Abstract  This article introduces a new concept to the study of decentralization processes: policy dynamism. At its core is the notion that the sequential and temporal process of health decentralization affect the nature of intergovernmental relationships and municipal bureaucratic capacity. Examining the case of Brazil, I argue that the rush to decentralize health services to municipalities has, in the absence of sufficient financial and technical assistance from the federal and state governments, increased state-municipal conflict over the management of health policy, limiting municipalities’ ability to increase bureaucratic capacity. Consequently, some states have attempted to recentralize reforms, generating further conflict between both subnational levels of government. While some municipalities have tried to overcome these problems by creating associations and working with international organizations, several bureaucratic obstacles remain. This article attributes these outcomes not to federal institutions and economic constraints (the traditional approach in the literature) but rather to the noninstitutional, temporal policy dynamics of decentralization.

Introduction

Developing nations are now seeking to improve the provision of social services by decentralizing those services to state and municipal governments (Kaufman and Nelson 2004; Samuels and Montero 2003; Smoke, Gómez, and Peterson 2006; Haggard and Kaufman, forthcoming; Burki, Perry, and Dillinger 2000). The Federal Republic of Brazil is a perfect example of this. While the government decentralized fiscal and financial powers to the states shortly after independence in 1889, it only recently began devolving new welfare functions to states and municipalities.
In 1988, the government decentralized new administrative responsibilities in health care management to the municipalities. A somewhat functional form of decentralization took place overnight. That is, while the states and especially the municipalities were immediately given authority over administering health programs, they gradually financed many of these initiatives on their own, while simultaneously relying on fiscal transfers from the federal government. Transfers have gradually increased but have never been sufficient to meet state and, especially, municipal needs. This, in turn, has created an imbalance of state and municipal health administrative capacity, because state health agencies have more technical and financial resources than municipalities do. State and municipal governments do not fund all health initiatives on their own. Health financing is therefore still heavily influenced by the federal government. This form of decentralization has created a health care system that is universal and decentralized in theory but financially centralized in practice.

In this article, I introduce a new concept to the decentralization literature: policy dynamism. This approach examines the sequencing and tempo of decentralization and how the process of decentralization, in turn, shapes the performance of municipal health agencies. Since the early 1980s, policy dynamism has left Brazil’s municipal health agencies (e.g., hospitals and clinics) incapable of strengthening their capacity to manage, regulate, and provide health care services. This challenges the overall benefits of decentralization. In contrast to other studies emphasizing the role of political institutions in the bureaucratic reform process (Haggard 1995; Kaufman 1999), moreover, this article suggests that we consider the noninstitutional, temporal effects of policy dynamism as an alternative causal variable that shapes the capacity of municipal health agencies to adjust and make decentralization work.

1. In this article, I define decentralization as the central government’s assignment of new health policy and managerial responsibilities to both the state and municipal governments. Decentralization may include the center’s assignment of new fiscal and social-policy responsibilities, which may vary from a form of deconcentration (which is restricted to administrative autonomy) to something more devolutionary (which includes both administrative and financial autonomy). On the issue of health care policy, Brazil has followed a more devolutionary path. As I see it, what is most important for decentralization to progress is that municipal governments both receive and retain a relatively high degree of policy and administrative autonomy. A recentralization of authority to the states in any of these areas would therefore constitute a reversal of progress.

2. This is a key distinction and a problem that needs to be addressed. As in Brazil, a government may completely decentralize health administrative autonomy—that is, the management and implementation of policy—but not financial autonomy. In Brazil, while states and municipalities are capable of financing policies through taxation and borrowing, they are still very much dependent on the federal government for additional revenue, especially since many of the states and municipalities are highly indebted.
The general outcome of interest is the nature and functioning of the intergovernmental system for municipal health administration. Constitutional reforms in 1988 led to the immediate assignment of new financial and administrative functions to municipalities, but the sequencing of decentralization has been different for each level of government. That is, since the early twentieth century, states have had much more experience with health administration, specifically for public health. Municipalities, however, received no health care responsibilities until 1988.

This difference in the sequencing of decentralization has had serious consequences for the fast-paced tempo of decentralization and consequently the functioning of municipal health administration. At the time of the handover, municipalities were neither administratively nor technically prepared to handle the responsibilities of managing health care services. States were, however, and this led to municipal bureaucratic inefficiencies and a renewed interest by governors in taking back these administrative functions and withholding state-level support for much-needed administrative reforms. This phenomenon has complicated the relationship between municipalities and state governments. In addition, one must keep in mind the sheer quantity of both urban and rural municipalities, which total 5,043. This large number of municipalities causes fragmentation in the health care system that also complicates the strengthening of administrative capacity, because it limits the municipalities’ ability to obtain technical assistance from state governments.

In order to understand how policy dynamism has affected the nature and functioning of municipal health administration, I examine three key areas: (1) state and municipal government conflict; (2) the absence of sufficient municipal bureaucratic capacity; and (3) municipal entrepreneurship in seeking technical assistance and guidance outside of the state and federal governments’ purviews. The last is a more recent and interesting development, because state and municipal health officials in other nations have more generally been known to lobby federal legislatures for a change in policy instead of engaging in entrepreneurial activities (Montero 2001). The fact that we find similar initiatives occurring in other developing nations suggests that municipal entrepreneurship increases as state governments employ various tactics to regain control of health policy making from municipalities (Gómez and Edmonds-Poli 2001).

I close by conducting a cross-national comparison of the decentralization of health management. This is done in order to reveal the potential generalizability of the policy-dynamism approach. Moreover, the wider applicability of this approach shows that both nascent and more advanced
democracies (especially in Europe) are confronting similar policy challenges with decentralization.

**Decentralizing Health Management in Brazil**

In Brazil, the decentralization of health policy has historically been viewed as a key strategy for increasing the legitimacy and support of the federal government. As Malloy (1979) argues, this was especially the case under Brazil’s various military regimes (1964 – 1985). Even before that time, however, Getúlio Vargas’s military dictatorship (1930 – 1945) had decentralized management of public health services to the states (mainly in response to diseases such as yellow fever, malaria, and cholera) in order to advance economic development and increase the dictator’s political legitimacy. While the central government financed all health policies, the states were in charge of administering the provision of health care services (De Mello 1977; Sherwood 1967). During this period, moreover, the municipalities had no authority over any aspects of health care management.

Vargas’s ability to increase his legitimacy stemmed from the fact that epidemics were widely perceived to pose a major threat to both civil society and economic development (Hochman 1998). Other health issues, such as general health insurance, primary health care, and management, were administrative issues that did not pertain as much as political and societal attention did. Diseases such as yellow fever, malaria, and tuberculosis reached their apogee in case and death rates throughout the 1930s and 1940s. Therefore, successfully responding to these diseases helped to increase the military’s legitimacy and political support, especially as the government simultaneously pursued other reforms, such as recentralizing economic and political authority, that had the potential of undermining their rule (Malloy 1979).

In addition, the military’s willingness to work with influential members in civil society contributed to its popularity (Carrara 1999). Indeed, the emergence of very influential social movements in favor of combating disease coupled with the military’s unwavering commitment to modernity established precedents that continued to inspire military reformers to prioritize public health over any other health policy issue. No other issue attracted nearly as much social concern and thus political salience (Larvie 2003). Consequently, by the 1950s and 1960s, public health issues would usurp roughly 50 percent of the total federal health budget, indicating that the government was fully committed to combating disease (Filho
This knowledge contributed to the political elite’s perception that public-sector decentralization would be the best strategy for killing two birds with one stone: obtaining greater political popularity and legitimacy while protecting civil society and the economy through aggressive public health campaigns.

