

## Federative coordination and decentralization: Brazilian experience in health

Descentralização e coordenação federativa:  
a experiência brasileira na saúde

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**Abstract** *This article deals with intergovernmental relations in health within the 20 years of implantation of the Unified Health System (SUS), in the light of the historical course of Brazilian federalism and its implications to health. Initially, a theoretical-conceptual review was carried out on the topic of federalism, social welfare and federative coordination of health, considering the international debate and the historical analysis of the Brazilian case. Following the article analyzes the federal performance in the intergovernmental coordination of national health policy during the period of implantation of SUS, based on a research about the role of the Brazilian Ministry of Health from 1990 to 2002, which involved documental analysis and interviews with federal officials and other key actors in national politics. It was observed that health policies registered, in the past 20 years, changes in five relevant aspects that characterize federalism: institutional arrangements and rules for decisions in the federal government; the set of territorially based actors; legal arrangements to define responsibilities among government levels; intergovernmental fiscal transfer arrangements; informal arrangements among governments - vertically and horizontally.*

**Key words** *Unified Health System, Intergovernmental relations in health, Federalism and health, Health decentralization, Ministry of Health*

**Resumo** *O artigo aborda as relações intergovernamentais em saúde nos vinte anos de implantação do Sistema Único de Saúde, à luz da trajetória histórica do federalismo brasileiro e de suas implicações para a saúde. Inicialmente faz uma revisão teórico-conceitual dos temas federalismo, proteção social e coordenação federativa na saúde, considerando o debate internacional e a análise histórica do caso brasileiro. A seguir, analisa a atuação federal na coordenação intergovernamental da política nacional de saúde no período de implantação do SUS, a partir de uma pesquisa acerca do papel do Ministério da Saúde brasileiro de 1990 a 2002, que envolveu análise documental e realização de entrevistas com dirigentes federais e outros atores da política nacional. Observou-se que a política de saúde registrou nos últimos vinte anos mudanças em cinco atributos relevantes para a caracterização do federalismo: os arranjos institucionais e regras para decisões no governo federal; o conjunto de atores com base territorial; os arranjos jurídico-legais para definir responsabilidades entre níveis de governo; os arranjos fiscais intergovernamentais; os arranjos informais entre governos, verticais e horizontais.*

**Palavras-chave** *Sistema Único de Saúde, Relações intergovernamentais em saúde, Federalismo e saúde, Descentralização em saúde, Ministério da Saúde*

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## Introduction

Brazilian health policy has gone through deep changes in the past 20 years related to transformations in its structure and in the role of the State and to the implementation of the Unified Health System (SUS).

The main characteristic of the previous health policy had been institutional fragmentation, caused by the existence of two federal ministries carrying out the policy, the subordinate role of states and municipalities, the privatization of the health services delivery and the weak regulatory power of the State.

Brazilian State - between the 1930s and the 1980s, period in which this health system was hegemonic - had a central role in the implementation of policies aimed at consolidating national development based on industrialization, with participation in the productive sector and in the financial intermediation, under tax and administrative centralization. The social policy of the time was highly directed to work regulations and it was dependant on economic development.

The context in the 90s was different, characterized by a period of economic decline with fiscal adjustment and an increase in unemployment rates, as well as fast demographic and epidemiologic changes. The new concept impelled renovations in the structure and in the operation mode of the national State and social policies, affecting federative institutions and intergovernmental relations.

Before this, amid Brazilian redemocratization, the health sector reform movement suggested the creation of a unified health system, which would be universal and have the participation of the three governmental levels in policy formulation and implementation, as written in the 1988 Constitution.

As a result, in the 1990s, the Ministry of Health went through a process of political-institutional redefinition, starting from two simultaneous movements: the unification of the national control over policies and the political-administrative decentralization.

The first movement implied the effort of horizontal unification of control by means of a structure comprising a single national sanitary authority. Decentralization, on the other hand, strengthened sanitary authorities - at state and municipal levels - by a process that involved several rounds of negotiation, generating several forms of partitioning power and resources among the three government levels.

It is important to highlight that the federative issue is not new in the health policy matter. There has been a wide experience with federative models in health since the institution of Republic; these un-

derstood as forms of relation among government levels in the public service provision, with different degrees of centralization and decentralization involving horizontal and vertical tensions.

Even if the federative issue has always been present in Brazilian health policies, it assumes a different importance in the 1990s. The SUS implementation reveals the effort to strengthen a national policy in a federative and democratic context, expressed in the institutional configuration of the system and in the decentralization process regulation.

