


The coordination role of Rio Grande do Norte state government in response to covid-19: Innovation in times of crisis?¹


A atuação coordenadora do governo do Rio Grande do Norte no combate à covid-19: inovação em tempos de crise?

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Abstract

From a case study of the State of Rio Grande do Norte, in Brazil, this article discusses the role of states in coordinating healthcare with its local governments in the context of the new coronavirus pandemic. The absence of federal government initiatives in responding to the pandemic in Brazil have been acknowledged by several specialists as an unprecedented event in the Brazilian federation, breaking with a recurrent pattern of national coordination and regulation by different governments since the 1988 Constitution. In this sense, states and municipalities had to adopt their own initiatives to respond to the pandemic. Qualitative research based on the collection of documents (local media, epidemiological reports, and state regulations) and in-depth interviews with state and municipal managers reveals significant changes in the state-municipal relationship throughout the pandemic period in Rio Grande do Norte, a state historically characterized by the lack of state coordination. The pandemic, thus, functioned as an exogenous shock, which induced changes in the pattern of state coordination in healthcare. It is unclear, however, whether these changes are one-off or permanent since the weight of increasing returns - a specification of a path dependency process - seem to work as a mechanism producing inertial dynamics of difficult disruption with the past.

Keywords: Intergovernmental Relations; States; Healthcare; Federal States; Covid-19.

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Resumo

A partir de um estudo de caso do Rio Grande do Norte, este artigo discute o papel dos estados na coordenação da saúde durante a pandemia do novo coronavírus. A ausência de coordenação federal no enfrentamento do surto pandêmico no Brasil tem sido compreendida por diversos analistas como algo inédito na federação brasileira, rompendo com um padrão recorrente de normatização e indução nacional por diferentes governos desde a Constituição de 1988. Nesse sentido, estados e municípios passaram a adotar iniciativas próprias para o enfrentamento da pandemia. A partir de uma pesquisa qualitativa baseada em dados documentais - mídia local, boletins epidemiológicos e regulamentações estaduais - e em entrevistas semiestruturadas com gestores estaduais e municipais, foi possível identificar mudanças na relação estado-municípios durante a pandemia no Rio Grande do Norte, caso marcado, historicamente, pela ausência de cooperação estadual. A pandemia, dessa forma, funcionou como um choque exógeno, que induziu uma mudança no padrão de atuação do governo estadual na saúde. Não está claro, porém, se essas alterações são pontuais ou permanentes, na medida em que o peso do autorreforço - especificação dos efeitos do legado histórico - atua como um mecanismo que produz dinâmicas inerciais de difícil rompimento com o passado.

Palavras-chave: Relações Intergovernamentais; Estados; Saúde; Federação; Covid-19.

Introduction

One of the challenges faced by federal States concerning service provision refers to the need of cooperation among levels of government that are politically and administratively autonomous. In fact, the literature on the relationship between federalism and public policies in Brazil shows that a new pattern of intergovernmental relations took place from the 1990s onwards, producing national coordination (Abrucio, 2005; Arretche, 2012). Different public policy instruments have been used since then: the adoption of national parameters and institutional designs that induce service provision by subnational governments, typically attached to financial resources; the strengthening of information and evaluation systems, and the establishment of intergovernmental negotiation arenas, among others. The result was a progressive role of the Federal Government as an inducer of national policies (Arretche, 2012; Bichir et al., 2020; Franzese; Abrucio, 2013).

The Brazilian literature is rich in studies on the effects of national coordination on municipal policies, especially the social ones. Examples of the effects of federal policies include the expansion of enrollments in municipal schools (Gomes, 2009); the municipalization of primary care (Viana; Machado, 2009; Viana et al., 2008); the dissemination of Social Assistance Reference Centers (CRAS), and the creation of a national database to implement the income-transfer program *Bolsa Família* (Cavalcante; Ribeiro, 2012; Licio, 2013).

