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# Regionalization and political dynamics of Brazilian health federalism

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## ABSTRACT

The implications from the Brazilian federal structure on the regionalization of health actions and services in the National Unified Health System (SUS) were analyzed, considering that the regional health planning in Brazil takes place within the context of intergovernmental relations as an expression of cooperative federalism in health. The analysis was based on a historical approach to Brazilian health federalism, recognizing two development periods, decentralization and regionalization. Regional health planning of SUS was explored in light of the theoretical framework of federalism. It is concluded that relative centralization of the process is needed in intergovernmental committees to actualize federal coordination and that it is essential to consider formalizing opportunities for dissent, both in regional management boards and in the intergovernmental committees, so that the consensus decision-making can be accomplished in healthcare regionalization.

**DESCRIPTORS:** Single Health System, organization & administration. Regional Health Planning. State Health Plans. Decentralization. Local Health Systems.

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## INTRODUCTION

A particular feature of the Brazilian federal structure is the existence of three autonomous spheres of government: federal, state and municipal. This situation is codified by the Federal Constitution of 1998, which definitively assigns municipalities as federal entities.

The institutional organization of the National Unified Health System (SUS) reproduces the three level structure and legitimizes the autonomy of each level of government in the management of health actions and services within the national health system. This is how Brazilian health federalism is structured.

Regionalization is a SUS directive coming from the fundamental need to integrate components to guarantee the right to health in the country. Due to the federal nature of the system, this can only be realized through institutional arrangements between federal entities. Therefore, to consolidate regionalization of health actions and services in Brazil, the effects of federalism and of developing intergovernmental relations should be considered, while understanding regional bodies as administrative entities unrelated to federal entities.

The present study aimed to examine implications of the Brazilian federative structure on the process of SUS regionalization, focusing on current political dynamics of Brazilian health federalism. Therefore, the study analyzes the role of regional management and intergovernmental boards in establishing federative mechanisms for cooperation and coordination necessary to implement the system's organizational directive.

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## FEDERATIVE COORDINATION IN COOPERATIVE FEDERALISM

Federalism is an organizational form of the contemporary nation and was born of a dialectic equilibrium between centralization and decentralization of political power. The federal system creates coexistence of autonomous political units that together make up the federation, represented by the Union established in the Federal Constitution.<sup>10</sup>

The federal level best fulfills the necessity of maintaining unity in a diverse system, without concentrating power in one nucleus or destroying concentration. From its invention in the United States during the 18<sup>th</sup> century to its current form, federalism acquired different forms as the federative principle was implemented with specific adaptations according to the historical, social, economic and political circumstances in which the state was constituted.<sup>16</sup>

At the current historical moment in which the federal state has the preponderant role promoting social well being, mutual collaboration between federated units to reach social and economic objectives has been one of the principal instruments of action by federations. The concept of cooperation stems from an understanding that certain public functions cannot be the exclusive or hegemonic domain of one federal entity, since they imply interdependence and common interests. This model, which currently predominates, is denominated cooperative federalism.<sup>6</sup>

Due to the nature of the federal State, the combined action of federal entities in public policy should preserve the liberty of each party and, at the same time, allows for the adoption of coordinated and socially effective actions. Therefore the political dynamic of federalism is directly connected to the establishment of harmony between the principle autonomy and participation of federal entities, as mutually dependent and complementary.<sup>12</sup> This objective can only be reached through a coordinated federative system.<sup>16</sup>

Within federations, development of public policies to promote collective well being requires construction of shared decision-making processes to guide planning and execution of action in the socioeconomic sphere. These processes generally occur through two basic types of mechanisms, representing the inherent dilemma between decentralization and centralization: direct bargaining among local governments and incentives promoted by the central jurisdiction.

Structures that promote direct bargaining between local authorities privilege the autonomy of federal entities and attempt to build cooperative agreements through horizontal interaction among sub-national jurisdictions. These structures originate from the premise that

in decentralized systems local governments are more accountable and better able to improve conditions for their citizens because of direct relationships, since they are better informed of citizen preferences and therefore better able to decide about allocation of resources. Nonetheless, the exclusive use of this model presupposes that local governments can bargain directly under theoretical circumstances that are difficult to occur simultaneously, which includes agreement among all entities in regards to the benefits produced, symmetry of information and bargaining positions, perfect representation of the interests of citizens and the absence of costs in transaction and implementation of agreements.