Decentralization of health care to the states occurred only in the area of public health during this period. All other aspects of health care, such as health insurance, were highly centralized. Beginning with Vargas in 1933, the central government provided a Bismarckian form of health insurance that, while falling under the purview of the Instituto Nacional de Assistência Médica da Previdência Social (National Institute of Medical Assistance for Social Welfare or INAMPS), only provided health insurance for workers in the formal sector. While the military governments temporarily experimented with the decentralization of privatized health care through partnerships between state-run hospitals and private health care providers, they did not proceed with privatization, and health care quickly reverted back to state ownership (Weyland 1996). Furthermore, the military never devolved health insurance responsibilities to the states and municipalities (Arretche 2005). Instead, health insurance was tightly managed by INAMPS at the federal level, despite incessant efforts by civil society and progressive bureaucrats within INAMPS to decentralize it (Weyland 1996). Federal resistance to this proposal emerged on the grounds that it would increase the government’s administrative costs (ibid.). These problems notwithstanding, the impetus for decentralization was born, dovetailing nicely with new social pressures for redemocratization.

It is important to emphasize here that, while the states had a lot of experience with decentralization, the municipalities did not. Indeed, with the exception of the 1946 constitution, which sought to increase municipal responsibilities through the decentralization of public works, municipalities did not have much responsibility for health care. In the early 1960s, for example, they spent, on average, only 3.4 percent of their total budgetary outlays for health care (Sherwood 1967: 80). This consisted mainly of expenditures for hospital construction, maintenance, and especially the purchase of hospital beds (ibid.: 80–81). The budgetary allotment for health expenditures was much smaller when compared to the outlay for other, similarly decentralized policy responsibilities, such as public works (39 percent of total expenditures), general administration (15.3 percent), miscellaneous services (14.6 percent), education (8.8 percent), industrial services (6.2 percent), financial administration (5.9 percent), and debt service (3.9 percent) (ibid.: 80).
In sum, the decentralization of health policy certainly existed prior to the 1988 constitutional reforms, but this was strictly limited to public health, while health insurance and health care was financed and administered by the federal government through INAMPS. There were efforts to decentralize privatized health care toward the end of the military campaign. Yet this strategy failed due to escalating costs. Crucial to our interests is the fact that the municipalities had absolutely no experience with administering health care. Although they spent a small portion of their budget on health infrastructure, they did not have any experience with administratively managing and implementing health programs. The 1988 constitutional reform was the first and only time the municipalities would receive these types of responsibilities.

Earnest efforts to advance the health decentralization process began in 1982, with the creation of the Integrated Health System (Ações Integradas de Saúde or AIS). In light of the hyperinflationary episode and efforts to reduce public-sector expenditures, the government sought to off-load all managerial and health policy responsibilities to the states through this initiative. These policies included not only public health but all other forms of health policy as well. The primary mission was to create, for the first time, a universal health care system, managed and controlled by the states, with an emphasis on primary care provision, an increased reliance on underutilized public facilities, and greater control over high-cost medical procedures and contracted service costs (Harmeling 1999). The goal was to fully decentralize the management and direct provision of all types of health care services, not only public health, as had happened in the past. Up until that point, these responsibilities were controlled by the Ministério da Saúde (Ministry of Health), through INAMPS. The AIS therefore increased the role and influence of the governors and state health secretariats, in turn contributing to the ongoing expectations that they should continue to manage all aspects of health policy. The AIS was also guided by the general belief that devolution would help increase policy efficiency through increased accountability and a reduction in administrative expenditures, thus expediting fiscal stabilization. Nevertheless, the federal government used INAMPS to retain full control over the financing and design of all health care programs.3

3. Instituto Nacional de Assistência Médica da Previdência Social (National Institute of Medical Assistance for Social Welfare or INAMPS) was responsible for transferring revenue collected from federal taxes, which were obtained from the states and general payroll taxes, and then redistributing revenues based on need. The poorer states were taxed less, with the government collecting approximately 6.2 percent of total revenues for those regions in 1981,
The next phase of decentralization came in 1987 with the introduction of the Sistemas Unificados e Descentralizados de Saúde (Unified Decentralized Health System or SUDS). This system essentially carried over the same principles outlined by the AIS, which included guaranteeing a universal right of access to all health services, augmenting state management and regulation of public and private health care facilities, and increasing the participation of civil society in the policy-making process (Odegbile 2001; Harmeling 1999). Under this program, however, the federal government further decentralized the decision-making process to state governments while increasing their control over the managerial and administrative aspects of health care. At the same time, SUDS gave the states the ability to decide if they should decentralize new administrative and policy responsibilities to the municipalities. Prior to 1988, decentralization to municipalities never occurred, and if it did, it was a very minor delegation of authority, done mainly to assist state control over health management and care. The decentralized health system thus marked the first attempted (although never completed) effort to create parallel managerial and policy implementation responsibilities at the state and municipal levels (Odegbile 2001). This, in turn, set the groundwork for the complete devolution of these responsibilities to the municipalities through the 1988 constitutional reforms.

Before this occurred, however, it was clear that SUDS marked a substantial increase in the governors’ authority to determine how much managerial autonomy the municipalities should receive (Nascimento 1999; Lobato 1998). Receiving this type of discretion further contributed to the governors’ sense of power and control over the municipalities. What is more, the governors were now required to control all staffing and training initiatives, which were previously controlled by the Ministério da Saúde, through SUDS. The priority under SUDS was to further increase the states’ managerial discretion over health care, despite the government’s new interest and effort to assign similar responsibilities to the municipalities.

The reforms that occurred in 1987 set the stage for the creation of Bra-
zil’s first universal welfare state. In hindsight, it seems that the hasty devolution of decision-making authority to the states under SUDS signaled the central government’s commitment to preparing the states for universal coverage. As one can imagine, the debates that ensued over the creation of a universal health care system were heated: the private sector, public sector, unions, and civil society all had conflicting interests over the types of policies to be implemented (Souza 1997; Lobato 1998). Nevertheless, by the time the new constitution was drafted in 1988, the authors of the first “Constituição do Cidadão” (“Citizen’s Constitution”) agreed that it was citizens’ right to have full access to health insurance (Lobato 1998).

The first decentralized universal health care system to emerge out of the 1988 constitution was the Sistema Único de Saúde (Unified Federal Health System or SUS). This system was established in order to completely decentralize health policy to the states and especially the municipalities. The goal was to bring health services closer to the people in order to target programs more effectively and to increase efficiency. The states and municipalities received different types of responsibilities, however. For the first time, the municipalities were in charge of administering and providing primary health care services, while the states were responsible for helping establish health policy goals and providing technical and financial assistance.

Indeed, starting in 1988, the municipal health secretariats were the only governing bodies in charge of planning, managing, and directly administering all aspects of health care (Silva and Tapia 2006). While creating health policy and providing services was a key goal of the 1988 reforms, equally as important was establishing a centralized administrative and managerial structure (ibid.). Mainly working through the hospitals, municipal health officials became responsible for concentrating and managing all aspects of health-service planning, financing, and employment. The states no longer took part in any of these initiatives, despite the fact that they had handled these responsibilities since 1982. Through the decentralization of managerial control, the municipal health secretariats became much more accountable for their actions.

In addition to creating health policies and programs (although in periodic consultation with the state health secretariats), the municipal health secretariats also worked with private and public hospitals to provide primary health care services, such as surgeries, medical treatment, and prevention services (Tavares de Almeida 2006). This collaboration was facilitated by the federal government’s transfer of all previously federally controlled hospital and ambulatory health care services to the municipal
secretariats (Medici 2004). In addition to being responsible for staffing hospitals with municipal government employees—both public and private, although most hospitals were privately owned—municipal secretariats were also responsible for contracting out services to the private sector, providing community outreach services, and increasing the number of public-sector jobs available for health care specialists (Silva and Tapia 2006).

