The crisis of cooperative federalism in the health policies in Brazil

A crise do federalismo cooperativo nas políticas de saúde no Brasil

José Mendes Ribeiro[1], Marcelo Rasga Moreira[2]

ABSTRACT This article analyzes the main aspects of federative political systems according to classical and contemporary theories and the case of the Brazilian health sector. Brazil presents a federative configuration founded on cooperation as a result of the democratic transition in which the consensual dimensions of democracy were strengthened. On the other side, the weakening of the madisonian aspects of separation of the functions and judicial review compromised the policy coordination and the accountability in health policy. It is argued that cooperative aspects are compromised by the singularity of municipalities with federative power without the creation of compensatory institutions of the competitive deficits.

KEYWORDS Federalism. Unified Health System. Public health policy.

RESUMO *Este artigo analisa os aspectos principais dos sistemas políticos federativos segundo teorias clássicas e contemporâneas e o caso do setor saúde brasileiro. O Brasil apresenta uma configuração federativa fundada na cooperação como resultado da transição democrática na qual foram fortalecidas as dimensões consensuais da democracia. Por outro lado, o enfraquecimento de aspectos madisonianos de separação de funções e revisão judicial comprometeu a coordenação política e a responsabilização na política de saúde. Argumenta-se que os aspectos cooperativos são comprometidos pela singularidade de municípios com poder federativo sem a criação de instituições compensatórias dos déficits competitivos.*

PALAVRAS-CHAVE *Federalismo. Sistema Único de Saúde. Políticas de saúde pública.*

[1] Fundação Oswaldo Cruz (Fiocruz), Escola Nacional de Saúde Pública Sergio Arouca (Ensp), Departamento de Ciências Sociais (DCS) – Rio de Janeiro (RJ), Brasil.
ribeiro@ensp.fiocruz.br

[2] Fundação Oswaldo Cruz (Fiocruz), Escola Nacional de Saúde Pública Sergio Arouca (Ensp), Departamento de Ciências Sociais (DCS) – Rio de Janeiro (RJ), Brasil.
rasgamoreira@gmail.com

 DOI: 10.1590/0103-11042016S02

Introduction

The federalism as an institutional arrangement has relevance for the analysis of policies in Brazil, not only for the obvious fact of configuring its political system, but for the commuter historical trajectory in which a smaller or larger centralization was associated with the different republican regimes. The variable federative configurations regarding the political cycles, in terms of degrees of autonomy of the state governors, resulted in a model that is unique among the main nations due to the tripartite distribution of powers between Union, states and municipalities, from the Constitution of 1988.

The concept of federalism follows the political, legal or fiscal theories that support the analyzes of several authors. Therefore, literature registers more the debate about modalities than an objective and direct definition. To allow a synthetic conceptual definition, Valeriano Costa (2007) highlights two models. One is the north american, in which preexisting states do not dissolve into a non-unitary State and that centralizes some of the power. The other model, which includes Brazil, follows the reverse path, where originally unitary States decentralize power to form a federation.

An important part of the debate about types of federalism revolves around legal and fiscal approaches. In this essay, however, the political dimensions will be highlighted and with emphasis on the dynamics of cooperation and competition and the mechanisms of institutional counterweights.

The basic ground of all federative arrangements is the goal of avoiding the tyranny of absolute power control in an individual, political fraction, or institution. This contrasts with unitary regimes, where concentration of decision and political accountability is the goal pursued, and the counterweights result from elective processes and legal institutions.

For the health sector, the institutional mechanisms of weights and counterweights – typical of the main federative arrangements in the world and with variations, in which different cases are highlighted, such as the north american and the germanic – and the dynamics between cooperation and competition – expressed in the Unified Health System (SUS) – represent, together with public sector financing, the main political issues related to the crisis of the cooperative federalism of the brazilian health system.