This article deals with the federative coordination of Brazilian health policy in the 1990s, focusing on the action of the Ministry of Health, which has been underexplored in the literature of the field. In order to do this, it brings forward a theoretical-conceptual review of federalism, federal role and federative coordination of health, based on international debate and on the discussion of the Brazilian case in a historical perspective. Following, it presents the research methodology concerning the role of the ministry from 1990 to 2002, which substantiates the SUS federative coordination analysis. The fifth session of the article deals with research results. Finally, the challenges for the consolidation of federative coordination of health are discussed.

## Federalism and the Role of National State in Health Policy

Decentralization is a remarkable phenomenon in the recent processes of State reforms<sup>1</sup>, presenting particularities in federations which vary according to the country's characteristics, the federative model and the political areas.

Even though there are slightly over twenty federations formally known, there is a great diversity of historical course and political-institutional configuration among the group of countries that fit this description. The constitutional-legal framework is not enough to characterize federations, being also necessary to consider the process of public policies implementation to understand the nature and specificities of federative regimes<sup>2</sup>.

Examining the influence of federalism in social policies according to the expenditure and extension of coverage was stressed in macro-quantitative studies in the 1970s, which mostly suggested that federalism had hindered the expansion of social policies, for tax and institutional reasons.

This kind of exclusively quantitative approach was contested by Obinger *et al.*<sup>3</sup>, who investigated the complex relations between types of federalism and social policies models, based on historical anal-

ysis of intentionally chosen countries. Such study, which investigates the mutual characteristics and influences of combinations between State structure and social policies, advocates that it is necessary to separate two different periods: the “golden age” and the “new politics” of *Welfare State*, since the research on the social policies dynamics of the golden period doesn't offer great lessons to understand the present period. Looking at the relation between State structure and social policies is different in each moment, as it is different to examine this relation in secular or recent federations.

In view of the imprecision concerning the concept of federalism, the authors describe federations based on their institutional characteristics, which would be a set of: arrangements and rules for the decisions of the central government so as to incorporate territorial interests, which differ as to the right of veto of subnational governments; territorially based actors with varied ideas and interests; legal arrangements to define responsibilities among levels of the government; arrangements for intergovernmental tax transferences; informal arrangements among governments, both vertical and horizontal<sup>3</sup>.

Thus, federalism does not represent a single institutional arrangement, it conforms several types which may comprise different degrees of centralization and decentralization.

Regarding the relations between State structure and social policies, the study advocates that the design of the federative institutions and the power resources of the actors involved are important factors in the definition of a specific type of arrangement. The different courses and characteristics of the social welfare systems in countries may influence the conformation of distinct federative arrangements, in a two-way relation, since the Welfare State can be a key element of the state intervention model and of the operation of the federative structure<sup>3</sup>. The authors conclude that only a historical approach can establish the interconnections between the type of federalism and the social policy model, which justifies the approach adopted in this article.

Another issue, of a controversial nature, is the debate on federalism motivated by world transformations in the last decades. Authors identify in federative systems, interesting elements to deal with the complexity of contemporary societies, such as institutional flexibility which allows *ad hoc* adjustments in the processes of planning and decentralizing public policies<sup>5</sup> and the fact that federation opposes regional identity and national equality.

Comparative studies have investigated the challenges of national coordination of health policy in federations that have been going through decen-

tralization processes<sup>6,7</sup>. Banting *et al.*<sup>6</sup>, when comparing the federalism implications in health policies of five countries, considered as relevant variables the national policy framework and formulation process. France<sup>7</sup>, on the other hand, claims that the challenge of creating a national health system in a federative country is reflecting the heterogeneity of regional needs and at the same time reducing the inequalities to achieve national citizenship.

### Centralization, decentralization and federative coordination in Brazil in a historical perspective

The Brazilian federalism origin in the republican Constitution of 1891 was related to the idea of allowing greater decentralization and autonomy for the regional elites, keeping together members that could aspire to existence as independent political-territorial units<sup>8</sup>. From that moment, the alternation between periods of centralization and decentralization has been mentioned as a historical trait of Brazilian federalism, consisting in a pendular movement that studies relate to authoritarian regimes or to democratic order.

