Intergovernmental health policy decisions in Brazil: cooperation strategies for political mediation

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Accepted 15 March 2005

The advantages of established intergovernmental decision-making arenas for the implementation of health policies in decentralized settings are not well known. This paper presents the case of the joint health management committee, known as the Tripartite Committee, created to formalize intergovernmental decisions about the implementation of policies of the Brazilian Unified Health System. This paper adopts a descriptive approach for the strategic analysis of decision process among governmental actors from three federative levels, as well as of mechanisms for the negotiation of their interests in the formalization of health policy agreements. The roles and positions of governmental actors within the Tripartite Committee were analysed, together with the definition of decision agendas and strategies. The data come from normative documents and proceedings of the Tripartite Committee, interviews with their governmental actors and observations of their meetings. The distinct governmental actors from the Tripartite Committee employed cooperation strategies with permanent negotiations oriented towards interchanges and political mediation. The power of the federal Government is also pre-eminent for the constitution of decision agendas and in the shaping of negotiation processes and priorities. The Tripartite Committee formalized agreements between unequal administrative and political powers to ensure a systemic integration of governmental policies and a self-regulation of the political autonomies. There are some divergences within the governmental actors’ interpretation of key policies and processes in this decision arena; the primacy of political or technical criteria as well as the applicability of laws or ad hoc norms. Although such cooperation strategies may slow down the decision-making process and render it more complicated, they also define more clearly areas of institutional responsibility and ensure a broader support from different levels of government for the implementation of public health policies.

Keywords Brazil, health reform, decentralization, health policies, health decision process, health decision space, intergovernmental decisions
KEY MESSAGES

- The institutionalization of intergovernmental arenas of decision-making about health policies is a complex innovation in federalist countries.

- According to some, this institutionalization has had a favourable influence on the decentralization of health policies and has contributed to some of the results of government actions. For others, it has limited the governmental capacity for planning and acting in the sphere of health because of the excessive bureaucratization and the greater influence of corporate groups and alliances.

- In Brazil, the institutionalization of intergovernmental health decision-making arenas has promoted cooperation strategies with permanent negotiations oriented towards political mediation; these define more clearly areas of institutional responsibility and ensure broader support from different levels of government for the implementation of public health policies.

Introduction

Within the context of intergovernmental decentralization of health policies, the representatives of the different levels of government develop strategies and arenas in which they can negotiate, formalize agreements and make their decisions together. These joint decisions essentially concern the definition and regulation of the nature and degree of political autonomy at each level, the sharing of government prerogatives and responsibilities, and the integration of health policies.

Numerous investigators have tried to identify the formal relations established between the representatives of different levels of national and sub-national government from the point of view of political and administrative decentralization in the field of health. These studies have sought to understand and account for the ways and means by which decentralization of financial resources and governmental autonomy take place (Rondinelli et al. 1983; Musgrave and Musgrave 1989; Wright 1990; Agranoff 1992; Scicchitano and Hedge 1993; Putnam 1994; Christie 1996; Bossert 1998; Driessen et al. 2001).

According to some authors, the existence of arenas and processes for government decision-making has had a favourable influence on the decentralization of health policies (Mills et al. 1990; Saltman and Figueras 1997; Garman and Hilditch 1998; Theret 1999). These authors find that the existence of these decision-making arenas and processes has contributed to some of the results of government actions, and have improved the ability of policy makers to understand policy alternatives or to make choices and express preferences concerning the ways of implementing such policies.

For other authors, the multiplication and permanence of these arenas and processes for intergovernmental decision-making and the manner in which they are regulated limit, to some extent, the governmental capacity for planning and acting in the sphere of health (Anton 1997; Sparer 1999). Some limitations were attributed to the more complex nature of the arenas for political representation, because of the slower government decision-making processes, excessive bureaucratization and the greater influence of corporate groups and alliances (Banting and Corbett 2001).

In Brazil, the analysis and discussion of these issues have taken place as a result of the ongoing implementation and organization of the national public health system, the Unified Health System (SUS), which owes its legal existence to the Federal Constitution of 1988. One of the orientations of the current Brazilian health legislation concerns the political and administrative decentralization of health services and actions, with institutional prerogatives and responsibilities being shared among the federal, state and municipal authorities.