Since the Constitution of 1988, through the infra-constitutional legislation and, in a progressive and additive character, by the different Orders and Decrees of the federal government, more and more are emphasized the cooperative factors in the management of responsibilities and attributions among the federated entities. The relations between federalism and sectoral policies are, however, populated by controversies.

The inductive policies of regional cooperation stumble upon two major obstacles: (i) the open competition between state and municipal governors for resources, incentives and prerogatives in the provision and access to health services; and (ii) the dissemination of hundreds of multipartite institutions in the form of state and regional colleges which, for the exercise of effective power, should constitute hundreds of asymmetrical regional mini-governments and which have, largely, become powerful veto structures coordinated policies in the SUS.

Despite the goals of decentralization of the federative system are virtuous, although social virtues are also observed in unitary and centralized systems, in the context of the brazilian health sector, the crisis related to cooperative aspects is evident.

In this essay, are discussed, initially, some foundations of the different federalist regimes in the classical and contemporary traditions and their mechanisms of counterweights and cooperative dynamics. Next, the characteristics of the brazilian federalism are analyzed with emphasis on the current

configuration in the health sector, based on the constitutional provisions of 1988. Finally, some ideas are presented in a preliminary character to overcome the framework of crossed and sustained vetoes among thousands of political actors that prevent the coordination of the public health system in terms of universal access and reduction of regional inequalities. Therefore, the objective is to discuss the political crisis of cooperative federalism within the SUS – using classic and contemporary aspects of political theory about federalism – and to outline strategies to solve problems of political coordination related to the enormous asymmetries between municipalities and regions of the Country.

Classical approaches of federalism

The federalism as the theme of modern political philosophy appears strongly from Machiavelli, that includes confederation mechanisms as one of the methods used by nations to extend and consolidate powers. In the Discourses, Book II, published in 1531, (MACHIAVELLI, 2007), it is emphasized:

> He who has read the ancient history carefully, must have observed that three methods were used by the republics to extend their powers. One of them, followed by the ancient Etruscans, is to form a confederation of many States, in which none takes precedence over the rest in authority or hierarchy and each allows others to share their achievements, as the Swiss League States do today and were made by the Aquean and Etolians in Greece in times past. (MAQUIAVELLI, 2007, P. 160).

This system of alloys is treated as inferior, by the limits to the expansion of territories and participants, to the longstanding roman model of formation of coalition with allies, with preservation of control and supremacy of central government, but, superior to the direct domination adopted by spartans and athenians, considered useless and failed according to historical experience. Machiavelli attributed to the confederation system of the etruscans the longevity and sustainability of these people in terms of regional control, although the sharing of achievements and the system of consultations within such Leagues impeded their territorial expansion or the proliferation of partners.

In a more contemporary sense, decentralized political systems, in which the partnership expressed by national cohesion cohabits with the separation of rights and responsibilities, are, in the classical tradition, linked to the greater activism of citizens in regions closer to their dwelling or work, that is, a democracy of local dimensions. Territorial decentralization is a theme linked to the associative life of local and regional individuals and collectives. For Alexis de Tocqueville (2003), in his classic of 1835, it represented the main distinctive mark of the United States against the centralized french system. The virtues of decentralized systems, in terms of control of the tyranny of rulers, greater representation of citizens and autonomy of local governments, within the nation, were debated in the years preceding the federative constitution of the United States of America.

This process was analyzed in terms of logic applied to politics and the evidence of historical experience by Robert Dahl (1989). His analysis, from the north american constitutional debate, and the emphasis on the separation of powers (executive, legislative and judiciary), through the means of external controls over the tyranny of majorities or minorities, the ways of dealing with the rule of decision by majorities and the systems of counterweights led to the elaboration of a type defined as 'madisonian democracy'.

Such a model contrasts with the 'populist democracy', that would be characterized by the absolute rule of majorities. The limits of these models and the combination of their

virtues – to add majority rules and external control over tyrannies – were the pluralistic basis of 'polyarchical democracy' that has been experienced according to distinct rules between electoral periods (between governments) and between elections (governments processes more subject to contradiction).