The 1988 reforms also required that municipalities create community health councils in which citizens could participate and amplify their interests. Through these councils, health secretariats introduced new initiatives tailored specifically to community needs, such as the creation of a program to deploy family doctors and medical teams to distant communities. This program, which was initiated by the 1988 reforms, continues to this day.

Because of the 1988 reforms, states’ responsibilities for providing health care services decreased substantially. After the reforms, the states were only obligated to provide technical and financial assistance, not the direct provision of health services, to the municipalities (Silva and Tapia 2006). Furthermore, they were responsible for working with municipal health secretariats, through joint state-municipal health councils, for creating planning strategies and goals, as stipulated in article 18, sections 1 and 2, of the 1988 constitution (ibid.). The state health secretariats were to be stewards and assistants in the municipal health secretariats’ efforts to manage and provide primary health services. They were also responsible for periodically coordinating with the Ministério da Saúde to ensure that municipalities were adhering to their new policies (Arretche 2004). Regardless of these new roles, the 1988 reforms substantially reduced states’ autonomy and control over health policy. Consequently, several governors and health secretariats initially resisted these reforms (Silva and Tapia 2006).

Notwithstanding the quick decentralization of these new responsibilities to the state and municipal governments, one major problem loomed: that is, the federal government never clearly defined and determined the roles and responsibilities of the states and municipalities with respect to

4. In 1999, according to Mobarak, Rajkumar, and Cropper (2003), 67 percent of all Sistemas Único de Saúde (SUS) hospitals were privately owned. The remainder of the hospitals were owned by either state governments (8 percent) or municipal governments (23 percent). In 1999, only 27 percent of the clinics were privately owned, with state and municipal governments owning 3 percent and 69 percent of clinics, respectively.
SUS guidelines. It is important to note, however, that while Lei Organica (Organic Law) 8.142/90 clearly specified that the federal government retained the right to control the transfer of federal revenues for SUS initiatives, it did not clearly specify the rules and responsibilities of the states in this regard.

For instance, the constitution should have been clearer about how much the states should provide technical, financial assistance in the form of SUS transfers to the municipalities and when they should provide this assistance. As figures 1–5 illustrate, state-level SUS transfers have been quite low and unpredictable. While the 1988 constitution does specify that it is the states’ responsibility to provide technical, financial assistance to municipalities, it does not specify when states should do this or how much assistance they should provide. Such clarity is important because without it, state-level assistance is left to the complete discretion of the governors, a practice that, of course, can easily lead to political manipulation. Recent municipal health officials argue that this problem has negatively affected their ability to adequately finance important health programs for condi-

5. This law governed the conditions for health promotion and protection, powers and resources for each level of government, and procedures for managing health policies at the state and municipal level, including community participation through health councils and conferences (Lobato 1998).
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Figure 2  Rio de Janeiro: Total Expenditures for Municipal Health and Financial Aid from Federal and State Governments, 1997–2004 (R$ millions)

Source: Ministério da Saúde (n.d.)

Figure 3  São Paulo: Total Expenditures for Municipal Health and Financial Aid from Federal and State Governments, 1997–2004 (R$ millions)

Source: Ministério da Saúde (n.d.)
Figure 4  Manaus, Amazonas: Total Expenditures for Municipal Health and Financial Aid from Federal and State Governments, 1997–2004 (R$ millions)

Source: Ministério da Saúde (n.d.)

Figure 5  Salvador, Bahia: Total Expenditures for Municipal Health and Financial Aid from Federal and State Governments, 1997–2004 (R$ millions)

Source: Ministério da Saúde (n.d.)
tions such as tuberculosis and AIDS (Vera Galesi, director of the División TB, Centro de Vigilância Epidemiológica, Ministerio da Saúde Pública, Estado de São Paulo [Tuberculosis Division, Center for Epidemiological Surveillance, Municipal Health Department of São Paulo], interview, July 16, 2006; Bettina Durovni, director of the División de AIDS, TB, e Cólera, Departamento Municipal de Saúde Pública, Rio de Janeiro [AIDS/Tuberculosis/Cholera Division, Municipal Health Department of Rio de Janeiro], interview, July 18, 2006).

Finally, the same can be said for technical, human-resource assistance. While the 1988 constitution notes that this kind of assistance is also the states’ responsibility, it does not specify the type and amount of technical, human-resource assistance that states should give to the municipalities. Health care staff in most of Brazil’s municipalities are still underpaid. Thus it is difficult to train and retain staff. Again, the fact that specific provisions for this type of assistance are not clarified in the constitution leaves the amount of technical, human-resource assistance given open to state-level discretion and manipulation.

These problems have inevitably contributed to numerous ambiguities surrounding the SUS program. These ambiguities have kept the door ajar for the center to periodically intervene and decentralize/recentralize administrative functions between the states and municipalities—a problem that has contributed to bureaucratic ineptitude and hostilities between the states and municipalities.

Shortly after SUS’s implementation, new legislative programs were added to its framework: the Basic Operational Standards (Norma Operacional Básica do Sistema Único de Saúde or NOB) Numero Um (1991), NOB Numero Dois (1993), and NOB Numero Tres (1996). Under each of these programs, the decision-making, managerial, and regulatory aspects of health care began to change. The initial intent behind these programs was to further increase state and municipal governments’ managerial and bureaucratic responsibilities in providing health care services. More specifically, these programs sought to create a set of measures designed to lay a framework for a planning information system, to establish mechanisms for allocating funding to the states and municipalities, and to better define their managerial roles (Almeida et al. 1999).

Under the first legislative program, the role of the municipalities increased, allowing them, for the first time, to have complete autonomy over the managerial and regulatory process. Under the second one, however, the Ministério da Saúde reduced the municipalities’ managerial autonomy by making it more conditional, based on sound financial man-
agement, human resource capacity, and reduced corruption. Managerial autonomy could then be classified as incipient, partial, or semicomplete (Nascimento 1999). Under the third and final program, the Ministério da Saúde gave the state health secretariats complete discretion to determine these levels of autonomy (Lobato and Burlandy 2000). State health secretariats also focused on municipal financial and administrative capacity when deciding how much autonomy to devolve. Municipalities falling within the partial or semicomplete classifications continued as direct health-service providers, and the state assumed complete managerial authority. There has been wide variation in the provision of autonomy by state governments, with most municipalities receiving partial (low) levels (ibid.) — the exception, of course, being the larger, more developed cities, such as São Paulo and Rio de Janeiro.

These limitations notwithstanding, other initiatives introduced through this program try to increase municipal managerial autonomy through special initiatives, mainly in the hopes of kindling new interest in modernizing and enhancing administrative performance. It did so by creating two new managerial levels for the provision of basic health care services. The first is known as a *pacote especial* (special package) of procedures to be defined locally according to certain parameters, financed through the Piso da Atenção Básica (Program for Basic Assistance or PAB) and distributed on a per capita basis to the municipalities. The other is known as the Gestão Plena do Sistema Municipal (Full Management of the Municipal System or GPSM). In addition, the Ministério da Saúde provided financial incentives for mayors to implement and manage two new programs, Programa Saúde da Família (the Family Health Program or PSF) and Programa de Agentes Comunitários de Saúde (the Community Health Agents Program or PACS) (Almeida et al. 1999).

