The Origins of Strong Institutional Design:

Policy Reform and Participatory Institutions in Brazil's Health Sector

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Over the past twenty-five years, countries throughout the world have passed national reforms that create participatory policymaking institutions: formal spaces that engage citizens or civil society groups in debating and deciding public policy. Latin America has emerged as a vanguard in the adoption of participatory institutions, with sixteen of the seventeen democratic countries in the region creating national frameworks for participatory institutions across a wide array of policy areas.[1] Yet many "mandatory" participatory institutions lack meaningful prerogatives or authority. In contrast, Brazil's national system of health councils is notable for its strong institutional design. A national legal framework mandates that all governments at the federal, state, and municipal levels implement health councils that engage health system beneficiaries, service providers, and workers in setting health policy and overseeing spending. Strong institutional design grants these councils extensive policymaking prerogative, which is backed by decision-making authority and enforcement mechanisms. Why and how do some participatory institutions, such as the Brazilian health councils, develop strong institutional designs to incorporate civil society actors into the policymaking process?

I argue that bundling participatory institutions with substantive policy reforms can unleash a path-dependent process that results in the development of a strong institutional design. Brazil's health councils were created as part of a sweeping overhaul of the health sector that extended universal coverage to all Brazilians, eliminated existing state agencies, and decentralized the financing and administration of health policy. Bundled policy reforms, such as the Brazilian health reform, can create opportunities and incentives to build a strong institutional design. First, substantive policy reforms introduce shifts in the political opportunity structure that make it easier to pass the laws and regulations needed to establish a strong design. Second, these policy changes can create incentives for otherwise reluctant stakeholders to mobilize behind a participatory institution as an instrument to obtain their policy goals.

This article makes important contributions to the study of participatory policymaking by exploring how participatory institutions accumulate formal authority over time. While establishing formal rules is not enough, institutional design shapes the potential of participatory institutions to incorporate the voices of civil society into the policymaking process.[2] As Leonardo Avritzer explains, "Design is not neutral. On the contrary, different designs have different consequences in the organization of political institutions."[3] While emphasizing the importance of institutional design, existing scholarship views design as an independent variable that affects the potential impact of participatory institutions, rather than an outcome that itself merits careful attention. However, strong designs do not simply appear; they develop through protracted political processes that span years, or even decades. Given that institutional design can shape the ultimate impact of participatory institutions, we must take seriously the crucial prior question of why and how strong institutional designs emerge in the first place.

As existing studies show, building a strong institutional design requires sustained support from politicians and civil society. However, existing explanations fail to account for why these actors gain a stake in participatory policymaking in the first place. Some studies have focused on how politicians adopt participatory institutions to dismantle their opponents' clientelist networks and construct rival electoral coalitions.[4] This electoral mobilization explanation fails to account for the development of the Brazilian health councils, which gained a powerful institutional design under right-wing and centrist presidents in the 1990s who opposed the expansion of participatory policymaking. Others emphasize the importance of autonomous and powerful civil society organizations that can hold governments accountable and can mobilize citizens to participate.[5] However, this approach fails to explain why civil society actors choose to mobilize in support of participatory institutions, instead of dedicating their limited time and resources to alternative strategies, such as lobbying or protest. In contrast to these explanations, this article points to the role of substantive policy reforms in creating political openings and incentives for otherwise disinterested actors to invest in participatory institutions.

This study of institutional design also has important implications for scholars of institutional strength and change. It challenges Levitsky and Murillo's conceptualization of strong institutions as those with high levels of enforcement and durability over time, but overlooks institutional design.[6] In contrast, I contend that the design component is key to overall institutional strength, in addition to enforcement and durability. Institutional design is essential to clarify what, exactly, must be enforced, and what must endure over time for an institution to be considered strong. Understanding the roots of strong institutions requires an analysis not only of their implementations, but also of their designs, and how they evolve over time.

Moreover, this article suggests an alternative view of the process of institutional conversion, which occurs when "political actors are able to redirect institutions or policies toward purposes beyond their original intent. . . . [when] actors who are not part of the coalition that created formal rules redeploy these rules to achieve their own

(sometimes very different) goals."[7] Scholars typically depict conversion as a means to subvert an institution.[8] However, this article reveals that conversion can strengthen fragile institutions by mobilizing well-resourced stakeholders behind the construction of a strong institutional design. In Brazil, diverse political and societal actors—including groups that already enjoyed access to policymaking—united to push for an expanded institutional role for the health councils. Rather than perverting the original aims of the institution, conversion can enable participatory institutions to reach their objective of including marginalized groups in the policy process.

This analysis draws on data collected during one year of field research in Brazil. I observed participatory council meetings at the municipal and national levels of government to gain an inside perspective on the institutional practices and dynamics within the councils. I also conducted fifty-nine semi-structured interviews with politicians, bureaucrats, civil society actors, and experts, which provided detailed information on the politics behind the construction of the councils and their role in the policymaking process.

Defining Strong Institutional Design

A strong institutional design grants a participatory institution formal authority to translate the inputs of societal participation into procedural outputs for the policy process. A strong institutional design includes three key components. First, the formal framework must outline clear and extensive prerogatives that the participatory institution will perform at each stage in the policymaking process. A weak design will grant the participatory institution a role in minor issues in the policy sector, while a strong design will involve it in the most important ones, such as budget allocation. Second, these prerogatives must be backed by formal decision-making (rather than consultative) power.[9] The design must spell out the authority of the participatory institution vis-à-vis other state institutions, delineating how to integrate the participatory institutions' decisions into policymaking. In contrast, a participatory institution with a weak design may be granted permission to contribute to debates and develop proposals, but the channels by which these debates and proposals affect policy change will not be specified. Third, a strong institutional design establishes effective enforcement mechanisms to punish non-compliant governments that fail to respect the decision-making authority of the councils.

Scholars and policy practitioners alike have touted the Brazilian health councils for having an unusually strong institutional design.[10] Laws and regulations grant the health councils extensive prerogative in setting policy priorities, designing specific policies and programs, deciding how funds will be allocated, and overseeing policy implementation and health spending. The health councils have formal rule-making authority, meaning that their decisions carry legal weight. Moreover, the extensive prerogative and decision-making authority of the health councils are backed by enforcement mechanisms. Most importantly, health council approval is needed to

receive federal transfers, giving the councils de facto veto power over the budget. While it remains rare for health councils to exercise this power, it is not simply an empty threat: the federal government halted transfers to São Paulo in the mid-1990s because the mayor, Paulo Maluf, excluded the municipal health council from health decisions. During interviews, politicians, bureaucrats, and councilors alike identified this enforcement mechanism as viable and politically powerful. While this design does not guarantee that the health councils will always have influence, it does make them a valuable institutional space to advocate policy change. As Luciana Tatagiba argues: "the legal authority to deliberate on public policies is the main force of the councils as spaces potentially capable of inducing democratic reform of the state."[11]

Creating a strong institutional design does not happen at a single moment in time; it occurs through a prolonged period of legal construction and adaptation. After the initial legislation is passed, additional laws and decrees are needed to flesh out a regulatory framework that provides more concrete guidelines about the prerogative, authority, and enforcement mechanisms of participatory institutions. Indeed, an appropriate regulatory framework cannot be crafted prior to implementing participatory institutions, because the myriad challenges associated with implementation are not known in advance.[12] To show why some participatory institutions construct a strong design, we must develop an explanation that accounts for not only the initial creation of the participatory institution, but also the extended process of strengthening its institutional design.