Even not dealing directly with the federative issue, Dahl (1989) illuminates the madisonian model constructed during the federative pact as the basis of the compromise to be preserved in modern polyarchies, whether by separation of powers or by concentration of powers, as in british parliamentarianism. The madisonian foundations involve the search for cooperative separations and without concentration of powers and their central objective is to achieve the 'non-tyrannical republic'.

The virtues, in terms of efficiency and equity of democratic systems sensitive to the activism of their individuals and communities, were also highlighted in the well-known work of Robert Putnan (2000) as resulting from regional civic traditions of long historical maturity and leading to the formation of the social capital.

Although traditions, historical examples, analyzes and theories about concentration of political power, as opposed to decentralized regimes, are manifold, it is a fact that the north american federative model, although present, today, in this format in a few countries, is paradigmatic for this debate.

Its foundations date back to the debates that preceded, in 1787 and 1788, the finalization of the Constitutional Convention, in 1789. The debates in the most outstanding State Conventions became known by the theoretical essays of their main leaders, mainly in the press, that became reference from the compilation known as Federalist Papers (HAMILTON *ET AL.*, 2003), published in 1788. The type of federalism that results can be considered an order oriented to the maximum preservation of the regional powers whose origins can be related to the confederation model of the Leagues, described by Machiavelli.

In the north american federative model there is an important political decentralization at the state level and a clear separation of functions between Union and states in terms of attributions and responsibilities. The federal conflicts are solved by the judiciary (judicial review) and have their main brands in federal accountability and autonomy. In this model, federalism implies a system of checks and balances oriented to prevent the concentration of powers in a single individual or institution. The contradictions of the madisonian model, which was implemented according to classic federative institutions, were pointed out by Dahl (1989) and include problems associated with the realization of the majority rules and the deficit of centralization, that are observed in unitary and parliamentary countries, such as the United Kingdom, where the concentration of powers was also effective in controlling the tyranny of the majority. The most mixed and contradictory polyarchic solution approaches the democracies of more settled configurations observed in continental european countries.

Unit countries, such as the United Kingdom, constituted the majoritarian, highly centralized model, structured in a high concentration in parliament through the winning party or coalition. The 'tyranny of the majority' is controlled by elections pulverized in districts and consolidated in the formation of the government. The decentralization to local institutions occurs within the framework of specific policies and under the aegis of the central government. It is important to highlight, however, that several countries are undergoing reforms that make this dynamic centralization/decentralization more complex and full of nuances. On a reciprocating basis, centralized countries and majority regimes adopt some reforms in the name of greater decentralization and vice versa.

Lijphart (1999) analyzed, in a comparative

perspective, the style of consensus-based democracy strengthened in the post-war period as opposed to the majority. The decentralization is manifested both in unitary and federative systems, but, in its typical forms, consensual democracy occurs in federative or semi federative systems, populated by decision-making institutions of a multipartite character that are neo-corporative or configured according to regions with different cultures, as a form of maintenance of the national unity. The majority rule is not, therefore, the final ordaining of a wide range of political solutions. For Lijphart (1999), this system, despite the slower decision-making process, is superior in terms of social protection and redistributive social and economic development. It is worth remembering that such arrangements are closely associated with the setting up of the western european welfare state. Schools that have succeeded in focusing on modes of governance have given new clout to settled decision-making processes.

The consensual and counterbalanced structure, however, can pave the way for successive vetoes that paralyze the decision-making process. Moreover, the cooperative orientation of federated systems of consensual character may imply loss of sharpness of attributions and responsibilities, to compromise the madisonian dimensions (desirable or not) of the political system.

The german case, classified in the Lijphart (1999) model at the pole of consensual democracy, has been criticized internally for the possible effects of its cooperative federalism as an obstacle to the decision-making process and inhibiting economic growth, which has led to the creation of parliamentary committees to promote the revision of its federative system regarding their horizontal cooperative aspects. Hillgruber (2005), however, criticizes such intensions and demonstrates the advantages of the cooperative model against the return of the radical separation of federative powers.