For some authors, the intergovernmental decision-making arenas and processes have brought about positive changes in terms of transfer of public resources and cooperation between different levels of government (Lima 1999; Collins et al. 2000; Mendes 2001; Silva and Labra 2001; Viana et al. 2002). However, others (Guimarães 1997; Ribeiro 1997; Misoczky 1999) have asserted that these decision-making arenas merely express the predominance of agreements among corporate groups which institutionalize their conflicts, build up bureaucratic alliances and impose technical considerations over political ones as a criterion for decision-making.

In spite of the abundance of Brazilian publications on the broader topic of health system reform and decentralization, only a few empirical studies have been published that specifically address intergovernmental decision-making arenas and processes. Those studies that have specifically addressed this topic have highlighted the positive role played by formal intergovernmental decision-making arenas in implementing existing health legislation, ensuring a better distribution of financial resources among the different levels of government and improving the rationalization of health services and actions.

Most empirical studies on the topic of formal intergovernmental decision-making arenas have focused on decisions about systemic integration mechanisms for assigning public resources and sharing responsibilities for care, based on an analysis of results measured quantitatively. However, there have been a few qualitative studies presenting the views of the governmental actors involved in the process, expressing and analysing their interests, aims and power relations.

It is important to investigate the particular features of Brazil’s experience, bearing in mind the national and international debate over the importance of intergovernmental decision-making arenas and the role played by policy makers in decentralizing health policies.

Background

Brazil is a federation made up of 26 States, one Federal District and over 5500 municipalities which enjoy federative status and
political, administrative and financial autonomy. It is a huge country with a wide range of regional situations, restricting any political and administrative decentralization.

One strategy employed to regulate the intergovernmental decentralization process and integrate health policies was the establishment, by ministerial decree in 1991, of the National Joint Health Management Committee, known as the Tripartite Committee, in which the three levels of government were equally represented. Between 1994 and 1995, some 26 State Joint Health Management Committees, known as Bipartite Committees, were set up in all of the states, with equal representation of municipal and state health managers.

There is no legislation regulating the role of the joint health management committees; instead, there are regulations set by ministers. According to the ministerial regulation which established the joint health management committees, their primary objectives are to regulate all the operational aspects of the health policy decentralization process. They are defined as arenas in which health managers at the three levels of government may discuss, negotiate and agree on decisions. Their normative aims are to promote and manage intergovernmental integration and decentralization, and to draw up and discuss proposals on the implementation and operation of the Unified Health Service. One inherent feature in the decision-making process of the joint health management committees is the normative requirement for all their decisions to be reached by consensus among all the government representatives.

At present, the Tripartite Committee has 15 permanent members. Five are appointed by the Minister of Health, five by the joint national directorate representing the health management state agency (CONASS), and five by the joint national directorate representing all the municipal health management agencies (CONASEMS). The composition and distribution of representatives of state and municipal health management agencies in the Tripartite Committee are based on geographical criteria and cover Brazil’s five major regions.

The bureau of the Tripartite Committee is located at the Ministry of Health in the Federal Capital, where it employs technical support staff (on loan from the Ministry of Health). Meetings of the representatives of management bodies in the Tripartite Committee are held monthly and are sponsored by the Ministry of Health.

Over the last 10 years, the government representatives in the joint intergovernmental health management committees have developed, discussed, negotiated and decided on administrative and operational regulations for the establishment of Brazil’s Unified Health System. These regulations institute mechanisms for funding, planning, managing and organizing public health services throughout the country.

The purpose of this article is to provide a descriptive study with a strategic analysis of this particular intergovernmental decision-making arena and process within Brazil’s Unified Health System: the Tripartite Committee.

Methods

The approach adopted for this study uses the conceptual and methodological model from strategic analysis, which explored a rich field of research into power as a theoretical category of analysis applied to the field of health (Testa 1995; Matus 1996). This approach has sought to analyse asymmetry in the power relations between government actors depending on their resources, interests and political aims.