Argument: Bundled Reforms and the Politics of Institutional Design

This article adopts a "policy creates politics" approach, asserting that shifts in institutions and the substance of public policy can lead to broader transformations in interest representation. While others have viewed participatory institutions through the lens of deepening democracy, particularly in the context of Latin America's high levels of clientelism and exclusion,[13] I contend that we must also consider the emergence of these institutions as part of a broader restructuring of the administrative state.[14]

I propose a theory that highlights the powerful and long-term effects of the policy-reform origins of participatory institutions. The phrase "reform origins" refers to the content of the original policy reform that created the participatory institution. Does the reform simply establish a participatory institution, or is the participatory reform bundled with other changes that transform the content, governing institutions, and objectives of the policy sector? For instance, Brazil's health reform changed the content of health policy by initiating new preventative health programs. The reform also altered governing institutions by devolving power to municipal governments and creating health councils. Finally, it transformed the objectives of the health sector by shifting from a curative and exclusionary model, to a preventative and rights-based model. In contrast, procedural reforms establish a participatory institution but change little else in the policy sector, thereby creating fewer opportunities and incentives to strengthen the councils' institutional design.

Scholars of the policy process note that state reforms that invoke a major shift in the political and institutional environment are more likely to become institutionalized.[15] Others argue that the content of policy reforms can reshape the dynamics of interest representation by mobilizing supporters, demobilizing opponents, and introducing instability that disrupts policy monopolies.[16] Drawing on these ideas, I contend that bundling substantive and participatory reform can trigger the development of a strong design for participatory institutions in three ways.

First, substantive policy reforms introduce institutional openings in the political opportunity structure, making it easier to pass the legal changes needed to construct a strong institutional design. Policy reforms that decentralize services, create new programs, or restructure financing require new laws and regulations. Skilled policy entrepreneurs that favor participatory policymaking can take advantage of these moments of flux to insert clauses that expand the prerogative and authority of participatory institutions. Moreover, substantive reforms can interrupt existing policy monopolies and weaken the power of potential opponents. The reform may eliminate state agencies or funding sources, restricting the privileged access of vested interests to block the development of a strong design for participatory institutions. Even if these vested interests are not eliminated, they may be put on the defensive and thus forced to compromise, limiting their capacity to halt the institutional-design process.

Second, bundling participatory reform with substantive policy changes can attract the support of unexpected allies who might not otherwise mobilize behind participatory policymaking. This broad alliance goes beyond the "usual suspects" that typically support participatory policymaking, such as grassroots organizations, to include surprising advocates, such as subnational governments, professional associations, and business interests. Some members of this reform coalition may be indifferent—or even opposed—to the idea of participatory policymaking in another context, yet will advocate for a strong institutional design if they have a stake in the reform's substantive policy changes. A broad reform coalition with access to extensive organizational and material resources is helpful in engaging large-scale demonstrations and lobbying efforts to pressure the government into establishing a strong design.

Given the technical and political complexity involved in implementing sweeping policy reforms, the mobilization of a broad reform coalition is also crucial for attracting the support of reformist politicians that might not otherwise support participatory policymaking. Technically, if civil society actors possess unique information, the participatory institution can serve as a site to develop much-needed policy proposals. Politically, participatory institutions secure buy-in among diverse geographical and functional stakeholder groups. In federal countries, such as Brazil, buy-in is essential to ensure successful policy implementation on the ground.

The bundling of participatory and substantive reforms can also create powerful feedback effects that strengthen the institution-building process over time. As the participatory institution gains formal policymaking authority, it can attract additional supporters from society that seek to take advantage of this space in order to advance their substantive policy interests. For example, conservative politicians with little

commitment to the norms of participatory policymaking might try to mobilize their supporters to participate on the councils, lest rival parties gain greater access to policymaking. Furthermore, bolstering the initial institutional design can create additional institutional openings, which strengthen institutional design: councilors take advantage of their access to the policy process to expand the participatory institution's policymaking prerogative, authority, and enforcement mechanisms.

I do not claim that bundling substantive and participatory reform will always lead to the development of a strong design for participatory institutions. Not all reforms create the same degree of institutional opening, nor do they necessarily mobilize support in favor of participatory institutions. Instead, the following analysis of Brazil's health councils elaborates the mechanisms by which bundled policy reforms could enable the development of a strong design for participatory institutions.

Brazil's Bundled Health Reform

Prior to the onset of health reform, Brazil's health system reflected societal inequalities. The wealthy, middle class and unionized working class gained access to medical care via a centralized, state-run health system, INAMPS (*Instituto Nacional de Assistência Médica da Previdência Social*). INAMPS received ample state funding and provided broad coverage for its members, with an emphasis on quality, hospital-based curative care rather than broad, preventative public health efforts.[17] The private sector played an integral role in service delivery: in 1975, the federal government had 3,585 contracts in the provision of medical care; of these, 3,191 were with private companies.[18] Under the old health system, options were limited for the approximately 40 percent of the population not in the formal sector, and thus excluded from the health system.[19] Public health remained the poor cousin of curative medical care, receiving only 15 percent of public financing in health in the late 1970s.[20] When the uninsured did require medical attention, their options were limited to seeking uncertain help from philanthropic hospitals, or visiting dilapidated public hospitals, which were few and far between.

