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Federalism and health policy: the intergovernmental committees in Brazil

Federalismo e política de saúde: comissões intergovernamentais no Brasil

Cristiani Vieira Machado[I]

Luciana Dias de Lima[I]

Ana Luiza d´Ávila Viana[II]

Roberta Gondim de Oliveira[III]

Fabíola Lana Iozzi[IV]

Mariana Vercesi de Albuquerque[IV]

João Henrique Gurtler Scatena[V]

Guilherme Arantes Mello[VI]

Adelyne Maria Mendes Pereira[VII]

Ana Paula Santana Coelho[VIII]

[I] Departamento de Administração e Planejamento em Saúde. Escola Nacional de Saúde Pública Sergio Arouca. Fundação Oswaldo Cruz. Rio de Janeiro, RJ, Brasil

[II] Departamento de Medicina Preventiva. Faculdade de Medicina. Universidade de São Paulo. São Paulo, SP, Brasil

[III] Escola de Governo em Saúde. Escola Nacional de Saúde Pública Sergio Arouca. Fundação Oswaldo Cruz. Rio de Janeiro, RJ, Brasil

[IV] Programa de Pós-Graduação em Medicina Preventiva. Faculdade de Medicina. Universidade de São Paulo. São Paulo, SP, Brasil

[V] Departamento de Saúde Coletiva. Instituto de Saúde Coletiva. Universidade Federal do Mato Grosso. Cuiabá, MT, Brasil

[VI] Departamento de Medicina Preventiva. Escola Paulista de Medicina. Universidade Federal de São Paulo. São Paulo, SP, Brasil

[VII] Laboratório de Educação Profissional em Gestão em Saúde. Escola Politécnica de Saúde Joaquim Venâncio. Fundação Oswaldo Cruz. Rio de Janeiro, RJ, Brasil

[VIII] Departamento de Ciências da Saúde. Centro Universitário Norte do Espírito Santo. Universidade Federal do Espírito Santo. São Mateus, ES, Brasil

Correspondence:
Cristiani Vieira Machado
Departamento de Administração e Planejamento em Saúde
Escola Nacional de Saúde Pública Sergio Arouca – Fiocruz
Rua Leopoldo Bulhões, 1480 sala 715
Manguinhos
21041-210 Rio de Janeiro, RJ, Brasil
E-mail: cristiani@ensp.fiocruz.br

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ABSTRACT

OBJECTIVE: To analyze the dynamics of operation of the Bipartite Committees in health care in the Brazilian states.

METHODS: The research included visits to 24 states, direct observation, document analysis, and performance of semi-structured interviews with state and local leaders. The characterization of each committee was performed between 2007 and 2010, and four dimensions were considered: (i) level of institutionality, classified as advanced, intermediate, or incipient; (ii) agenda of intergovernmental negotiations, classified as diversified/restricted, adapted/not adapted to the reality of each state, and shared/unshared between the state and municipalities; (iii) political processes, considering the character and scope of intergovernmental relations; and (iv) capacity of operation, assessed as high, moderate, or low.

RESULTS: Ten committees had advanced level of institutionality. The agenda of the negotiations was diversified in all states, and most of them were adapted to the state reality. However, one-third of the committees showed power inequalities between the government levels. Cooperative and interactive intergovernmental relations predominated in 54.0% of the states. The level of institutionality, scope of negotiations, and political processes influenced Bipartite Committees' ability to formulate policies and coordinate health care at the federal level. Bipartite Committees with a high capacity of operation predominated in the South and Southeast regions, while those with a low capacity of operations predominated in the North and Northeast.

CONCLUSIONS: The regional differences in operation among Bipartite Interagency Committees suggest the influence of historical-structural variables (socioeconomic development, geographic barriers, characteristics of the health care system) in their capacity of intergovernmental health care management. However, structural problems can be overcome in some states through institutional and political changes. The creation of federal investments, varied by regions and states, is critical in overcoming the structural inequalities that affect political institutions. The operation of Bipartite Committees is a step forward; however, strengthening their ability to coordinate health care is crucial in the regional organization of the health care system in the Brazilian states.

DESCRIPTORS: Federalism. Unified Health System. Health Policy. Health Care Management. Intergovernmental relations.

RESUMO

OBJETIVO: Analisar a dinâmica de funcionamento das Comissões Intergestores Bipartites em saúde, nos estados do Brasil.

MÉTODOS: A pesquisa compreendeu visitas a 24 estados, observação direta, análise documental e realização de entrevistas semiestruturadas com dirigentes estaduais e municipais. A caracterização das comissões de 2007 a 2010 considerou quatro dimensões: (i) institucionalidade, classificada como avançada, intermediária ou incipiente; (ii) conteúdo das negociações intergovernamentais, qualificado como diversificado/restrito, aderente/não aderente à realidade estadual e compartilhado/não compartilhado entre estado e municípios; (iii) processo político, considerando o caráter e a intensidade das relações intergovernamentais; e (iv) capacidade de atuação, avaliada como elevada, moderada ou baixa.

