionals in Brazil as its own word. "Inampista" is a Brazilian Portuguese word, meaning INAMPS-like, which these actors commonly use to characterize various abusive practices of private hospitals, including the practice of triaging hospital patients according to profit motive (e.g. a given hospital's prioritizing the patients who receive treatment in order to maximize provision of procedures and service that sit atop the list of SUS's most lucrative reimbursements).

[8] The Conceição Hospital Group (GHC) of federally-owned and operated hospitals in Porto Alegre includes (GHC 2011)

[9] PSF is the federal government's flagship program for encouraging municípios to broaden their provision of primary preventative health care. Though technically a federal program, PSF is a programmatic option that the Health Ministry recommends to municípios for delivering primary health care services. Municípios can opt to do so or not, according to their wims. However, implanting a new PSF team imposes between 75% and 85% of all human resource, equipment, and facilities costs on municípios, calling into question its status as a federal program.

[10] The history of clinic-level health councils as an interface between neighborhood associations and the state dates back to well before the beginning of the dictatorship and, as such constituted an important historical reference point for these associations as they made such demands on the PT during the early 1990s. Although too lengthy to be explored at length here, it is important to note that neighborhood associations in Lomba de Pinheiro, Partenon, Cruzeiro, and other city regions with large hospitals built during the military dictatorship had long organized local health councils to advocate for patient interests. These seminal experiences constituted an important historical foundation and point of leverage for the later demands that neighborhood associations began making during the early 1990s for local "social control" – not in the Weberian sense but in the sense of civil society control over state actions connoted by *controle social* – of government health programs. This was especially so for their demands to oversee federally imposed health programs like PSF, which drew immediate skepticism from neighbhorhood association leaders. Many of these leaders' memories of repression by the military dictatorship and its ineffectual, top-down provision of curative health care in these large clinics was still quite fresh as recently as the late1980s.

[11] CMS constitutes the primary participatory institution for channeling civil society influence into health policy-making, leading one commentator to call it the most empowered participatory institutions in all of Brazil (Avritzer 2009)

[12] This is true, whether these professionals come to work in clinics through ESF, or through standard work regimes already in place in Health Centers before PSF came along.

[13] In 2011, the município elected to create a new "Public Foundation of Private Rights," to hire and manage the workers who staff PSF in the city (CMS2011#4). Wearing a different hat as President of the Doctors Union of the State of Rio Grande do Sul, Barcellos vociferously opposed the proposal and engaged in heavy lobbying of vereadores to reject the proposal (Interview with Barcellos in 2010)

[14] Of the remaining 2124 employees, 1707 worked in either municipally-run hospitals or Emergency Service Units (UPAs).

[15] Because this argument relies heavily on Barcellos' own accounts, it should be noted that Barcellos had personal reasons to critique health policy under other PT administrations. In 1995,Barcellos left the PT to help found the more leftist Party of Socialism and Freedom (PSOL or *Partido de Socialismo e Liberdade*). Also, from 1998 to 2000, Barcellos himself served as municipal health secretariat in arguably the most left-leaning PT administration to have governed Porto Alegre: that of Raul Pont between 1996 and 2000. While this makes it unsurprising that he would critique the other, more centrist PT administrations in the city, statistical records show that Barcellos' tenure witnessed that largest expansion of municipally employed health workers of any of the administrations he critiques. In other words, statistical records bear out his subjective account of all other PT administrations' unwillingness to expand this decisive state capacity for basic health care provision.

[16] Dating from the Vargas era, CLT (*Consolidação de Leis Trabalhistas*) are Brazilian labor laws that still regulate all private employement contracts today. Among the other benefits they require of employer, they guarantee workers 13 months of salary per year.

[17] These increases during Barcellos' administration notwithstanding, Porto Alegre's generally meager record of adding new public health employees contrasts sharply with that of Belo Horizonte's record, where Sanitarista proposals for expanding public health care employees became the over-riding, hegemonic political goal of enacted health policy during the same period. See Chapter 3.

CHAPTER 7

MUNICIPALIZATION-AVERSE CONDITIONS, CLIENTELIST REGIMES, AND AN OBSTRUCTED HEALTH DEVELOPMENTAL STATE IN RIO DE JANEIRO

Reflecting a longstanding literature on clientelist politics and underperformance in Rio de Janeiro's public service sectors during and since re-democratization (Arias 2006, Gay 1994, 1999; Perlman 1976, 2009), Chapter 4 demonstrated the município's comparatively meager record since 1988 of expanding provision of primary public health services. During a period in which Belo Horizonte undertook dramatic expansions in this regard and Porto Alegre undertook more moderate expansions, Rio de Janeiro remained one of the most underperforming of any large Brazilian city, both in terms of populational coverage through the Family Health Program (FHP) (7.2% in 2008), as well as the primary care appointment rate (1.75 in 2010), more generally.[1] This chapter argues that this perhaps unsurprising outcome occurred in Rio de Janeiro because the public health policymaking and state-building ideologies and political programs of progressive political parties and civil society activists from the Sanitarista Movement remained marginalized within a clientelist regime of state-society politics in the municipio that instead thrived on ruling politicians' clientelist and patronage-oriented mode of engaging economic elites. One intermediate result of these politics was a municipal health secretariat that struggled to meet all of three of the major organizational challenges involved in building a health developmental state. In short, this government built few

primary care clinics, hired only small numbers of primary health care workers, and developed few state capacities to geographically target the few clinics and workers it did create toward the most pressing epidemiological risks. In sum, the clientelist regime long known to scholars of Rio de Janeiro's politics ultimately obstructed efforts to build a local health developmental state and this resulted in only meager expansion in primary health care delivery between 1988 and 2011.

In this sense, these politics in the public health sector of Rio de Janeiro's municipal government echo those of the nation-state politics of public health in Brazil until the mid-1990s. Weyland demonstrates that, historically, the nation-state politics of health care provision between 1985 and 1992 roughly approximated this definition of a clientelist regime, arguing that "leaders of the health reform movement occupied positions inside the public bureaucracy from which they could launch their progressive efforts" and that "members of the movement gained posts in different public agencies" (1995: 1700). Yet he argues that they "soon became absorbed into the rampant bureaucratic politics that ravages the Brazilian state" and that "clientelist politicians in the government and in Congress soon offered strong resistance to equity-enhancing change and pressed for the dismissal of members of the health reform movement from the public bureaucracy" [posing] "the most important obstacle to health reform" (1700). While Weyland notes that, "reform-minded public health experts…gained their most powerful support not from society, but from inside the public bureaucracy itself, namely from municipal and state governments…but did not have sufficient influence on policy making," his analysis speaks primarily to the pre-1990 period, before the Integrated Health System (SUS) was created and local governments received sweeping new powers

to institutionalize the health sector at their own pace and in more and less sophisticated degrees.

Indeed, newer accounts of the national politics of HIV and AIDS policymaking after the mid-1990s liken the Brazilian nation-state under President Henrique Cardoso to an "activist state" (Biehl 2007: 68) that invented new ways to expand free and universal provision of anti-retroviral drugs, a program which is widely credited with stemming the epidemic from taking the destructive path observable in other large Southern democracies like South Africa.

Rio de Janeiro's regime qualifies as a clientelist regime because, in contrast to the participatory and pragmatist regimes articulated in prior chapters, the same proposals of progressive political parties and sanitaristas for state-building in the public health sector in other these other municípios ultimately struggled to become more than just proposals and ideologies. The ultimately failed efforts of sanitaristas to advance state-building for public health during the early 2000s articulate this most clearly. In 2001, Dr. Sérgio Arouca, one of the most venerable sanitaristas in contemporary Brazilian history and a drafter of Article 196 in the Constitution of 1988 that declared public health as a citizenship right, became the Municipal Health Secretary of Rio de Janeiro. In this role, Arouca followed the same pattern observable in Porto Alegre and Belo Horizonte of sanitaristas occupying high level policy-making positions atop the public health bureaucracy in local government. Yet Arouca's time in the post was especially short-lived, ending after Mayor Maia fired him by email following a party political shake-up and a dispute that Arouca raised regarding the finances of the municipal health secretariat (Folha de São Paulo: June 2, 2001, June 4, 2001). In March of 2005, these deficits in

local government's lack of emphasis on public health reached their apogee under Mayor Cesar Maia of the center-right PFL party. Citing massive corruption and under-performance in all facets of the city's public health care delivery, President Lula Inácio Lula da Silva declared a public disaster in Rio's public hospital sector, a status that paved the way for the federal Health Ministry to take over the operation of hospitals throughout the city (Folha de São Paulo: March 19, 2005). During that year, Rio tied with Brasília for last (at less than 7%) among all large Brazilian municípios in the populational coverage of the Family Health Program.

Background

The municipality of Rio de Janeiro, which ranks second in population size in Brazil at approximately 8 million people, is particularly known for its history of clientelist patronage politics and widespread urban violence. These clientelistic politics have been famously described by classics like *The Myth of Marginality: Urban Poverty and Politics in Rio de Janeiro* (Perlman 1976) and Robert Gay's *Popular Organization and Democracy in Rio de Janeiro: A Tale of Two Favelas* (Gay 1994) as well as more recent books such as Desmond Arias' *Drugs and Democracy in Rio de Janeiro: Trafficking, Social Networks, and Public Security*" (Arias 2006). Social movements actors in Rio de Janeiro have traditionally been weaker than those in São Paulo and Porto Alegre and have remained unlinked to actors in political society (Baiocchi 2002). Partly as a result, the Workers Party (PT) has been historically weak in Rio de Janeiro, despite its contributions and status as the chief political party proponent of redistributive public infrastructure spending elsewhere in Brazil during the last 25 years.

Furthermore, it has been persuasively argued that neighborhood associations in Rio de Janeiro – a major locus of civil society mobilization in the other Brazilian cities I examine – are more typically co-opted by illicit drug syndicates (Leeds 1996). In "Cocaine and Parallel Polities in the Brazilian Urban Periphery: Constraints on Local-Level Democratization," Elizabeth Leeds argues that drug syndicates have set up parallel governance structures by colonizing neighborhood associations, frustrating prospects for democratic practices including the ability to vote in un-coerced ways in free and fair elections – or in deeper, and more extensive participatory modes of democracy, such as the quasi-corporatist modes of decision making we see in Municipal health Councils. Thus, the case of Rio de Janeiro historically illucidated the limitations of attempts by civil society to take an active role in promoting the ideology of universal health care. It may also shed light on the real dangers of co-optation that threaten civil society actors, who attempt to work through institutionalized channels, particularly when the self-organizing capacity and autonomy of such actors is constrained.

Rio de Janeiro's Clientelist Regime

Between 1993 and 2008, César Maia played an outsized role within the politics of city government in Rio de Janeiro's, serving as the município's mayor for a total of 12 years and three terms. Indeed, only the election of the Luiz Paulo Conde to the mayorship between 1997 and 2000 interrupted Maia's control of local government during a 16 year period that proved crucial for the growth of local state capacities for public service delivery across urban Brazil. Social scientists of Rio's politics during this period broadly understand his rule to be one that thrived upon clientelist exchange and an entrenched pattern of patronage politics that stunted public service provision in a variety of sectors.

The primary public health care sector proved hardly immune to these general patterns, even during Maia's last two administrations, when federal and state government applied increasing pressure to improve its performance in this and other sectors that include public housing, hospital care, sewage, sanitation, and others.