Brazil's 1988 Constitution and 1990 health statute bundled the creation of participatory health councils and sweeping substantive changes to the health system with the establishment of the Unified Health System (SUS—*Sistema Único de Saúde*). Whereas the old health system was exclusive, centralized, hospital-based, and technocratic, SUS would be rights-based, universal, decentralized, preventative, and participatory. Article 196 of the 1988 Constitution shifted the objectives of health policy by presenting health as "a right of all and a duty of the state." Under the old health system, those outside the formal labor market had no right to health. Under SUS, every citizen of Brazil has the right to health. Bringing new beneficiaries into the health system and expanding preventative care required the establishment of new health programs and policies, and while the prior system was fragmented and centralized, SUS would be unified, integrated, and decentralized. As part of an integrated system, health agencies at the federal, state, and municipal level would work together, with the bulk of

health service delivery happening at the municipal level. SUS would have a participatory orientation, with health councils operating at all levels of the government to oversee the implementation of the integrated and decentralized system.[21] According to the 1990 health statute, the health councils would have a considerable role in the policymaking process:

> The health council, in permanent and deliberative character . . . will act in the formulation of strategies and in the oversight of the execution of health policy at the corresponding level of government, including in economic and financial aspects. The decisions of the council will be accepted by the legally-constituted chief executive at each level of government (Law 8142 of 1990, Article 1).

In sum, Brazil's health councils originated in a bundled reform that not only created a new participatory institution, but also disrupted the objectives, governance structures, and content of health policy, opening the door to participatory institution building in subsequent years.

The Roots of Brazil's Bundled Health Reform

How and why did the health councils become bundled with the substantive elements of Brazil's health reform, including the expansion of preventative health programs, universalization of coverage, and decentralization? The origins of Brazil's bundled health reform stem from two factors that emerged during the 1970s and 1980s: the advent of grassroots health movements that used a social-rights discourse and efforts by dedicated experts to transform health service delivery.

During the later years of Brazil's military dictatorship (1964–1985), a new form of civic organization emerged in Brazil's urban periphery: social movements that linked together material demands—including healthcare—with calls for an expansion of social-citizenship rights. Brazil experienced a massive increase in urban mobilization in the 1980s: the number of civic associations tripled in Belo Horizonte, doubled in Rio de Janeiro, and increased by one-third in São Paulo.[22] These movements mobilized around material grievances—such as housing, the cost of living, nutrition, and healthcare—and framed their claims through a social-rights framework.[23] They demanded not only the expansion of core social services, but also a return to democracy and a greater role in the policymaking process.[24] The popular health movement (*movimento popular da saúde*) emerged as part of this new mode of civic activism as militants questioned the poor quality and limited coverage of health services and demanded the expansion of healthcare as part of their citizenship rights.[25] Rejecting clientelist dynamics, these activists sought a new mode of engagement with the state via participatory spaces in which they could articulate demands, push for accountability from the state, and shape the implementation of programs.[26] Thus, by the 1980s, civil society was already mobilized around the idea of a rights-based and participatory reform of the health system.

During this period, health professionals also organized in favor of health reform. A group of public health academics and professionals, called *sanitaristas*, were motivated by an ideological commitment to rights-based and universal healthcare.[27] In the 1970s and 1980s, the *sanitaristas* adopted a strategy that they called "occupying the state": they assumed positions in the bureaucracy with the aim of dismantling the old health system and advancing their reform objectives.[28] Military leaders named *sanitaristas* to key positions in municipal and state secretariats of health, as well as federal posts in INAMPS, and the Ministry of Health. From these positions, *sanitaristas* initiated a series of policies to decentralize healthcare, expand coverage, and promote preventative health interventions. For example, in 1976, *sanitaristas* in the Ministry of Health launched PIASS (*Programa de Interiorização das Ações de Saúde e Saneamento*), which established primary healthcare posts in rural areas of the Northeast and the state of Minas Gerais.[29] Despite making important advances, however, the *sanitaristas*' strategy of occupying the state reached its limits by the mid-1980s. Deepening reform would require eliminating INAMPS, the centralized agency that administered the previous health system and prioritized a curative model of care. Yet *sanitarista* bureaucrats could not unilaterally dismantle the agency, given the power of private-sector actors that received state contracts.[30]

In the face of these institutional obstacles, the *sanitaristas* switched to a mobilizational strategy, joining forces with the popular health movement and other stakeholder groups. Achieving the *sanitaristas*' reform objectives would be easier if changes to the health system were debated and decided on in the public sphere, and not behind the closed doors of the bureaucracy.[31] Furthermore, the fact that the popular health movement had already mobilized around a rights-based health system made working together easier. The *sanitaristas* began advocating for participatory institutions as a means to advance the health reform and secure its implementation in the future.

To advance these goals, *sanitaristas* called for the 1986 National Health Conference, which brought together thousands of Brazilians—including representatives from the popular health movement, patients groups, health workers unions, clinics and hospitals, health bureaucrats from all levels of government, and members of Congress—with the aim of designing a new health system. The final conference report called for a new health system that would be unified, decentralized, participatory, and integrated, and argued that health councils must serve as an integral component of the health system.[32] Thus, the conference report called for a bundled health reform that linked major substantive changes to the health sector with the creation of a participatory institution.

The alliance between these diverse stakeholders was formalized in May 1987 with the creation of the National Health Plenary, a coalition that sought to work out the details of the new health system according to the principles established in the 1986 Conference. The participants in the National Health Plenary all had a stake in the substantive elements of the proposed health reform. Beneficiary groups, including the popular health movements and disease-specific associations, stood to benefit from the introduction of new health services and universal coverage. Unions of healthcare

workers were interested in the health reform because it offered enhanced job security and benefits for health workers. Finally, subnational governments would benefit from the fiscal and administrative decentralization of the health sector and had a major stake in ensuring that these additional responsibilities did not become an unfunded mandate.[33]

While these actors had vested interests in the proposed substantive changes, their stakes in the participatory elements of the reform were less direct. Beneficiary groups—especially the popular health movement—seemed to have the most to gain from the health councils, since they lacked other avenues to influence health policy. Yet public health professionals (and, to a lesser extent, unions) already enjoyed access and thus were less dependent on the opening of new participatory spaces to channel their demands. Moreover, subnational governments would seem particularly unlikely to support the construction of health councils that could limit their discretion and authority.

These diverse stakeholders developed an interest in building a strong design for the health councils for two reasons. First, the 1986 National Health Conference established participatory health councils as an integral part of the health reform's decentralized structure, along with the establishment of modern financial accounting systems and information management procedures. Thus, any attempt to weaken the health councils was interpreted by these stakeholders as an attack on decentralization.[34] Second, the health councils would serve as an arena for members of the reform coalition to advocate for the ongoing implementation of SUS. The National Health Council would serve as a site to deliberate the development of the new regulatory framework, and subnational councils would play a key part in monitoring implementation of SUS throughout the country. Thus, the health councils became useful for members of the reform coalition to achieve their substantive policy goals.