The oversimplified view of such association, though, was questioned by authors that have warned about the asymmetrical character of the centralization-decentralization movement and the need to understand the continuity elements in these processes. For Kugelmas *et al.*<sup>9</sup>, instead of a complete annulment of previous institutional mechanisms of each pendular movement, what happens is a change in the pattern of the relationship between the levels. Recent studies have discussed that centralization processes are possible even during democratic periods, which would be the main attribute of the present State<sup>10</sup> policy.

In health, the federative issue has taken a long course and different federative models can be identified in a historical perspective, understood as relationship patterns among government levels in the provision of health services, based on specific alliances. For this reason, considering the historical-structural singularities of federalism and the course of health policy in Brazil is important in the discussion of the recent period, so as to learn about continuities and ruptures with previous patterns.

The federative issue was present both in the hegemonic period for the First Republic public health model and in the conformation of the dual and fragmented model post-1930, period in which two federal ministries shared duties in the provision of health services.

In the First Republic, the absence of a strong State to face public health challenges of the time - such as endemic and epidemic diseases, called by Hochman<sup>11</sup> sanitary interdependence problems - was questioned, placing public health fate in the hands of states and municipalities lacking power and organization, controlled by private interests. On the other hand, the authoritarian bias of a policy strongly anchored on the federal government was criticized.

The public health and welfare model of the First Republic, analyzed by Hochman<sup>11</sup>, displays a solution for the federative issue, included in the political-constitutional order established in 1891. For the author, due to the health reform claims that linked the constitution of nationality to the overcoming of endemic diseases and great debates on the solutions for sanitary problems, the health services were redesigned and expanded. The states were granted with the federal support by means of agreements for health and sanitary actions. That made feasible the central government's action in the states, without harming their autonomy, consisting in a "co-operative formula" which made possible the State's power expansion all over the national territory.

After 1930, a reorganization asserted the State power and the nationalization of the policy and a stratification was consolidated in the health system model, founded on the division and distribution between two ministries - Education and Public Health (MESP) and Labor, Industry and Trade (MTIC)<sup>12</sup>.

Since the medical care welfare policy carried out by the MTIC was aimed at formal wage-earners in urban centers, MESP's universal policy, which considered health a public asset, should take care of the populations that lived outside urban centers. MESP's policy was created based on the relation between local powers and federal government. The expansion of health services for those not protected by social security was made possible because of the relation between the representatives of the federal public power and the holders of local-regional powers, associated to the states. In the field of public health, facing the federative issue became crucial to define the model for provision of health services<sup>12</sup>.

In the beginning of the 1960's, the discussion about a new federative arrangement was given impetus and decentralization with a municipal emphasis was defended at the 1963 National Health Conference.

In the authoritarian period - from 1964 to mid 1980s - federative issue was resolved in a diverse fashion, with an impetus to concentrate the financial and normative power in the Union. Such move-

ment was strengthened by the dominance of the social security model, highly centralized and administrated by federal government agencies.

In the 1980s, the association between democracy and decentralization of policies gains strength and is translated in the 1988 Constitution, which redesigns State structure under a decentralized federation logic, emphasizing the role of the municipalities.

On the other hand, despite the 1988 Constitution, with a decentralization style for political forces involved in the redemocratization and with decentralization measures in several areas, Almeida<sup>10</sup> argues that the State model formed in the last twenty years is based on a strong national center, with decision capability and plenty of resources to regulate on subnational levels and markets. Such model is anchored, in part, in the legacy of the modernization process conducted by the State in the 20th century, in the recent institutional rules and in a belief of the importance of the ruling role of the federal Executive branch, which had conditioned the preferences of relevant political players.

Expressions of this model are registered in social policies, such as the federal normative capacity, the incentives linked to specific programs and the decisive role of the federal government in the definition of cooperation terms among levels of the government<sup>10</sup>. Thus, the recent experience of creating a new federative pact reveals that the national Executive branch is still very important in planning and regulating public policies.

This is not compatible with the sector policies of decentralization, since as Abrucio<sup>13</sup> points out, decentralization requires a national project and the building of new capacities for subnational governments and for the federal government itself, which must be qualified to transfer the functions and practice of a coordinating role. For the author, **federative coordination** consists in forms of integration, sharing and decision present in federations, which express through: local rules that force players to share decisions and tasks; forums and political mechanisms of intergovernmental negotiation; operation of representative institutions; the coordinating and/or inducing role of the federal government.

Therefore, the SUS implementation was characterized by a complex process: the federal centralization allowed a decentralization policy with a federal dominance in terms of norms, financial incentives and other instruments of national induction. Decentralization, on the other hand, was supported by social and political players of subnational levels who were strongly organized and by federal administrators in specific periods.