Yet Rio de Janeiro's enduring record of under-performance in the primary public health sector arose from an engrained pattern of clientelist state-relations in the city that transcended Maia's administrations and the many political parties (PMDB; PTB; DEM) he represented. While these clientelist relations inspired a general sense of outrage among a broad cross-section of civil society activists that included the city's sanitaristas, the city's prominent sanitaristas were somewhat exceptional in their brazen (but ill-fated) efforts to pragmatically address such persistent deficits in the primary public health care sector by attempting to reform the sector from the inside-out. In January of 2001, with the support of a broad coalition of center and center-right political parties that included Sérgio Arouca's own PPS party, César Maia returned as mayor of Rio de Janeiro for what became his second and third 4-year terms in the office. Owing to the support that Arouca's PPS party provided for his candidacy, Maia, who then represented the PFL, appointed Arouca to the top politically appointed post atop the municipal health care bureaucracy. But Arouca inherited a bureaucracy with few capacities for delivering primary care, a consistent record of centralized administration by a long line of mayors with established records of using the secretariat as a tool in their patronage stratagems. Owing much to this history, Rio's sanitaristas, many of whom worked alongside Arouca in the national public health school that now bears his name, generally agreed that the

Municipal Health Secretariat of Health and Civil Defense (SMSDC) operated in a state of cronic crisis (FIOCRUZ 2003).

Following the nearly ten year administration of Ronaldo Gazolla as SMSDC Secretary, Arouca entered into the role of Municipal Health Secretary touting proposals to expand primary health care that not only echoed the longstanding sanitarista ideology he advocated on the national political stage as a framer of Article 196 in the Constitution of 1988, but also defied pre-existing patterns in Rio de Janeiro. On one level, Arouca's effort in 2001 to legislate the ideology of universalizing access to basic health services *on the municipal level* mirrors that of fellow sanitaristas and Municipal Health Secretaries in other cities, including Dr. Lúcio Barcellos in Porto Alegre and Dr. Lídia Tonón, Dr. Cézar Campos, Dr. Evilázio Teubner, and Dr. Helvécio Miranda Magalhães Júnior in Belo Horizonte. Yet in comparison to Belo Horizonte and Porto Alegre, Arouca's appointment in Rio de Janeiro was not only a first for sanitarista activists in the city, but also an unusual turn civil societies that had long been excluded from politically appointed roles in city government. The core of Arouca's initial efforts in this regard was a bold proposal for implanting 650 FHP

(FIOCRUZ Virtual Library http://bvsarouca.icict.fiocruz.br/sanitarista03_02_p.htm)

Conclusion

In sum, the politics of public health in Rio de Janeiro's public health sector since re-democratization confirm some but not all of the basic predictions on offer in the development literature. On the most basic theoretical level, scholars alternatively argue that programmatic leftist parties in power (Huber and Stephens 2001) or self-organized, autonomous civil societies (Evans 2008) are two causes of capability-expanding

development. And between 1993 and 2009, two mayors from a changing cast of right-center political parties constituted the core of a clientelist regime of state-society politics that became infamous throughout Brazil for its nearly un-checked levels of clientelism and patronage politics. In this sense, few observers of existing literature on development would be surprised that the lack of a ruling programmatic party in Rio de Janeiro during this period coincided with formidable levels of corruption and underperformance in the public health sector, even in a country and a city long known for its rent-seeking politics and minimalistic and exclusive provision of public services to a narrower class of economic and political elites nurtured by the country's military dictatorship.

Yet it is not the case, as scholars sometimes argue for civil society in Rio de Janeiro more broadly, that self-organized, autonomous civil societies were completely absent in the city, at least within the politics of public health. Indeed, the National Public Health School, which now bears Dr. Sérgio Arouca's name, amounts to a kind of last bastion for sanitarista activists in an age in which health workers commonly produce the increasingly specialized and lucrative medical procedures prioritized by an alliance between the burgeoning private hospital and insurance industries. As the successful 2010 presidential campaign of Workers Party candidate Dilma Rousseff propagated a public health platform of improving access to complex emergency procedures, it was sanitarista activists based in Rio's National Public Health School (ENSP-Fiocruz) and the affiliated Brazilian Center for Health Studies (CEBES) who most vocally criticized the strategy, counter-arguing that her proposals for prioritizing emergency room and specialized medical care amounted to "blocking out the sun with a sieve" (*tapar o sol com a peneira*) (Dr. Nelson Rodrigues dos Santos in *Folha de São Paulo*: September 19, 2010).

The politics of Rio's clientelist regime demonstrate that pragmatist civil societies like those of the city's perhaps unmatched numbers of sanitaristas had little to no actual effect on policymaking and state-building for public health because they proved almost structurally incapable of transforming their ideology of universalizing access to primary health care into policies that advance the ideology. On the most fundamental level, this blockage resulted from a clientelist regime in which the sustained rule of decidedly anti-progressive political parties in local government shielded sanitaristas from exerting appreciable influence within the regime. Thus, the case of meager primary health care expansion in Rio de Janeiro complements existing theories of development by demonstrating that pragmatist civil societies like those of the city's formidably numbers and robustly organized sanitaristas are a necessary, but not a sufficient condition of capability-enhancing development. Although Dr. Sérgio Arouca, arguably the most influential sanitarista in Brazilian history, attempted to create such linkages to the city's right-leaning mayors, these efforts were short-lived and ineffective because these mayors actively marginalized Arouca and other universal public health activists from achieving appreciable influence into municipal health policymaking and state-building. Even Rio's sanitaristas, arguably Brazil's most organized pragmatist civil society could not save the public health sector from languishing under the reins of political leadership that saw the sector primary as one more lucrative source of clientelist gain.

Notes:

[1] It is worth noting Rio de Janeiro undertook a very late-breaking expansion of the FHP after 2010 that raised populational coverage of the program to over 27% by 2011. Yet this expansion still failed to raise its appointment rate above the median for large capital-city municípios.

CHAPTER 8

PRAGMATIST CIVIL SOCIETIES AND DEVELOPMENT IN URBAN BRAZIL

I have argued that, alongside locally-specific structural factors, state and federal influences, three types of locally divergent civil society-state regimes – participatory regimes, insulated regimes, and pragmatist regimes – explain much of the observable variation in both the intermediate outcome of state capacity to provide health care, as well as the ultimate outcome of changing magnitudes and inequalities of actual service delivery across major Brazilian cities. More specifically, these divergent regime types explain variation in a key intermediate outcome: the emergence, consolidation, or obstruction of local-level developmental states for the public health sector or "healthy states," which are governance structures characterized by three robust capacities: first, cadres of municipally-employed, primary public health professionals; second, municipally-operated primary care clinics; and lastly, technical capacities to target health professionals and clinics to high epidemiological risk. By conditioning the rise, consolidation, or obstruction of local healthy states, divergent regimes account for variation in the ultimate outcome under investigation in the project: expansions in municipal provision of primary public health care during the last twenty years. Using a descriptive quantitative analysis of a measure called the primary care appointment rate, I documented substantial variation in the records of Brazil's most populous, capital-city governments in expanding primary service provision since 1988. Drawing on a

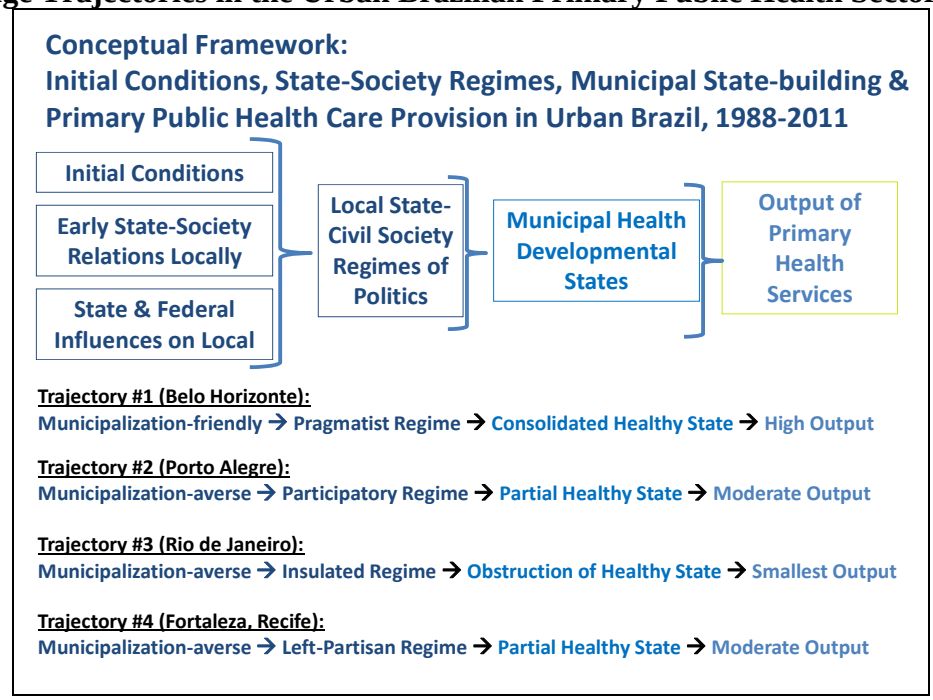
comparative-historical analysis of cities, my inferential analysis showed that locally variable types of state-society regimes molded the extent to which local state structures generated "equalizing expansions" in primary care provision. They did so by conditioning the intermediating mechanism of state-building, particularly state-building of a kind that equipped municípios to expand service provision in city regions characterized by historically low Municipal Human Development Indices (M-HDI).

This process unfolded in three distinct ways across Brazil's largest municípios between 1990 and 2010. First, in Porto Alegre, participatory regimes counter-intuitively produced only modest equalizing expansions in primary service provision. By and large, this was because, while participatory publics managed to begin building key facets of a healthy state during the mid-1990s – especially primary care clinics located in the city's generally lower-HDI and geographic peripheral neighborhoods – they ultimately struggled to advance a related project to expand the ranks of municipally-employed primary health care workers. Secondly, in municípios like Rio de Janeiro and Salvador, insulated regimes proved incapable of generating even the relatively modest levels of equalizing expansion witnessed in Porto Alegre because the isolation of all relevant civil societies from political and health policy-making influence ultimately left the ideology of state-building for the public health sector without an agent. Sanitaristas became insulated for different reasons in these three cities. In Rio de Janeiro and Salvador, where the left and left-center political parties with whom sanitaristas allied never won municipal power, health activists lacked the proximity to state power that was required to formulate and advance a reform program. In Fortaleza and Recife, although the much-celebrated

Workers Party won local power, the pragmatist public of sanitaristas struggled to advance their reform program until late in the 2010s.

Finally, I showed that Belo Horizonte generated the most robust primary health care expansions witnessed in all of urban Brazil during the last twenty years because the city's pragmatist regime consolidated formidable health developmental state structures that endure into the present day. As in all other cities examined in this dissertation, sanitaristas in these municípios advocated a longstanding ideology of expanding the public infrastructure required to expand local state delivery of primary, preventative health care services. But unlike insulated in insulate regimes, pragmatist sanitaristas did by instead maintaining a formidable presence within a variety of left and left-center political parties that held local power for sustained periods. And unlike Porto Alegre's participatory publics, they instead negotiated specific compromises with capitalists from the private sector hospital industry and the growing private insurance industry, which resulted in an ability to protect health developmental state structures from the evisceration they suffered in Porto Alegre during the 2000s. Also, unlike the participatory publics of Porto Alegre, who effectively placed all of their reformist ambitions in the basket of one political party (The Workers Party or PT), the pragmatist sanitaristas of Belo Horizonte advanced their agenda through the political platform of several left and left-center parties that won mayoral power and held sizeable seat shares on city council. The chart below summarizes these variable trajectories.

Figure 8.1
Change Trajectories in the Urban Brazilian Primary Public Health Sector



Alternative Explanations of Development

Answering the puzzle of sub-national variation in changing state provision of basic health services sheds theoretical light on longstanding debates in political and urban sociology about the origins of development. While this project provides partial confirmation for perhaps the most authoritative theory of development – the theory that leftist parties expand development more than any other single factor – it complements that finding with an accompanying, inductively-derived explanation. Specifically, the project hypothesizes that during the neoliberal era, an additional, necessary condition of capability-enhancing development became autonomous and organized civil societies that were fundamentally pragmatist in their ideologies, goals, and means for achieving those goals. I argue that – along with ruling leftist parties – sanitaristas were a second, necessary condition of equalizing expansions in primary public health service provision

throughout urban Brazil during the last twenty years. This study argues that variable sanitarista approaches to mobilizing município-level party and state structures around capacity-building for universal health care provision were highly consequential for subsequent shifts in primary public health provision after 1990.