Not all actors benefited from the new health reform. The proposed health reform would weaken the power of private-sector actors that had benefitted from cozy relationships with state agencies in the past.[35] However, by 1987, it had become clear that some type of reform would happen, and private sector service providers worked with the National Plenary to ensure that they would continue to have a role in the new health system.[36] In these negotiations, private sector providers prioritized their demands for a mixed public-private health system, while ceding to proposals for participatory health councils. [37] By gaining the acquiescence of private-sector groups, the reform coalition ensured that future clientelist politicians would have fewer tools to block the creation and implementation of the new health system—including the participatory health councils.

Creating the Initial Legal Framework

The 1988 Constituent Assembly served as one of the defining moments of the democratization process and thus presented a tremendous opportunity for the health reform coalition to consecrate their vision of a rights-based, participatory health system. The National Health Plenary played an active role in the Constituent Assembly,

traveling throughout the country to collect signatures for a proposed popular amendment for the constitution, ultimately obtaining 54,133 signatures from representatives of 168 different civil society organizations.[38] The final 1988 Constitution included articles that reflected the core principles of bundled health reform from the 1986 National Health Conference, including the emphasis on popular participation as well as the calls for universal coverage, integrated service delivery, and decentralized administration of healthcare.

This success in advocating bundled health reform at the constituent assembly advanced, in part, due to the limited opposition by private-sector actors that had been appeased during earlier reform discussions. During the National Health Plenary, members of the health reform coalition had already negotiated with private-sector service providers that stood to lose from the new health system, securing providers' acquiescence to the bundled health reform.[39] Still, some conservative politicians viewed the participatory institutions in the new health system with wariness, fearing that the councils would provide access to the left at their expense. A top bureaucrat at the time argued that gaining private sector buy-in made the movement's proposal seem non-partisan, and thus palatable even to conservative politicians:

> In the final vote it was important that the conservative sectors ended up supporting the creation of SUS, agreeing with its principles. [. . .] We gave up a few things, but the important thing is that in the core of the question we did not cede anything: universal coverage, equity, decentralization and *controle social* [societal oversight via councils]. *Controle social* was the most difficult to achieve.[40]

In the end, nearly all of the final constitutional text for the health system would come from the reform coalition's popular amendment, including provisions saying that SUS would be governed through popular participation of the community.

Following this, the health reform coalition turned its attention to the next task: translating the principles of a rights-based, participatory health system into law. Brazil's new president, Fernando Collor de Mello (1990–1992), staunchly resisted the establishment of a decentralized and participatory health system. It was only through extraordinary levels of mobilization that the reform coalition managed to overcome Collor's intransigence. In 1989, to prepare for the upcoming legislative battle, the National Health Plenary developed concrete legal language based on the bundled reform proposed at the 1986 National Health Conference. The coalition mobilized beneficiary groups and secretaries of health to lobby their members of Congress, arguing that the health reform was something that their constituents demanded. Eduardo Jorge, a *sanitarista* physician and Congressional deputy from São Paulo, explained:

> Members [of the reform coalition] sought out deputies that were in the opposition so that these deputies realized that they had constituencies that were networked and capable of criticizing them. . . . A deputy isn't afraid of a broad-based protest. If his constituency is from [the interior states of] Pernambuco, or Paraíba, or Amapá, then his constituency isn't very affected by this protest, so he is immune and resistant to pressure of this sort. . .. But, when the federal deputy from Ceará [a small northeastern state], for example, receives a

> visit from state deputies, and from city councilmen, and from municipal secretaries of health from the interior of Ceará, he pays attention because he knows that this issue will have repercussions for his city, for his constituency.[41]

Ultimately, the health reform coalition secured passage of its health statute legislation in September 1990. This bill mandated the creation of participatory health councils with formal policymaking and budgetary authority at all levels of government.

Despite this success in Congress, President Collor line-item vetoed eleven key articles of the bill, including those related to decentralization, integrated service delivery, and societal oversight via health councils and conferences. In the explanation of his veto, Collor argued that the provisions related to the councils and conferences were unconstitutional, since only the executive had the authority to create state agencies, and that the councils should be considered state agencies.[42] This veto outraged proponents of the health reform. Politicians, subnational governments, beneficiary groups, and even private sector service providers—presumed opponents of the health councils—united to advocate a new bill that would mandate decentralization and the creation of health councils.[43] These reform advocates worked with Alceni Guerra, the Minister of Health, to develop a new bill that would recoup the vetoed articles from Law 8080 nearly verbatim.[44] Law 8142 was proposed on November 16, 1990 and passed just six weeks later. Facing intense political pressure from Congress and stakeholders with a vested interest in the reform, Collor reluctantly signed the second bill into law, just two months after the line item veto.[45] If the coalition had not mobilized subnational secretaries of health and other stakeholders with a vested interest in the substantive elements of the reform, it is unlikely that it would have been able to ensure the passage of a health statute that established mandatory health councils at all levels of government with formal policymaking and budgetary authority. It also would have been challenging to advance this proposal if private sector opponents had not started from a weak position and looked to prioritize their top concerns—which did not include opposition to language about popular participation.

While the 1988 Constitution and the 1990 health statute provided an important legal foundation, the institutional design was not yet complete. Translating the core principles of SUS into reality would require extensive additions to the legal and regulatory framework. The shift to decentralized and integrated administration necessitated clarifications of the new roles and responsibilities for agencies at each level of government and the elimination of the old health agency, INAMPS. New financial instruments would need to be established to transfer health funds to subnational governments. Moreover, ensuring that subnational governments fulfilled their responsibilities would require additional monitoring and enforcement mechanisms. Finally, the concrete prerogatives and authorities of the health councils would need to be delineated. Although the health statute had stated that councils would have a "permanent and deliberative character" at all levels of government, only 39 percent of municipalities had established the "mandatory" councils in 1992.[46] In sum, extensive regulatory orders were needed to develop a strong institutional design.

Developing the Councils' Regulatory Framework

The 1990s and early 2000s were a period of considerable instability in the health sector, as new rules and regulations led to shifts in its bureaucratic structure, financial flows, and programming. Between 1991 and 2002, six regulatory orders were passed to flesh out the governing institutions of SUS. The first two orders, passed during the tumultuous Collor government, contradicted the mandates of SUS. However, the remaining regulatory orders focused on the decentralization of health services and financing to subnational governments. These regulatory orders provided key political openings for reform advocates to push for the implementation of SUS—and in the process, they clarified and expanded the prerogatives, lines of authority, and enforcement mechanisms of the health councils.

In the early 1990s, both SUS and the health councils faced an uncertain future. While Collor had been unable to stop the passage of the 1990 health statute, he resisted implementing the reform. In 1991 and 1992, Collor's government issued regulatory orders that contradicted the 1990 health statute's mandates to decentralize responsibilities and finances to municipal governments.[47] Moreover, these regulatory orders did nothing to develop the institutional design of the health councils.