The mechanisms intended to manage public policies through federal incentives to the sub-national spheres assume that federative coordination requires a certain degree of central decision-making. The principal idea is that the central jurisdiction should utilize institutional resources to influence the decision of local governments, since the quality of actions depends on incentives and controls. These instruments would be the best alternative for the introduction of national-level public policies and allow greater stability and control in implementation of actions. Full implementation of this model removes citizens from decision-making and presumes that the central agent is always well-informed and interested in generating the best results for lower-level jurisdictions.<sup>9</sup>

## BRAZILIAN HEALTH FEDERALISM

The Brazilian Federation developed from the dismantling of the Imperial Government, along with the installation of the Republic, and followed a path counter to the majority of federal states comprised until now. During the dialog around its development, Brazilian federalism experimented with relatively well-defined cycles of centralization and decentralization. Before the New Republic, the centralization periods (1930-1945 and 1964-1985) were associated with authoritarian governments, and the decentralization periods (1889-1930 and 1946-1964) were in general characterized by the hegemony of regional oligarchs in the management of national politics.<sup>1</sup>

The Constitution of 1988 instituted cooperative federalism in Brazil and definitively established municipalities together with the states and the Union, as part of a particular tripartite federalism in Brazil. This is how local power was consolidated in the organization of the Brazilian state, leading to transfer of tasks and resources to municipal governments responsible for the provision of goods and services to citizens.<sup>5</sup>

After acknowledgement of the right to health in Brazil, SUS was created within this context, as a federative institution guided by political-administrative

decentralization. The constitutional norms and regulations described in the Organic Law of Health<sup>a,b,c</sup> delimits the national federative structure in the health sector and sets responsibilities for all federated entities in health promotion, protection and improvement actions, with autonomy for each sphere of government to manage the system within their domain.<sup>8</sup> This is how the political organization of health federalism in Brazil was established.

### MUNICIPALIZATION OF HEALTH DURING THE DECADE OF BASIC OPERATIONAL NORMS

Political-administrative decentralization, as dictated in the terms of Article 9 of Law 8,080/90, was developed considering the “emphasis in decentralization of municipal services” associated with the “regionalization and hierarchy of the health services network”. The first decade of the implementation of SUS followed a move towards decentralization of social policies in the 1990s,<sup>2</sup> so that municipal health was prioritized while regionalization was practically ignored.

The first decade of the SUS was marked by a process of intense transfer of skills and resources to municipalities, guided by normative tools from the Ministry of Health: the Basic Operational Norms (NOB). Through financial incentives and the definition of criteria for capabilities, the successive NOBs led municipalities to progressively assume responsibility for the management of health actions and services in their territory.

The primacy of municipalities in decentralization led to advances for SUS, especially concerning commitment and increased capacity of health management in municipalities.<sup>7</sup> In addition, this effort allowed for the establishment of important components for the system, especially the affirmation of Health Councils in the three spheres of government, the progressive modification of financing criteria – moving from payments for outputs to automatic per capita transfers – and the creation and consolidation of intergovernmental associations: the Tripartite Inter-managers Committee (CIT) at the federal level and the Bipartite Inter-management Committees (CIBs) at the state level.<sup>14</sup>

Nonetheless, the municipal emphasis in health also had some collateral effects that showed particularities in the political dynamic of Brazilian health federalism. Decentralization was introduced in this period based on the practice of direct relations between federal and municipal spheres, adopted since the beginning of the

process.<sup>11</sup> The frailty of relations between states and municipalities made it difficult to define responsibilities and even the mandate of health services when proposals for the redefinition of this sphere began. Despite an attempt to strengthen the role of states in SUS policy management by improving the functioning of CIBs and establishing Pacts and Integrated Health Care Programs (PPIs) through NOB/96, it was insufficient for the organization of care networks based on the precepts of regionalization. A complication was that states continued to not be provided with financial incentives to assume these functions.<sup>15</sup>

Political concentration in the process of decentralizing was crucial to reach municipalization. It also created obstacles to structuring mechanisms of federative coordination that should be performed by state governments. In terms of regionalization, these factors were critical in changes to the political management of SUS during the following decade.