In addition, the more recent program’s emphasis on the quality of municipal managerial performance at three levels — incipient, partial, and semicomplete — emphasized the need to improve the technocratic expertise of staff members while improving bureaucratic efficiency. Two problems emerged, however, which limited municipalities’ ability to achieve these goals. First, the fragmentation of municipalities, that is, the geographical distance between municipalities in the more rural areas of the nation and the federal and state governments’ inability to reach and work closely with them complicate the latter’s ability to provide technical support. Additionally, in the larger, more rural areas (such as the Amazon), intermunicipal cooperation is much more difficult simply because of vast distance and difficult terrain, which complicate travel and timely assistance (Arretche
and Marques 2002). There is also the absence of a tradition of intermunicipal networking and support for health, which reflects the municipalities’ lack of historical experience with rendering health services on their own. Second, municipal conferences held over the provision of health services and continued to be dominated by officials and societal members seeking to maintain clientalistic networks of corruption (Almeida et al. 2000). These factors contributed to bureaucratic inefficiency and further corruption. But this is not the complete story.

Perhaps the most surprising development occurred only two years after the implementation of the more recent SUS program. In 1998, the federal government amended the 1996 program by deciding to recentralize the health managerial process back to the states. Almeida et al. (1999: 10) note that this “reversed the previous shift toward the municipalities, restored and strengthened the states’ role in coordinating and conducting the state health system, of which the respective municipal systems are a part.” Furthermore, they claim that “the state level is being restored as the sphere for co-ordination and articulation of the various municipal health service networks” (ibid.: 10). The federal government, through the Ministério da Saúde, recentralized and weakened municipalities’ autonomy in managing and regulating health policy. Moreover, this occurred despite municipalities’ increased responsibility in health care expenditures (see figures 1–5).

But why did this occur? In an era of increased political, fiscal, and administrative decentralization, why has the government introduced reforms that easily allow for the recentralization of authority back to the states? The following section submits a potential theoretical explanation. This is followed by empirical evidence.

**Policy Dynamism, Temporal Decentralization Processes, and Bureaucratic Reform**

To date, scholars of comparative politics, social welfare, and economic development have not paid enough attention to the issues of decentralization sequencing and tempo and their effects on bureaucracy. I refer to the sequential and temporal process of decentralization as policy dynamism. This is a temporal, noninstitutional decentralization process that shapes the design of intergovernmental relations and bureaucratic capacity. Scholars have overlooked this kind of approach mainly because they have strictly focused on only the tempo of decentralization, that is, the
fast or slow pace of reform and its consequences. While the tempo of
decentralization is important for understanding the immediate challenges
of policy implementation, this article suggests that it may be more help-
ful to combine this approach with a study of the historical sequencing of
decentralization. This combined approach can explain the differences in
previous experiences with decentralization between state and municipal
governments and the resulting differences in the degree of expectation
between these two levels of government in controlling health administra-
tion. This examination, in turn, helps to explain the tensions that arise
between both levels of government whenever an immediate “big-bang”
decentralization occurs.

The recent work of Shah and Thompson (2002) and Dickovick and
Eaton (2006) provides a good example of how the tempo of decentraliza-
tion affects policy performance. Through a comparative analysis, both sets
of scholars explain that the reasons why decentralized fiscal and welfare
policies often fail is because state and municipal governments are given
too much discretion for borrowing, expenditures, and administration too
quickly. In the absence of autonomous federal and/or state-level fiscal and
financial regulatory institutions, these big-bang decentralization processes
can lead to fiscal profligacy, deficits, and debts (Dickovick and Eaton 2006;
Rodden, Eskeland, and Litvack 2003). Additionally, for Brazil, Argentina,
and South Africa, Dickovick and Eaton (2006) and Dickovick (2002) find
that, because the federal constitution immediately decentralized financial
borrowing and taxation privileges to state and municipal governments,
presidents seeking to stabilize the macroeconomy were delayed because
of the incessant bargaining that occurred over changes to the revenue-
sharing process. This research illustrates that, even within different politi-
cal regimes, decentralizing too much fiscal discretion without the proper
hard budget constraints in place can lead to an increase in the bargaining
power of state and municipal governments. This occurs because these
economies are often perceived as being too big to fail, given the severe
ramifications that their failure could have for the macroeconomy (Stein
1999). Consequently, the federal government is often forced to bail out
state governments (Dickovick and Eaton 2006; Rodden, Eskeland, and
Litvack 2003). Elsewhere, I have argued that this dilemma often leads to a
policy-fluctuations problem, in which the government incessantly reforms
intergovernmental fiscal policy (i.e., decentralizing, recentralizing, and
back again) in order to avoid fiscal imbalances (Gómez 2003).

Shah and Thompson (2002), however, concern themselves with the
differences between the big-bang and gradual approaches to decentral-
ization. Shah and Thompson (ibid.: 18) explain that big bangs have two defining characteristics: “(a) [they are] holistic (comprehensive) and; (b) [they are] implemented at a lightning speed.” They argue that the holistic approach ensures that all pieces of the puzzle fit together—in other words, the desired balance in autonomy and accountability is achieved while providing incentives for cost efficiency. Local governments are given the resources and responsibilities they need all at once. Alternatively, Shah and Thompson (ibid.: 18–19) find that some governments take a more gradual approach to decentralization when (a) there is a strong political commitment to reform in the foreseeable future; (b) state and municipal governments do not have the institutional and fiscal capacity needed to handle all measures at once; and (c) the central government perceives that local capture by elites will lead to inefficiency, graft, and the inadequate distribution of social services.

The problem with this argument is that Shah and Thompson (2002) fail to realize that big bangs often occur when state and municipal governments do not have the administrative capacity needed to implement policy. As Smoke, Gómez, and Peterson (2006) and Barr (2006) argue, big bangs often occur because governments have political (mainly legitimacy and electoral) incentives to quickly off-load their responsibilities onto state governments, overlooking the administrative capacity of state and municipal governments. Indeed, as the Brazilian case in this article illustrates, governments may still pursue big-bang reforms even when they know full well that municipal health agencies are not prepared to handle new responsibilities. Therefore, in contrast to Shah and Thompson’s (2002) claim, the tempo of decentralization may not have anything to do with the actual characteristics of state and municipal governments.

While recent literature discussing the sequencing of decentralization policy explains how these processes increase the bargaining power of state and municipal governments (Falleti 2005; Montero 2001; Gómez 2003), we still know little about how the sequencing of decentralization complements studies that focus on the tempo of decentralization and how these two processes, in turn, affect the capacity of municipal governments to finance and implement new decentralization programs. While recent research investigates how greater technical training, transparency, education, and social networks enhance bureaucratic capacity and the delivery

6. I would like to thank Thomas Bossert at the Harvard School of Public Health for discussing this issue with me and explaining how this problem has negatively affected health policy performance in other countries, such as Colombia.
of social services at the lowest tiers of government (Grindle 1997; Tendler 1997), research on the specific linkage between the sequencing and tempo of decentralization and bureaucratic capacity is still wanting.

What is meant by the sequencing of decentralization? And why is it important? Sequencing refers to the various historical phases of decentralization and their relevance for future policy reforms. This concept is important because it helps us to better understand the sources of intergovernmental conflict (e.g., between states and municipalities) and why these conflicts intensify during and after big-bang reforms. Past decentralization policies have long-lasting effects on future decentralization reforms, especially state-level expectations of control over certain policy domains. This is because previous experiences with decentralization at the state level continue to perpetuate states’ expectations that they will control administration and policy at subsequent points in time. Political coalitions between governors and state health officials form and converge over these expectations, strengthening the power and influence of elites. These coalitions make it difficult to change expectations and the desire to maintain control over policy.

A problem, then, emerges when the rules of decentralization suddenly change. As is customary with big-bang reforms, governors and their administrators are accustomed to controlling all aspects of health care, and conflicts of interest between state and municipal governments inevitably ensue. This situation, in turn, complicates coordination and support for much-needed municipal administration reform.