Constructing the regulatory framework behind the health system became an easier task once Collor was impeached in 1992.[48] In 1993, the old health agency, INAMPS, was eliminated with Law 8689; 96,000 employees were dismissed or transferred to new agencies.[49] The elimination of INAMPS disrupted the old iron triangles between that agency and private sector service providers, neutralizing potential opponents and opening up additional space for advocates of the new participatory health system. Later that year, the Ministry of Health approved a new regulatory order that established initial guidelines for decentralization. The 1993 regulatory order introduced a procedure to transfer funds to the state and municipal levels, established information and monitoring systems, and outlined new roles and responsibilities of both state agencies and health councils at each level of government.[50] This order gave the health councils formal policymaking and budgetary authority—a key feature of the councils' strong institutional design. Nevertheless, it did not clarify how this authority would operate in practice, nor did it establish enforcement mechanisms, meaning that further regulatory orders would be needed.

The regulatory framework behind the health councils expanded further during the presidency of the centrist technocrat, Fernando Henrique Cardoso (1995–2002)—an unlikely government to construct powerful participatory institutions.[51] Indeed, Cardoso's first Minister of Health, Adib Jatene, initially opposed installing the National Health Council, arguing that the Council was no longer necessary.[52] The Cardoso administration supported the implementation of the decentralized and integrated health system as a more efficient alternative to the unequal and patronage-ridden health system of the past, yet it did not embrace the social-rights framing advocated by the health reform coalition.[53] Cardoso seemed more likely to dismantle than construct

participatory institutions—yet he oversaw an important strengthening in the councils' institutional design due to his interest in the substantive elements of the health reform.

Over the course of Cardoso's two terms in office, health became an increasingly important policy sector for the government, both in order to demonstrate the administration's commitment to meeting basic social needs and as part of its efforts to enhance state efficiency and dismantle old patronage networks.[54] Addressing health would prove to be a daunting challenge: when Cardoso took office in 1995, implementation of SUS had stalled. By 1996, only about 40 percent of Brazilian municipalities had completed the necessary administrative reforms needed to take on the new responsibilities associated with decentralization, as outlined in the 1993 regulatory order.[55] Funding for the health system was not guaranteed. According to a 1995 survey of Brazil's eleven largest cities, the main problem facing the country was the crisis in the health system—even greater than the perennial problem of unemployment.[56]

The Cardoso government faced pressing technical and political needs to address these challenges. Technically, the government needed information and proposals about how to decentralize administrative responsibilities and resources to municipalities in a way that would not also lead to an increase in graft and mismanagement.[57] Many of the country's top health policy experts were *sanitaristas* that now sat on the National Health Council; the Cardoso administration could not exclude these actors from deliberations if it hoped to make meaningful advances in implementation. Politically, successful reform implementation would require buy-in among key stakeholders in the sector. State and municipal governments would be charged with administering health policy, hospitals and clinics would provide services, and health workers ultimately would deliver care. The National Health Council served as the venue to coordinate these diverse actors. Although the Cardoso administration did not actively support participatory policy-making, it needed the input of the National Health Council in order to advance its substantive policy objectives and thus engaged the Council in policymaking.

In 1996, the government sought to develop a new regulatory order to address shortcomings in SUS. The Ministry of Health oversaw a long process of discussion and negotiation among major stakeholders on the National Health Council to develop a consensus proposal for the order.[58] The fact that these negotiations took place within the National Health Council enhanced the council's legitimacy as the arbiter of societal disputes on the health system. Moreover, it provided the health reform coalition with an opportunity to expand the prerogatives of health councils at all levels of government, and to introduce enforcement mechanisms for governments that did not comply with the participatory mandate. The 1996 regulatory order established that health councils must be involved in major decisions related to health financing and budgets; human resources; and the implementation, monitoring, and evaluation of health programs. Moreover, this order created a powerful enforcement mechanism by giving health councils the responsibility to approve all federal transfers.[59] Due to the economic leverage of this enforcement mechanism, the percentage of Brazilian municipalities that had created a health council jumped from 70 percent in 1996 to 83 percent in 1997, and continued to climb steadily, reaching nearly universal compliance by the mid-2000s

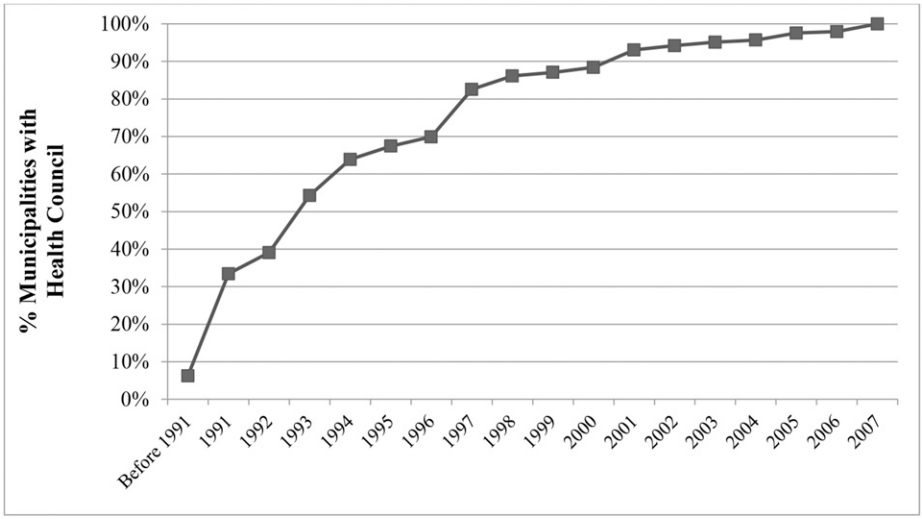
(Figure 1). The 1996 regulatory order would prove to be the most consequential component of the health councils' strong institutional design.[60]

As this section has shown, this period of instability created openings to strengthen the health councils' institutional design, while bundling the councils with substantive changes to health programs and institutions attracted the backing of stakeholders and reformist politicians. Many of these actors might otherwise not have supported participatory institutions, yet did so in pursuit of other policy goals.

From Strong Institutional Design to Institutionalization The strong institutional design of Brazil's health councils does not merely exist on paper. By 2007, 5,564 of Brazil's 5,565 municipalities had established a health council.[61] Most councils also fulfill two of the crucial prerogatives given to them: having formal policymaking authority (85 percent) and overseeing the budgetary process (73 percent).[62] Although the roles and responsibilities of the health councils may not be identical throughout the country, Brazil has had a surprising degree of success in routinizing this system of health councils.