However, the literature has advanced little on the understanding of the role of Brazilian states in the federation. Most studies point to them as actors that do not influence the national decision-making process significantly (Arretche, 2012), contrary to what had happened at other times in Brazilian history (Abrucio, 1998). This gap on the states would reflect not only the strengthening of the Union and the municipalities in the coordination and implementation of social policies, respectively, but also state governments inertia or the lack of clarity about their responsibilities. In this regard, the literature argues that horizontal (between states) and vertical (between states

and municipalities) cooperation – the latter being one of the main responsibilities of states in social policies (Silva, 2020) –, would not have been set as a policy agenda for most state governments.

However, recent studies show that states can have a greater centrality in the federation when they play a cooperative role with their municipalities, ensuring the coordination of service provision, minimum standards of quality and access, and reducing inequalities in local state capacities (Gomes, 2009; Julião; Olivieri, 2020; Segatto, 2018; Segatto; Abrucio, 2018; Silva, 2020; Tendler, 1998). One exemplary case is the state of Ceará, which since the 1990s has acted as a coordinator in various policies, especially in healthcare and education (Silva, 2020).

The covid-19 pandemic has brought up a discussion about the different roles played by the states, especially within the Brazilian National Health System (SUS, in Portuguese). It is quite consensual among analysts that Bolsonaro government (2018-2022) changed the typical and historic pattern of national coordination adopted by different governments since the democratic 1988 Constitution was enacted (Abrucio et al., 2020; Kerr et al., 2020). The absence of national coordination would have the potential not only to deepen regional inequalities, but also to produce ineffective responses to the current health crisis by states and municipalities, given the absence of common and national guidelines.

Considering this novel political-institutional context, this article analyzes the decisions taken by the Rio Grande do Norte (RN) state government at the beginning of the pandemic and its effects on the ability to coordinate its municipalities' actions. The initial period is understood as decisive in this article, as a critical juncture in sense adopted by historical institutionalism (Pierson, 2000). The case of RN is of analytical interest as its trajectory in health policy has been characterized by the absence of state-level coordination (Silva, 2020). However, the pandemic opened a window of opportunity – in the analytical terms proposed by

Kingdon (1995) –, to shift the state government's policy agenda and potentially to change the pattern of subnational relations.

The empirical analysis was based on qualitative and historical investigation strategies, based on data collected from local media, epidemiological bulletins, and 2020 regulations issued by the State of RN. We mapped state programs and decisions related to the combating covid-19, seeking to identify changes in the state government relationship with municipalities. We also used data extracted from DataSUS/Ministry of Health² to illustrate the state government's existing capacity in terms of the provision of high-complex healthcare service such as hospital care in its territory. In addition, we conducted interviews with state and municipal officials from the health secretariats in order to complement and better understand our data. The interviews were recorded with the consent of the participants and followed standard protocols to guarantee anonymity.

Faced with a lack of national coordination towards the pandemic and with the need to produce subnational coordination on its own, the state of RN acted by issuing broad and comprehensive coordination and norms to induce municipalities' behavior in an unprecedented way (Gomes, 2020). However, if the adopted strategy seemed to work at the beginning, after a certain point the coordination capacity disappeared (Gomes; Santos, 2020). A new strategy then was adopted. If initially the state government used an imposing and hierarchical order in a top-down fashion, the political resistance of some municipalities produced a search for dialogue and persuasion this time. The analysis shows, therefore, the changes that occurred and the lessons that were learned, as well as the limitations.

This article is divided into three sections, in addition to this Introduction. In the first section, we address briefly issues raised by the literature on the state governments' role regarding the SUS. In the second, we present the path of lack of coordination and cooperation in RN, which functions as a strong mechanism of path

² Ministério da Saúde – Cadastro Nacional dos Estabelecimentos de Saúde do Brasil (CNES) e Sistema de Informações de Beneficiários (SIB). Available only in Portuguese on: <https://datasus.saude.gov.br/>. Access on July 18, 2022.

dependence - or self-reinforcement -, in which previous choices influence and limit future ones producing inertial effects that are difficult to break, as they present increasing returns dynamics (Pierson, 2000), even when the policy agenda changes. In the third section, we discuss the transformation in the state-municipal relations during the pandemic in RN, with some empirical examples that demonstrate changes and continuities. Finally, we present considerations about coordination strategies in federal States and highlight possible further developments.