Thus, decentralization sequencing, when combined with a fast-paced tempo, allows us to better understand the reasons why state governors may resist decentralization to the municipalities. At the same time, the sequencing also explains how the fast-paced tempo and consequences of decentralization create new preferences by state governors to scale back reforms and/or attempt to recentralize newly decentralized municipal administrative functions back to the states. Most important, the tempo of big-bang reforms imposes immediate threats to historically powerful governors who previously wielded complete administrative authority over health policy. This threat eventually generates preferences for a recentralization of administrative authority back to the states, especially when governors believe that recently empowered municipal health agencies do not have the technical capacity needed to adequately administer health care programs.

The next issue we need to address is how the policy dynamics of decentralization shape state government preferences at the ex ante (policy
implementation) stage (see table 1). For instance, under big-bang reforms, municipal bureaucrats often do not have the time needed to acquire the technical training and expertise found in experienced state-level health agencies. State agencies are often the first in line to receive new managerial and expenditure responsibilities and, accordingly, have much more time to develop administrative experience. These differences in sequencing have consequences for the nature of state-municipal relationships, specifically for which level of government should control health administration. Because municipalities lack the opportunity to develop managerial expertise, states develop preferences to regain their control over health administration. This, in turn, prompts governors to pressure the legislature for a recentralization of authority back to states. Indeed, as seen in Brazil, the immediate decentralization of administrative authority to inadequately prepared municipalities in 1988 ultimately induced governors to pressure the federal government for a recentralization of managerial authority back to the states ten years later.7

One can link the sequencing and tempo—in other words, policy dynamism—of decentralization to municipal bureaucratic performance by exploring how the ex post outcomes (outcomes after policy implementation) of attempting to recentralize health administration back to the states generate conditions that limit bureaucratic capacity building at the

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7. It is important to make the distinction between a recentralization of “managerial authority” and a recentralization of “policy.” While governors may wish for the latter, often they realize that formal constitutional changes cannot be made—especially in terms of decentralized health. However, governors may press for greater managerial influence by either intervening directly in municipal health policy or influencing policy through the provision—or not—of resources, such as training and supplies.
municipal level. Municipal bureaucratic capacity building can be limited by two factors: increased state-municipal bureaucratic tensions, on one hand, and the resulting lack of technical, administrative, and financial support that municipalities receive from state governments, on the other. State governments, in fact, use the latter as a tactic to limit municipal administrative capacity.

While the literature is just now beginning to address these issues, researchers, for the most part, have only focused on state-government suppression of broader municipal political and policy-making autonomy, especially for political purposes (McCarten and Vyasulu 2006; Gómez and Edmonds-Poli 2001). However, this literature does not specify the motivations and tactics that state governments use to suppress municipal bureaucratic capacity, especially in terms of health care management.

In addition, it is important to note that the presence or absence of an opposition party at the municipal level does not instigate this kind of state resistance. Rather, the broader loss of institutional and policy autonomy that historically influential governors experience leads to suppression tactics. A sudden loss of autonomy, even to a mayor from the same political party, challenges the governor’s authority, which in turn prompts opposition to decentralization. Other scholars have noted this type of response, especially as it pertains to fiscal and social-policy decentralization (Samuels 2003; Rodden, Eskeland, and Litvack 2003; Arretche 2005).

This argument seems to hold only for those countries with a long history of state-level political and policy control — for example, Argentina, Mexico, and India. Note, however, that the argument may not hold for decentralized polities in which state governments do not have such histories. In cases in which the decentralization process is new — especially in regions that have been historically dominated by highly centralized governments, such as Asia and most of Eastern Europe — the timing and extent of health policy decentralization have been the same for states and municipalities, thus providing similar levels of administrative and policy experience (Smoke, Gómez, and Peterson 2006). In other words, there is no difference in the sequencing of decentralization between both levels of government; consequently, few tensions emerge between them when attempting to reform health administration and policy (see figure 6).

Alternatively, when the prior sequencing of decentralization favors state governments and when state governments are hostile toward municipalities, what can the latter do to strengthen their bureaucratic capacity? One possibility is for state and municipal governments to work independently and/or together in order to find alternative ways of obtaining technical and
financial resources. The work of Fox (1999) and Gómez and Edmonds-Poli (2001) has shown, for example, that in the absence of federal and state-level assistance, municipalities will become entrepreneurial in finding new ways of funding new social-policy initiatives (e.g., through the marketing of municipal bonds). In these contexts, two strategies may emerge: (a) the creation of municipal associations in order to lend support to one another and to increase intermunicipal competition in a constructive manner, and (b) the establishment of strong links with international lending institutions.

Indeed, Nickson (1995) illustrates that the formation of municipal associations in Latin America has a rich tradition. However, Nickson’s analysis only pertains to the broader demands for political autonomy. It does not discuss how these associations are created for specific policy objectives (e.g., greater managerial autonomy and technical assistance). Yet, as this article illustrates, the creation of municipal associations for greater technical training and efficiency is taking place at a heartening pace, underscoring the fact that mayors create agencies in order to find

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8. According to Nickson (1995), municipal associations were formed as far back as 1939 in the Dominican Republic, 1954 in Paraguay, and 1967 in Venezuela. However, these associations were marginalized and abolished under the ensuing authoritarian regimes of the 1970s and 1980s.
alternative ways of increasing their managerial autonomy. Efforts to establish strong partnerships with international lending institutions, such as the Inter-American Development Bank and the World Bank, also indicate that, when in need, municipalities will work hard to find alternative means of finance and technical assistance (Reich 2002; Lieberman, Capuno, and Minh 2005; Fox 1999).

That these developments are occurring in several municipalities around the world suggests that there is ample room for cross-regional comparisons (Gómez 2003). Interestingly, the research to date suggests that municipal entrepreneurship increases in cases in which municipalities are historic victims of state suppression tactics (McCarten and Vyasulu 2006).

The fast-paced decentralization of health care management to the municipalities in 1988 had effects for state-municipal relations that eventually reduced the municipalities’ managerial autonomy. Understanding this situation sets the groundwork for comprehending recent entrepreneurial strategies at the municipal level.

The Consequences of Policy Dynamism

The consequences of policy dynamism first emerged when the 1988 constitution was introduced. With this constitution, the Brazilian government hastily devolved all health-management and policy responsibilities from the states to the municipalities. The problem with the constitution was that it automatically decentralized functional responsibilities to the municipalities without properly ensuring that they were adequately prepared to handle those responsibilities. That is, municipalities did not have the administrative and technical capacities needed to effectively manage and implement health policy. This complicated the governmental response to increased health inequality and epidemics.

Indeed, Lobato and Burlandy (2000) note that, during this period, the municipalities did not know how to properly recruit effective health care staff, retain them with sufficient salaries, and provide them with technical training. Furthermore, municipal health secretariats could not train their health-sector workers to become good administrative managers, nor could they provide them with safe and clean administrative environments (Barros 1996; Lobato and Burlandy 2000). Consequently, many municipal health care administrations became very ineffective in training staff, retaining them, and managing policy.

After the 1988 reforms, it became increasingly evident that the municipalities were not administratively prepared for decentralization. Because
of these problems, by the time the 1998 subnational debt crisis arose and the urgency to stabilize the macroeconomy increased, the federal government had good reason to recentralize the management and regulation of health care back to the states. As mentioned earlier, this recentralization process began to occur on the eve of Brazil’s 1999 currency devaluation crisis (Almeida et al. 1999).