### REGIONALIZATION FROM THE HEALTH CARE OPERATIONAL NORMS TO THE HEALTH PACT

After implementing decentralization in the first decade of SUS, it became evident that the municipalized structure was incapable of providing the necessary conditions to realize the objectives of the national health system given the extreme heterogeneity that characterized the Brazilian Federation. The need for rationalization of the system was critical to resolve the fragmentation of services and disparities in productive scale and capacity between municipalities, given the risk of efficiency loss and therefore worse results. Recognition of this situation<sup>13</sup> led to regionalization in the beginning of the 2000s, with the Operational Norm of Health Care (NOAS).

In NOAS, regionalization was emphasized as a necessary strategy for the decentralization process to increase *pari passu* with the organization of the care network, allowing the full provision of services to the population. The state sphere began to organize health regionalization after the Regionalization Director Plan, an instrument that interprets regional planning in accordance with the specifics of each state (and the Federal District), in consonance with available resources. Resources were allocated according to the Integrated and Pact Program and new resources specified in the Financial Director Plan were provided. Guaranteed access to health services at any care level was intended through regional planning, based on

<sup>a</sup> A Lei Orgânica da Saúde é composta pelas Leis Federais no 8.080/90 e no 8.142/90.

<sup>b</sup> Brasil. Lei n.8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial União*. 20 set 1990; Seção 1:018055.

<sup>c</sup> Brasil. Lei n.8.142, de 28 de dezembro de 1990. Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS) e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências. *Diário Oficial União*. 31 de dezembro de 1990; Seção 1:025694. Seção 1.

functional and resolute systems, for the organization of hierarchical service networks and the establishment of inter-municipal referral and counter-referral mechanisms and timelines.

In practice, NOAS attempted to modify Brazilian health federalism by forcing regional levels (care modalities, regions and macro-regions) upon states and municipalities, while working on the existing political-administrative organization where the management of systems was already decentralized to the municipalities.

Although significant opportunities were identified, there were substantial obstacles in implementation of operational guidelines set out by NOAS. The assignment of competencies for regional planning to state secretaries was resisted by municipalities, which had obtained autonomy in health management and perceived a degree of recentralization. In addition, political and financial concentration in the federal sphere was established during the 1990s – which facilitated the Ministry of Health in municipalization through NOBs – and created difficulties for the implementation of regionalization as an organizational directive of the system. Due to prior relegation of the state sphere and minimal assimilation of federative cooperation mechanisms, the NOAS proposal was not well received because it challenged the political structure instituted by municipalization. Instead of cooperation, disputes arose between state and municipal governments over the administration of services,<sup>3</sup> and guidance from the federal government was insufficient to create space for federative coordination at sub-national levels.

Given the circumstances, an idea developed by the Health Ministry and CIT was strengthened. Effective assumption of responsibility by managers should come from a voluntary accord where health managers of the three spheres of government agree to the negotiated responsibilities and define goals to be reached through cooperation and solidarity, establishing a management pact. This proposal was accepted and, after its approval by the CIT and the National Health Council (CNS), was ratified as part of the non-statutory normative instrument called the 2006 Health Pact 2006.

In the 2006 Pact, the national directorship of SUS reaffirms regionalization as a basic part of the system and calls it “the guiding framework of the Administrative Pact”, orientating the decentralization process and intergovernmental relations. Development of the operational instruments instituted by NOAS (Regional Leadership and Investment Plans and Integrated Programmatic Pacts) is shared between states and municipalities, under the coordination of state administrators. The goal is to improve access and quality of care, reduce existing inequalities, guarantee

integrated care, strengthen the management capacity of states and municipalities and rationalize the expenditure and use of resources, allowing for improved scale of health actions and services with regional scope. It is assumed that all municipalities have the capacity to offer basic health care actions and services and perform basic health surveillance. All other actions, which the 2006 Pact calls complementary, can be bargained among municipal managers, in order to ensure the completeness of access to their populations.

It is hoped that health regions would be delineated through understanding between state and municipal managers, as legitimized in the CIB deliberations. In cases where municipalities are in frontiers with other countries, the 2006 Health Pact foresees the need of deliberation in CIT in order to delineate frontier regions. There is not a predefined cutoff point for the level of assistance to be made available, so that the CIBs have autonomy to define the actions and services offered in each health region. The only recommendation is for sufficiency in basic care and some services of medium complexity.