On the other hand, problems generated by excessive or dysfunctional decentralization have been pointed out in an important literature in political science, such as in governance failures (JESSOP, 2003) or in the loss of government capacity due to excessive outsourcing (PETERS, 2009). The specialized literature on health policies highlights the lack of evidence on the advantages of decentralized systems in international experience (COSTA-FONT; GREER, 2013).

Implications of federalism for Brazil and the health sector

By its institutional characteristics, Brazil, if studied, would be included in the map of Lijphart (1999) closest to the pole of consensual democracy due to its federative system. The institutional dimensions of Brazil, after the 1988 Constitution, also define the case between forms of cooperative federalism, at least in terms of institutional rules. However, the effectively cooperative character of our federalism is something to be demonstrated, given a series of events known as tax wars, regulations of royalties, penalties for states that cannot charge the Services Tax over Merchandise Circulation (ICMS) on its oil production, fiscal crisis of the states, among many.

With regard, specifically, to the health sector, the crisis of cooperative federalism is evident. State governments subject to recurring fiscal crises and, in many cases, abandoning the health agenda fail to fulfill the strategic and essential role of coordinating regional policies in the name of greater equalization. Municipal governments have fiscal, government, and health care capacities very disparate in all states and large regions. The competition for resources and the imposition of barriers of access to other municipalities are routines in the SUS and contribute to minimize the positive effects of

a large number of municipal experiences in terms of good policies and regional cooperation. The fragility of the regional colleges of policy-making – with their different denominations according to successive ministerial ordinances and presidential decrees – does not allow the imposition of rules on their own neighborhoods. Effectively cooperative dimensions are yet to be adequately demonstrated against the competitive dimensions of financial resources, professionals and the shielding or disincentive of access of the citizens to SUS services in the largest urban centers. In addition, the benefits of radical decentralization of policies, such as health, in countries with large populations, areas and huge regional inequalities, such as Brazil, have yet to be demonstrated.

A federative pattern with madisonian objectives, even that diffuse, served as a guideline for the institutional design of the Republic of 1889. The democratic and dictatorial cycles that followed can be summarized in authoritarian centralization in the New State of Getúlio Vargas and in the Military Dictatorship of 1964; and federative decentralization of the post-war and democracy of the Constituent, of 1988.

In an approach that excludes the dictatorial cycles, one can be considered that the republic was born in the form of a madisonian federalism and has arrived until here in the form of a cooperative federalism of characteristics quite unique between the other nations.

The national literature in the social sciences is extremely qualified for studies on such cycles, and several divergent approaches are identifiable among specialists. Here, it is highlighted just a few important references as support for the specific discussion of the institutional crisis of the health sector and within the limits of this essay.

Abrúcio (1998) analyzed the historical role of governors in the democratic transition defined by the 1988 Constituent. The 'state federalism' was the matrix of the democratic transition pacts and their fiscal repercussions. This 'state ultra presidentialism' must be analyzed along with the transformations of public administration matrices since the twentieth century and its tradition of centralization and vulnerability to capture by traditional corporate interests and in conflict with the dynamics of universalist reforms, well analyzed by Nunes (1997). These processes followed the variations in the patterns of federalism in the brazilian history.

The fiscal decentralization of the Constituent of 1988 implied greater fiscal autonomy and greater participation in national collected revenues, as demonstrated by several experts, including political processes and their implications (GIAMBIAGI; ALÉM, 2008).

However, the fiscal turn, to the detriment of the power of the state governments, occurred from the 1990s, especially from the different macroeconomic adjustments that followed throughout the years 2000. The specific impact of state crises and the renegotiation of debts in the first Fernando Henrique Cardoso government are responsible, according to Monteiro Neto (2014), for the loss of federative power of the state governments. The complexity of fiscal and political configurations, their repercussions for sectoral policies and relations with the party-political system were analyzed by Arretche (2004), and the specific loss of capacity of important state governments was perceptible in the post-democratization period.