Recentralization, a consequence of the policy-dynamism problem, was also aided by the types of institutions governing the health care management process. That is, it was aided by the presence of ambiguous laws and institutions introduced through Lei Organica 8.142/90, which guided the SUS program. That the federal government never clearly specified the municipalities’ responsibilities in managing health care facilitated the subsequent recentralization of authority to the states in 1998. It is not clear in the literature whether drafting ambiguous laws was the government’s intent or simply the result of uncertainty about what lay ahead. What is clear is that legal ambiguity provided a window of opportunity for those interested in reducing the municipalities’ subsequent managerial and regulatory autonomy.

Geographical factors also contributed to the recentralization process. Working closely with Brazil’s 5,042 municipalities did not generate incentives for the Ministério da Saúde to spend more time and energy retraining and guiding municipal health agencies. It made better sense to give more discretion back to state governments that had, on average, more experience with public health administration. Although state governments were responsible for working with municipalities and providing technical assistance under the AIS in 1982, by 1998 the municipalities were fiscally constrained and deluged in debt, making it difficult to adequately manage policy. Recent efforts by the Ministério do Planejamento (Department of Planning) in Brasília, the nation’s capital, to establish workshops and assign federal technocrats to provide technical assistance and guidance to the municipalities, especially in the poorest northeastern corridor of the country, indicate that municipal governments were never prepared to handle new managerial responsibilities (Ministério do Planejamento 2002).

Did politics drive the recentralization process? To suggest that Brazil’s influential governors may have pressured President Fernando Henrique Cardoso and the federal legislature into giving them more authority in 1998 is not a ridiculous proposition. Indeed, the highly fragmented, polarized nature of the Brazilian legislature, combined with the career incentives that legislatures have to support their governors, made it very easy for governors, especially from the largest states, to exert pressure and
incite the government to recentralize. The nature of the federal system emboldened governors’ abilities to achieve recentralization, because their strength in policy making and financial autonomy through decentralization increased their political influence (Samuels and Abrucio 2000). This, in turn, has allowed the governors to influence the creation and reform of social policy. Yet, while strong, federal and subnational pressures for reform did not appear to be the primary causal factor. Rather, it seems that the policy dynamics of decentralization eventually motivated the governors, especially those from large states such as São Paulo and Rio de Janeiro, to press to regain control over the health care process.

Published research that discusses subnational pressures for health-sector reform after decentralization is nonexistent, at least for the moment. Based on unpublished work and data, however, it seems that state-level preferences and pressures for recentralization mainly stemmed from the governors after the consequences of functional decentralization emerged. This interest in recentralization increased throughout the financial crisis of the late 1990s, when state and municipal governments were deluged in debt. The consequences of functional decentralization had finally come to light. Although potentially challenging states’ ability to handle the recentralization of authority, these fiscal conditions did not stop governors from asking the federal government for greater managerial and even financial control.

Indeed, by 2001 the federal government began to pay heed to these subnational requests. That year, the Ministério da Saúde signaled its intent to recentralize greater regulatory and coordinating authority to the state governments (Medici 2002). Moreover, for the first time the federal government hinted at recentralizing financial control for all health services to the states (ibid.). This seems to suggest that despite the states’ fiscal problems, the Ministério da Saúde believed that they could handle these new responsibilities better than the municipalities could. Although recentralized financial control has not yet taken place, governors’ unwavering pressure for reasserting states’ control over municipalities has paid off. This has been the case especially for municipalities, such as the large cities of Rio de Janeiro and São Paulo, that continue to struggle with fiscal problems.

In sum, the sequencing of decentralization contributed to the recentralization of managerial authority in 1998 and attempts to recentralize the financing of health care back to the states in 2001. This sequential process provides more theoretical leverage in accounting for recentralization, because it explains why municipalities never developed the bureaucratic
capacity and traditions needed to convince federal and state-level politicians that they were prepared to manage policy. The 1988 constitution quickly decentralized new managerial responsibilities to the states, beginning with the Lei Organica 8.142/90 of 1990. Unlike the states, municipalities did not have any time to develop the managerial expertise needed to adopt these responsibilities effectively. What is more, neither the states nor the municipalities had any control over increasing their annual allotments of fiscal revenues. Consequently, they could not increase spending to modernize institutions because the federal government controlled all moneys.

A wiser approach would have been to decentralize authority more gradually to the municipalities. Gradualism, as Shah and Thompson (2002) explain, acknowledges the fact that subnational institutions, especially municipalities, are not prepared for functional responsibilities. Federal governments, however, often rush to decentralize because of the mounting costs of retaining these responsibilities and because of state and municipal political pressures. Several nations around the world—for example, Vietnam, India, Brazil, and Cambodia—are quickly realizing that big-bang approaches to reform do not work as intended and that they need to recentralize authority back to state and/or the federal governments (Lieberman, Capuno, and Minh 2005; Smoke, Gómez, and Peterson 2006).

The ramifications of Brazil’s sequential drive extended beyond the recentralization of authority, however. The policy dynamics of decentralization added to growing hostilities and tensions between states and municipalities while contributing to the latter’s inability to acquire the technical and administrative support needed to effectively manage health policy.

The Peril of Policy Dynamism: State-Municipal Conflicts and the Limits to Bureaucratic Reform

Despite the municipalities’ increased experience with health financing and expenditures, the federal and state governments realized by the late 1990s that the municipalities were not prepared to handle the administrative functions given to them. The consequences of this realization led to several outcomes: (a) growing tensions between states and municipalities over the management of health care services; (b) states withdrawing technical assistance to municipalities and instead concentrating on and reverting back to their control over the health care management process;
and (c) increasing municipal entrepreneurship in working with other cities and international organizations to develop the skills and experience necessary to regain their control over health care.

Taking away responsibility from municipal politics, which many consider to be the “springboard” into national politics, is, of course, likely to generate hostility and resistance (Myers and Dietz 2002). Indeed, this occurred in Brazil. Immediately after the recentralization of managerial authority to the states in 1998, the mayors of the largest municipalities complained that they should retain control over the managerial process. The states rebutted that the municipalities were not prepared to handle those responsibilities (Heirmann 2002). Conflicts of interest ensued.

Growing tensions between states and municipalities did not help the municipalities to acquire the skills and resources needed to properly adopt and manage health care services. Since 1998, although mayors requested technical training and staff support from state health agencies, the governors refrained from providing any assistance and instead began to concentrate on their own managerial capacities (ibid.). Because state health secretariats were not willing to provide assistance, health officials at the municipal level were forced to try to obtain assistance from various universities, nonprofits, and international organizations (ibid.). While some municipalities have found technical assistance, the majority have not. Again, the poorest municipalities have suffered the most, being incapable of obtaining assistance because of their geographic location in the remote northeast and because of their dire financial circumstances.

While municipal health care agencies vary in their levels of performance, several studies confirm that they are, on average, inefficient in using monetary resources effectively, revealing their mismanagement of federal funding. Indeed, a major problem has been the lack of transparency in the financing of health policy. The challenge is that, in Brazil (and other nations), the sources of health financing are different from those that manage and redistribute money (Savedoff and Hussmann 2006). Consequently, while the federal government has transferred money for specific programs, often mayors and municipal health secretariats have redistributed the money to other social programs that provide more political payoffs. This was and continues to be a major problem in Rio, where several key vertical programs— for example, money provided by the federal government for tuberculosis treatment— have been rechanneled for other, more politically popular antipoverty programs (Ezio Santos de Filho, interview, July 12, 2006; Filho 2006). There is thus a lack of transparency when it comes to municipal health financing in Brazil (Filho 2006).
Corruption involving the unwillingness of mayors and municipal health secretariats to improve their civil service administration has also been a problem. For example, some scholars find that, within several municipalities, old institutions and political networks continue to delay the adoption of new managerial strategies (Ramminger 1997; Almeida et al. 1999, 2000; Tendler 1997). These activities are considered to be corrupt because they protect the employment of civil servants at the expense of hiring new ones who have better training and experience. Other studies have shown that the protection of employment has been a vital source of patronage and support for the mayors and governors (Samuels and Abrucio 2000). Although President Cardoso was concerned about these problems, few efforts were made to resolve them (Faria 2000).