Thus, the inductive theory of inequality-reducing development I articulate in the project dialogues with but ultimately diverges from several other, alternative explanations on offer in sociological theory of development. I categorize existing literature into three principal theories of redistributive development, whose explanations alternatively highlight leftist political parties, state capacity, social movements defined by relatively uncompromising ideological ambitions. The first "leftist parties" framework proposes that leftist political parties in elected state power expand redistributive development in response to demands of lower and working classes (Bradley et al 2003; Huber, Ragin, and Stephens 1993; Huber and Stephens 2000, 2001; Huber et al 2006; Rueschemeyer, Stephens, and Stephens 1992). A second framework argues that the "Weberianness" of state institutions (Evans and Rauch 1999) and other state capacities to effectively execute development policy (Chibber 2003) can expand development by building social networks, not only between state and capitalist actors (Evans 1995), but also between state and civil society actors (Evans 2008). A third framework not only suggests that social capital and civic associations can expand development (Putnam, Leonardi, and Nanetti 1993; Woolcock 1998), but also shows that microfinance collectives can promote female participants' social capital and consequently, their demand-making around public infrastructure (Sanyal 2009: 546). Related theories of resource mobilization imply that redistributive development may respond to on-the-ground numbers of activists from civil

society associations that recruit citizens to agitate for development expansions (McAdam, Tarrow, and Tilly 2001; Tarrow 1994).

First, arguably the dominant explanation of development in sociological theory, the leftist parties framework points to a common explanation in democratic states of the global North (Bradley et al 2003; Huber and Stephens 2000, 2001) and South (Huber et al 2006): electoral representation by left-leaning political parties in representative democratic institutions. The framework highlights that especially (but not only) in countries with relatively lengthy histories of formal democracy, leftist parties in state power often promote redistributive agendas, not only because of the political power they acquire from harnessing working class votes (Rueschemeyer, Stephens, and Stephens 1992) but also because these parties' institutionalize deep-seeded solidarities with historically marginalized classes and their normative demands for both recognition and redistribution.

The "state capacity" paradigm is a second theoretical framework that provides theoretically relevant alternative explanations of development. For example, Peter Evans' authoritative study of the Korean and Indian developmental states argues that one of two interrelated keys to successful state promotion of industrial development in Korea (and its relative failure in India) was the ability of bureaucrats and politicians to become sufficiently embedded with capitalists to first identify their constraints to production and then channel them technically appropriate amounts of state financing (1995). Equally important was these state officials' corporate coherence, especially their adherence to internal, bureaucratic norms of insulation that precluded them from seeking prohibitively large rents. Additional sociological literature converges on this view that (whatever its

origins) the combination of embeddedness and autonomy is an important cause of state capacities for development (Chibber 2003) far beyond these two countries (Evans and Rauch 1999). Further, these twin state capacities of bureaucratic embeddedness and targeting ability are not only important for explaining nation-states' industrial policy effectiveness. They may also plausibly predict the effectiveness of efforts by "21st century developmental states" to pursue "more aggressive state action in ramping up the effective delivery of capability-enhancing services" (Evans 2008: 13) like housing and sanitation.

The "social capital and resource mobilization" paradigm is a third framework to offer predictions of redistributive development. Other analysts helpfully trace the theoretical lineage of social capital and its relevance to democracy (Paxton 2002; Portes 2003), while usefully highlighting that some civic associations have had especially deleterious consequences, as Riley (2005) found for fascism in Europe. Viterna and Fallon (2008) insightfully explain the gendered outcomes of multiple, new democratic states as a partial function of women's pre-transition mobilizations and the relative connectedness or isolation of women's movements from ruling political parties. Tsai argues that even in non-democratic countries like China, "encompassing and embedding solidary groups" induce state redistribution by holding local state officials "informally accountable" for public goods provision via their judgments about the moral standing of these officials (2007).

This work helpfully moves beyond the somewhat generic definitions of volunteer associations in Putnam et al (1993) to show that even "when formal institutions of accountability are weak, citizens can still make government officials organize and fund

the public goods that they want and need when they have the right kind of social groups" (Tsai 2007: 370). Recent sociological studies suggest that the "right kinds" of social groups in one Indian state were women's microfinance organizations that facilitated women's collective actions to attend otherwise male-dominate village councils and register demands for improved public infrastructure and resources (Sanyal 2009: 546). Resource mobilization theory offers further clues as to what other relevant social groups and associations might be in democratic settings geared toward redistribution, pointing specifically to the number of on-the-ground social movement activists that recruit citizens to agitate for development. The framework also proposes that the skills of these activists in creating, maintaining, and expanding relevant social networks can ultimately matter for the viability of mass mobilizations (Tarrow 1994).

To a limited extent, the findings of this project support authoritative sociological theories, which model leftist party rule as a *necessary* condition of welfare state expansion (Bradley et al 2003; Huber, Ragin, and Stephens 1993; Huber and Stephens 2000, 2001; Huber et al 2006; Rueschemeyer, Stephens, and Stephens 1992). Seen in the larger comparative context of the study, however, another theoretical implication arises from the fact that, while left-leaning political parties were present in all positive cases of equalizing expansions, they were also present in negative cases of absent or extremely weak equalizing expansions. Specifically, when we consider that leftist party rule by the Workers Party coincided with a near absence of equalizing expansions in the negative case of Fortaleza, it is not possible to conclude that leftist party rule was by itself a *sufficient* condition of large or even modest primary health care expansions in urban Brazil. Indeed, the only condition that was present in all positive cases of expansion was

pragmatist civil societies. My findings suggest that primary health care expansions in urban Brazil arose from the conjunction of pragmatist sanitaristas – who by definition occupied positions of influence within a multiplicity of left-leaning parties – with locally-ruling, left-leaning parties (not only the PT). If the public health sector can be taken as any indication of social development more generally, then my analysis contradicts the current, dominant narrative that PT rule alone is what accounts for expanded social development in contemporary Brazil.

The 21st Century Developmental State

Recent sociological work proposes that one promising, if seemingly paradoxical foundation for achieving Senian development involves civil societies building momentum to construct developmental state structures by using institutionalized processes of democratic deliberation to define the means and ends of developmental state interventions. In particular, the work of Peter Evans argues that capability-enhancing development is likely to emerge from modern states that proactively deliver capability-expanding services like health and education in response to public processes of democratic deliberation about the ends and means of such interventions (2008: 13-14). Thus, a central explanatory variable from the erstwhile economic growth model – namely developmental states that foster industrial expansion (Evans 1995) – may be usefully adapted to conceptualizing and explaining the kinds of state interventions that advance the definition of capability expansions outlined by Sen. In short, a key contemporary analog to the industrial developmental state may well be a "21st century developmental state" that advances Senian development outcomes by pursuing more aggressive state action "in ramping up the effective delivery of capability-enhancing services" like health

and education (Evans 2008: 13). Yet for Evans and other scholars, the "21st century developmental state" – or the "21DS," as I will call it throughout the remainder of this chapter – may take on a broader multiplicity of institutional forms than the well-documented form of the 20th century developmental state did.

As the analysis to come will show, such 21st century developmental states increasingly take the tangible, institutional form of what I conceptualize as local-level "health developmental states", or "healthy states" for short. I define healthy states as formal governance structures characterized by three, key state capacities: first, large numbers of municipally-employed, primary public health professionals; second, formidable networks of municipally-operated primary care clinics; and lastly, technical capacities to target health professionals and clinics to high epidemiological risk. I argue that the historical process of constructing local-level healthy states across urban Brazil during the last twenty years has important implications for conceptualizing the 21DS and theorizing the conditions of its emergence. Specifically, I argue that this process suggests the need for a broader, four-sphere explanatory model of state-society relations that can accommodate how a decidedly pragmatist subset of civil society actors led state-building around one particular, capability-enhancing development objectives: namely, universal public health care provision.

The very notion of a 21DS presents several vexing, internal tensions related to the fact that such a state "must take more responsibility, achieve greater autonomy in relation to private elites and construct more complex and demanding forms of embeddedness" than its predecessor (2008: 17). No tension is more daunting to resolve than the dilemma of where capable and willing builders of the 21DS might come from, particularly given

the ubiquitous pitfall that true developmental alliances for capability expansion are likely to be supplanted by local capital and transnational allies, as has been argued to have occurred in South Africa. Prospects for constructing actually-existing 21DSs – and the new, more demanding forms of embeddedness on which they depend – are especially dim because of the master dilemma that no obvious agent of such a project is in evidence. Whereas capital-owners and state actors formed a natural alliance around the mutually-beneficial, shared project of constructing 20th century developmental states to expand industrial production, the mission of expanding capabilities is one whose comparatively lengthy time horizons and more easily-discounted social as opposed to private returns ultimately confound the formation of any natural alliance to construct a 21DS. In short, "since more efficient administrative structures ultimately depend on new forms of embeddedness, state-society ties are the crux of the problem of constructing a 21st century developmental state" (Evans 2010: 50).

For Evans, however, a glimmer of hope remains that the new and deeper forms of embeddedness, which constitute a kind of master requirement for constructing a 21DS, might ultimately emerge. These hopes hinge on the likelihood that, in theory, the full range of distinct social actors – civil society, the state, labor, and even capital – all stand to benefit in different ways from constructing a 21DS. Capitalists stand to benefit from an expansion in the kinds of healthier, better educated workers they require to compete in increasingly knowledge-based, bit-driven service industries. Workers stand to gain from expanded numbers of high-quality and potentially higher-paying jobs. Reformist state actors stand to benefit, not only from the improved information they receive about how to most efficiently allocate state investments to expand capabilities, but also from

coordinating with actual recipients the prioritization and delivery of particularly capability-enhancing services, all in ways that better ensure that such investments produce the desired effects. And civil society actors stand to benefit from using deliberative institutions to transform preferences for capability-enhancing services into on-the-ground realities. Yet little, few theories and little empirically robust scholarship exists for illuminating the kinds of state-society politics through which civil societies might go about building 21st century developmental states.

Municipal Health Councils

Although this project began with a hypothesis drawn from arguably the most influential alternative explanation of public service expansion in urban Brazil – that of participatory institutions of various kinds (Avritzer 2002, 2009; Wampler 2009; Marquetti, Pires, and Campos 2008) – previous chapters spoke little of this alternative explanation. The involvement of Brazilian civil societies in participatory democratic institutions has captured the imaginations of scholars and activists the world around. One such participatory instiutiton – Municipal Health Councils (MHCs) in which participants possess constitutionally-enshrined authorities to co-author health policies with local elected officials – increasingly draws the gaze of these observers.[1] Present in nearly all 5563 Brazilian *municípios*, MHCs offer participants formal authorities to ratify proposed annual health care budgets, reports on prior years' health spending, and multi-year strategic plans. Yet analysts disagree about whether these formal authorities translate into practical policymaking powers for civil society participants. Analysts on one end of the spectrum in this ongoing debate hail MHCs as "the most important participatory mechanism in Brazil,"[2] an institution that is "difficult to disempower," and an "effective

influence on public policy"[3] that devolves participants practical veto powers over proposed policies and budgets.[4] For scholars on the opposite end of this debate, civil society participants in MHCs not only fall far short of exerting these muscular powers, in practice, but also risk outright de-politicization and lost autonomy at the hands of decentralized power flows[5] and the pre-determined policy agendas that political society actors foist upon participants.[6]

During my fieldwork on municipal public health politics in urban Brazil, I found that civil society participation in MHCs more commonly falls in between these two extremes, in a zone of engagement with the local state that I came to think of as "positional participation". In positional participation, highly autonomous and self-organized civil society actors occupy these institutions, but in a largely instrumental fashion by which they supplement the more fundamental policymaking struggles that their allies wage in other, more central channels of electoral and bureaucratic politics. When highly autonomous and self-organized civil society actors with considerable power resources pursue their policy agendas through positional participation like MHCs, they are typically circumspect in their understanding of these institutions as moderately empowered but nontrivial positions from which to advance larger, shared policy agenda.