The protagonism of the governors is responsible for the configuration of fiscal federalism and for cooperative arrangements, but it is the basis of the current federal conflict. In addition, due to their lack of direct action, they appear among those political representatives for regional inequalities and fragility of regional cooperation institutions in their states in the health sector.

In relation to the brazilian case, there is a growing concern to strengthen or recover the cooperative aspects of federalism defined in the democratic transition. As well portrayed

by experts on the strengthening of the state sphere in the political form of an ultra presidentialism (ABRÚCIO, 1998) or by the new fiscal division for the fiscal decentralization of federal resources to subnational governments (GIAMBIAGI; ALÉM, 2008), it can be affirmed that expectations for a decentralized and cooperative system stem, largely, from the capacity of state governments to develop redistributive policies in their sphere of power.

In terms of horizontal federalism, municipalities among themselves, induced and coordinated by state governments, would be able to establish a consensus democracy and reduce serious regional inequalities. This would be, in terms of an optimistic view of the constitutional arrangement of 1988, structured nationally according to a vertical federative arrangement, through which the Union, based on a classical presidential system, would perform the compensations by means of inducing inequalities between the great regions.

However, the process that followed the 1988 constitutional pact, as the 1990s progressed, highlighted the fiscal crisis and the political weakening of governors, the fiscal war between states and the inability to promote the reduction of social inequalities through sectoral policies. The 1988 Constitution was carried out amidst concerns related to the federative pact and to a higher federative balance in fiscal terms. Nevertheless, decentralization efforts in this area have come up against structural aspects. The assumption of homogeneity among the entities as a parameter of decentralization has proved to be very fragile. The main mark of the inequality between these entities was given by the municipalities become federative entities not subordinated to the states. The lack of homogeneity and the lack of state controls, coupled with the decentralization of Union resources without the clear definition of subnational competencies, contributed to the failure of regional redistributive policies (VERGOLINO, 2014).

Moreover, the macroeconomic adjustment of the 1990s reduced the capacity of state governments, as the federal government imposed on the renegotiation of debts the limitation of the role of state governments in brazilian federalism. The result was the biggest fiscal centralization in the Union, although the aggregate of municipalities increased their participation at the end of the decade of 2010 (MONTEIRO NETO, 2014).

As Vergolino (2014) points out, the success of federalism depends on the combination of autonomy (self-determination of federated entities) and cooperation (solving everyday conflicts of a vertical and horizontal nature). However, his evaluation of the brazilian case on fiscal autonomy in the states showed a strong predominance of the Southeast and South regions over the North and Northeast regions, and a mosaic in the Central-west, but, lower than the one observed for the regions of better performance. This framework has contributed to reinforce the regional inequalities that traditionally mark the Country.

Among these regional inequalities, the health sector is one in which this process of political fragmentation and federative competition are most evident. There is a certain consensus among national authors about the possible advantages of municipalization, decentralization and regionalization as a good policy. However, evidence of success on this agenda is fragile, and several authors focus their analysis on assigning the causes of the constraints of cooperative federalism to factors external to the system.

The specialized literature on health policies is quite cohesive in claiming for the advantages of decentralized systems, although this convergence undoes itself when it comes to demonstrating the true cooperative characteristics of federalism in the sector.