Municipal health administrations also lack the proper staffing and managerial expertise needed to implement policies. Lobato and Burlandy (2000) find that health care managers earn low salaries and still lack the administrative structure needed to develop their new roles as managers. Also, these agencies have not effectively developed planning activities, which involve developing plans of action, scheduling, following up, monitoring, and assessment (ibid.). This has added substantially to the poor quality of administrative staffing and a decreased morale in the workplace.

Considering that most state governments have not been helpful in resolving these problems, several municipalities have taken the alternative, entrepreneurial route: that is, they have created new municipal associations in order to inspire one another, share knowledge, and establish stronger links with international organizations. In 1999, for example, several municipalities created what is now known as the Movimento Saudável da Municipalidade (the Healthy Municipality Movement). Several cities, such as Campinas, Santos, Curitiba, São Paulo, and Fortaleza, declared themselves as healthy municipalities and now work and compete with one another to obtain domestic and international recognition (Valencia 2002). A healthy municipality is described as one that is committed to eliminating corruption, providing social services in a timely manner, and maintaining a balanced budget (ibid.). In order to inspire each other to become healthier, municipalities participating in the movement have agreed to organize and participate in competitions for prizes. In 1999, for example, Campinas won the World Health Day best project award for their extraordinary management practices and efficiency in urban transportation (ibid.). Congreso de Secretárias de Saúde Municipais (the Congress of Municipal Secretaries of Health or CONASEMS), a large nonprofit
research organization, liked the idea so much that they became committed to helping municipalities create public contests.

Several municipalities are also working hard to establish Rede Brasileira de Municipalidades e Cidades Saudáveis (the Brazilian Network of Healthy Municipalities and Cities). The focus of this organization is to establish a network of supportive municipalities interested in enhancing the provision of health care and urban infrastructure and reducing corruption and violence. On August 9, 1999, several mayors organized a conference at the Pan-American Health Organization (PAHO) and World Health Organization (WHO) offices in Brasilia. The participants included ten mayors and eighteen municipal secretaries of health from twenty-eight municipalities in thirteen states (ibid.). At the end of the meetings, Dr. Angel Valencia, PAHO/WHO representative in Brasilia, noted that there was a renewed sense of commitment among the mayors to working together to make all of Brazil’s municipalities healthier (ibid.). Several new projects were proposed, and the participants agreed to organize and participate in yet another conference several weeks later on August 28, at the inaugural session of the twenty-fifth CONASEMS.

In addition to creating new associations and participating in conferences, Brazil’s municipalities are also establishing strong links with international lending institutions. In particular, several cities have actively sought the support of the Inter-American Development Bank (IDB) and the World Bank, pioneers in working with local governments to implement poverty alleviation and urban infrastructure projects. For example, Jack (2000: 26) explains that the IDB has been working with municipalities “to create new independent regulatory agencies, to cover issues of public information, solvency, accreditation of plans, quality, consumer rights, and risk management.” Jack also maintains that these connections have helped municipalities regulate health insurance programs, which have a long history of corruption because of the vested private-sector interests that are trying to safeguard these connections.

The IDB’s assistance in providing municipalities with the technical support needed to enhance bureaucratic efficiency is a good example of how several international agencies and think tanks are working with Brazil’s municipalities. What is most important is that mayors are demanding more assistance. Without the direct support of state health agencies and the federal government, there appears to be a new consensus among mayors that municipalities need to collectivize in order to find international assistance in acquiring more technical knowledge and guidance for managing health care programs.
This entrepreneurial impulse has not been directly and solely attributed to a lack of municipal financing. Rather, it has been caused by a combination of increased technical need and inadequate financial assistance from the federal and state governments. While municipalities have received a steady stream of federal funding for health care (especially for AIDS),\(^9\) many have not received an adequate amount of financial assistance for other health sectors and arguably more pressing health concerns, such as tuberculosis and malaria. As figures 2 through 5 illustrate, federal and state financial assistance for SUS (the universal health care system) has been next to nothing for both the richest and the poorest municipalities. However, while federal assistance for SUS increased for Rio de Janeiro (which has consistently been on the verge of bankruptcy), there has been only a modest increase in support for other municipalities. Worse still, neither federal nor state transfers come close to covering municipal health care expenditures. As these graphs illustrate, municipal expenditures for SUS far exceed any amount of revenue obtained from the federal and state governments. These conditions have put severe constraints on municipalities’ abilities to strengthen their health care systems.

In addition to these constraints, economists have argued that the fear of losing financial autonomy — especially for health policy — instigated municipal interest in creating municipal associations for technical support (Medici 2002). Continued fiscal imbalances among the larger cities have caused federal officials to be concerned that municipalities are not capable of managing and financing health policy (ibid.). This concern, in turn, has prompted municipal officials to continuously pursue initiatives that increase their financial and technical capacity.

Municipal entrepreneurship is not at all unique to the Brazilian case. Municipalities in several other developing nations are also experimenting with the creation of new associations, bond markets (to establish independent sources of funding for health care programs), and collaborative projects with international organizations (Gómez and Edmonds-Poli 2001). In cases similar to those of Brazil’s, Mexico’s and India’s municipalities, for example, suffered from a lack of financial and technical support in providing social services and maintaining sound economies. Seeking to increase their economic and political autonomy while striving to increase

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\(^9\) It is interesting to note the contrast in levels of federal financial and technical assistance for AIDS when compared to other health sectors. Federal funding for AIDS has increased and remained high over the years (for a host of reasons that I cannot concisely state here), while funding for other health sectors has not. This reflects a high level of favoritism with respect to the types of health issues to which the government is willing to respond.
local political competition, mayors from the opposition parties in both cases established new municipal bond markets and asked for the support of international donor agencies, such as the U.S. Agency for International Development, to help modernize bureaucratic agencies (Gómez and Edmonds-Poli 2001). The fact that municipalities in developing nations are engaged in similar entrepreneurial activities suggests that we have a lot to learn from cross-regional comparisons of how municipalities strive for more efficiency in the provision of social services while increasing democratic competition and participation at the lowest tiers of government (Gómez 2003).

**Conclusion**

This study of the politics of decentralizing health care management in Brazil has provided some key lessons for scholars concerned with the ramifications of decentralizing administrative functions too quickly. First, we have learned that the consequences of an immediate big-bang decentralization can lead to subnational bureaucratic incapacity in managing health policy. This study has shown not only how the fast-paced timing of decentralization provides an inadequate amount of time for municipalities to develop managerial expertise but also how the historical sequencing of decentralization, when combined with its fast-paced tempo — in other words, the challenge of policy dynamism — shapes governors’ preferences for recentralization of managerial authority back to the states. Recentralization efforts heighten tensions between state and municipal governments, decreasing any opportunity for constructive state-municipal cooperation for greater financial and technical support. As seen in Brazil (post-1998), such factors have undermined municipalities’ ability to adequately manage health care policy.

These challenges notwithstanding, what is interesting to note about this case study is that it shows how municipalities can work around these constraints. Many of Brazil’s cities have actively pursued the development of new municipal associations and programs with international lending institutions in order to obtain more technical and financial support. The incentives to engage in these activities increased once the inclination to recentralize began in the late 1990s. Paradoxically, this study further suggests that, in an era of increased health policy decentralization, any recentralization of managerial authority may have the beneficial consequence of increasing municipal entrepreneurship for greater financial and technical capacity.
This study has not tested and refined a hypothesis in order to construct a new generalizable theory of decentralization. Instead, it highlights the shortcomings of recent theoretical and empirical research and suggests new areas for future research.