To operationalize the planning and management of health regions, the 2006 Pact established Regional Management Boards (CGR). The CGRs were conceived to function as deliberative bodies similar to CIBs, differentiated by their scope, restricted to regions and with obligatory participation of all municipal managers involved regionally. Identifying prior existence of informal regional associations that functioned by representation of municipal managers (in the same mold of CIBs), the Management Pact<sup>d</sup> defines: “In the representative regional CIB, when it is not possible to immediately incorporate all health municipalities in the health region, a timeline for adaptation should be agreed with the shortest possible length for inclusion of all managers from the respective associations of regional management”.

Management and the decision-making process for health regions should be performed together by the state and municipal spheres through the CGRs, performed according to the Ministry of Health through cooperation and solidarity with consensus decision-making. This characterization is often found in official publications by the Ministry of Health to describe the process of regional planning.<sup>d</sup>

## CURRENT POLITICAL DYNAMIC OF REGIONALIZATION

The regionalization proposal of the 2006 Pact stems in part from the success of the decentralization/municipalization process of the 1990s – and its undesired effects

<sup>d</sup> Ministério da Saúde. Portaria n. 399/GM de 22 de fevereiro de 2006. Divulga o Pacto pela Saúde – 2006-Consolidação do SUS e aprova as diretrizes operacionais do referido Pacto. Diário Oficial União. 23 de fevereiro de 2006. Seção1.

related to system fragmentation – and attempts to reach results not obtained by the NOAS through modification of some precepts of the regional management model. The intent of this new proposal is to reduce the protagonist role of the Ministry of Health in direct relationships with municipalities and increase participation of states. The increased freedom of sub-national governments to direct the regionalization process reveals the solidifying of a policy rearrangement at the national level. The strategy is to increase flexibility, which has been prioritized by NOAS, and to intensify policy bargaining, privileging agreements in the state/regional context. The challenge is how to develop regional management mechanisms that can be utilized by the diverse regions of the country, considering the current political and financial concentration in the federal sphere and the need to promote more effective participation by state governments, while preserving municipal autonomy in implementation of health actions and services.

In regards to the regions, state governments are responsible for coordinating the planning process, which municipalities are part of as autonomous political entities. Therefore, regionalization implies two themes in the context of inter-federative relations: decentralization for the states and centralization (or recentralization) for municipalities.

Before the 2006 Pact, inter-federative models for interaction functioned under a fragmented SUS that resulted from municipalization. The NOAS proposal relied on persuasion by the federal sphere to define policy format and on waiting for acceptance by municipal governments and collaboration of state governments. The response was unsatisfactory, since the political environment was not favorable to a top-down installation of regionalization, and in addition, incentives for participation by states were missing. On the other hand, the experience of intermunicipal consortiums, since the 1980s, demonstrated that free and voluntary association between municipalities was insufficient to guarantee universal and equal access to SUS at the regional level.<sup>e</sup>

The most significant innovation brought by the 2006 Pact was the creation of regional management boards (CGRs), which institutionalized horizontal relationships between municipal governments and the use of shared decision-making processes for the definition of regional health policies. Considering the formal objectives of the 2006 Pact and the need to operationalize cooperative federalism, these associations are indispensable to overcome the intrinsic difficulties in Brazilian health federalism, representing a proposal for equilibrium

between the two basic mechanisms of federative cooperation and coordination: direct bargaining between local governments (horizontal relationships) and support from the central entity (vertical relationship).

Because they stem from planning by states and mandate regional planning (with all municipalities obligated to participate), the CGRs approximate the persuasion mechanisms used in NOAS, which privileges federative coordination. Since all activity related to regionalization undertaken by states should be agreed to in the CIBs, the potential for excess power at this level is limited by institutional design.

In regards to cooperation, there is increased municipal autonomy in deliberations over policies of regional import. The CGRs resemble a consensus model of public administration similar to the public consortiums and have the essential difference of compulsory participation. Mechanisms for co-management are constructed through horizontal interaction between municipalities, although vertical interaction is maintained by the permanent presence of representation of states (the co-management model currently determined by the Ministry of Health<sup>f</sup>).