On the one hand, civil society actors who engage in positional participation in MHCs recognize that these spaces offer them few if any levers of state power. On the other hand, their activism in these spaces often supplements their counterparts' efforts to advance shared policy agendas in other, more efficacious spheres such as electoral and bureaucratic politics. From within these trenches, the actual practices of councilors range broadly but include mobilizing campaigns to increase their own numbers, exposing

bureaucratic rent-seeking and under-performance, publicizing the policy agendas they endorse, and waging often symbolic struggles to gain access to the constitutional and legal rights they are commonly denied. Thus, councils neither reduce to the uniformally depoliticizing vectors of decentralized power or instrumental vessels for political society dominance of civil society they are sometimes describes as, nor do they empower civil societies to influence policy in uniformally agentic ways that is sometimes ascribed to them.

While the theoretical and substantive interests of many scholars in participatory governance has led them to examine such institutions through the lens of the civil society actors who participate in them, I propose to invert this approach here. Namely, I propose to examine the civil societies on their own terms, as actors who encounter participatory governance institutions as one of several possible channels through which they may or may not opt to advance their policy agendas. My findings draw on participant observations, in-depth interviews, and archival research conducted in several large and politically progressive cities Brazilian cities such as São Paulo, Belo Horizonte, and especially Porto Alegre. Because health councils in all these cities possess formidable capacities to critique government policies in the language of governance that constitutes the terms of political and bureaucratic debate over state action in the public health sector, they constitute “limit cases” for testing claims about the policymaking powers they offer participants.

Through a historical analysis of the unfolding relations between Porto Alegre’s municipal state and its Municipal Health Council (MHC) between 1993 and 2010, I found that two separate civil societies – the Health Professionals (Sanitarista) Movement

and activists for participatory democracy – defined MHCs as a positional terrain of struggle for advancing their shared agenda of universal state provision of basic health care. Although these movements shared an agenda for universal health care provision with political society elites in state power, both civil society actors and the dominant political society actors – the Workers Party (PT) – ultimately relegated Municipal Health Councils to an ancillary sphere for advancing that agenda.

A first main finding that arises from this analysis was that, even under the most favorable conditions, civil society actors exerted very limited policy-making influence through its participation in MHCs between 1992 and 2004, in part because they themselves assigned only peripheral importance to activism in these arenas. The pre-2004 period of more harmonious council relations with a hegemonic party in state power featured a surprising absence of autonomous council influence into actual policy-making. Yet close examination of relations of health policy production inside and outside of the council demonstrates that this was not because of the supposedly unadulterated dominance of policy-making and council politics by governing elites, as some literatures claim. Rather, this was largely due to the choice of health and popular social movements to work through state and participatory budgeting channels, but rarely through council channels.

A second finding was that under far less promising circumstances – namely, a chapter in the council's history between 2005 and 2010, in which civil society and dominant political society actors opposed one another's agendas – the authorities commonly attributed to council participants proved apocryphal, in practice. The second, post-2005 period of antipathetic relations with emergent governing elites found

councilors pyrrhically struggling to access the very levers of policy influence that the power-sharing literature assumes to exist but are almost universally absent, in practice. MHCs proved incapable of influencing policy during this period because state officials ignored their many and vociferous demands to review government spending reports and proposed annual budgets. Further, while Council leaders effectively brought attention to the fact these circumventions amounted to breaches of legal and constitutional requirements, they never crystallized into the veto point that many analysts claim to be the institutional backbone of "power-sharing" arrangements. In neither period was the council a sight of autonomous civil society influence into actual policy-making, as the "power-sharing" paradigm claims. But neither was the council the unimpeded vector of power or the empty vessel for power-brokering by dominant political society actors that the "depoliticization" paradigm claims.

Gaps between Theory and Practice in Porto Alegre's Municipal Health Council

Since its inception in 1992, Porto Alegre's municipal health council – the MHC most commonly hailed as a model for health councils in Brazil (Avritzer 2009) – has never autonomously influenced the formulation of actual health policy through the wielding of its veto powers. Rather, during the 1992-2004 era, while municipally elected party leaders of the Worker's Party (PT) commonly consulted the council on policymaking initiatives, the council rarely exerted direct or purely autonomous influence on city health policies. During the post-2005 period in which the PT lost its sixteen-year grip on mayoral power, the council continued to be largely impotent in regards to actual health policymaking, as ruling parties that long clashed with the PT systematically

ignored the council. What both periods share, however, is that none of the four central mechanisms of supposed council influence actually operated, in practice.

Drawing on over 30 in-depth interviews with councilors, politicians, and health activists; participant observations of council meetings; and a content analysis of 16 years of the council's minutes, resolutions, and minutes of the council's technical commission, I identified four disjunctures between the constitutional promises of MHCs, on the one hand, and the political realities of policymaking in large municípios, on the other, ultimately account for the council's irrelevance within overarching policymaking processes in which they are little more than an accessory, at best. Analysts commonly point to four central features of MHCs. First, they emphasize that MHCs are permanent, constitutionally mandated institutions in which 50% of seats are technically reserved for civil society actors. Secondly, analysts highlight that the formal right of MHCs to approve or reject the municipal state's spending summaries from prior periods ultimately forces the local state to transparently disseminate its accounting for the prior service and infrastructure projects it undertook using public funds. Third, existing literature argues that the right of councils to approve the local state's strategic plans for upcoming service and infrastructure expansions allows them to proactively influence the contents of public policy, a pattern that Avritzer (2009) calls "co-governance". Lastly, existing research on health councils underscores the relevance of councils' formal right to reject proposed annual health budgets of the mayor. Here, analysts emphasize that such rejections legally entail a freeze on the transfer of federal funds to municípios, transfers which account for the vast majority of all large municípios' health budgets. One recent analysis described this last condition as follows: "As the release of federal monies depends on the

conselho's approval of health plans and budgets, some measure of agreement, if not consensus, is required for health services to continue to function (Cornwall 2008: 510)". A crucial formal caveat is that council rejections entail a stoppage in the flow of federal funds for SUS, which constitute the lion's share of most large municipalities' public health budgets. Taken together, the MOS envisioned that these new authorities of MHC councilors might create a new agent for reducing inequality: citizen-users on the council with both a vested interest and formal authorities to advocate for expansions of primary services into poor, peripheral regions of Brazilian cities (and in rural regions of the country).

Since the 1992 formation of Brazil's first MHCs, these four muscular legal provisions have rarely functioned as prescribed across urban Brazil, including in Porto Alegre, the Brazilian city that became famous worldwide for its participatory politics. During two distinct phases in the history of Porto Alegre's MHC, on-the-ground political realities fell far short of these legal requirements, although in slightly different ways. First, during the pre-2005 period, on which several analysts have focused when drawing theoretical inferences about the relevance of Brazilian health councils for democratic theory, comparatively harmonious relations predominated between MHC participants and governing elites from the Workers Party (PT). Many analysts infer from this period of relatively minimal conflict between council participants and governing elites that these two actors harmoniously co-authored health policies in the ways that the Brazilian Constitutions and Laws 8142 and 8080 require. My analysis, however, shows that during this period, enacted health policies in the município did not, in fact, emerge from council participants autonomously exerting these muscular powers within the policymaking

process. Rather, Workers Party (PT) mayors and the health activists they appointed to high-level political appointee levels advanced policy agendas for universal health care provision, typically garnering MHC support for these proposals only after their enactment, if at all.

These and additional disjunctures between the legal promises and political realities of MHC authorities are even more clearly observable during the second, pre-2005 period of Porto Alegre's council. In these more recent politics of MHC-state relations, a general climate of animosity prevailed in which governing elites from more centrist political parties clashed with longtime councilors, who are activists in well-known Workers Party (PT), MOS, and health workers unions. It is these conflicts which most clearly expose the non-functioning of the legal requirements that are commonly thought to induce autonomous civil society influence into health policymaking. Specifically, during this period, the council began routinely rejecting the few Spending Summaries, and proposed Municipal Health Secretariat budgets but these rejections had no palpable consequences. In what councilors describe as a concerted tactic of circumventing the council entirely, governing elites failed to even present Proposed Budgets and Municipal Health Plans for upcoming years. As in the pre-2005 period, however, these failures to comply with Laws 8142 and 8080 were practically inconsequential and never triggered the stoppage of funds that analysts assumed to eventuate from such legal breaches.

Existing literature argues that the right of councils to approve the secretariat's strategic plans for upcoming service and infrastructure expansions allows them to proactively influence the contents of public policy, a pattern that Avritzer (2009) calls

"co-governance". My analysis of council records, however, found that such approvals were typically non-existent.

Analysts of health council often highlight a second legal right: the right to approve or reject the municipal state's spending summaries from prior quarters and full years. Maria Leticia de Oliveira Garcia, the Coordinator of Porto Alegre's MHC since 2008, cited these legal requirements during a recent council plenary on August 26, 2010, which was called to review the government's spending summary for 2009. Leticia emphasized that the Annual Health Management Report is a key instrument through which governments must comply with the requirements of Unified Health System, namely by presenting the its results in annual health programming during the prior year. Citing the July 27, 1993 federal Law 6689, which specified these requirements in greater detail and formally extinguished the prior federal health bureaucracy (INAMPS), Leticia read these legal requirements directly from Article 12: "…the manager of SUS, in every sphere of government, will present three times per year to the health council in a public meeting, in the municipal camera of deputies, and the state-level legislative assembly, data describing the amount and source of all applied resources, audits conducted, initiative begun in the period, as well as the offer of services provided in its health network, including both contracted services [those contracted out to private sector providers] and convened services [those conducted in the public network of facilities by public employees" (Lei 8689: 1993 cited in Porto Alegre Municipal Health Council Minute#19: 8/26/10).

Much existing research on municipal health councils argues that councils possess a de facto veto over federal provision of health funding to the municipal health secretariats with which they are constitutionally required to develop strategies for health care

provision. This veto, in turn, is argued to establish councils as a formidable, institutionalized political presence within municipal policy making. On the one hand, Article 4 of Federal Law 8142 clearly states that: "To receive the [federal] resources [for health] outlined in Article 3 of this law, municípios, states, and the federal district require: I) a Health Fund, II) a Health Council, whose composition observes Decree # 99,438 of August 7, 1990; III) a Health Plan; IV) management reports that uphold Article 33 of Law 8,080 of September 1990…" (Lei Federal 8142)[7]. Noting this law, one analyst argues that "As the release of federal monies depends on the *conselho*'s approval of health plans and budgets, some measure of agreement, if not consensus, is required for health services to continue to function" (2008: 510). In a more unequivocal statement of this assumption, Coelho asserts that "the strength of MHCs largely derives from the law granting them veto power over the plans and accounts of the Health Secretariat. If the council rejects the plan and budget that the Health Secretariat is required to present annually, the Health Ministry, which manages 55% of the public health budget, does not transfer funds" (2006: 660). Given that federal funding constitutes the vast majority of any município's annual health budget, such a veto appears as a costly sanction, in theory.