The formal authority translates into widespread legitimation of the health councils. Although stakeholders may not agree with every agenda promoted through the councils, no major actors publicly dispute the idea that Brazil's health councils advocate the public interest and are an essential component of democratic rule. Among the fifty-nine

Figure 1 Municipal Compliance with Health Council Mandate, 1991–2007



Source: Perfil dos Conselhos de Saúde Dataset, Ministério da Saúde.

politicians, bureaucrats, councilors, and other experts interviewed for this study, not a single person questioned whether the health councils should exist. Numerous interviewees across the ideological spectrum—including members of Congress from opposition parties—described the councils as being a crucial part of the state apparatus. Even conservative politicians accept the existence of the health councils, as exemplified by one conservative federal deputy, who stated: "When we saw that the councils were gaining force, that they were gaining muscle in policy, everyone realized that they had to participate too [to prevent the left from dominating.]"[63] Politicians and bureaucrats accept that the health councils should exist, in the same way that they accept that local governments must collect basic service delivery statistics and adopt modern accounting procedures for purposes of oversight.

Moreover, Brazil's health councils have gained a policymaking role that includes determining policy priorities, developing of the budget, and overseeing policy implementation. The inclusion of participatory institutions in policymaking is especially visible with the National Health Council. Top government officials, including the Minister of Health and leadership from the Congressional Health Caucus, regularly attend council meetings to discuss major policy developments happening within Congress and the administration. Furthermore, council representatives attend and participate in Congressional seminars and hearings. Among the dozen national politicians interviewed, each voluntarily mentioned interacting with the National Health Council when asked about their contact with civil society groups. The strong institutional design of the Brazilian health councils has led to high levels of implementation and has opened up channels for civil society groups to become incorporated into the policymaking process.

Conclusion

Through an analysis of Brazil's health councils, I have demonstrated that substantive policy reform can create the openings and incentives needed for participatory institutions to develop strong institutional designs. Brazil's health councils arose as part of a sweeping policy reform that created instability in the policymaking process and displaced potential opponents of participatory policymaking. Moreover, Brazil's health policy reform sparked the mobilization of a coalition of beneficiaries, professionals, unions, and subnational governments. This reform coalition mobilized in support of substantive policy changes as well as the creation of health councils, which would serve as the site for battles about reform implementation.

One key implication of this study is that scholars of institutional weakness should think carefully about the process of formal institutional design. Like other scholars, I have shown that institutional design does indeed matter for the construction of powerful participatory institutions. In addition, I have also shown that institutional design does not happen at the moment when a participatory institution is first created, but rather unfolds over years. Indeed, if the moment of initial institutional creation is not followed

by iterated regulations, the participatory institution will fail to become institutionalized, since these regulations are crucial in establishing prerogatives and enforcement mechanisms. Studies of institutions typically conceptualize institutional design and implementation as distinct stages, yet this study shows that the two processes overlap and are inseparable from one another.

Moreover, this study challenges Levitsky and Murillo's conceptualization of institutional strength as consisting of enforcement and durability.[64] While enforcement and durability are key elements of institutional strength, these dimensions miss the prior question of whether the institution has been fully constructed in the first place. If the institutional design of Brazil's health councils had stopped after the 1990 health statute, the prerogative of the councils would have been too limited for the health councils to have any meaningful power. Complete enforcement of this tepid mandate would not have made this feeble system of health councils a stronger participatory institution than one with more fully developed prerogatives that are only enforced in a fraction of municipalities. Likewise, the dimension of durability proves problematic because it presumes that maintaining the original institutional design will enhance the overall strength of the institution. In other words, Levitsky and Murillo's perspective views the institutional change process of layering as a symptom of institutional weakness. Yet, an analysis of the Brazilian health councils suggests that a failure to engage in this process of layering would have resulted in a weaker participatory institution with less fully-developed responsibilities and toothless (or non-existent) enforcement mechanisms.

Additionally, this article suggests an alternative view of the institutional change process of conversion, in which political actors refashion an existing institution for a new purpose. In the 1980s, these health councils were proposed in Brazil as a means for marginalized and excluded groups—such as health system beneficiaries—to gain access to the policymaking process as part of democratization. Over time, they attracted the interest, support, and participation of actors that could hardly be considered "marginalized" groups, including subnational governments and health professionals. Yet, even if participatory councils incorporate the "wrong" kind of civil society group—elite actors that already enjoy access to the state—this does not necessarily mean that marginalized groups do not also enjoy greater state access. Rather than undermining the goals of the institution, conversion can trigger the institution-building processes needed for participatory institutions to incorporate new marginalized groups into policymaking.

Finally, this study has broad implications for other institutional reforms designed to enhance democratic quality. The key to developing a powerful institutional design for participatory institutions is to merge substantive and participatory reforms in order to spark mobilization by a broad reform coalition. This logic may extend to institutional reforms that increase transparency and oversight of public policy, such as laws that establish the right to request public records, mandate the creation of modern accounting practices, and establish new horizontal accountability agencies. These reforms threaten established political power and, on their own, seem unlikely to attract the sustained and active mobilization needed to ensure their implementation over time. Yet, bundling

these crucial initiatives with substantive policy reform may give rise to virtuous cycles of mobilization and institutional development that can both strengthen the state and deepen democracy in the developing world.

NOTES

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1. Panama is the only country in the region without a national participatory institution.

2. Archon Fung and Erik Olin Wright, "Thinking About Empowered Participatory Governance," in Archon Fung and Erik Olin Wright, eds., *Deepening Democracy: Institutional Innovations in Empowered Participatory Governance* (London: Verso, 2003), 3–42; Brian Wampler, *Participatory Budgeting in Brazil: Contestation, Cooperation and Accountability* (University Park: The Pennsylvania State University Press, 2007); Leonardo Avritzer, *Participatory Institutions in Democratic Brazil* (Baltimore and Washington, D.C.: Johns Hopkins University Press and Woodrow Wilson Center, 2009).

3. Avritzer, 2009, 10.

4. This electoral strategy is most associated with leftist parties, particularly Brazil's Workers' Party (PT); see Daniel Chavez and Benjamin Goldfrank, eds., *The Left in the City: Participatory Local Governments in Latin America* (London: Latin America Bureau and Transnational Institute, 2004); Rebecca Abers, *Inventing Local Democracy: Grassroots Politics in Brazil* (Boulder: Lynne Rienner Publishers, 2000); Wampler, 2007. However, politicians from non-leftist parties in other countries, such as Mexico and Argentina, also have constructed participatory institutions as a partisan strategy. See Andrew D. Selee, "An Alternative to Clientelism? Participatory Innovation in Mexico," in Andrew D. Selee and Enrique Peruzzotti, eds., *Participatory Innovation and Representative Democracy in Latin America* (Washington, D.C. and Baltimore: Woodrow Wilson Center Press and the Johns Hokins University Press, 2009), 62–88; Enrique Peruzzotti, "The Politics of Institutional Innovation: The Implementation of Participatory Budgeting in the City of Buenos Aires," in Selee and Peruzzotti, eds., 40–61; Françoise Montambeault, "Overcoming Clientelism through Local Participatory Institutions in Mexico: What Type of Participation?," *Latin American Politics and Society*, 53 (Spring 2011), 91–124.