The model shaped in the last two decades, in which a general centralization movement and sectorial decentralization processes were combined, required the adoption of intergovernmental coordination strategies in the federal level.

## Methodology

The research which informed the analysis on federative coordination of health policies in Brazil, aimed at characterizing the role and operation of the Ministry of Health in the direction of the national health policy from 1990 to 2002. The focus of historical neoinstitutionalism<sup>14,15</sup> was adopted because of the acknowledgement of the importance of state institutions and power relations in health policy. In federations, it is important to consider the repercussions of responsibility definition and the articulation mechanisms among government levels for public policies<sup>8</sup>, besides institutional aspects (sectorial course) or political ones (players chosen in a certain scenery).

The research emphasized both historical-structural and institutional issues that had an effect over the characteristics of the process of health decentralization and the logic of federal intervention in the period, and the importance of the ideas in policy planning<sup>16</sup>. The analysis category adopted was the officials view about the federal role in federative coordination, attempting to discuss a possible influence of the key actors' views in how the Ministry of Health performed.

The methodology strategies used were:

- For the characterization of the decentralization process and federal performance: literature review, document analysis (federal documents and norms); analysis of primary data provided by the Ministry and secondary data from health information systems;

- For the identification of the officials' views about federative coordination: semi-structured interviews with selected people according to criteria such as formal position, institutional power and period of professional experience at the federal level, being: thirteen federal administrators (ministers and secretaries of the first rank); three federal officials that filled key positions related to decentralization; five representatives of states or municipalities that worked in the National Council of Health Secretaries (CONASS) and/or National Council of Municipal Health Secretaries (CONASEMS).

## Results

### Decentralization process and federal performance in health

In the 1990s, decentralization was a-priority in the national health agenda<sup>17,18</sup>, being a frequently mentioned sector because of its achievements in the area of decentralization, allied to the effort to constitute a new federative arrangement.

The ministerial administrations in the period differed as to the dimension of the decentralization prioritized, being possible to identify moments of decentralization that display both varied forms of federal regulation and performance of the Ministry of Health, and the force of different ideological matrixes associated to the issue of decentralization. This because, besides the matrix that associates decentralization to democratization and the changes in public administration in a federative logic, the emphasis in the introduction of market mechanisms and privatization can be seen in specific contexts such as decentralization processes.

The pace and intensity of decentralization in health from the federal level to states and municipalities in Brazil varied according to four dimensions, represented by the transference of: services and public staff; responsibilities and attributions; financial resources; power over health policy. The decentralization pace also differed among the fields of policies (health care, epidemiologic surveillance or sanitary regulation). It is also possible to identify differences as to strategies, criteria and "target-level" of the decentralization process (municipalities or states).

The analysis of the decentralization process in the light of the political-institutional context and the variables indicated allow us to identify different moments of decentralization and characteristics of the federal performance throughout the 1990s, as summarized in Chart 1.

Thus, health decentralization between 1990 and 2002 was influenced by different political contexts and presented variable adherence to more general State reform agendas, having continuance traces and inflections between ministerial administrations.

In the first half of the 1990s, the decentralization process reflects the 1980s struggles against the centralization of the authoritarian period. In the case of health, given the existence of a national organization to represent municipalities (CONASEMS), this influence stretches until today.

**Chart 1.** Characteristics of the decentralization process directed by the Ministry of Health from 1990 to 2002.

Period	Degree of decentralization by dimensions				Fields	Level of government-focused
	Services and staff	Attributions	Financial resources	Decision power		
Fernando Collor Government 1990-1992	High	Medium	Low	Low	Health Care	Municipalities
Itamar Franco Government 1993-1994	High	Medium	Low	Medium	Health Care	Municipalities
Fernando Henrique Cardoso Government 1995-1997	Medium	Medium	Medium	Medium; High (few municipalities)	Health Care	Municipalities
Fernando Henrique Cardoso Government 1998-2000	Medium	High	High	Medium	Health Care Epidemiologic Surveillance Sanitary Regulation	Municipalities/ States
Fernando Henrique Cardoso Government 2001-2002	Medium	High	High	Medium	Health Care Epidemiologic Surveillance Sanitary Regulation	States/ municipalities

it continues

The opposition of the municipalist movement to the centralization of resources and to a strong federal role in the regulation affected health decentralization conceptions, especially in the mid 1990s.