In practice, however, Porto Alegre has never witnessed such a veto in the nineteen year history of the council, despite repeated failures of its municipal governments to even author the required health plans and health management reports, much less present them to the council for its approval. Actual freezes of federal health funds have never emerged from these many failures of Porto Alegre's health secretariat to comply with the constitution and federal laws. Although existing literature assumes that federal health funds will cease flowing to any município that lacks an active council, a health plan, and

routine, state-authored management summaries of its prior activities, state officials in Porto Alegre routinely circumvent these rules without triggering this assumed punishment. Among the many reasons for this is that both state officials and councilors openly recognize that such an eventuality would most punish the users of SUS in Porto Alegre. Because of this, aiming to freeze federal health funds is simply not one of the several tactics that councilors adopt in their many attempts to induce state action. As Oscar Paniz, the current vice-coordinator of the council emphasized during an interview last October, since SUS in Porto Alegre is already vastly under-funded, it would be highly counterproductive to attempt to freeze the already sparse federal funds for health which do flow to the health secretariat. (Interview with Paniz).

Further, municipal health bureaucrats and politicians are all too aware of the illogic of such a potential tactic for all parties involved. Indeed, during one health council meeting during November of 2006, as relations between the council and secretariat officials continued to deteriorate, the secretariat's representative on the council seemed to hold this reality over the head of the council: "If this council resolved, pure and simple, because of its antipathy for the secretariat or any other reason, to pass a veto on all projects, it would cost us resources that are absolutely fundamental for serving our population, since this would mean giving up federal and state resources" (Porto Alegre Municipal Health Council Minutes from meeting on 01/19/2006). The fact that vetos have not occurred in Porto Alegre, arguably the most famously progressive large city in Brazil, suggests a mythical quality of the health council's "veto".

Porto Alegre's councilors recently began responding to these disjunctures between formal and enacted political rights in at least four ways. First, the council began mounting

legal challenges to attain practical access to some of its rights to influence health policymaking and oversee policy implementation. Second, in a symbolic and pragmatic battle fought with the municipal health secretariat, it pursued several quasi-legal overtures to gain more autonomous control of its own budget. Third, it undertook mobilizational efforts to generate a new generation of health activists, whom it hoped would raise awareness about the universal right to health and actively pursue its realization in years to come. Finally, its oversight of private contractors exposed bureaucratic non-performance, corruption, and until recently a shocking absence of basic contracts between the municipal health secretariat and the private and quasi-public entities it pays to provide services that the state itself cannot.

First, particularly since the end of the Workers Party's 16-year hold on mayoral power in 2005, municipal health councilors in Porto Alegre have spent much of their enormous amounts of volunteered time struggling through legal (TCU and TCE) and quasi-legal (Ministerio Publico) channels to simply force the municipal health secretariat to present its spending summaries, proposed budgets, and strategic plans. Secondly, since 2007, Porto Alegre's councilors invested large amounts of their volunteered time attempting to win legal decisions regarding the administrative procedures that regulate the council's access to its own budget. Although such struggles might on first glance seem picayune and peripheral, especially in comparison to the council's constitutionally enshrined status as a health policy maker with the power to reject the mayor's budget, councilors nevertheless greeted as a major symbolic victory a December 2009 TCE decision entitling councilors to an expedited administrative process for pre-approval of their own business travel expenses. Councilors spent enormous amounts of time building

partnerships with the state government ombudsman (*Ministerio Publico*) in order to win such decisions, not only because of their symbolic value as validation of the council as an inherently political agent, on par with the mayor, health secretary, and state legislators. Councilors claim that such judicial decisions also have the practical effect of giving the council greater autonomy over its own budget. Given their contention that the municipal health secretariat routinely holds the council budget hostage as punishment for opposing its initiatives or exposing its own non-performance and sometimes corruption, such seemingly small victories have important practical implications. Prime among these is the freedom to travel to conferences and meetings with national health councilors in Brasilia and across the country, where councilors formulate major policy positions and develop strategies for influencing policy, and gaining practical access to the tools which would allow them to evolve such influence, in practice.

Third, councilors have attempted to "re-mobilize" the popular movement for health, which they believe propelled the major conquests of public health in Brazil, such as the creation of SUS and the crystallization of a universal citizenship right to equally access state-provided health care. Fourth, Porto Alegre's MHC has invested particularly sizeable amounts of time and energy in overseeing the various private entities that provide public health care in the município.

Councils as Venues for Exposing Bureaucratic Non-Performance

Yet the legal right to review municipal health plans, audit the municipal health fund, and co-author the municipal health funds – with non-compliance supposedly triggering a stoppage of federal funds – are not the only legally enshrined tools of councils for influencing policy and overseeing its implementation. Council meetings

themselves also serve as a forum in which citizens can complain and voice concerns regarding the failures of service provision in various hospitals, outpatient health centers, pharmacies, and the like. During open comment periods of Porto Alegre's meetings, it is commonplace for councilors and users who are not on the council to accuse the secretariat of both incompetence and corruption. During several 2009 council meetings, councilors, health center workers, and patients filled the public comment period with complaints about the absence of guards from a private security firm called Reação, which the secretariat was paid to patrol 55 health centers, hospitals, and emergency rooms in the município, many of which were located in its peripheral regions. Although it is the rare council meeting in which recriminations are not voiced regarding absenteeism, robberies, or otherwise dangerous working conditions in health centers of the município's peripheral regions, four city councilors attended the health council meeting I attended on May 21, 2009. The city councilors reported on an investigation they were conducting into this absenteeism and other abnormalities in Reação's contract with the secretariat. (Porto Alegre Municipal Health Council Minutes 05/21/2009)

The recriminations voiced in these and several meetings prior that year elicited no secretariat response and complaints of absentee security guards in health posts persisted. Early in 2010, however, the Ministerio Público for the State of Rio Grande do Sul, which places something of an ombudsman's role in the state's judicial system, traced the February 26, 2010 murder of Porto Alegre's municipal health secretary at the time, Eliseu Santos, to an ill-fated corruption scheme involving him, one of his deputies in the health secretariat, and Reação's owner. It cites the cause of the murder as a conflict arising from bribes that Santos and his SMS deputy demanded in exchange for renewing Reação's

contract to provide security in the município's health posts (Zero Hora: 05/10/2010; 07/08/2010). Specifically, the MP alleges that hit-men hired by the firm's owner murdered Santos in reprisal for his breaking a contract with the firm in March of 2009 after the firm's owner refused to pay Santos the bribe.[8] Ultimately, however, what led to the exposure of the alleged scandal has little to do with the health council itself. Rather, the council's prior inability to induce the secretariat to regulate Reação and force it restore guards into health centers, even after councilors exposed the non-performance of the firm and began linking it to corruption within the health secretariat, illustrates that councilors remain relatively powerless in their attempts to generate state responses to rampant problems of under-performance by the private corporations that the secretariat contracts to provide publlic services.

This grotesque scandal aside, it is important to note that councilors more routinely accuse the secretariat of much more fundamental failings, including the lack of basic administrative capacities for spending the already limited budget that it does have. For example, one persistent critique that councilors make of the secretariat is that millions of unspent reais accumulate in its bank accounts annually while Porto Alegre has quietly crept to the top of national rankings for municípios with the highest tuberculosis infection rates. During an August 26, 2010 council meeting held (in addition to its regularly schedule bimonthly meetings) for the purpose of presenting its evaluation of one of the first Management Summaries it has actually received from the secretariat – the Spending Summary for 2009 – this critique arose again as one of the central justifications the council offered for rejecting the summary. In a lengthy decision of the council's technical

commission, which evaluated and critiqued the secretariat's over 300 page summary in prior meetings of its own, it concluded that:

> "SMS includes an analysis indicating that during 2009 it spent 87.32% of its budget and that in 2008 this proportion was 92.27%. Yet, the fulfillment of the Municipal Health Fund remained, as in recent periods, characterized by the under-utilization of available resources, adding up to a significant amount: $5,571,079.02 reais [about $USD 3,376,411.52]…there exist extremely large amounts of resources from prior years's budgets which continue accumulating in bank accounts. In addition to this, the municipal health budget was neither discussed nor approved by the Municipal Health Council" - Porto Alegre Municipal Health Council Minute 08/26/2010

Despite many cases which appear to fit the basic legal requirements for federal funding freezes as outlined in Law 8142, there are no known cases with major Brazilian municípios in which such breeches have themselves triggered funding stoppages. For example, one egregious case of such breeches having generated no practical consequence comes from São Paulo, where tension and outright hostility began defining relations between the council and the municipal health secretary during 2008. In that year, the center-right mayor Gilbert Kassab assumed power and began what several councilors understand to be a concerted campaign not just to ignore the council but to actively undermine its very ability to meet. During a council meeting I attended on September 17, 2009, a dominant theme throughout its eight hour deliberations that day was the absence of any representative of the health secretary or mayor at council meetings since 2007. More importantly, José Guilherme de Andrade, a longstanding health activist and member of the council recounted how in February of 2008, Mayor Kassab went so far as to lock councilors out of a municipal health secretariat building where they have had office space and have held meetings for nearly twenty years.

Two meeting minutes of São Paulo's council from early 2008 describe the meetings as having taken place, "on the street in front of the health secretary building and in the presence of the Military Police and Metropolitan Civil Guard… as a result of having been barred from accessing the building by the mayor" (São Paulo Municipal Health Council Minutes 01/21/2006, 02/21/2006). Yet, despite actively impeding the very ability of the health council to meet, such actions have not had the consequences that existing literature assumes to emerge from such breeches. The federal health ministry never denied funds to the municipality of São Paulo following these breeches. Nor did the Health Ministry so much as threaten a stoppage or otherwise reprimand the secretariat during this period. As such, it is perhaps no surprise that the council during 2008 and 2009 was quite far afield from engaging in the kinds of substantive negotiations over the contents of the secretariat's budget for the upcoming year, which capture the imaginations of some health council scholars. Nor was São Paulo's council actively involved in advocating for a particular substantive policy agenda, as the terms "co-governance" and "power-sharing" might suggest. Rather, councilors were merely struggling with more basic problems like finding a place to meet after the mayor locked them out of their office and meetings spaces in the health secretariat building.

This particular manifestation of an all too familiar pattern of discontinuity between the theory and practice of constitutional and legal requirements in Brazil is hardly specific to Porto Alegre or São Paulo. After interviewing municipal health councilors, searching complete longitudinal records of their minutes, and searching the major newspapers of Porto Alegre, São Paulo, Belo Horizonte, Recife, Rio de Janeiro, and Florianópolis, only two cases of federal funding freezes of any kind emerged: São

Paulo in 1990 and Rio de Janeiro in 2006. Importantly, however, neither resulted from specific actions of the municipal health council. Indeed, the first case – São Paulo in 1990 under the notoriously corrupt mayoralty of Paulo Maluf – occurred before the council even existed. The second case of Rio de Janeiro in 2006 was one in which the federal Health Ministry took over management of hospitals in the município (Folha de São Paulo 3/24/2005)[9]. Yet, what induced this takeover was massive corruption and underperformance in the administration of health care in the city, not failures to present spending plans or summaries to the health council. The very fact that only two such federal health funding freezes to municípios occurred during the last twenty years in large Brazilian cities – neither of which was triggered by the actions of health council – further speaks to the general impotence of councils within the overarching politics of public health in which they are always embedded. In Porto Alegre, something closer to the opposite is true: the few legal tools that its extremely active and technically competent councilors possess for inducing an institutionally retrograde health secretariat (SMS) into action ultimately offer very little purchase, in practice. One of the qualities of the overarching municipal politics of public health in the city, which emasculates these legal and constitutional tools, is the perhaps surprisingly limited state capacity of Porto Alegre's municipal health secretariat.

Yet, as the analysis in prior chapters of this dissertation showed, these discontinuities between the theory and practice of politics within the municipal health councils of cities like Porto Alegre, São Paulo, and even Belo Horizonte did not preclude sometimes robust expansions in primary health care provision. But what the combined findings of those chapters and the analysis above suggest is that the most direct causes of

these expansions were pragmatist regimes in which sanitaristas acted through the regulative institution of appointed and elected state offices and participatory regimes in which deliberative civil societies operated, primarily through participatory budgeting institutions and in less efficacious ways (for actual policymaking) through municipal health councils.