The role of state governments in the SUS in Brazil

Although in recent decades there has been a strengthening of federative coordination in Brazil, there is variation depending on sectorial policies, with healthcare being an exemplary case. Throughout the 1990s, several regulations were fundamental for the development of the SUS (Viana et al., 2008). They ratified the federal government's normative power, defined mechanisms for the resource redistribution, stipulated minimum national standards, and built intergovernmental decision-making arenas (Franzese; Abrucio, 2013).

SUS' initial regulations (Brasil, 1990) were not enough to leverage the process of service decentralization. It was only with the institution of Basic Operational Norms (NOBs) by the Ministry of Health - linking the transfer of federal resources to service provision by municipalities - throughout the 1990s that all subnational governments joined the SUS (Arretche, 1999). During this period, the challenge was to implement municipalization in order to guarantee primary care provision across the country. Also through these regulations, the Tripartite and Bipartite Inter-management Commissions were created, finally including subnational governments in the decision-making process at the national and state levels (Franzese; Abrucio, 2013).

Once the primary care service provision in all cities was guaranteed, efforts at national standardization shifted to create the regionalization of services, which required a greater level of complexity.

The first actions to induce regional healthcare provision emerged with the Healthcare Operational Norms (NOAS) 01/2001 and 02/2002, which introduced some regional planning instruments. These regulations, however, were not enough to produce the Brazilian states' coordination behavior regarding regional supply of healthcare services within their territory (Viana et al., 2008).

In 2006, the Pact for Health (Ministerial Ordinance n° 399, of February 22, 2006) (Brasil, 2006) tried to advance this process by creating the Regional Health Collective Bodies or Regional Inter-management Committees (CIR), establishing the regionalization coordination as a state-level function. According to the Ordinance, the states should assume the responsibility of "coordinating the process of setting the care network design within inter-municipal relations and the participation of the municipalities of the region" (Brasil, 2006). The Pact for Health also made municipal governments responsible for providing comprehensive care to users, leaving to the states and the federal government the role of co-financing and providing services in a complementary manner. This institutional scenario deepened the state government's coordination responsibility, especially in relation to the territorial organization of medium and high complexity healthcare services - specialized care that involves, for example, supplies and equipment that became critical during the pandemic, such as those necessary for the deployment and functioning of intensive care units (ICU).

However, studies show that there is a deep interstate diversity in the regionalization implementation (Lima et al., 2012; Menicucci; Marques, 2016) and, therefore, in state coordination (Silva, 2020). This heterogeneity can be explained by historical and political-institutional constraints (Lima et al., 2012), scarcity of resources (Menicucci; Marques, 2016), previous policy trajectory, existence and performance of subnational policy communities, and the state political leadership profile (Silva, 2020). Therefore, although SUS' institutional design enhanced intergovernmental cooperation, it was not enough to induce or constrain the state governments' coordination

role, as it depends on factors related to their local or regional contexts.

The heterogeneity of actions taken by state governments is also evident in relation to the adoption of measures to reduce covid-19 transmission in Brazil (Moraes, 2020). Due to the federal failure to coordinate actions nationally, subnational governments, especially the states, took on such a role (Abrucio et al., 2020, Kerr et al., 2020). In the absence of national coordination, minimizing the damage caused by the pandemic implied the necessary coordination role by state governments, at least within their jurisdictions.