In the second half of the decade, especially after 1998, decentralization was connected to health services regional organization induction strategies. The decentralization process was extended to the areas of epidemiologic surveillance and sanitary regulation, under strong federal regulation. Efforts to recover the role of the state government level were intensified. The operational norm in force attempted to change previous conceptions of decentralization, imposing a new redistribution process of resources, a new primary health care model – the Family Health Program – and strategies to reinforce systemic rationality<sup>18</sup>. New resource transference mechanisms (per capita and for specific programs) were suggested and instruments were adopted to create a new intergovernmental arrangement, allowing states to have more space. Some regions (north and northeast) and levels of care

(primary health care), barely present in the discussions of the first half of this decade were prioritized. In this period, there is an attempt to replace a vertical federalist arrangement between the Union and the municipalities for a horizontal one: inter-regions, intermunicipalities and interstates.

In this context of redefining intergovernmental relations in health, the role of the federal health authority becomes strategic since it is evident that he should act as a coordinator and compensator of inequalities. The issue of federative coordination becomes very important, as a counterpoint to the concept of decentralization as a unidirectional movement from the federal government to the municipalities.

A different matter is related to the political-institutional and financial condition in which decentralization occurs, which takes us to the analysis of gaps in the federal performance of federative coordination. This is not a simple matter, since the main reason that favors the emphasis on decentralization in health policy has been the establish-

Chart 1. continuation.

Period	Main decentralization strategies and instruments in force	Type of decentralization	Federal functions emphasized
Fernando Collor Government 1990-1992	Basic Operational Norms in 1991 and 1992 Municipalization agreements Terms for health services transfers	Tutored decentralization for the municipalities	Financing (payments), control, inspection.
Itamar Franco Government 1993-1994	Basic Operational Norms in 1993 Federal conditional financial transfers Terms for health services transfers	Preparing for "full" municipalization	Financing, negotiation, intergovernmental articulation, decentralization promotion, support to states and municipalities
Fernando Henrique Cardoso Government 1995-1997	Basic Operational Norms in 1993 Federal conditional financial transfers	Municipalization with direct intergovernmental transfers Formulation of the following model	Policies formulation and induction, financing, coordination, and regulation
Fernando Henrique Cardoso Government 1998-2000	Basic Operational Norm in 1996 Other federal norms Federal conditional financial transfers Primary health care <i>per capita</i> transfers Incentives to specific health programs	Decentralization with strong federal induction; massive municipalization of primary health care and attempt to recover the role of the states Formulation of the following model	Policies formulation and induction, financing, regional organization induction and regulation
Fernando Henrique Cardoso Government 2001-2002	Operational Norm for Health Care Other federal norms Federal conditional financial transfers Primary health care <i>per capita</i> transfers Incentives to specific health programs	Decentralization with regionalization under strong federal regulation; recovery of the role of states Decentralization by partitioning functions	Policies formulation and induction, financing, regional organization induction and regulation.

Source: Elaborated by the authors.

ment of a great consensus on the topic since the end of the 1980s, even if influenced by different ideology matrixes and political agendas<sup>19</sup>.

This way, the decentralization process in SUS, emphasized as a priority strategy and advancing even in adverse conditions, expresses the contradictions between the broad agenda of health sector reform and the liberal State reform agenda hegemonic in the 1990s, since both influenced health policies.

That is, the decentralization progress highlights structural problems of the SUS as well as gaps in the federal government action, related to the adverse political and economic context in which the health policy was implemented.

The operation gaps of the Ministry of Health in federative coordination are linked to the absence of a comprehensive investment policy, which is not restricted to health, but relates to the characteristics of the macroeconomic policy in the period and

its effect in social policies. Not creating a new national development project in the democratic context and the dominance of practices that prioritize the market constitute obstacles for an integrated national plan and for the investment in several sectors<sup>20,21</sup>. Some expressions of this in health are: the frailty of federal planning and investment; the scarce consideration of regional diversity and of particularities of metropolitan regions in the design of decentralization strategies; fragmentation and insufficient articulation with other economic and social public policies.

In summary, from 1990 to 2002, there was a political-administrative decentralization process in health never seen before, under the regulation of the Ministry of Health. The characteristics of this decentralization in the different moments conditioned and were conditioned by the redefinition of the federal role in the period. The federal performance gaps in federative coordination, related to more general issues regarding the performance of the State and the different reform agendas in progress, defined the possibilities of health decentralization.