Pragmatist Regimes and Development

In documenting and explaining the substantial variation in primary health care expansion across three large capital city municipalities (Belo Horizonte, Porto Alegre, and Rio de Janeiro), this projects found that pragmatist civil society actors from the sanitarista movement were particularly effective agents for constructing health-focused, 21st century developmental states in urban Brazil. By pursuing their ideology of universalizing access to basic health care in a politically opportunistic fashion through which they penetrated a broad array of other political spheres such as unions and political parties in cities like Belo Horizonte, sanitaristas helped advance a major state-building project in the primary public health sector by mobilizing a broad range of other, more deliberative civil societies as well as organized labor and state actors around their objectives. Thus, rather than being mobilized by state actors, such pragmatist civil societies exhibited a capacity for strategically and ephemerally entering the state, while avoiding co-optation by returning to more traditional civil society institutions.

I argue that this story of the recent expansion in primary public health care provision across urban Brazil can help shed light on our understanding of how 21DS structures emerge and what sustains them. In particular, Brazil's record speaks directly to several vexing, internal tensions within the very notion of a 21DS, especially the

proposition that such structures "must take more responsibility, achieve greater autonomy in relation to private elites and construct more complex and demanding forms of embeddedness" than its predecessor (2008: 17). Perhaps no tension is more daunting to resolve than the dilemma of where capable and willing builders of the 21DS might come from, particularly given the ubiquitous pitfall that true developmental alliances for capability expansion are likely to be supplanted by local capital and transnational allies, as has been argued to have occurred in South Africa. Prospects for constructing actually-existing 21DSs – and the new, more demanding forms of embeddedness on which they depend – are especially dim because of the master dilemma that no obvious agent of such a project is in evidence. Whereas capital-owners and state actors formed a natural alliance around the mutually-beneficial, shared project of constructing 20th century developmental states to expand industrial production, the mission of expanding capabilities is one whose comparatively lengthy time horizons and more easily-discounted social as opposed to private returns ultimately confound the formation of any natural alliance to construct a 21DS. In short, "since more efficient administrative structures ultimately depend on new forms of embeddedness, state-society ties are the crux of the problem of constructing a 21st century developmental state" (Evans 2010: 50).

If the state-society ties forged by sanitaristas proved beneficial for the expansion of primary health care throughout Brazil, as I have argued, this synergy would seem to have benefitted from the middle class positions that sanitaristas occupied as doctors, professors, researcher, and graduate students. This cannot be denied. Yet it is also the case that their class status played a role in keeping sanitaristas to the primary communicative institutions of the movement, from more formalized structures like

CEBES, Fiocruz, and Medical School campuses across urban Brazil – and, interestingly, to less formal structures like the "mineiro sanitarista party" that systematically occupied key offices over the last thirty years in Belo Horizonte. As such the curious affinity between the middle class status of sanitaristas and their sustained mobilization around social movement ideologies like universal access to health care constitute a relevant counterpoint to social movement theory. This relationship constitutes one avenue for future research on civil societies in contemporary Brazil and beyond.

[1] This legal framework emerges first from the Constitution: Brasil. *Constituição Da República Federativa do Brasil*. Brasília, DF.: 1988. Two federal laws specify the ways in which municípios must recognize councils in order to receive federal health care funding: *Lei 8,142 De 28 De Dezembro De 1990,* Public Law 8,142, (1990): *Lei 8689 De 27 De Julho, 1993,* Public Law 8689, (1993) .

[2] Coelho 2006: 657

[3] Avritzer 2009: 132

[4] Coelho (2006) and Avritzer (2009)

[5] Alvarez, Sonia E. "Beyond the Civil Society Agenda?: "Civic Participation" and Practices of Governance, Governability and Governmentality." Brown University Watson Institute for International Studies, September 17, 2008.

[6] See especially Humphreys, Macartan, William A. Masters, and Martin E. Sandbu. "The Role of Leaders in Democratic Deliberations: Results from a Field Experiment in São Tomé and Príncipe." *World Politics* 58, (2006): 583-622.

[7] The degree specifies two additional requirements – counterentry of health resources in the respective budget and a commission known as the PCCS for elaborating 2-year estimates of the expected careers, jobs, and salaries required for implementation – but neither councilors nor analysts commonly invoke these requirements.

[8] The police and state prosecutors that hold ultimate responsibility for indicting suspects concluded that the murder was an armed robbery gone awry (Zero Hora 03/03/2010). But soon after the city's police chief resigned amidst allegations that due to his personal connections to Reação's owner, a former police officer himself, he pressured investigators into conducting a less than scrupulous investigation of the case. The investigation's findings generated no small amount of cynicism and outrage among councilors and civil society activists in Porto Alegre, many of which have long accused the police and courts of being highly corrupt themselves.

[9] Although the ministry stopped short of taking over the município's network of primary care facilities, its hospital takeover led to a confrontation in which then-mayor Cesar Maia deployed the Municipal Police to hospitals in a symbolic and ultimately unconsequential display of resistance of federal intervention. The ministry subsequently directed the state government to manage all of its SUS funds.

APPENDIX 1.
DATA ON POPULATION, UN-INSURED POPULATION, BASIC PUBLIC HEALTH SERVICES, AND HEALTH TEAMS

(SEE PAGES BELOW)

Appendix 1 Table 1. Un-insured Population and Basic Health Service Provision in the Município of Belo Horizonte, 1988-2011

Year	Population [a]			All Basic Procedures [b]									
	Total	% Un-insured	Un-insured	Total	Municipal: PSF	Municipal: Non-PSF	% All Mun.	State	%	Federal	%	Private	%
2011	2,385,639	44.60	1,063,995	17,880,204	1,585,607	16,078,951	98.79	82,753	0.46	65,002	0.36	67891	0.38
2010	2,375,444	46.80	1,111,708	15,509,613	247,858	14,971,376	98.13	129,852	0.84	77,163	0.50	83364	0.54
2009	2,452,617	52.90	1,297,434	19,114,787	4,195,871	14,607,310	98.37	145,506	0.76	80,874	0.42	85226	0.45
2008	2,434,642	54.60	1,329,315	14,596,085	1,097,853	13,125,854	97.45	185,142	1.27	97,247	0.67	89989	0.62
2007	2,412,937	56.50	1,363,309	16,170,334	1,635,382	14,231,080	98.12	81,421	0.50	123971	0.77	98480	0.61
2006	2,399,920	59.10	1,418,353	16,160,747	1,640,545	14,209,831	98.08	82,626	0.51	132864	0.82	94881	0.59
2005	2,375,329	60.40	1,434,699	17,139,781	1,967,562	14,807,848	97.87	91,326	0.53	118844	0.69	154201	0.90
2004	2,350,564	60.60	1,424,442	16,123,589	1,905,543	13,931,284	98.22	14,780	0.09	148118	0.92	123864	0.77
2003	2,305,812	61.00	1,406,545	18,095,810	1,968,524	15,693,388	97.60	1,174	0.01	190240	1.05	242484	1.34
2002	2,284,468	58.80	1,343,267	16,388,154	699,247	15,148,273	96.70	0	0.00	318594	1.94	222040	1.35
2001	2,258,857	57.70	1,303,360	21,610,188	136	20,992,591	97.14	0	0.00	361002	1.67	256459	1.19
2000	2,154,161	57.90	1,247,259	13,715,887	23	13,026,132	94.97	0	0.00	435172	3.17	254560	1.86
1999	2,139,125	NA	NA	16,912,046	0	16,088,915	95.13	0	0.00	484479	2.86	338652	2.00
1998	2,124,146	NA	NA	18,476,234	0	17,214,202	93.17	0	0.00	629702	3.41	632330	3.42
1997	2,109,225	NA	NA	25,841,422	0	23,801,118	92.10	0	0.00	806342	3.12	1233962	4.78
1996	NA	NA	NA	26,167,014	0	23,589,869	90.15	0	0.00	1066673	4.08	1510472	5.77
1995	2,097,311	NA	NA	23,033,951	0	18,551,687	80.54	1,325,329	5.75	1230851	5.34	1926084	8.36
1994	2,079,280	NA	NA	11,950,916	0	9,254,700	77.44	1,014,424	8.49	567164	4.75	1114628	9.33
1993	2,060,804	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1992	2,083,176	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1991	2,020,162	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1990	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1989	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1988	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA

[a] All population figures are from TCU (1992-2011) except for 1991, which are IBGE (1991); [b] Municipal PSF figures are from SIAB (1994-2011); All other figures are from SIA (1994-2011); All other fields are the author's calculations; NA = data were not available or could not be accessed by the time of writing

Appendix 1 Table 2. Un-insured Population and Basic Health Service Provision in the Belo Horizonte Metropolitan Region, 1988-2011

Year	Population [a]			All Basic Procedures [b]									
	Total	% Un-insured	Un-insured	Total	Municipal: PSF	Municipal: Non-PSF	% All Mun.	State	%	Federal	%	Private	%
2011	5,460,400	57.60	3,145,264	47,232,894	3,463,258	43,333,236	99.08	178,723	0.38	65,002	0.14	192,675	0.41
2010	5,413,627	59.67	3,230,441	42,759,571	2,291,768	39,805,161	98.45	341,989	0.80	77,163	0.18	243,490	0.57
2009	5,649,932	65.42	3,696,213	53,688,283	6,024,962	46,641,238	98.10	694,984	1.29	80,874	0.15	246,225	0.46
2008	5,577,029	66.57	3,712,537	47,537,142	3,731,668	42,965,966	98.23	514,763	1.08	97,247	0.20	227,498	0.48
2007	5,454,971	68.33	3,727,286	44,306,279	4,227,936	39,219,879	98.06	415,898	0.94	123,971	0.28	318,595	0.72
2006	5,494,095	70.82	3,891,107	44,889,964	4,134,473	39,944,579	98.19	321,007	0.72	132,864	0.30	357,041	0.80
2005	5,391,284	72.19	3,892,012	46,454,910	3,329,294	42,281,863	98.18	315,217	0.68	118,844	0.26	409,692	0.88
2004	5,287,713	72.54	3,835,682	47,130,879	3,307,178	43,059,177	98.38	231,725	0.49	148,118	0.31	384,681	0.82
2003	5,100,559	73.72	3,760,049	47,932,186	3,119,052	43,948,556	98.20	236,996	0.49	197,250	0.41	430,332	0.90
2002	5,011,383	72.36	3,626,136	44,925,910	1,811,515	41,966,031	97.44	345,665	0.77	386,950	0.86	415,749	0.93
2001	4,922,942	72.20	3,554,527	47,508,821	1,096,334	45,089,245	97.21	352,707	0.74	429,581	0.90	540,954	1.14
2000	4,669,274	72.07	3,364,942	37,986,708	941,204	35,588,434	96.16	425,307	1.12	493,090	1.30	538,673	1.42
1999	4,586,037	NA	NA	40,863,330	503,671	38,835,227	96.27	284,362	0.70	546,106	1.34	693,964	1.70
1998	4,503,102	64.00	2,881,985	39,957,443	81,459	37,607,120	94.32	274,300	0.69	686,877	1.72	1,307,687	3.27
1997	4,420,299	NA	NA	50,102,512	NA	46,160,772	92.13	804,462	1.61	825,470	1.65	2,311,808	4.61
1996	NA	NA	NA	46,376,001	NA	42,027,249	90.62	468,307	1.01	1,081,758	2.33	2,798,687	6.03
1995	4,191,254	NA	NA	41,550,144	NA	35,228,860	84.79	2,013,534	4.85	1,247,492	3.00	3,060,258	7.37
1994	4,125,588	NA	NA	21,049,293	NA	17,548,216	83.37	1,187,524	5.64	575,685	2.73	1,737,868	8.26
1993	4,058,267	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1992	3,982,881	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1991	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1990	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1989	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1988	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA

[a] All population figures are from TCU (1992-2011); [b] Municipal PSF figures are from SIAB (1994-2011); All other figures are from SIA (1994-2011); All other fields are the author's calculations; NA = data were not available or could not be accessed by the time of writing

Appendix 1 Table 3. Un-insured Population and Basic Health Service Provision in the Município of Porto Alegre, 1988-2011

Year	Population [a]			All Basic Procedures [b]									
	Total	% Un-insured	Un-insured	Total	Municipal: PSF	Municipal: Non-PSF	% All Mun.	State	%	Federal	%	Private	%
2011	1,413,094	50.50	713,612	10,971,214	3,463,258	5,603,538	82.64	784,916	7.15	416,541	3.80	702,961	6.41
2010	1,409,939	50.80	716,249	10,731,267	2,291,768	6,315,657	80.21	782,060	7.29	494,048	4.60	847,734	7.90
2009	1,436,123	54.90	788,432	13,713,839	6,024,962	5,692,047	85.44	725,716	5.29	429,018	3.13	842,096	6.14
2008	1,430,220	58.20	832,388	12,635,874	3,731,668	6,796,740	83.32	695,152	5.50	644,624	5.10	767,690	6.08
2007	1,420,667	60.80	863,766	10,769,474	4,227,936	3,873,297	75.22	842,891	7.83	1,002,232	9.31	823,118	7.64
2006	1,440,939	63.80	919,319	10,942,569	4,134,473	3,836,126	72.84	1,196,499	10.9	1,049,743	9.59	725,728	6.63
2005	1,428,696	66.40	948,654	9,728,997	3,329,294	3,639,373	71.63	1,065,751	10.9	1,000,972	10.2	693,607	7.13
2004	1,416,363	66.80	946,130	9,345,324	3,307,178	3,467,634	72.49	1,054,000	11.2	942,697	10.0	573,815	6.14
2003	1,394,085	71.10	991,194	10,196,142	3,119,052	3,913,596	68.97	1,045,429	10.2	1,203,241	11.8	914,824	8.97
2002	1,383,454	73.40	1,015,455	9,178,684	1,811,515	4,212,171	65.63	831,592	9.06	1,748,066	19.0	575,340	6.27
2001	1,373,313	75.70	1,039,598	8,047,919	1,096,334	3,817,044	61.05	802,047	9.97	2,028,801	25.2	303,693	3.77
2000	1,321,886	77.70	1,027,105	7,003,707	941,204	3,602,157	64.87	350,065	5.00	1,860,765	26.5	249,516	3.56
1999	1,314,032	NA	NA	6,654,107	503,671	3,364,740	58.14	351,414	5.28	2,210,555	33.2	223,727	3.36
1998	1,306,195	NA	NA	8,676,445	81,459	3,566,304	42.04	598,068	6.89	3,694,804	42.5	735,810	8.48
1997	1,298,107	NA	NA	11,403,041	0	3,142,604	27.56	2,425,888	21.2	4,769,607	41.8	1,064,942	9.34
1996	0	NA	NA	9,799,839	0	1,610,426	16.43	2,270,642	23.1	4,745,522	48.4	1,173,249	11.9
1995	1,295,940	NA	NA	10,795,002	0	1,634,093	15.14	2,009,765	18.6	5,465,154	50.6	1,685,990	15.6
1994	1,292,899	NA	NA	5,550,098	0	759,114	13.68	958,242	17.2	2,770,248	49.9	1,062,494	19.1
1993	1,280,114	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1992	1,265,546	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1991	1,263,402	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1990	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1989	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1988	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA

[a] All population figures are from TCU (1992-2011) except for 1991, which are IBGE (1991); [b] Municipal PSF figures are from SIAB (1994-2011); All other figures are from SIA (1994-2011); All other fields are the author's calculations; NA = data were not available or could not be accessed by the time of writing

Appendix 1 Table 4. Un-insured Population and Basic Health Service Provision in the Porto Alegre Metropolitan Region, 1988-2011

Year	Population [a]			All Basic Procedures [b]									
	Total	% Un-insured	Un-insured	Total	Municipal: PSF	Municipal: Non-PSF	% All Mun.	State	%	Federal	%	Private	%
2011	3,977,457	64.40	2,561,482	24,449,533	1,331,165	20,999,948	91.34	807,253	3.30	416,541	1.70	894,626	3.66
2010	3,960,068	65.10	2,578,004	22,279,561	987,085	18,967,892	89.57	799,075	3.59	494,048	2.22	1,031,461	4.63
2009	4,064,186	69.00	2,804,288	20,868,545	994,781	17,683,993	89.51	735,598	3.52	429,018	2.06	1,025,155	4.91
2008	4,035,194	71.80	2,897,269	18,470,200	1,017,347	14,220,216	82.50	695,515	3.77	644,624	3.49	1,892,498	10.2
2007	3,959,810	73.30	2,902,541	18,697,589	806,837	14,814,525	83.55	842,891	4.51	1,002,232	5.36	1,231,104	6.58
2006	4,101,032	74.90	3,071,673	16,209,532	1,191,981	11,712,828	79.61	1,196,499	7.38	1,049,743	6.48	1,058,481	6.53
2005	4,042,724	77.00	3,112,897	16,569,584	571,731	12,797,208	80.68	1,065,751	6.43	1,000,972	6.04	1,133,922	6.84
2004	3,983,980	77.40	3,083,601	14,622,536	638,807	11,063,937	80.03	1,054,000	7.21	942,697	6.45	923,095	6.31
2003	3,877,844	80.00	3,102,275	15,655,398	383,209	11,692,336	77.13	1,108,301	7.08	1,204,841	7.70	1,266,711	8.09
2002	3,827,266	81.60	3,123,049	16,597,265	323,266	12,511,880	77.33	906,219	5.46	1,748,066	10.5	1,107,834	6.67
2001	3,779,002	82.90	3,132,793	15,608,229	237,816	11,599,281	75.84	893,877	5.73	2,028,801	13.0	848,454	5.44
2000	3,633,256	83.80	3,044,669	13,242,610	270,382	9,890,764	76.73	448,544	3.39	1,861,513	14.0	771,407	5.83
1999	3,584,892	NA	NA	12,133,123	138,182	8,639,980	72.35	539,452	4.45	2,210,555	18.2	604,954	4.99
1998	3,536,694	64.00	2,263,484	14,511,718	65,226	8,233,874	57.19	979,702	6.75	3,695,177	25.4	1,537,739	10.6
1997	3,489,398	NA	NA	17,759,934	0	7,122,181	40.10	3,359,544	18.9	4,769,926	26.8	2,508,283	14.1
1996	NA	NA	NA	16,485,489	0	5,587,440	33.89	3,439,951	20.8	4,745,959	28.7	2,712,139	16.4
1995	3,435,645	NA	NA	17,497,156	0	5,156,767	29.47	3,226,805	18.4	5,467,075	31.2	3,646,509	20.8
1994	3,382,236	NA	NA	9,332,113	0	2,572,668	27.57	1,746,511	18.7	2,771,488	29.7	2,241,446	24.0
1993	3,327,474	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1992	3,265,197	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1991	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1990	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1989	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1988	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA

[a] All population figures are from TCU (1992-2011); [b] Municipal PSF figures are from SIAB (1994-2011); All other figures are from SIA (1994-2011);All other fields are the author's calculations; NA = data were not available or could not be accessed by the time of writing

Appendix 1 Table 5. Un-insured Population and Basic Health Service Provision in the Município of Rio de Janeiro, 1988-2011

Year	Population [a]			All Basic Procedures [b]									
	Total	% Un-insured	Un-insured	Total	Municipal: PSF	Municipal: Non-PSF	% All Mun.	State	%	Federal	%	Private	%
2011	6,355,949	44.30	2,815,685	24,371,452	899,812	21,231,403	90.81	1,559,702	6.40	591,935	2.43	88,600	0.36
2010	6,323,037	45.30	2,864,336	14,583,294	104,514	12,330,089	85.27	1,510,274	10.3	486,932	3.34	151,485	1.04
2009	6,186,710	47.70	2,951,061	13,000,191	987,942	9,732,810	82.47	1,195,549	9.20	852,974	6.56	230,916	1.78
2008	6,161,047	49.50	3,049,718	14,728,167	2,269,367	9,797,249	81.93	1,544,793	10.4	803,558	5.46	313,200	2.13
2007	6,093,472	50.80	3,095,484	15,352,738	2,050,596	10,002,393	78.51	2,029,324	13.2	788,712	5.14	481,713	3.14
2006	6,136,652	48.30	2,964,003	17,361,335	1,860,240	11,086,535	74.57	2,904,845	16.7	769,569	4.43	740,146	4.26
2005	6,094,183	49.00	2,986,150	20,894,883	2,528,846	14,248,192	80.29	2,561,486	12.2	748,811	3.58	807,548	3.86
2004	6,051,399	50.40	3,049,905	19,222,186	721,937	13,839,122	75.75	3,114,943	16.2	726,720	3.78	819,464	4.26
2003	5,974,081	56.30	3,363,408	19,931,937	77,172	15,392,634	77.61	2,601,834	13.0	954,159	4.79	906,138	4.55
2002	5,937,253	56.20	3,336,736	21,449,027	45,585	15,607,139	72.98	3,693,189	17.2	1,161,306	5.41	941,808	4.39
2001	5,897,485	54.90	3,237,719	22,538,198	24,283	16,620,631	73.85	3,865,885	17.1	1,083,307	4.81	944,092	4.19
2000	5,613,897	56.70	3,183,080	21,735,056	4,799	16,162,816	74.38	3,553,665	16.3	1,160,480	5.34	853,296	3.93
1999	5,598,953	NA	NA	20,665,300	NA	15,299,153	74.03	2,510,463	12.1	1,890,732	9.15	964,952	4.67
1998	5,584,067	NA	NA	21,959,649	NA	14,682,915	66.86	3,396,166	15.4	2,156,419	9.82	1,724,149	7.85
1997	5,569,181	NA	NA	25,202,418	NA	15,164,114	60.17	4,258,074	16.9	3,123,961	12.4	2,656,269	10.5
1996	NA	NA	NA	23,578,872	NA	13,937,766	59.11	3,875,986	16.4	2,913,026	12.3	2,852,094	12.1
1995	5,606,497	NA	NA	20,675,548	NA	11,344,846	54.87	2,499,300	12.0	3,289,071	15.9	3,542,331	17.1
1994	5,577,141	NA	NA	11,334,359	NA	4,994,863	44.07	2,817,592	24.8	1,764,522	15.5	1,757,382	15.5
1993	5,547,033	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1992	5,508,048	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1991	5,480,768	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1990	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1989	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA
1988	NA	NA	NA	NA	0	NA	NA	NA	NA	NA	NA	NA	NA

[a] All population figures are from TCU (1992-2011) except for 1991, which are IBGE (1991); [b] Municipal PSF figures are from SIAB (1994-2011); All other figures are from SIA (1994-2011);All other fields are the author's calculations; NA = data were not available or could not be accessed by the time of writing

Appendix 1 Table 6. Un-insured Population and Basic Health Service Provision in the Rio de Janeiro Metropolitan Region, 1988-2011