In this scope, politics is a means of distributing power and strategy a means of implementing policies. Political mediation is a theoretical category related to the search for intermediate objectives and temporary agreements between parties in a process of social agreement, although without necessarily giving up their own individual aims (Meszárós 1989).

The interplay and interaction involved in implementing policies make it possible to understand a symbolic logic, expressed in the form of strategies that may vary depending on the time and situation. These relational strategies may lead to convergence and cooperation or to divergence and competition or conflict.

This study is built around one case, the Brazilian Tripartite Committee, using a descriptive approach based on data and information from primary sources (interviews, reports based on direct observation) and secondary sources (documents). Information was collected using:

(1) Normative documents: formal documents available in the secretariats of both committees and covering a 5-year period (1997–2001) were copied and analysed.

(2) Reports on direct observation of meetings: the author attended meetings of the joint management committees selected for the case study over an 18-month period (January 2001–June 2002). Field reports, employing participant observation, were produced for all the meetings attended.

(3) Interviews with key informants: an outline was prepared with open questions linked to the aims of the study (opinions about the role of government representatives, the decision-making process, etc.). The interviewees were chosen from two federal, three state and three municipal representatives of management bodies of the Tripartite Committee, using criteria such as seniority, origin in different regions of Brazil, different states or municipalities, and positions held in the representative bodies of the health management agencies at the national and state levels. The limits of the study were determined by criteria for exhaustiveness and recurrence, depending on the topics covered and the requirements of the technique employed for processing and analysis.

The interviews occurred between January 2001 and June 2002, and were recorded before being transcribed. Confidentiality was ensured at all the interviews, together with compliance with the code of ethics for research involving human beings, approved by resolution no. 196/96 of the Brazilian National Health Council.

The texts were scanned and the empirical categories were coded using QRS-NUDIST ver. 4.0 software, adapted to the processing of qualitative data. The technique used to determine the empirical categories was the analysis of content by theme and category (Bardin 1979). Some key themes were defined previously, on the basis of the aims of the study; others, which
had not been predicted, emerged from the processing of the empirical material.

For the descriptive analysis, a sequence of combined focuses suggested by Testa (1997) was employed:

1. Systematic description of data and information;
2. Identification, interpretation and explanation of the meanings originated in the discourses of the actors or texts examined;
3. Synthetic analysis and understanding of the inherent significance of the content of the units of meanings and contexts identified in the above, in terms of any dialectical contradictions and lines of convergence between the concepts, political positions and strategies of the different actors involved.

Results

In the Tripartite Committee, informal negotiations about the approval and operation of ministerial norms that were created ad hoc predominated in the decision process.

The rules of procedure of the joint management committees set deadlines and information channels to allow representatives of all levels of government to submit proposals for inclusion in the agenda. However, in practice the agenda of the Tripartite Joint Management Committee is essentially decided by the Ministry of Health.

Some of the municipal and state representatives interviewed described the difficulties they encountered in having their own items included in the agendas, because they were overburdened with items previously submitted by the Ministry of Health. They think that this unilateral approach to proposals and norms makes it difficult to implement them nationally, as well as restricting the emergence of the municipal and state demands.

In addition, one constant complaint made by the representatives of the Ministry of Health and of the municipalities is that only transfers of federal funds to finance health policies are included on the agenda. This complaint is directed towards the state governments, since both federal and municipal representatives find that the state budgets lack transparency.

In this intergovernmental decision process, the ministerial actors frequently employed cooperation strategies oriented for ‘interchanges’, offering financial resources in exchange for adherence to their political and campaign proposals.

Some of the municipal and state representatives argued that many of the proposals made by the Ministry of Health are not really discussed as they should, i.e. their relevance, merits or justification, but are simply discussed to decide how they should be implemented. In such case, the representatives show a sense of pragmatism because they have realized that unless they negotiate and reach the consensus required for decisions, the decisions will be taken by the Ministry.