#### **Federative Coordination in the view of the Ministry of Health officials**

The interviews with federal health officials showed that a frequent reference to explain the role of the Ministry of Health is the Brazilian federative system. All the interviewees mentioned the role of the ministry in federative coordination of health policy, highlighting the challenges of articulating sectorial actors and/or dealing with the country's heterogeneity.

However, there were differences in the perspectives of how this coordination should be carried out. In the interviews with officials from the first ministerial administration of the period studied - Alcení Guerra's, from 1990 to the beginning of 1992 - it wasn't possible to identify a clear view of the federal role in federative coordination. This seems to relate to the initial character of the SUS implantation, in the adverse context of Collor's government, in which health decentralization was restricted to the transference of staff and service to other levels of government, under unfavorable political and financial conditions. The interviewees mentioned the relation between the administrative reform in Collor's government and health decentralization, as well as the initial character of SUS implantation, as factors that hindered the definition of a new federal role in the period.

In the subsequent administrations, the federative issue was more strongly placed for the Minis-

try of Health. The research identified three different views on the role of the Ministry in federative coordination, which were related to the different ministerial administrations. The first view emphasized the federal role in promoting decentralization/municipalization and in supporting the states and municipalities. The second one focused the federal role as a national coordinator, face to the challenges of the federative pact, decentralization and partitioning of attributions among government levels. The third view emphasized the federal stewardship, normative and regulation roles.

The first view was the dominant one among officials in the Haddad/Santillo (1993/1994) and Albuquerque (1997) administration. In the speech of this group of officials that emphasize the role of Ministry in promoting decentralization and supporting the states and municipalities, it is common to hear criticism to power's concentration in the federal level, carried out by means of excessive norms or conditional financial transfers. The officials in the Albuquerque administration, active in the context of Fernando Henrique Cardoso's government, in which the debate on State reform reached its climax, were more emphatic about the need to reduce the action scope of the Ministry of Health.

The second view of federative coordination - represented by the emphasis on the federal coordinator role face the challenges of intergovernmental division of attributions and articulation - was clearer among officials from the Jatene administration (1995-1996). Such officials pointed out the complexity of the federative arrangement and the process of establishing intergovernmental alliances, highlighting its essential character for the implementation of health policies.

A third approach regarding federative coordination was observed among officials from the Serra-Negri period (1998-2002) who emphasized the role of the Ministry of Health in inducing policies and in regulating the decentralization process. The officials in this group highlighted the role of federal norms and financial mechanisms in the federative coordination.

Even if the attributions underlying the three views of the ministry's role in federative coordination are not conflictive or incompatible - support to other government levels, articulation with division of attributions and federal induction / normalization - the results suggest a association between the predominance of a certain view, the *modus operandi* of the different ministerial administrations and the characteristics of the decentralization process in the different moments of the period studied.



## Discussion

The relations between federalism and health policies in the Brazilian case can be analyzed in the light of two aspects emphasized by *Obinger et al.*<sup>3</sup>. The first is recognizing two-way relations between the type of federalism and the characteristics of the welfare system in a specific country. The second is the importance of specific contexts in which such relations occur, considering structural variables and their dependence on the historical moment (path dependence).

The course of federalism in Brazil shows an association between the federative issue and the construction of a National State, with the presence of a strong federal Executive branch in several moments (especially as of 1930), conforming different federative arrangements<sup>9</sup>. As to social policies, the federal Executive branch's action was remarkable to constitute a welfare system, characterized by the centralization of decision, finance and administration<sup>22</sup>, with occasional transference of attributions to sub-national levels. In Brazilian history, federalism was not an "independent" variable that conditioned the government's actions. Instead, it displayed traces of a state intervention model in most part of the 20th century, characterized by a power concentrating federal Executive branch which, however, even in authoritarian periods, didn't completely destroy the foundations of a federation.

In the 1990s, some important changes were observed in the Brazilian State carried out by the 1988 Constitution in a democratization and economic liberalization context. Such changes were expressed in two poles: federalism and social welfare. Considering the type of federalism, the changes were propelled by consensus referring to decentralization, supported by different ideologies. In what regards to the social welfare, they were conditioned both by the logic of expansion of rights related to the Social Security proposal and by the restrictions imposed by the liberal agenda to the increase in state activity and public expenditure.

Health policy represents a fertile field to analyze such relations, since it has shown, in the past two decades, transformations in social welfare and federative perspectives, in a scenario influenced by political agendas with different meanings. In this context, it is relevant to understand how the changes produced in both ends are related and included in a more general movement of State transformation.