RESULTADOS: Dez comissões apresentaram institucionalidade avançada. O conteúdo das negociações foi diversificado em todos os estados e na maioria aderente à realidade estadual. Entretanto, um terço das comissões expressaram assimetrias de poder entre esferas de governo. Relações intergovernamentais cooperativas e interativas predominaram em 54,0% dos estados. As dimensões de institucionalidade, conteúdo das negociações e processo político influenciaram a capacidade de atuação das Comissões Intergestores Bipartites na formulação da política e na coordenação federativa em saúde. Predominaram comissões com capacidade de atuação elevada nas regiões Sul e Sudeste e comissões com capacidade de atuação baixa no Norte e Nordeste.

CONCLUSÕES: A variação regional entre as comissões sugere a influência de condicionantes histórico-estruturais (desenvolvimento socioeconômico, barreiras geográficas, características do sistema de saúde) na sua capacidade de coordenação intergovernamental em saúde. No entanto, em alguns estados, observou-se a possibilidade de superação de parte das dificuldades estruturais por meio de transformações institucionais e políticas. A realização de investimentos federais diferenciados por macrorregiões e estados é fundamental para a superação de desigualdades estruturais que repercutem nas instituições políticas. A atuação das CIB constitui um avanço, mas o fortalecimento de sua capacidade de coordenação federativa em saúde é crucial para a organização regionalizada do sistema de saúde nos estados brasileiros.

DESCRITORES: Federalismo. Sistema Único de Saúde. Política de Saúde. Gestão em Saúde. Relações intergovernamentais.

INTRODUCTION

Federations represent systems of the political and territorial organization that require the combination of “self-rule and shared-rule”.[4] Federal countries can be identified on the basis of institutional characteristics, including: legal arrangements, which define the government responsibilities; rules and decision-making mechanisms that incorporate territorial variables and interests; fiscal arrangements; intergovernmental transfers; formal and informal arrangements between vertical and horizontal governments.[10,11,18]

The federal institutions influence and are influenced by social policies through relations that vary according to regional and temporal contexts.[10] This influence is expressed through the emergence of new elements and definition of strategies and shared political processes.[12]

Therefore, the formulation and implementation of social policies in federations require federal coordination strategies, for example, intergovernmental negotiation committees.[1,2]

Brazil is a territorially extensive, unequal, and populous federation, consisting of 26 states, a federal district, and more than 5,560 municipalities. Although the federation legal framework has been historically relevant for health care, it assumed greater importance after the promulgation of the 1988 Constitution, which established a public and universal Unified Health System (SUS), guided by the establishment of administrative and political decentralization, with a single health authority at each government level.

In this context, the implementation of a national health care policy requires intergovernmental coordination strategies, aiming at harmonizing political and administrative decentralization with regional and hierarchical organization of health care services, the scope of which can extrapolate municipal and state boundaries. The experience in the first 25 years of the creation of SUS was marked by the adoption of innovative coordination strategies, including the establishment of intergovernmental commissions on health care at the national and state levels.[3,9,17]

In 1991, the Tripartite Commission, consisting of representatives of the three levels of government, started discussions on health care policies at the national level. Bipartite Committees were structured between 1993 and 1995 in the Brazilian states and were equally formed by representatives of the State and Municipal Health Secretariats. The attributions of Bipartite Committees included developing proposals for the decentralized management of SUS, adaptation of national guidelines to the conditions of each state, monitoring and evaluation of the decentralized health care management, competence to decide on criteria for the allocation of federal health care resources, and development of proposals for the operationalization of health-related policies.[8]

Since then, the committees have operated in negotiations related to decentralization, distribution of federal and state financial resources, assignment of responsibilities, and creation of partnerships between federal entities. These committees were important at different stages of the decentralization process, guided by the operational rules of SUS.[5] Since 2006, the national guidelines of the Health Care Pact represented a new incentive to intensify intergovernmental negotiations, with an emphasis on regionalization and with implications for BIC operations.[7,a]

Studies on Bipartite Committees are scarce and generally involve few cases; however, some studies have described their potential functions, including the establishment of intergovernmental partnerships and the consolidation of balanced and participatory negotiations between managers.[6,13,15] In addition, previous case studies have suggested divergences among states in the management of these committees.[9]

The present study aimed to analyze the dynamics of operation of Bipartite Committees in the Brazilian states.

METHODS

The study focused on the evaluation of the performance of Bipartite Committees in the 24 Brazilian states between 2007 and 2010. During this period, dynamism in intergovernmental relations was achieved by government adherence to the Health Care Pact and the emphasis on regionalization. The states of Maranhao and Tocantins were not included in this analysis because of political problems during the study period.

The methods included visits to the 24 states, direct observation of the dynamics of the executive secretariats and of committees' meetings (technical or plenary), document analysis (regiments, official documents, and records), and performance of four semi-structured interviews in each state with the Secretary of State for Health, the Chairman of the Board of Municipal Health Secretaries, the executive secretary of eachcommittee, and the state health official responsible for the regionalization process.