‘I think that the decision is taken by the Ministry of Health. You do one thing in an effort to reach a consensus. If you fail, the Ministry of Health adopts the norm regardless of whether there is a consensus…’ (Interview No. 09, state representative)

Certainly, on many occasions, the Ministry of Health submitted to the Tripartite National Committee norms that had already been issued and were in operation. On other occasions, it issued norms without submitting them to negotiation at the intergovernmental level. Such cases generally concerned matters relating to federal financial capacity and the willingness of the federal Government to cover the cost of particular health policies or measures.

One representative of the Ministry did not think that norms or proposals were imposed unilaterally, but rather that the health system’s major source of funds was following a legitimate and temporary strategy.

‘Obviously, we each use the means available to us; since the Ministry of Health provides most of the funding, it has to use this as a means of persuasion and of conviction, and as time goes on, it will have to accept negotiation.’ (Interview No. 06, federal representative)

The meetings of the Tripartite Committee are governed by formal rules to clarify such issues as coordination, agendas and ways of taking and formalizing decisions. However, in practice it is the informal rules that predominate in the decision-making dynamics. During the informal negotiations, temporary and changing coalitions are made between the representatives of the three levels of government, depending on their positions with regard to the items on the agenda.

When mediation is used to reach informal prior agreements, the matter is rapidly decided in the formal meeting. When it is impossible to reach an informal agreement, a decision on the controversial matter is postponed. The postponing of controversial decisions generally leads to the establishment of a technical group in which all three levels of government are represented. The group analyses the issue and has a deadline for making a compromise proposal. The controversial issue is put on the agenda for discussion only when an informal agreement has been reached.

The formal outcome of the meetings is the pact on joint decisions. These decisions derive their legitimacy essentially from the trust built up between the government actors. It is rare for these pacts not to be complied with, but when this happens, it gives rise to tension and conflicts that are difficult to resolve.

The positions taken by government representatives on the performance of the Tripartite Committee were both convergent and divergent. The same was true about their positions on specific themes inherent in their roles within the context and prospect of decentralization of health policies.

One position, on which representatives of the three levels of government interviewed agreed, is that there is still a disproportionate distribution of administrative resources, with a heavy concentration at the federal level. For these interviewees, it would be possible to correct this imbalance only through a broader reform (fiscal, political, etc.). They take the view that, in terms of decentralization strategy, the joint health management committees facilitate and catalyse some reforms that are necessary in order to decentralize health policies.

In the opinion of all interviewees, the lack of any specific legislation to regulate the existence and activity of the Health
Intergovernmental Committees is an obstacle to a clearer definition of their rights and responsibilities. In their view, mere regulation by ministerial norm is insufficient to consolidate the role of these joint management committees in decentralizing government.

Analysis of opinions regarding the process of intergovernmental decentralization of power and political autonomy in the health sector reveals another area of divergence. Some people think that the municipalities have not benefited sufficiently from political and administrative decentralization and that legislation giving municipalities managerial autonomy has not been complied with. These government actors draw attention to the excessive and normative control exercised by the Ministry of Health and the State governments over the municipalities. They also point to the excess of ministerial ad hoc norms, some issued without any form of consultation and others approved by the Tripartite Committee, which significantly alter what is already predicted in the law, and note that it is only responsibilities and tasks that are decentralized, while policy matters have been ‘recentralized’.

Another view is that excessive decentralization benefiting the municipalities led to a certain fragmentation of the health system and a distortion of the role played by the State governments. The same people point to ambiguities or shortcomings in health legislation, and justify adjustments to or adaptation of legislation through norms that have been agreed on by all three levels of government. In their opinion, times have changed, and there is a need for a major revision of the way the health system is organized.