Historical antecedents of the (non) coordination pattern in Rio Grande do Norte

Like other states in the Northeast region of Brazil, in terms of socioeconomic context, a large proportion of RN population lives in a situation of high social vulnerability and, as a consequence, the majority of the people depend exclusively on the public (and free) SUS - more than 80%, according to DATASUS estimates. Estimations from the Beneficiary Information System (SIB/ANS/MS), for example, point to a coverage rate of private health insurance plans of only 16% of the population in RN in 2020. Nevertheless, the historical trajectory of cooperation actions by the state government with the municipalities, in practice, never existed before the pandemic. Back in 1997, this issue was discussed by the current secretary of health of the state of RN, Cipriano Vasconcelos. Vasconcelos (1997) argued then that the state of RN, from 1989 to 1995, chose to delay the implementation of the sanitary reform, remaining as the main direct provider of healthcare services, that is, without acting as a co-manager of healthcare services.

In this sense, the municipalization process, foreseen in the SUS design, was not coordinated in the state of RN, and much less induced by the local Public Health Secretariat (SESAP/RN). At the time, the creation of the Bipartite Inter-management Commission and the State Health Council was postponed. According to

Vasconcelos (1997), this was the result of the lack of a state health movement capable of influencing the government's decision-making agenda in addition to the predisposition of the state's political elite to maintain clientelism practices.

This trajectory did not change in the following years. The main administrative reforms of this period did stipulate the state government secretariats' responsibilities, but it did not include the role of the state government in coordinating healthcare service provision (Silva, 2020). Besides, there was no provision of any structure or support for the municipalities to implement the Family Health Program, the main primary care policy promoted by the federal government. The primary care municipalization in the RN was, therefore, executed by federal initiatives with no state government involvement in this process (Araújo, 2000).

The change in state government's role only occurred during the term of Wilma de Faria (2003-2010) as a state governor, from the left-wing Brazilian Socialist Party (PSB). With an election marked by the discourse of breaking with traditional oligarchies, the state government approached specialists from the Federal University of Rio Grande do Norte (UFRN), who worked at the Center for Studies on Collective Health (NESC). The NESC, led by Cipriano Vasconcelos, signed an agreement with SESAP and the Pan American Health Organization (PAHO) to review the Master Plan for Health Regionalization, which had been discussed in the early 2000s and published in 2004 (Silva, 2020). In one of the seminars promoted, the then assistant secretary, Petrônio Spinelli, remarked: "the state needs to focus on the work of support and coordination to build the SUS effectively" (Vasconcelos; Pinheiro, 2008, p. 88-89).

In that period, the state had resources to co-finance primary and pharmaceutical care, which had been listed in the 2010-2011 State Health Plan (Rio Grande do Norte, [2008]). However, this change did not continue in the following governments, and the state's role as a provider of healthcare services did not change. In 2006, the Pact for Health (Brasil, 2006) came into force, a federal regulation that, among other things, deepened the

cooperative prerogative of state governments and attributed to the municipalities the responsibility for the integral healthcare of their population.

Thus, the trajectory of the RN health policy was marked by omission with regard to the state government's coordination. There was no closer relation between the state and local administrations in support for the process of primary care municipalization, insofar as the first chose to remain as the main service provider but with no collaboration. Members of the current high-ranking bureaucracy of SESAP (Silva, 2020) agree with this view, which seems to be an essential component for attempts to change the pattern of relationship between the state and municipalities during the pandemic.

The beginning of the pandemic and the need for a quick response by the state government opened a window of opportunity for the state to become a coordinator of actions to combat covid-19 within its territory, in a similar fashion presented in the diagnosis built by the NESC/UFRN specialists before, and who, by 2020, were occupying high-level positions in the new government inaugurated in 2019. In an unprecedented way, the RN government started to regulate actions in the face of the pandemic that would be enforced to all municipalities in the state. The next section presents a brief record of the initial moment of these actions, which shows an imposing coordination style by the state government and the inflection towards a negotiated coordination.