The SUS institution brought about a rupture with the previous health system model, especially by recognizing health as a citizen's right and the State's duty, to be secured by extensive economic and social policies.

Due to decentralization in health policies, changes in the five conditions that characterize federalism have been registered in the last 20 years, highlighted by *Obinger et al.*<sup>3</sup>: institutional arrangements and rules for national decisions so as to include territorial interests (by means of intergovernmental commissions for health); the set of territorially based actors involved in the policy formulation and implementation (by the increase of local administrators and health counselors); legal arrangements to define responsibilities among government levels (health laws and federal norms); intergovernmental financial transfers arrangements (changes in the federal transfers and in the participation of government levels in health expenses); informal arrangements among governments - vertical and horizontal (relations between SUS officials and public administrators).

There are continuities and discontinuities in the national direction of decentralization and in the mechanisms of federative coordination of health. Among the elements of continuity, the strong federal presence in the period is highlighted, related to more general characteristics of Brazilian State, such as the predominance of the federal Executive branch<sup>10</sup>. In health, this was expressed as the preponderance of the Ministry of Health in the regulation of decentralization by means of national rules negotiated with other levels of government, even if with power asymmetries in the intergovernmental relations.

On the other hand, there were variations in decentralization strategies, associated to movements aimed at restructuring the Ministry of Health's functions. Characteristics of the decentralization process in the different moments were influenced by aspects of political context and by different views on federal role in the coordination of health policies.

In the early 1990s, in the beginning of the SUS implantation, decentralization was pressured by Collor government's reforms, being translated as the transference of services and staff to other levels of the government, without the correspondent redistribution of resources and power. The adverse context, as well as the incipient bases of the new health system, hindered a clear view on the federal role in federative coordination of health.

In subsequent ministerial administrations, the intergovernmental coordination issue is more explicit. The three views on the federal role in federative coordination can be explained by aspects of the national context or can be backed by international literature.

This is how the first view - emphasis on decentralization promotion and on support to states

and municipalities - is characteristic of the country's context in the 1990s, distinguished by a combination of: emphasis on decentralization associated to democratization and to the strength of the municipalist movement; changes in the federalism rules; concomitance of the progressive health system reform agenda and the State reform liberal agenda, which adopted decentralization guidelines under different ideological matrixes.

The second view, which emphasizes the federal coordinating role facing the challenges of sharing and dividing responsibilities translates the dilemmas related to the essence of federalism itself: maintenance of unity amid diversity and the search for common rules for federative balance. Some officials defended a better division of attributions among the different government levels - even recognizing the existence of common competences - and the legitimacy of federal authority to politically and technically coordinate the federative articulation process.

The third view on the federal role in federative coordination, which emphasizes induction and normalization of policies, brings elements valued in international studies, such as the weight of national policy detailing and of the federal resources attempting to conform national sanitary standards. The logic of intense federal regulation in health, hegemonic in the end of the 1990s, is coherent with the

general movement of restructuring a strong central power, which has characterized public policies in the past twenty years<sup>10</sup> and was also mentioned by authors who studied the national health policy<sup>23-25</sup>.

In the SUS implantation, there were changes related to the horizontalization of the intergovernmental negotiation and conflicts in health. However, there is still the challenge to shape a federative coordination logic that values existing institutional channels and that favors reaching health policy goals of fighting inequalities and promoting national citizenship. At the same time, it is important to assure a certain flexibility to implement policies according to different territorial and social realities. Besides the changes in the federal role, it is necessary to restructure the state level role, which was limited by the emphasis on municipalization in the first twenty years of SUS.

If in the adverse conditions of the 1990s, the fight for the health reform ideals resulted in a resistance effort and in a relative (though unreal) isolation of the health policies from the liberal reform agenda, now the context is different. Today, the achievement of health as a citizen's right depends on facing the structural distortions of the Brazilian health system and on adopting a more comprehensive development and social welfare project. This is the main challenge posed to the State's role in health in the Brazilian federation.

### **Collaborators**

ALd'A Viana and CV Machado have participated to an equal extent in the preparation of the present article.