One interviewee explicitly described the two positions on this topic:

‘Look, I think that the situation is very dynamic. There was a time in the history of Brazil’s health system when all the trends got together to achieve a single objective, when there was convergence among the rightist, centrist and leftist political orientations to build such a public health system. Nowadays, I might say, almost as a joke, that I think there are two major facets to the Brazilian health sector: on the one hand, the fundamentalists who support the Unified Health System, who believe that what was laid down by the 1988 Constitution and by the Health Service Organization Act is unchangeable, as if the world were not undergoing constant changes. Then, there are those who are more open-minded towards revision…’ (Interview No. 01, state representative)

The joint health management committees were set up as decision-making arenas of a technical and administrative nature, with the aim of helping to establish the health system; however, there is no doubt that they are made up of government actors to whom political and party responsibilities have been delegated. In their government management role in the municipalities, states or at the Ministry of Health, these actors decide the very nature of health policies, and not merely their implementation. Opinions differ over the nature of their decisions (technical, administrative or political), and whether their role is mainly to decide health policies or simply to determine how these policies are implemented.

Some of the interviewees think that the activity of the joint management committees is far more technical and administrative, by which they mean that their decisions are based much more on technical criteria and on the objective of making intergovernmental health policies operational. According to their view, the predominance of technical criteria in decision-making represents a major advantage, because in this area political interference is considered as problematic [interference by political parties, groups with strong specific interests (lobbies), etc.].

Other interviewees expressed a variety of opinions, and pointed out that decisions are taken on the basis of essentially political interests, and that coalitions of groups and parties of the same political orientation are more important than any technical or administrative criteria, especially when decisions concern the funding and planning of health services. In this case, decisions dictated by electoral or political party considerations are perceived as political decisions.

Even though these different actors hold different positions and views about the problems faced and the direction taken by the health policy decentralization process, they seem to have no doubts about the positive role played by the joint management committees as arenas for political, technical and administrative mediation between health managers at the three levels of government.

The main advantages described by the representatives of the Tripartite Committee were the permanent negotiation and the need to determine clear and common objectives in order to reach political agreements. There was virtual consensus that because it is excessively broad, the health legislation contains many gaps and uncertainties regarding the rights and responsibilities of each level of government. One of the roles performed by the joint management committees is precisely to provide dynamic and ongoing regulation of this distribution of responsibility.

Most of the interviewees from the three levels of government affirmed that involvement in permanent negotiations has improved their capacity to carry out health programmes and measures, because it allows a greater interaction and exchange of governmental experiences.

‘Permanent negotiation goes much further, has much more impact on the implementation of actions, not only because it has a knock-on effect, but also because it facilitates things, it makes consensus possible and makes it easier to introduce a policy, a programme or a project… I think that this is the advantage of a decision-making arena.’ (Interview No. 02, municipal representative)

Discussion

Despite momentary tension and conflict, the decision process of the Brazilian Health Intergovernmental Tripartite Committee has taken place through cooperation strategies oriented towards permanent negotiation and political mediation.

These strategies of cooperation oriented towards political mediation are compatible with the trend towards the gradual and negotiated introduction of decentralization in Brazil. Their adoption may result in a slower and more complex
decision-making process; however, they also define more clearly areas of institutional responsibility and ensure a broader support from different levels of government for the implementation of public health policies.

The study identifies a number of opinions among the actors participating in this intergovernmental decision-making sphere regarding the role and performance of the joint health management committees in the process of decentralizing health policies. At a given historical moment during the reform of the Brazilian health system, the differences between managers were perhaps ‘dormant’ because of efforts to attain a common objective: the establishment of the Unified Health System. In this context, the creation of the joint health management committees drew on this predisposition and on the need for intergovernmental negotiation in the joint effort to set up the Unified Health System within a new legal and constitutional framework.

With the prospect of growth and consolidation of the Brazilian Unified Health System and as a result of the new political circumstances, the differences between the managers’ political positions became more evident. These different positions arose within the Tripartite Committee and resulted in differences of opinion and disputes, which were nevertheless reconciled by a constant desire to negotiate and reach intergovernmental agreements.

Despite the difficulties and problems involved in reaching these intergovernmental agreements, the adoption of mutually agreed decisions is a means of safeguarding the role of these actors on the political scene, as well as being a means of restricting outside political interference and unilateral intervention by any single level of government. On the one hand, governmental representatives who have less institutional (political, administrative and technical) power have an interest in holding back attempts by those with more institutional power to take unilateral initiatives. On the other hand, those levels of government that possess more power have an interest in securing legitimacy for their positions and aims through intergovernmental agreements.