5. Maureen Donaghy, "Do Participatory Governance Institutions Matter? Municipal Councils and Social Housing Programs in Brazil," *Comparative Politics*, 44 (October 2011), 83–102; Patrick Heller, "Moving the State: The Politics of Democratic Decentralization in Kerala, South Africa, and Porto Alegre," *Politics and Society*, 29 (March 2001), 131–63; Wampler, 2007.

6. Steven Levitsky and María Victoria Murillo, "Variation in Institutional Strength," *Annual Review of Political Science*, 12 (2009), 115–33.

7. Jacob Hacker, Paul Pierson, and Kathleen Thelen, "Drift and Conversion: Hidden Faces of Institutional Change," in James Mahoney and Kathleen Thelen, eds., *Advances in Comparative-Historical Analysis* (New York: Cambridge University Press, 2015), 180–81.

8. Ibid.; Wolfgang Streeck and Kathleen Thelen, eds., *Beyond Continuity: Institutional Change in Advanced Political Economies* (Oxford: Oxford University Press, 2005).

9. Wampler, 2007, 39; Fung and Wright, 20.

10. Luciana Tatagiba, "Os Conselhos Gestores e a Democratização das Políticas Públicas no Brasil," in Evelina Dagnino, ed., *Sociedade Civil e Espaços Públicos no Brasil* (São Paulo: Paz e Terra, 2002), 50–56; Wagner de Melo Romão, Adrián Gurza Lavalle, and Valeria Guarneros-Meza, "Political Intermediation and Public Policy in Brazil: Councils and Conferences in the Policy Spheres of Health and Women's Rights," in

Gisela Zaremberg, Valeria Guarneros-Meza, and Adrián Gurza Lavalle, *Intermediation and Representation in Latin America: Actors and Roles Beyond Elections* (New York: Palgrave-Macmillan, 2017), 31–51.

11. Tatagiba, 55.

12. Abers and Keck, *Practical Authority: Agency and Institutional Change in Brazilian Water Politics* (New York: Oxford University Press, 2013).

13. See, among others, Leonardo Avritzer, *Democracy and the Public Space in Latin America* (Princeton: Princeton University Press, 2002); Maxwell Cameron, Eric Hershberg, and Kenneth Sharpe, eds., *New Institutions for Participatory Democracy in Latin America: Voice and Consequence* (New York: Palgrave Macmillan, 2012); Selee and Peruzzotti, eds.; Gianpaolo Baiocchi, Patrick Heller, and Marcelo Silva, *Bootstrapping Democracy: Transforming Local Governance and Civil Society in Brazil* (Stanford: Stanford University Press, 2011).

14. For a similar approach that analyzes the emergence of Brazilian participatory institutions in other policy sectors as part of a restructuring of the state, see Abers and Keck; Michael Touchton, Natasha Borges Sugiyama, and Brian Wampler, "Democracy at Work: Moving Beyond Elections to Improve Well-Being," *American Political Science Review,* 111 (February 2017), 68–82.

15. Peter Hall, "Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain," *Comparative Politics*, 25 (April 1993), 278.

16. Frank Baumgartner and Bryan Jones, *Agendas and Instability in American Politics* (Chicago: University of Chicago Press, 1993); Andrea Louise Campbell, "Policy Makes Mass Politics," *Annual Review of Political Science*, 15 (2012), 333–51; Eric Patashnik, *Reforms at Risk: What Happens after Major Policy Changes Are Enacted* (Princeton: Princeton University Press, 2008).

17. Wealthy Brazilians also purchased supplementary private insurance.

18. Sarah Escorel, *Reviravolta na Saúde: Origem e Articulação do Movimento Sanitário* (Rio de Janeiro: Fiocruz, 1999), 55.

19. Vicente de Paula Faleiros, "A Previdência Social, o Estado e as Forças Sociais: A Previdência Social em Crise" (Brasília: CnPQ, 1995), 16.

20. Mónika Dowbor, "A Trajetória do Setor de Saúde no Brasil Pelo Prisma de Seus Principais Atores" (São Paulo: CEBRAP, 2007), 7.

21. SUS's participatory orientation involves both permanent policymaking councils, as well as periodic conferences that mobilize mass participation; see Leonardo Avritzer and Clóvis Henrique Leite de Souza, eds., *Conferências Nacionais: Atores, Dinâmicas Participativas e Efetividade* (Brasília: IPEA, 2013); Thamy Pogrebinschi and David Samuels, "The Impact of Participatory Democracy: Evidence from Brazil's National Public Policy Conferences," *Comparative Politics*, 46 (April 2014), 313–32.

22. Brian Wampler and Leonardo Avritzer, "Participatory Publics: Civil Society and New Institutions in Democratic Brazil," *Comparative Politics*, 36 (April 2004), 296.

23. Ana Maria Doimo, *A Vez e o Voz do Popular: Movimentos Sociais e Participação no Brasil Pós-80* (Rio de Janeiro: Relume-Duman, 1995).

24. James Holston, *Insurgent Citizenship: Disjunctions of Democracy and Modernity in Brazil* (Princeton: Princeton University Press, 2008), Chapter 7.

25. Pedro Jacobi, *Movimentos Sociais e Políticas Públicas: Demandas Por Saneamento Básico e Saúde: São Paulo, 1974–1984* (São Paulo: Cortez, 1993).

26. Wampler and Avritzer, 298–99. Interview with Jorge Kayano, São Paulo, November 17, 2008.

27. Sarah Escorel, Dilene Raimundo do Nascimento, and Flavio Coelho Edler, "As Origens da Reforma Sanitária e do SUS," in Nísia Trindade Lima et al., eds., *Saúde e Democracia: História e Perspectivas do SUS* (Rio de Janeiro: Editora Fiocruz, 2005), 63–65; Jacobi.

28. Escorel, Nascimento, and Edler, 65–77; Tulia Falleti, "Infiltrating the State: The Evolution of Health Care Reforms in Brazil, 1964–1988," in James Mahoney and Kathleen Thelen, eds., *Explaining Institutional Change: Ambiguity, Agency, and Power* (New York: Cambridge University Press, 2010), 38–62.