## References

1. Dente B. Governare in un contesto federale: quali lezioni per la transizione italiana? In: Dente B *et. al. Governare con il federalismo*. Torino: Fondazione Giovanni Agnelli; 1997. p. 1-37.
2. Watts R. *Comparing federal systems in the 1990s*. Kingston, Ontario: Queen's University; 1999.
3. Obinger H, Leibfried S, Castles F. *Federalism and the Welfare State*. Cambridge: Cambridge University Press; 2005.
4. Pierson P, editor. *The new politics of the Welfare State*. New York: Oxford University Press; 2000.
5. Sharpe J. Federalismo e decentralizzazione nel moderno stato democratico. In: Dente B, curatore. *Governare con il federalismo*. Torino: Fondazione Giovanni Agnelli; 1997. p. 39-62.
6. Banting K, Corbett S. Federalism and health care policy: an introduction. In: *Health Policy and Federalism Workshop*. 2001 Oct 15-16; São Paulo, Brazil.
7. France G. Compatibilità fra il federalismo e gli standard sanitari nazionali. In: France G. *Federalismo, regionalismo e Standard Sanitari Nazionali*. Milano: Dott. A. Giuffrè Editore; 2001. p.169-197.
8. Almeida MHT. Federalismo, democracia e governo no Brasil: idéias, hipóteses e evidências. *Revista Brasileira de Informação Bibliográfica em Ciências Sociais* 2001; 51:13-34.
9. Kugelmas E, Sola L. Recentralização/Descentralização - dinâmica do regime federativo brasileiro nos anos 1990. *Tempo Social* 1999; 11(2):63-81.
10. Almeida MHT. O Estado no Brasil contemporâneo. Um passeio pela história. In: Melo, CR, Sáez MA, organizadores. *A democracia brasileira. Balanço e perspectivas para o século XXI*. Belo Horizonte: Editora UFMG; 2007. p. 17-31.
11. Hochman G. *A era do saneamento: as bases da política de saúde pública no Brasil*. Rio de Janeiro: Hucitec/ANPOCS; 1998.
12. Fonseca CMO. *Saúde no Governo Vargas (1930-1945): dualidade institucional de um bem público*. Rio de Janeiro: Fiocruz; 2007.
13. Abrucio FL. A coordenação federativa no Brasil: a experiência do período FHC e os desafios do governo Lula. *Rev. Sociol.Polít.* 2005; 24:41-67.
14. Thelen K, Steinmo S. Historical institutionalism in comparative politics. In: Thelen K, Steinmo S, Longstreth F, editors. *Structuring Politics. Historical Institutionalism in Comparative Analysis*. Cambridge: Cambridge University Press; 1992. p.1-32.
15. Hall PA, Taylor RCR. As três versões do neoinstitucionalismo. *Lua Nova* 2003; 58:193-224.
16. Weir M. Ideas and the politics of bounded innovation. In: Thelen K, Steinmo S, Longstreth F, editors. *Structuring Politics. Historical Institutionalism in Comparative Analysis*. Cambridge: Cambridge University Press; 1992. p.188-216.
17. Levcovitz E, Lima LD, Machado CV. Política de saúde nos anos 90: relações intergovernamentais e papel das normas operacionais básicas. *Cien Saude Colet* 2001; 6(2):269-291.
18. Viana AL, Lima LD, Oliveira RG. Descentralização e federalismo: a política de saúde em um novo contexto - lições do caso brasileiro. *Cien Saude Colet* 2002; 7(3):493-507.
19. Viana AL. *Sistema e descentralização: a política de saúde no estado de São Paulo nos anos 80* [tese]. Campinas (SP): Universidade Estadual de Campinas; 1994.
20. Fiori JL. Para ler a vitória de Lula. *Princípios* 2002/2003; 67:16-18.
21. Sallum Jr. B. Crise, democratização e liberalização no Brasil. In: Sallum Jr. B, organizador. *Brasil e Argentina hoje: política e economia*. Bauru: EDUSC; 2004. p. 47-77.
22. Draibe SM. *O Welfare State no Brasil: características e perspectivas*. Campinas: NEPP/UNICAMP; 1993. [Caderno de Pesquisa n. 8]
23. Arretche M. Financiamento federal e gestão local de políticas sociais: o difícil equilíbrio entre regulação, responsabilidade e autonomia. *Cien Saude Colet* 2003; 8(2):331-345.
24. Baptista TW. F. Análise das portarias ministeriais da saúde e reflexões sobre a condução nacional da política de saúde. *Cien Saude Colet* 2007; 23(3):615-626.
25. Machado CV. O modelo de intervenção do Ministério da Saúde nos anos 90. *Cad Saude Publica* 2007; 23(9):2213-2126.

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