From “imposed” federative coordination to “negotiated” coordination: changes and continuities in health policy in Rio Grande do Norte

Elected in 2018, the current governor, Fátima Bezerra, from the left-wing Workers' Party (PT), appointed university professor Cipriano Maia, one of the NESC/UFRN founders - affiliated to the party and who had previously been Secretary of Health of the capital -, Natal, to the SESAP leadership. He and other members of his team discussed the lack of state coordination in health policies even

before taking office and, when starting their term, they established as a priority the regionalization process implementation to be conducted by SESAP (Silva, 2020).

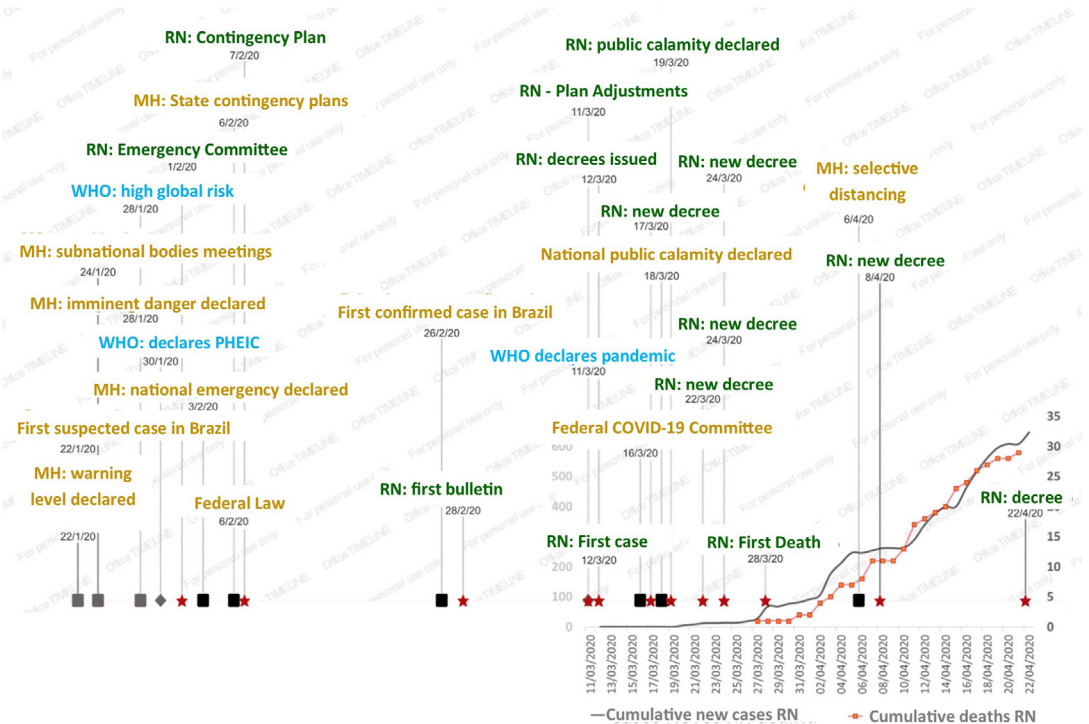
In order to alter the previous trajectory of “service management,” several changes were proposed by the state executive branch at the beginning of the administration in 2019, including a bill for regional (inter-federative) health consortia and another one for the regulation of the state health fund - approved in January 2020 (Rio Grande do Norte, 2020a) and regulated in March 2020 during the pandemic (Rio Grande do Norte, 2020b). The legal rule that creates the Fund reveals the State Health Secretariat's coordination role in the resource management and application of resources (art. 3). The Law on Regional Health Consortia (Rio Grande do Norte, 2020e), despite some criticism from the opposition in the Legislative Assembly, was approved at the end of 2020. One of our interviewees points out that the rule was inspired by Ceará's model, which seeks to expand medium and high complexity healthcare services in a regionalized manner and follows the logic of co-financing with state and municipal resources, which is being negotiated with each health region.