The lack of regional development policies appears in several studies as a relevant cause, often associated with evidence of socioeconomic inequalities (ARRETCHE; MARQUES, 2002; TRAVASSOS *ET AL.*, 2006; VIANA LIMA; FERREIRA,

2010; GADELHA *ET AL.*, 2011; VIACAVA; BELLIDO, 2016; PIOLA, FRANÇA; NUNES, 2016). Aspects directly related to fiscal federalism and demonstrating their effects on regional inequalities and as an opportunity for equitable reform are brought to the political debate (DAIN *ET AL.*, 2001; LIMA, 2007). Innumerable experiences of regional cooperation, however, are perceived and analyzed as successful cases of health districts and formulation of policies oriented to the consolidation of the decentralized model (MENDES, 1993). Following different guidelines, partnerships for free association between municipalities in the form of intermunicipal health consortia also demonstrate some successful cases of local cooperation. In these arrangements, municipalities formally associate themselves, institutionalized by councils of mayors, municipal councils, municipal secretaries, and share resources of attention for common use according to the rules of benefit sharing and costs in accordance with solidarity rules (RIBEIRO; COSTA, 2000; NEVES; RIBEIRO, 2006; MACHADO; ANDRADE, 2014). After the regulation, in the form of public consortia, such arrangements, although existing, have lost prominence in the political agenda.

The recurrent fiscal crises of the state governments emphasized their competitive dimensions – together with the renowned fiscal war –, reduced the capacity of equalization between their municipalities and regions and, mainly with respect to the health sector, generated overlaps with the emergent municipalism and assertive policies of mayors (initially) and municipal health secretaries (in the current framework). The cooperative dimensions of federalism in the health sector are manifested as inequality between local systems due to different fiscal and government capacities, such as lack of political coordination and low accountability among the three entities in terms of public policy results.

It can be said that the cooperative federalism of the health sector, in Brazil, today, resembles a pact of mutual non-accountability between the three levels of government. The consensual dimension of democracy in this case does not mean the slower and more negotiated decision-making process, but, rather, a system of cross-fire of vetoes between federative actors (Ministry of Health, National Council of State Health Secretaries and National Council of Municipal Health Secretaries) and corporate (National Health Council), where the contractual and responsible dimension gives way to inertia. The persistence of intense regional and local inequalities, the delegation of regulatory functions to regulatory and judicial bodies, overlapping functions and expenditures, intermunicipal and interstate access barriers and the political paralysis of the regionalization agenda are just a few of the many evidences in this sense.

Final considerations: the crisis of federative and shared management in SUS

There are many successful experiences in the SUS in all spheres of government. In common, they show the potential of the public system to meet its universalist goals. However, daily experience and the various analyzes highlighted here have demonstrated that cooperative federative dimensions in the health sector have failed to reduce their enormous regional inequalities. Substantial part of this results from factors external to the health sector and depends on social, economic, cultural and territorial variables. The predatory competition among states, in terms of resources, incentives and competitive development policies, also plays an important role.

In its turn, aspects related specifically to the health sector end up weakening equalization initiatives. The weaknesses of regional and local institutions of federative cooperation may be evidenced by the

inability to reduce inequalities, and the capacity of government in the context of health policy has shown to be low to alleviate them.

There is a need to recover the regulatory capacity of the public system. As discussed here, the regulatory functions are performed in an unsystematic manner, within a framework of judicialization and, systematically, by the various control bodies of the federal administration. Shared management colleges – Tripartite Interagency Commissions, National Health Council, Bipartite Interagency Committee and the various regional colleges – do not exercise coercive functions in terms of accountability for signed pacts and have low inducement capacity through financial incentives and *status*.

Faced with this framework, aggravated by the progressive scarcity of financial resources in the face of growing demand – due to population aging, persistence of endemics and epidemics, chronic diseases impacts, technological innovations and social perception of rights to health care – the SUS should undertake institutional innovations in response.

The necessary political response results, moreover, from its own successes. The perception of health as a duty of the State and universal right was understood, accepted and claimed by the population. Therefore, increased governance and policy coordination are required.

Some level of autarchic centralization, which improves systemic coordination, generates incentives for cooperation, induces decisively the reduction of regional inequalities and brings to health policy the accountability functions now delegated almost exclusively to the judiciary and executive organs of the executive (Office of the Comptroller General; National Audit Department of SUS) and the legislative (courts of auditors, especially the Federal Audit Court), can be reached through sectoral agreements.