Due to its decentralized nature, the model of direct bargaining between local governments has undeniable benefits in participation and brings citizens closer to decision-making processes but also brings some risks that should be considered.

First, it should be admitted that conditions do not exist in Brazilian federalism so that bargaining between municipal managers suffices to create regional health policies, when considering the SUS principals of universality and equality. The enormous asymmetry of information and political power between Brazilian municipalities prohibits the exclusive application of this model, due to the threat of increasing intra- and inter-regional inequalities and creating access barriers.

Therefore, decentralization of regional management to CGRs requires the redefinition of the role of CIBs, which become a privileged space for the coordination needed for health regions to function adequately. Decentralization of the decision-making process, as part of regional decision-making, does not occur without coordination, which requires relative centralization. In practice, the actual political agreements have led to this intergovernmental structure.

Another important point to consider is the assumption that deliberations in CGRs always occur by consensus. Consensus decision-making is traditionally associated

<sup>e</sup> Machado JA. Políticas públicas descentralizadas e problemas de coordenação: o caso do Sistema Único de Saúde [doctoral thesis]. Belo Horizonte: Faculdade de Filosofia e Ciências Humanas da Universidade Federal de Minas Gerais; 2007.

<sup>f</sup> Ministério da Saúde. *Secretaria Executiva*. Departamento de Apoio à Descentralização. Colegiado de gestão regional na região de saúde intraestadual: orientações para organização e funcionamento. Brasília, DF; 2009. (Série B. Textos Básicos em Saúde (Série Pactos pela Saúde 2006, 10).

with federalism and has been gaining importance in contemporary public administration. Nonetheless, it should be noted that consensus is often used improperly, as a synonym for unanimity.

In order to provide greater consistency, Barroso<sup>4</sup> (1994) explains that consensus can exist when a significant proportion of members are in agreement in regards to decisions about values that could create conflict and when there is affinity among group members and their society. Consensus is reached through means other than coercion. For consensus to exist, disagreement should be considered as natural as agreement, which is the main difference between unanimity. The author argues that, in modern social science theory, consensus is directly related to democratic ideas, and therefore it is not counter to a diversity of opinion but is counter to simple obedience. Barroso concludes that the institutionalization of opportunities for divergence is indispensable to counter the perverse effect of consensus theories, since the acceptance of differences is a basic principle in federalist attitudes.

Given these ideas, consensus should be considered in regards to shared decision-making processes to be developed in CGRs. How can consensus be built given the extreme asymmetries that characterize the Brazilian federation?

Municipalities with greater political power, in general, have larger populations and/or greater economic importance. They possess greater capacity in the care network. Therefore, consensus through CGRs could become a veiled (or open) form of concentrating power in larger municipalities, since smaller municipalities would not have the resources or power to disagree. This situation would subvert the associations. Given various political interests, it can not be assumed that municipalities that are regional leaders would always be interested in offering the same type of access, present in their municipality, to all residents regionally.

This reinforces the importance of central coordination in the regionalization process through the CIB and the need to formalize room for disagreements in CGRs and CIBs so that consensus can truly be constructed. The horizontal and vertical federative conflicts have to first surface so they can be attenuated and potentially resolved.

## FINAL CONSIDERATIONS

Regionalization of health actions and services in SUS is closely linked to the Brazilian federative organization in the health sector. Therefore the political dynamic of this process necessitates equilibrium between centralization and decentralization, which is an expression of federalism.

The 2006 Health Pact brings the possibility of important changes to the political dynamic of regional planning of SUS through a new model of intergovernmental relations in the health sector. Although the tools for persuasion by the federal sphere have been maintained, the current conditions favor decentralization of coordination to the state level. CIBs legitimized the process to a more significant degree than NOAS. Furthermore, there is indication of an institutional awareness that moving regional management to CGRs is plausible, which would consolidate shared decision-making processes as mechanisms of inter-federative cooperation at the regional level.

The current proposal of regionalizing health care results from two decades of political and institutional maturation of SUS and is one of the most ingenious models developed for cooperative federalism in Brazil. The identification of tensions and opportunities concerning this model should contribute to overcoming the dichotomy between centralization and decentralization, which is fundamental for the construction of mechanisms for federative cooperation and coordination necessary to fulfill the right to health in our country.

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