According to reports from the interviewees, the pandemic reinforced these efforts to strengthen the state government's coordination role, which was already on the agenda. The measures taken by the governor in terms of state regulation, at the beginning of the pandemic crisis, were unprecedented in the history of health policies in RN, being quite comprehensive and strongly binding, including municipalities (Gomes, 2020; Gomes; Santos, 2020). The decrees issued not only extended the suspension of activities and the operation of public and private organizations, but also ended up constraining the municipalities of RN to follow such regulations, which were, in most cases, complied with or even reinforced, as in the cases of the establishment of a lockdown by municipalities. Most decisions made by the RN government were taken before the confirmation of cases in a significant volume, following the guidelines of the Ministry of Health and the World Health Organization and by monitoring cases and measures adopted in other states, in addition to the sharing of information in

forums, such as the National Council of Municipal Health Secretariats (CONASEMS), the National Council of Health Secretaries (CONASS), and the Northeast Consortium.

Figure 1 shows that most of the decrees issued by the governor occurred between the confirmation of the first case in the state (March 12, 2020) and before the first death was confirmed (March 28, 2020).

Figure 1 – Events and decisions in Rio Grande do Norte and number of cases and deaths from covid-19. Jan. - Apr., 2020



Source: Authors' elaboration using case and death data from IRRD-PE.³

Initially, the state executive branch adopted the imposition of restrictive rules on isolation and mobility as a core strategy, but with no consulting, negotiation or even agreement of municipalities. Although a state committee was created in March 2020 to manage the health crisis, it only had representatives from the state executive branch and no seats for municipalities or other bodies related to public health. As a result, although fast and comprehensive, the state government's induction strategies applicable to public and private agents presented limits in terms of their effectiveness or implementation (Gomes, 2020). If initially the mayors of the largest cities aligned themselves with state regulations, the first inter-federal conflict began to emerge less

than a month after the beginning of the series of decrees by the governor. Essentially, the criticisms were directed at the legitimacy of state rules in the face of the autonomy guaranteed to the municipalities in the Brazilian federation.

State Decree No. 29.630, of April 22, 2020 (Rio Grande do Norte, 2020c), was emblematic in this regard. The regulation expanded containment measures and regulated the operation of supermarkets, street markets, and municipal and intercity transportation. The following day, the mayors of the three largest cities in the state issued decrees that annulled the state measures (Gomes, 2020). The mayor of the capital, Álvaro Dias, from the right-wing Brazilian Social Democracy Party (PSDB) - opposite

³ Available in the Portuguese language on: <https://www.irrd.org/covid-19/>. Access on July 18, 2022

pole to the governor -, stated in his municipal decree that the governor “usurped part of the municipal powers, specifically the hours of operation of public transportation of this Capital, the operation of the commerce, essential services and street markets operation” (Natal, 2020). Something similar is observed in Mossoró, a municipality commanded by former governor Rosalba Ciarlini Rosado (affiliated with the right-wing Progressive Party - PP), and in Parnamirim, governed by Rosano Taveira (affiliated with the right-wing Republicans). Like Natal, Mossoró and Parnamirim were also governed by opponents of governor Fátima Bezerra (PT). For the first time, state and municipalities entered into disagreement, politicizing decisions and regulations.

Gradually, the state executive branch changed the way to coordinate measures of combating covid-19, establishing negotiations with the municipalities. *Operação Pacto pela Vida* - created in May 2020 to inspect the enforcement of health measures by state police forces - is a landmark of this change. Before issuing a new decree, the governor began to negotiate and convince mayors through videoconferences until adhesion of all 167 municipalities in the state eight health regions was reached. In June 4, the governor issued State Decree No. 29.742/2020 (Rio Grande do Norte, 2020d), regulating the terms of state-municipality collaboration.

The formal instances of agreement were not used as mechanisms for negotiation and coordination of actions during the pandemic, except for the agreement on the distribution of a few resources linked to covid-19. As reported by one of the interviewees - a participant in these collective bodies -, despite the existence of the Bipartite Inter-management Commission (CIB) and the regional health collective body, the negotiations were carried out outside these formal arenas. In the case of the CIB, the few decisions related to combating the pandemic would have been the result of pressure from municipalities demanding joint decision-making and its effective implementation. In the case of regional collective bodies,

according to the interviewee, the participation of municipalities tends to be greater, since regional committees include representatives from the state, municipalities and universities that are in the territories of the health regions. These regional forums would have been fundamental for defining the contingency plans, which were prepared according to state planning guidelines.