29. Falleti, in Mahoney and Thelen, eds., 51–52.

30. Jairnilson Silva Paim, *Reforma Santiária Brasileira: Contribuição Para a Compreensão Crítica* (Salvador and Rio de Janeiro: Edufba/Editora Fiocruz, 2008), 98–99.

31. Eleutério Rodriguez Neto, José Gomes Temporão, and Sarah Escorel, *Saúde: Promessa e Limites da Constituição* (Rio de Janeiro: Editora Fiocruz, 2003), 47.

32. Ministério da Saúde, "Anais da 8a Conferência Nacional de Saúde: 17 a 21 de Março de 1986" (Brasília: Centro de Documentação do Ministério da Saúde, 1987), 382–88.

33. Tulia Falleti, *Decentralization and Subnational Politics in Latin America* (New York: Cambridge University Press, 2010), 180–85.

34. Interview with Ênio Servilha Duarte, Brasília, October 17, 2008.

35. Soraya Maria Vargas Cortês, "Sistema Único de Saúde: Espaços Decisórios e a Arena Política de Saúde," *Caderno de Saúde Pública*, 25 (July 2009), 1628; Kurt Weyland, *Democracy without Equity: Failures of Reform in Brazil* (Pittsburgh: University of Pittsburgh Press, 1996), 159–62.

36. Marta Arretche, "Toward a Unified and More Equitable System: Health Reform in Brazil," in Robert Kaufman and Joan Nelson, eds., *Crucial Needs, Weak Incentives: Social Sector Reform, Democratization, and Globalization in Latin America* (Baltimore: Johns Hopkins University Press, 2004), 166–68.

37. Interview with Crescêncio Antunes de Silveira, Brasília, March 16, 2009.

38. Vicente de Paula Faleiros et al., *A Construção do SUS: Histórias da Reforma Sanitária e do Processo Participativo* (Brasília: Ministério da Saúde, 2006), 52. The constituent assembly allowed citizens and civil society group to present "popular amendments"—proposed articles to be considered for inclusion in the new constitution.

39. Interview with Crescêncio Antunes de Silveira, Brasília, March 16, 2009.

40. Interview with Carlos Mosconi in Faleiros et al., 2006, 88.

41. Interview with Eduardo Jorge in ibid., 135.

42. Message No. 680, accompanying Law 8080 of 1990, September 19, 1990.

43. Faleiros et al., 2006, 116–18, 30–37.

44. A. I. Carvalho, *Conselhos de Saúde no Brasil: Participação Cidadã e Controle Social* (Rio de Janeiro: Fase/IBAM, 1995), 72.

45. Ibid.

46. Ministério da Saúde, "Perfil dos Conselhos de Saúde," (2009).

47. Eduardo Levcovitz, Luciana Dias Lima, and Cristiani Vieira Machado, "Política de Saúde nos Anos 90: Relações Intergovernamentais e o Papel das Normas Operacionais Básicas," *Ciência e Saúde Coletiva*, 6 (February 2001), 273–74; Weyland, 171–72.

48. President Collor was impeached in 1992 following a massive corruption scandal. He was replaced by his Vice-President, Itamar Franco, whose transitional government sought to build national unity and reduce social conflict.

49. Faleiros et al., 2006, 126.

50. NOB-SUS 1993, Portaria no. 545, May 20, 1993.

51. During the period of democratization in the 1980s, some politicians from Cardoso's party, the PSDB, supported the expansion of participatory institutions—particularly from their position in subnational governments. During the 1990s, however, the party shifted to the right as technocratic economists gained more influence in the party, particularly after the adoption of the successful *Plano Real* economic stabilization plan. The party remained centrist and prioritized the implementation of social policies that could tackle social inequities, yet prioritized efficiency over a mobilizational strategy to do so. On the trajectory of the PSDB from the 1980s-1990s, see Timothy Power, "Blairism Brazilian Style? Cardoso and the 'Third Way' in Brazil," *Political Science Quarterly*, 116 (Winter 2001–2002), 611–36.

52. Faleiros et al., 2006, 191–92.

53. Interview with Valéria Gonelli, Brasília, October 18, 2008; Interview with Maria do Socorro de Souza, Brasília, February 12, 2008. See also Raquel Raichelis, *Esfera Pública e Conselhos de Assistência Social: Caminhos da Construção Democrática* (São Paulo: Cortez, 1998); Faleiros et al., 2006, 169–70. It is important to note that *some* members of the Cardoso coalition—including former Minister of Health, Adib Jatene—supported the *sanitaristas* (Interview with Eliane Cruz, Brasília, February 2, 2009). Nevertheless, the overall tenor of the Cardoso administration was technocratic.

54. Candelaria Garay, *Social Policy Expansion in Latin America* (New York: Cambridge University Press, 2016), 148–54; Sonia Draibe, "A Política Social no Período FHC e o Sistema de Proteção Social," *Tempo Social*, 15 (November 2003), 72–76.

55. Eugênio Vilaça Mendes, *A Organização da Saúde no Nível Local* (São Paulo: Hucitec, 1998), 37.

56. Folha de São Paulo, "Saúde É Problema no. 1, Diz Pesquisa Realizada Pelo Datafolha em 11 Capitais," *Folha de São Paulo*, July 22, 1995.

57. For a discussion of how Cardoso's government relied on financial transfers and state reform to prevent mismanagement by subnational governments, see Marcus Andre Melo, "Unexpected Successes, Unanticipated Failures: Social Policy Reform from Cardoso to Lula," in Peter R. Kingstone and Timothy Power, eds., *Democratic Brazil Revisited* (Pittsburgh: University of Pittsburgh Press, 2008), 161–84; Fernando Henrique Cardoso, "Structural Reform and Governability: The Brazilian Experience in the 1990s," in Scott Mainwaring and Timothy Scully, eds., *Democratic Governance in Latin America* (Stanford: Stanford University Press, 2010), 338–62.

58. Levcovitz, Lima, and Machado, 280–84.
59. Part 17.9 of NOB-SUS 1996, Portaria no. 2203, November 5, 1996.
60. Additional regulatory orders in 2001 and 2002 clarified responsibilities and financing for regionalization of service delivery and bolstered subnational capacity in planning, programming, monitoring, and evaluation. These orders further specified the prerogatives of health councils in overseeing the design and implementation of health policy in tandem with the elaboration of new responsibilities for different levels of government.
61. Ministério da Saúde, "Perfil dos Conselhos de Saúde."
62. IBGE Perfil dos Municipios Brasileiros database, 2009.
63. Interview with Armando Abilio, Brasília, March 19, 2009.
64. Levitsky and Murillo.