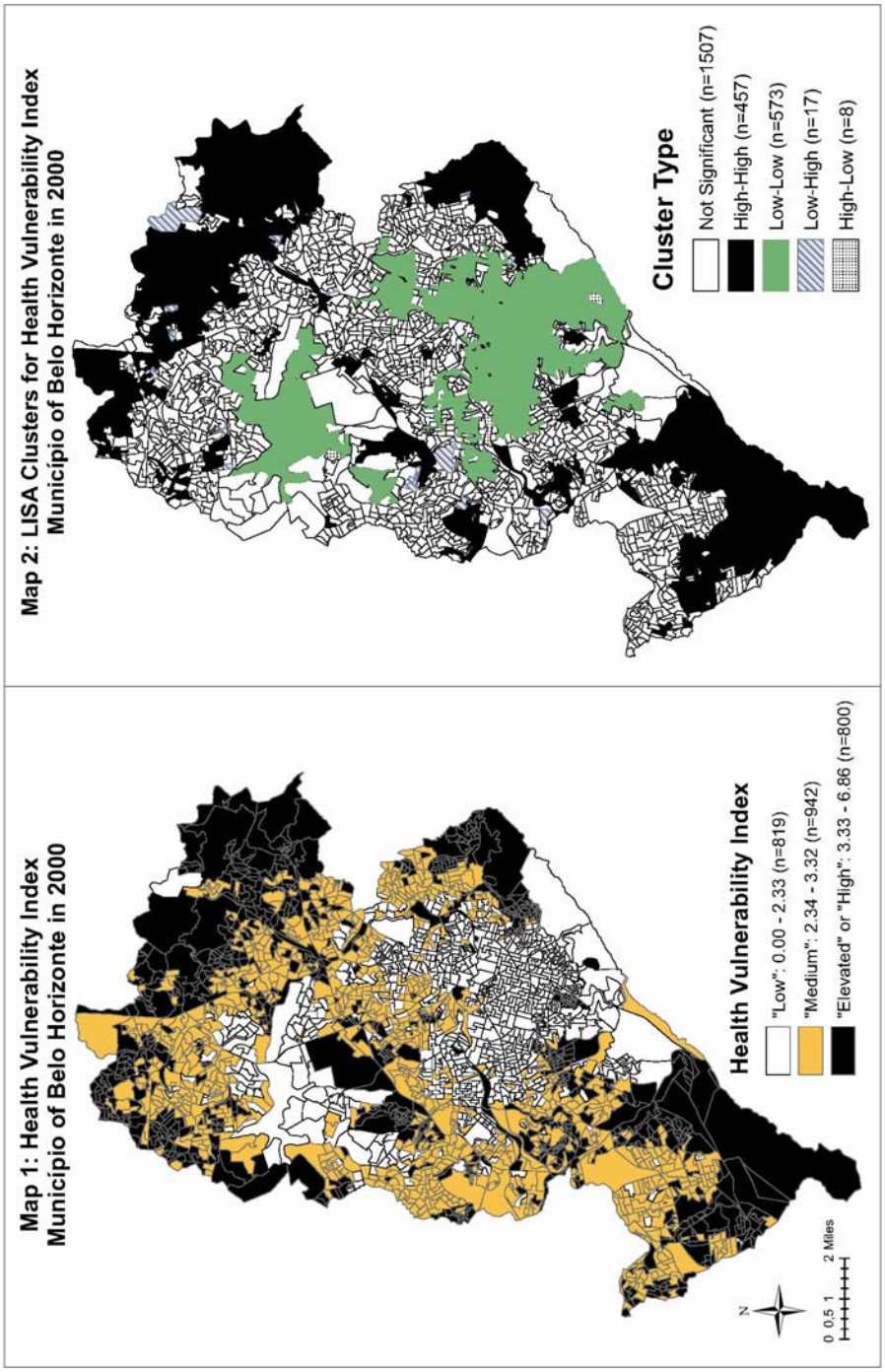
Year	Population [a]			All Basic Procedures [b]									
	Total	% Un-insured	Un-insured	Total	Municipal: PSF	Municipal: Non-PSF	% All Mun.	State	%	Federal	%	Private	%
2011	11,667,365	57.80	6,743,737	64,733,301	2,588,298	59,148,904	95.37	1,559,702	2.41	598,446	0.92	837,951	1.29
2010	11,602,070	58.90	6,833,619	57,964,059	1,893,071	52,892,581	94.52	1,510,274	2.61	490,486	0.85	1,177,647	2.03
2009	11,634,674	61.90	7,201,863	49,455,313	2,876,739	43,008,609	92.78	1,195,998	2.42	860,225	1.74	1,513,742	3.06
2008	11,557,888	63.20	7,304,585	59,980,920	4,012,463	51,473,924	92.51	1,544,793	2.58	840,697	1.40	2,109,043	3.52
2007	11,341,714	64.90	7,360,772	17,183,225	3,881,083	10,002,393	80.80	2,029,324	11.8	788,712	4.59	481,713	2.80
2006	11,467,222	63.80	7,316,088	18,939,136	3,438,041	11,086,535	76.69	2,904,845	15.3	769,569	4.06	740,146	3.91
2005	11,351,937	64.20	7,287,944	22,239,871	3,873,834	14,248,192	81.48	2,561,486	11.5	748,811	3.37	807,548	3.63
2004	11,025,905	65.40	7,210,942	20,874,627	2,374,378	13,839,122	77.67	3,114,943	14.9	726,720	3.48	819,464	3.93
2003	11,025,905	69.50	7,663,004	21,210,928	1,356,163	15,392,634	78.96	2,601,834	12.2	954,159	4.50	906,138	4.27
2002	10,925,926	69.70	7,615,370	22,653,079	1,249,637	15,607,139	74.41	3,693,189	16.3	1,161,306	5.13	941,808	4.16
2001	10,812,519	69.10	7,471,451	22,964,380	450,465	16,620,631	74.34	3,865,885	16.8	1,083,307	4.72	944,092	4.11
2000	10,360,200	70.20	7,272,860	22,008,449	278,192	16,162,816	74.70	3,553,665	16.1	1,160,480	5.27	853,296	3.88
1999	10,283,898	NA	NA	20,814,458	149,158	15,299,153	74.22	2,510,463	12.0	1,890,732	9.08	964,952	4.64
1998	10,297,868	63.90	6,580,338	21,990,773	31,124	14,682,915	66.91	3,396,166	15.4	2,156,419	9.81	1,724,149	7.84
1997	10,131,890	NA	NA	25,202,418	NA	15,164,114	60.17	4,258,074	16.9	3,123,961	12.4	2,656,269	10.5
1996	NA	NA	NA	23,578,872	NA	13,937,766	59.11	3,875,986	16.4	2,913,026	12.3	2,852,094	12.1
1995	9,959,575	NA	NA	20,675,548	NA	11,344,846	54.87	2,499,300	12.0	3,289,071	15.9	3,542,331	17.1
1994	9,884,264	NA	NA	11,334,359	NA	4,994,863	44.07	2,817,592	24.8	1,764,522	15.5	1,757,382	15.5
1993	9,807,033	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
1992	9,706,546	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
1991	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
1990	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
1989	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
1988	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

[a] All population figures are from TCU (1992-2011); [b] Municipal PSF figures are from SIAB (1994-2011); All other figures are from SIA (1994-2011);All other fields are the author's calculations; NA = data were not available or could not be accessed by the time of writing

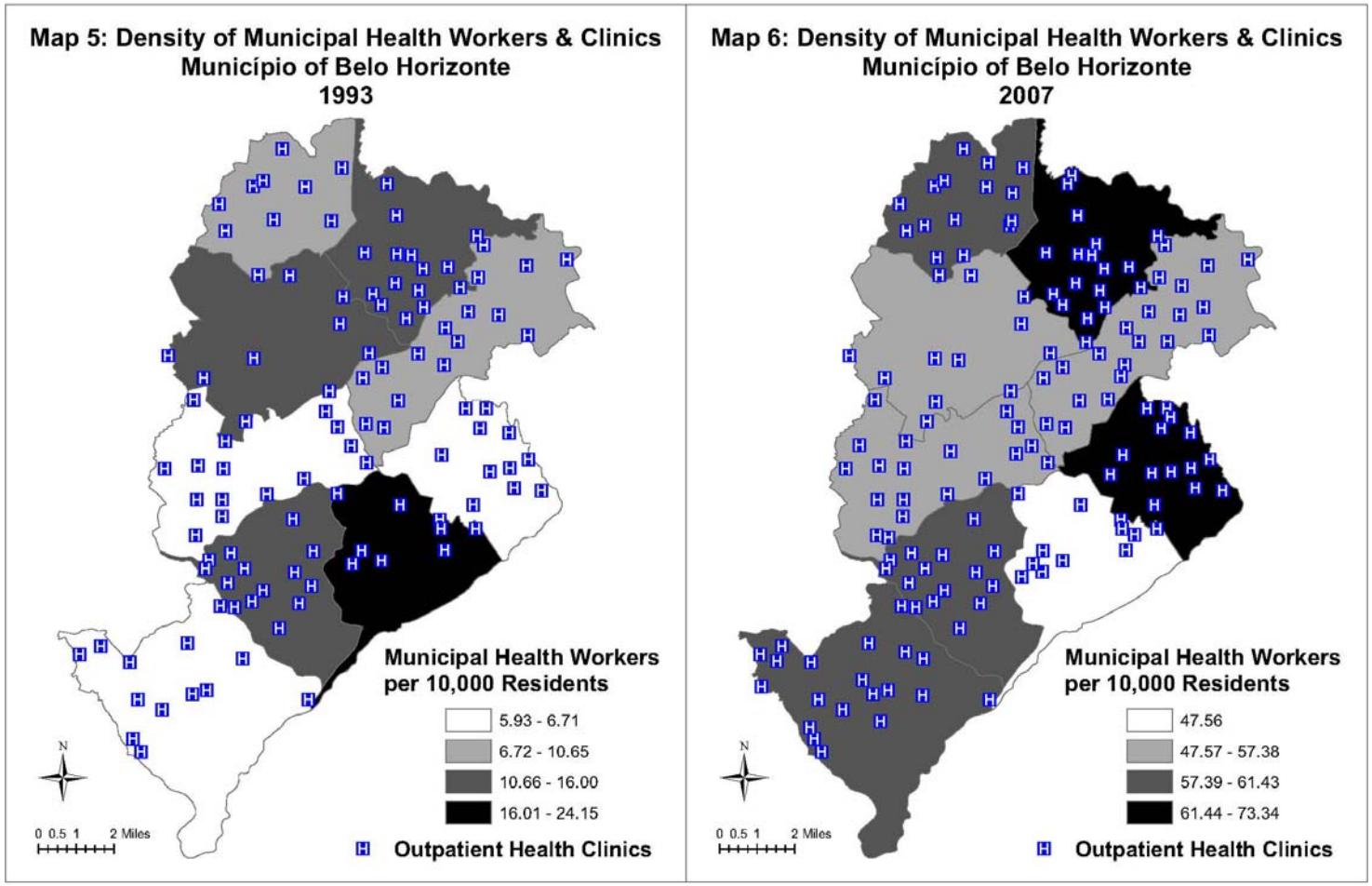
Appendix 1 Table 7. Number of Family Health (PSF) Teams			
Year	Município		
	Belo Horizonte	Porto Alegre	Rio de Janeiro
2011	528	95	506
2010	504	95	266
2009	504	93	165
2008	497	93	128
2007	484	92	131
2006	501	90	118
2005	504	82	96
2004	445	62	57
2003	382	63	23
2002	473	56	23
2001	382	43	0
2000	0	61	0
1999	0	30	0
1998	0	11	0
1997	0	30	0
1996	0	24	0
1995	0	0	0
1994	0	0	0

APPENDIX 2

MAPS ON HEALTH CLINICS AND WORKERS IN BELO HORIZONTE MUNICÍPIO



APPENDIX 2, CTD.


Map 5: Density of Municipal Health Workers & Clinics
Município of Belo Horizonte
1993
Municipal Health Workers
per 10,000 Residents
5.93 - 6.71
6.72 - 10.65
10.66 - 16.00
16.01 - 24.15
Outpatient Health Clinics
N
0 0.5 1 2 Miles
Map 6: Density of Municipal Health Workers & Clinics
Município of Belo Horizonte
2007
Municipal Health Workers
per 10,000 Residents
47.56
47.57 - 57.38
57.39 - 61.43
61.44 - 73.34
Outpatient Health Clinics
N
0 0.5 1 2 Miles

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