The rupture of the policy path of low initiative of agreement between state and municipalities in RN also produced changes, although limited, with regard to the expansion of ICU beds during the pandemic.⁴ The legacy of the state as the main provider of hospital services, with unequal regionalization provision, implied the coexistence of both municipal and state healthcare provision for medium and high complexity services all concentrated in only two cities in RN: Natal and Mossoró.

In this sense, the pandemic served as a window of opportunity (Kingdon, 1995) to change this situation, allowing the restructuring of regional hospitals to receive patients affected by covid-19, by expanding the supply of hospital and ICU beds in the state health regions. As reported by one of our interviewees, a state-level official, the objective was to expand access through investment in regional hospitals in strategic municipalities, such as Santa Cruz, São Gonçalo do Amarante and Parnamirim, through co-financing by the state and municipalities. Thus, state and federal resources began to be channeled towards the materialization of medium and high complexity services regionalization. Although this regionalization movement is linked to the provision of healthcare services for serious cases of people affected by covid-19, it is undeniable that this restructuring of hospitals changed the dynamics of SUS secondary and tertiary care in the state.

Table 1 shows this expansion based on the number of ICU beds made available by the three levels of government and by health regions, in January 2020 - therefore, before the pandemic - and February 2021.

⁴ At the end of March, SESAP launched a public notice for the installation of a field hospital in the capital. However, this attempt was frustrated, even generating a term of adjustment of conduct signed by the state government in joint action by the State and Federal Public Ministries. The contracting did not materialize, causing the state government to choose to hire beds from philanthropic hospitals and also to structure its regional hospitals.

Table 1 - Number of beds in an adult ICU (I, II, II and covid) in Rio Grande do Norte in January 2020 and February 2021, by health region

Health region	Period	Federal	State	Municipal	Total
1 st Health region - São José de Mipibu	Jan/2020	0	0	0	0
	Feb/2021	0	6	0	6
2 nd Health region - Mossoró	Jan/2020	0	9	0	56
	Feb/2021	0	18	0	105
3 rd Health region - João Câmara	Jan/2020	0	0	0	0
	Feb/2021	0	0	5	5
4 th Health region - Caicó	Jan/2020	0	0	0	0
	Feb/2021	0	35	0	35
5 th Health region - Santa Cruz	Jan/2020	0	0	0	0
	Feb/2021	0	6	5	11
6 th Health region - Pau dos Ferros	Jan/2020	0	6	0	6
	Feb/2021	0	16	0	16
7 th Health region - Metropolitan	Jan/2020	25	62	10	145
	Feb/2021	25	113	20	212
8 th Health region - Açu	Jan/2020	0	0	0	0
	Feb/2021	0	10	0	10
Total	Jan/2020	25	77	10	207
	Feb/2021	25	204	30	400

Source: Ministry of Health - National Registry of Health Establishments (CNES)⁵

As it can be seen, five health regions did not have any ICU beds before the pandemic. In the following year, there were beds of this type installed in all regions. The total number of beds in state hospitals grew by about 165% (127 beds were made available). Within the municipal network, the number of beds went from 10, at the beginning of 2020, to 30, in February 2021 (200%). In this case, an ICU was opened in hospitals in the metropolitan region - Santa Cruz and João Câmara. Therefore, the state government opted for the expansion of its own network of services in the health regions, and only in some cases there was an expansion of municipal services.

It is possible, therefore, to say that there is a reinforcement of policy path - of delaying the municipalization of healthcare services in the state and a low institutionalization of state-local cooperation (Silva, 2020) -, which results in the monopolization of medium and high complexity controlled by the state. Even with the expansion of the state coordination role,

the existence of state hospitals in health regions seems to have been a primordial situation in the decision taken by SESAP regarding the chosen regionalization format.