Interaction between these governmental actors generates constant tension between the types (political, technical or administrative) and levels of power that may potentially be brought into action and used, depending on the different aims and interests at stake. In practice, it is still the interests of the political leaders to whom the health managers’ representatives are linked that prevail (Minister of Health, governors, mayors, etc.). In addition, considerations of technical efficacy and administrative efficiency are of increasing importance. In this respect too, there are mediation strategies which seek to formalize technical and administrative criteria for decision-making, so as to restrict unilateral political interference.

The analysis of the information revealed by the discourse of government actors belonging to the Brazilian joint health management committees confirms a number of features identified by other studies of intergovernmental decision-making arenas and processes, some of which are mentioned in the introduction to this paper. They include:

- production of an excessive volume of (inter)institutional ad hoc norms (Banting and Corbett 2001);
- predominance of the informal decision arrangements (Wright 1990);
- predominance of the technical discourse to justify agreements among groups that seek political alliances and the institutionalization of conflicts (Ribeiro 1997).

However, positive features, some of them described in other studies, were also found, such as:

- wider dissemination and implementation of health programmes and measures thanks to a broader exchange among the different levels of government;
- the need for permanent negotiation to further mutual interests;
- mediation and regulation of the nature and limits of political and administrative autonomy depending on the degree of intergovernmental decentralization;
- reduction of political parties’ interference in decision-making; and
- cross-party action to consolidate and legitimize the public health system.

The views expressed by the actors involved in the joint management committees show that there are both benefits and drawbacks to this decision-making arena, although all of them recognize its usefulness and importance for the political and administrative decentralization of the government health sector.

For policy makers who are involved in intergovernmental decision-making arenas and processes, these analyses may foment discussion and examination of their own discourse and negotiation procedure, covering also the advantages and drawbacks of the strategies developed in this context. Nevertheless, this type of study is subject to certain limitations deriving from the emphasis on the procedural and political aspects of decision-making. It is also necessary to examine the ways and means by which these decisions are transmitted, and above all how they are implemented and what they achieve.

The findings of the study raise new topics for research into the kinds of strategies used to regulate intergovernmental political or administrative decentralization and to implement health policies decided within the joint health management committees and their results. Investigation of the internal dynamics of this decision-making arena, involving a study of the positions of and interaction between the actors themselves may provide new analytical approaches and further empirical evidence. Such analyses may complement other more contextual and normative types of evaluation.

Conclusions

The decision process of the Brazilian Health Tripartite Committee has been constituted from cooperation strategies based on permanent negotiation and oriented towards intergovernmental interchanges and political mediation.

Generally speaking, Brazil’s experience of the Tripartite Committee has revealed a number of difficulties, which mainly concern:

- the persistently unequal distribution of political and administrative power among the different levels of government;
• unilateral generation of ad hoc norms and institutional requirements, mainly by the Ministry of Health, without submitting them to intergovernmental negotiation;
• the preponderance of demands by the federal level of government on the agenda;
• the lack of discussion about the use made of state funds;
• the excessively informal nature of the decision-making process;
• the lack of any legislation precisely to define the rights and responsibilities of the joint health management committees.

Despite these difficulties, the different governmental actors involved in this decision process agree that the Tripartite Committee played a fundamental role in regulating the process of decentralization provided for by Brazil’s health legislation, and they believe that this will only be achieved by permanent negotiation between the three levels of government. They also agree that the intergovernmental permanent negotiations have improved their capacity to carry out health programmes and actions.

Acknowledgements

This investigation was supported by the Alliance for Health Policy and Systems Research, an initiative of the Global Forum of Health Research with the collaboration of the World Health Organization. The author thanks Ligia Maria Vieira da Silva of the Health Collective Institute/Federal University of Bahia (Brazil); Maria Eliana Labra of the Public Health National School/Oswaldo Cruz Foundation (Brazil) and Miguel Gonzáles-Block of the Alliance for Health Policy and Systems Research for their support, assistance and comments.

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