Such a model may consist of an autarchic institutionalization, that is, provided with greater formalisation, including the Tripartite Interagency Committee and the National Health Council, in a national institution provided with multipartite governance. It may be considered that the Ministry of Health is the appropriate body for these functions, but it is a fact that its inductive power is neutralized or (at least) contradicted by the collegiate of horizontal federalism.

A national coordination must have its prerogatives politically well delineated. The budget for health policies and services at the three levels of government cannot be transferred in a form of 'reverse fund', which is difficult to implement institutionally, but, a pact of authority delegation about the financial implementation of regionalization policies and equalization can be done in the name of a more central coordination.

The limits established for sector financing, considering the fiscal exhaustion of a large number of municipalities, the fiscal crisis in most states and the limits institutionally placed on federal health expenditure, generate a structural framework of scarcity when it comes to the assembly strategy in Brazil of a public system, of national and universal character, in the european molds and as defined in the democratic transition.

These obstacles already represent powerful impediments to the success of SUS, and there is no need to add factors such as decision making, superposition of functions, shielding of access between municipalities and competition for scarce resources. The autarchic centralization agreed upon and restricted to specific functions can be an incremental solution, that is, that does not alter the nature of the system, to favor the horizontal and vertical cooperative dimensions of brazilian federalism in the health sector. ■

References

ABRÚCIO, L. F. *Os barões da federação:* os governadores e a redemocratização brasileira. São Paulo: Editora Hucitec, 1998.

ARRETCHE, M.; MARQUES, E. Municipalização da saúde no Brasil: diferenças regionais, poder de voto e estratégias de governo. *Ciência & Saúde Coletiva,* Rio de Janeiro, v. 7, n. 3, p. 455-479, 2002.

ARRETCHE, M. Federalismo e políticas sociais no Brasil: problemas de coordenação e autonomia. *São Paulo em Perspectiva,* São Paulo, v. 18, n. 2, p. 17-26, 2004.

COSTA, V. Federalismo. In: AVELAR, L.; CINTRA, A. O. (Org.). *Sistema político brasileiro:* uma introdução. Rio de Janeiro: Konrad-Adenauer-Stiftung; São Paulo: Editora Unesp, 2007, p. 211-223.

COSTA-FONT, J.; GREER, S. L. (Org.). *Federalism and decentralization in European health and social care.* London: Palgrave; Macmillan, 2013.

DAHL, R. *Um prefácio à teoria democrática.* Rio de Janeiro: Jorge Zahar, 1989.

DAIN, S. *et al.* Avaliação dos impactos de reforma tributária sobre o financiamento da saúde. In: NEGRI, B.; FERRATO, G. (Org.). *Radiografia da Saúde:* 2001. Campinas: Editora Unicamp, 2001, p. 233-288.

GADELHA, C. A. G. *et al.* Saúde e territorialização na perspectiva do desenvolvimento. *Ciência & Saúde Coletiva,* Rio de Janeiro, v. 16, n. 6, p. 3003-3016, 2011.

GIAMBIAGI, F.; ALÉM, A. C. *Finanças públicas:* teoria e prática no Brasil. Rio de Janeiro: Elsevier, 2008.

HAMILTON, A.; MADISON, J.; JAY, J. *The Federalist Papers.* New York: Signet Classics, 2003.

HILLGRUBER, C. German Federalism: An Outdated Relict? *German Law Journal,* Charlottesville, v. 6, n. 10, p. 1269-1282, 2005.

JESSOP, B. *Governance and Metagovernance:* on reflexity, requisite variety, and requisite irony. Lancaster: Lancaster University, 2003. Disponível em: <http://www.lancaster.ac.uk/fass/resources/sociology-online-papers/papers/jessop-governance-and-metagovernance.pdf>. Acesso em: 20 dez. 2016.

LIJPHART, A. *Patterns of Democracy:* government and performance in thirty-six countries. New Haven: Yale University, 1999.