Even so, the state prominence in coordinating actions to combat the pandemic inaugurated a new pattern of action by the state government in local health policies, even if limited. This moment can be understood as an opportunity for a change in the government agenda. The lack of interest of the federal government in promoting national coordination and standardization of actions to combat the pandemic contributed to this new scenario, expanding the space for inter-federative coordination by the states.

According to one of the interviewees, a state health official:

the pandemic brought the need to strengthen the federative pact. [...] The state had to take measures and actions that should be carried out at the national

⁵ Available in the Portuguese language on: <https://cnes.datasus.gov.br/>. Access on July 18, 2022

level. So, four changes regarding the Minister of Health within a pandemic context, in addition to the absence of emergency aid at various times, changes in the conduct of policy, absence of clear protocols and ideological issues permeating the discussion on scientific evidence delayed and made the states to have to take on other measures. (Interviewee 1)

However, despite strengthening its role as coordinator of actions at the beginning of the pandemic, the initial strategy of hierarchical and imposing decisions with no prior coordination with the municipalities generated a reaction in municipal officials of non-adherence to the measures. The resistances of this first coordination experience seem to have led the state government to reconsider its strategy as it started to promote actions based on negotiations and agreements with the municipalities, especially in the cases of enforcement of sanitary measures and the expansion of medium and high complexity health services in different health regions.

Despite these changes, the disregard of the CIB as an arena for agreement and deliberation and the maintenance of the state government as the main service provider show clearly the effects of path dependence on current and future decisions.

Final considerations

The pandemic acted as an exogenous shock that induced a change in the pattern of the RN government's role in health policy. The health crisis scenario combined with the presence of experts at the highest level of the state secretariat - who were critics of state coordination fragility -, explain the opportunity to change the state policy agenda. The absence of national coordination also boosted this process as the RN and other Brazilian states had to give their own responses to the pandemic. The case studied in this article, however, shows that simply opening a window of opportunity (Kingdon, 1995) for change does not automatically produce the desired results. This article shows that the weight of self-reinforcement (or increasing returns) - or the effects of path-dependency (Pierson, 2000) - acts as a mechanism that produces inertial dynamics that are difficult to disrupt. At the beginning of the covid-19 pandemic, the centralization of decisions in the state executive

branch generated an unprecedented coordination role in the state.

Moments of crisis are potentially capable of generating collective action and a greater cooperation (Agranoff, 2012; Migone, 2020). The health crisis arose at a time when managers and officials in the RN government and in the health secretariat were members of a policy health community of actors that had a common vision or ideas concerning the coordination role of the state. The pandemic worked as a chance to advance this agenda. Cooperation, however, in addition to the necessary institutional factors and conditions, is also the result of chosen strategies. In the beginning, the RN government adopted norms of a more imposing and hierarchical style than collaborative in nature, which did not produce the adhesion of all municipalities, since they have political and administrative autonomy in the Brazilian federation. The identification of this barrier was central for the state executive branch to change its coordination strategy by adopting principles more related to Brazilian federalism and to the SUS governance structure itself: induction through dialogue and agreements.

Although state leadership and the pandemic have led to unprecedented state coordination, the absence of coordination mechanisms strengthening the administrative, financial, and service provision capacity of municipalities have prevailed. However, in the case of RN, the learning process regarding state-municipality collaboration during the pandemic may be a necessary experimentation to potentially produce new forms of more perennial interaction and dialogue. In this sense, the health crisis seems to have contributed to a change in the scenario of intergovernmental relations. It remains to be seen, however, whether this will be permanent or transitory.

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The study design and the structuring of the topics were made by the four authors in common agreement. Gomes and Santos collected and analyzed RN epidemiological data. Silva and Segatto wrote the theoretical and analytical arsenal. Gomes, Silva and Segatto worked on the text cohesion and wrote the introduction and conclusion.

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