Indeed, this study demonstrates the potential strengths of considering the sequencing of decentralization in the study of health decentralization processes, which is an issue that researchers seem to have overlooked. For example, scholars have tended to focus on the immediate and fast-paced tempo of decentralization without considering the utility of combining this approach with the historical sequencing of decentralization. For example, the work of Willis, Garman, and Haggard (1999); Samuels and Montero (2003); O’Neill (2006); Barr (2006); and Rodden, Eskeland, and Litvack (2003) all take a snapshot approach to the politics of decentralization. That is, they focus on the immediate presidential and political party incentives to decentralize, without considering how prior decentralization efforts shape contemporary processes. They are mainly interested in how decentralization serves to unload responsibilities onto state governments (thus freeing the federal government of its policy responsibilities), build and broaden legislative coalitions, and/or increase the political legitimacy of presidents and even authoritarian regimes (Eaton 2004).

The shortcoming of this literature is that it has not taken a policy-dynamism perspective into account in order to understand how a prior history of decentralization shapes its contemporary politics. As with Brazil, the decentralization of public health policy to the states throughout the 1930s eventually contributed to a high degree of state-municipal conflict over the control of health policy after health-management functions were quickly devolved to the municipalities in 1988. These tensions arose because of governors’ sudden loss of authority over health care management. This conflict of interest complicated municipalities’ ability to obtain technical and financial assistance from states, especially as the governors believed that the municipalities were unprepared to handle these new responsibilities due to their lack of experience in this policy area. Thus, in contrast to the aforementioned theoretical approaches, a more comprehensive theory of the politics of decentralization may require that we take into account historical policy sequencing and how the reforms of the past influence the more contemporary politics of decentralization.

The lack of policy-dynamism analysis is most vividly seen in the recent works of Shah and Thompson (2002) and Dickovick and Eaton (2006), who examine the tempo of decentralization but not the sequencing. In the absence of this kind of analysis, we end up knowing very little about
why conflicts of interest emerge between state and municipal governments after big-bang devolutions. Conversely, scholars such as Falleti (2005) and Montero (2001) have shown how the sequencing of decentralization affects the distribution of financial and political resources and thus the differences in the level of bargaining power between federal, state, and municipal governments, but they do not address the tempo of decentralization and its consequences. That is, they do not examine why the fast-paced tempo of decentralization — big bangs, for example — magnifies the level of conflict between state and municipal governments, compelling state governments to take advantage of their preexisting bargaining power in order to recentralize. Therefore, their approach tells us little about how the policy dynamics of decentralization further complicate intergovernmental relationships and municipal bureaucratic capacity.

This article also underscores the need to conduct further research on the comparative political economy of municipal social-policy reform. While the recent works of Nickson (1995), Campbell (2003), and Myers and Dietz (2002) have compared the decentralization of electoral competition and policy reform at the municipal level in Latin America, they have not compared the politics of reform after decentralization. In other words, these studies do not account for the political problems that mayors face after policy authority has been taken away from the governors and given, often too quickly, to them. Furthermore, this literature does not address the issue of what mayors have to do when they do not receive adequate financial and technical support from their governors. My study demonstrates that when mayors face these types of constraints, they often must resort to entrepreneurial activities, such as finding alternative means of finance and technical expertise. Future research will need to examine these issues from a cross-national comparative perspective and strive to establish similarities between different types of political systems in order to see if there are common municipal entrepreneurial strategies in the political economy of postdecentralization reforms.

What does this case study tell us about health decentralization in other regions of the world, such as Europe? If analyzed using the policy-dynamism approach, Western and Eastern European nations who have recently adopted decentralization as a principal means to rendering health services may want to be more careful about the timing of decentralization and the capacity that municipal governments have to implement policy. Recent evidence suggests that these two problems have challenged the decentralization process in this region (Bankauskaite, Saltman, and Vrangbaek 2004). However, analysts have thus far only looked at either
the capacity of municipal health administration or the timing of reform in these countries, not both.

Some claim that a major challenge to decentralization in Western Europe has ensured that municipal health agencies and hospitals have the adequate capacity needed to implement policy (Saltman and Figueras 1998). As is the case in Norway, when municipal governments are not prepared to implement policy, central governments have attempted to recentralize managerial authority back to the center (Bankauskaite, Saltman, and Vrangbaek 2004). Future Norwegian scholars may want to consider if the timing of decentralization was a problem and to what extent it complicated intergovernmental relations.

Others, however, have noted how the tempo of decentralization in several other European nations has been rather fast, with services often falling into the laps of municipal governments that are inadequately prepared to render them. This has especially been the case for former socialist states in Eastern Europe, although such problems are also beginning to emerge in Western Europe (Saltman and Figueras 1998). Going forward, scholars may want to examine the capacity of municipal health agencies in order to see if central and especially state governments doubt municipalities’ ability to render services or if the fear of losing autonomy motivates governors to suppress municipal autonomy. This approach is especially relevant to the case of post-Soviet Russia, in which state governments have had far more experience with decentralization than the municipalities (Newsholme and Kingsbury 1943) and in which state governments represented the interests of powerful central communist parties and/or parties aligned with the military.

However, one could argue that the historical uniqueness and institutional complexity of Brazil make it impossible to devise a generalizable theory of decentralization. Perhaps this may be the case, but perhaps it is not when we strive for generalizations within a restricted number of cases, such as those countries that currently experience similar problems with policy dynamism and consequently see similar entrepreneurial activities at the municipal level (Lieberman, Capuno, and Minh 2005). However, considering the dearth of evidence that exists on this issue and because many developing nations are still in the process of decentralizing health care management and/or are awaiting the results of this process, it may be more prudent to restrict the generalization of the Brazilian case study to only those nations that exhibit the following characteristics: large, highly decentralized federations; a long history of state-level political dominance with regards to health policy; and decentralization that has occurred essen-
entially overnight, without much assurance that municipalities are financially and administratively prepared to handle these responsibilities. Potential cases may include post-Soviet Russia, India, and Mexico. Some of these cases, such as Mexico and India, have already demonstrated this pattern of state-government suppression of municipal autonomy and entrepreneurship (Gómez and Edmonds-Poli 2001). This should encourage other scholars to conduct more cross-national comparisons in order to establish a more generalizable theory of the policy dynamics of decentralization.

Finally, by focusing on the challenge of policy dynamism, my analysis comports with Pierson’s (2005) suggestion that scholars consider how the temporal process of policy reform can be treated as an independent variable. In the realm of decentralization policy, research often overlooks the impact that policy sequencing and tempo has on municipal bureaucratic performance and policy outcomes. This leads us to overlook how the fast-paced timing of policy reform, for instance, shapes the rise of new preferences and interests in continuously recentralizing/decentralizing policy. Unfortunately, these incessant policy shifts are the main reason why decentralization often falls short of providing social services effectively (Gómez 2003). Any future big-bang approach to decentralization will more than likely generate new tensions between state and municipal political actors who differ in their levels of managerial experience. Big bangs represent fast-moving independent variables, whereas gradual decentralization processes are slow, well planned, and more likely to result in fewer tensions between state and municipal governments. Thus, understanding temporality in causal processes is important not only for our studies of decentralization processes but also for other areas in economic and administrative reform. To put it bluntly: it is time to take time seriously. As Pierson (2005: 1–2) maintains, we as social scientists often have limited time horizons in our analyses of causal processes, consequently focusing on the immediate rather than the more comprehensive historical and contemporary processes of reform: “In choosing what we seek to explain and in searching for explanations we focus on the immediate — we look for causes and outcomes that are both temporally contiguous and rapidly unfolding. In this process, we miss a lot.”
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