LIMA, L. D. Conexões entre o federalismo fiscal e o financiamento da política de saúde no Brasil. *Ciência & Saúde Coletiva,* Rio de Janeiro, v. 12, n. 2, p. 511-522, 2007.

MACHADO, J. A.; ANDRADE, M. L. C. Cooperação intergovernamental, consórcios públicos e sistemas de distribuição de cursos e benefícios. *Revista de Administração Pública,* Rio de Janeiro, v. 48, n. 3, p. 695-720, 2014.

MACHIAVELLI, N. *Discourses on Livy.* New York: Dover Publications, 2007.

MENDES, E. V. (Org.). *Distrito sanitário:* o processo social de mudança das práticas sanitárias do Sistema Único de Saúde. São Paulo: Hucitec; Rio de Janeiro: Abrasco, 1993.

MONTEIRO NETO, A. Governos estaduais no federalismo brasileiro: capacidades e limitações no cenário atual. In: ______. (Org.). *Governos estaduais no federalismo brasileiro:* capacidades e limitações governativas em debate. Brasília, DF: IPEA, 2014. p. 21-60.

NEVES, L. A.; RIBEIRO, J. M. Consórcios de saúde: estudo de caso exitoso. *Cadernos de Saúde Pública,* Rio de Janeiro, v. 22, n. 10, p. 2207-2217, 2006.

NUNES, E. *A Gramática Política do Brasil.* Rio de Janeiro: Zahar Editor, 1997.

PETERS, B. G. The two futures of governing: decentering and recentering processes in governing. *The Journal of Public Administration and Policy,* Budapest, v. 2, n. 1, p. 7-24, 2009.

PIOLA, S. F.; FRANÇA, J. R. M.; NUNES, A. Os efeitos da Emenda Constitucional 29 na alocação regional dos gastos públicos no Sistema Único de Saúde no Brasil. *Ciência & Saúde Coletiva,* Rio de Janeiro, v. 21, n. 2, p. 411-421, 2016.

PUTNAN, R. D. *Comunidade e Democracia:* a experiência da Itália moderna. Rio de Janeiro: FGV Editora, 2000.

RIBEIRO, J. M., COSTA, N. R. Regionalização da assistência à saúde no Brasil: os consórcios municipais no Sistema Único de Saúde (SUS). *Planejamento e Políticas Públicas,* Brasília, DF, n. 22, p. 173-220, 2000.

TOCQUEVILLE, A. *Democracy in America and two essays on America*. London: Penguin Books, 2003.

TRAVASSOS, C.; OLIVEIRA, E. X. G.; VIACAVA, F. Desigualdades geográficas e sociais no acesso aos serviços de saúde no Brasil: 1998 e 2003. *Ciência & Saúde Coletiva,* Rio de Janeiro, v. 11, n. 4, p. 975-986, 2006.

VERGOLINO, J. R. O. Federalismo e autonomia fiscal dos governos estaduais no Brasil: notas sobre o período recente (1990-2010). In: MONTEIRO NETO, A. (Org.). *Governos estaduais no federalismo brasileiro:* capacidades e limitações governativas em debate. Brasília, DF: IPEA, 2014. p. 63-117.

VIACAVA, F.; BELLIDO, J. G. Condições de saúde, acesso a serviços e fontes de pagamento, segundo inquéritos domiciliares. *Ciência & Saúde Coletiva,* Rio de Janeiro, v. 21, n. 2, p. 351-370, 2016.

VIANA, A. L. A.; LIMA, L. D.; FERREIRA, M. P. Condicionantes estruturais da regionalização na saúde: tipologia dos Colegiados de Gestão Regional. *Ciência & Saúde Coletiva,* Rio de Janeiro, v. 15, n. 5, p. 2317-2326, 2010.

Received for publication: November, 2016
Final version: December, 2016
Conflict of interests: non-existent
Financial support: non-existent