Analysis of the BIC dynamics considered four dimensions that guided the development of research instruments and fieldwork: the level of institutionality, agenda of intergovernmental negotiations, political processes, and capacity of operation.

The level of institutionality focused on normative, cognitive, and political aspects that gave the committee a positive role in intergovernmental negotiations, including the existence of permanent structures for resolving issues, frequency of plenary meetings, representativeness of the members, and legitimacy of each commission. These variables were measured on the basis of analysis of the regiments and records, observation, profiling of participants, and interviews. The level of institutionalization was classified as advanced, intermediate, or incipient.

The agenda of intergovernmental negotiations considered the diversity of the topics discussed in meetings (diverse or restricted scope), discussion of topics pertaining to each state and the applicability of national policies in each state (agendas adapted or not adapted to the reality of the state), and the creation of policy agendas taking into consideration the balance of power

[a] Ministério da Saúde. Portaria GM/MS, nº 399 de 22 de fevereiro de 2006. Divulga o Pacto pela Saúde 2006 – Consolidação do SUS e aprova as Diretrizes Operacionais do Referido Pacto. *Diario Oficial Uniao*. 23 Fev 2006 [cited 2013 Feb 7];Seção 1:43-51. Available from: http://dtr2001.saude.gov.br/sas/PORTARIAS/Port2006/GM/GM-399.htm

between states and municipalities (shared or unshared agenda). The classification of this dimension was based on analysis of meeting records and interviews.

The third dimension of analysis was the political processes and involved the evaluation of the profile and scope of intergovernmental relations in each committee through the identification of the prevalence of convergent or divergent views and interests (cooperative, cooperative-conflictive, and conflictive profiles) and the frequency and consistency of established relations (interactive, formalist, or restricted). Interviews were essential to the characterization of this dimension and were supplemented by document analysis.

The fourth dimension included the capacity of operation of Bipartite Committees and involved the ability to formulate and implement policies and establish partnerships between state and local governments to solve regional problems. The capacity of operation was classified as high, moderate, or low and focused attention on analysis of documents that reported meeting outcomes (e.g., creation of resolutions, guidelines, plans, and projects) in addition to interviews.

Table 1 provides the dimensions and variables adopted to characterize the Bipartite Committee´s dynamics in each state.

The study was approved by the Research Ethics Committee of the *Faculdade de Medicina* of the *Universidade de São Paulo* under Protocol 0175/09 on 5/6/2009 and followed appropriate guidelines.

RESULTS

In 2010, Bipartite Committees had been operating for 15-17 years, with differences in the dynamics of operation according to the state.

With regard to the level of institutionality, ten committees were classified as advanced, ten were considered intermediate, and four were incipient. However, the reality of the states and their municipalities was diverse (Figure 1). All commissions in the southern and southeastern states had advanced levels of institutionality. The other three committees with the same classification were located in the northeast (two) and midwest (one). Intermediate levels of institutionality predominated among committees in the north, northeast, and midwest regions. Two states in the north and two in the northeast had committees with incipient levels of institutionality.

Considering that Bipartite Committees were created at the same period, the time of operation was not an important variable for assessing the level of institutionality. However, BIC were influenced by other historical-structural and institutional characteristics (profile of municipalities, federal organization,

Table 1. Dimensions and variables adopted for the characterization of the dynamics of Bipartite Committees in the states. Brazil, 2007-2010.

Dimension	Variable	Type
Level of institutionality of Bipartite Committee	Creation of authorities for the integration and technical-political processing of the topics discussed (technical chambers, working groups, and similar structures) Frequency of operation of plenary sessions among committees and their internal organization structures (technical chambers and others) Regional representativeness (through the selection of representatives or the regular operation of regional bodies) Legitimacy of Bipartite Committee as an authority for the negotiation and technical-political decisions (includes the legitimacy of state and municipal authorities)	Advanced Intermediate Incipient
Agenda of the intergovernmental negotiations in Bipartite Committee	Topic Diversity Presence of state-related topics (pertaining to states and municipalities) and their applicability to the local reality Joint construction of the agenda with power equality between the states and municipalities (shared)	Diversified or restricted Adapted or not adapted Shared or unshared
Political processes	Scope of intergovernmental relations: Predominance of convergent or divergent views and interests (predominantly cooperative or conflictive) or the marked presence of cooperation and conflict (cooperative-conflictive) Intensity of intergovernmental relations: irregular or infrequent (restricted), associated only with formal procedures (formalists), dynamic, intensive, and comprehensive (interactive)	Predominance of intergovernmental relations: cooperative, conflictive, cooperative-conflictive; interactive, formalist, or restricted
Capacity of operation of Bipartite Committee	Ability to formulate and implement policies Ability to generate intergovernmental cooperation (partnerships, formalization of commitments, and the overcoming of impasses and conflicts)	High Moderate Low

Source: Prepared by the authors.

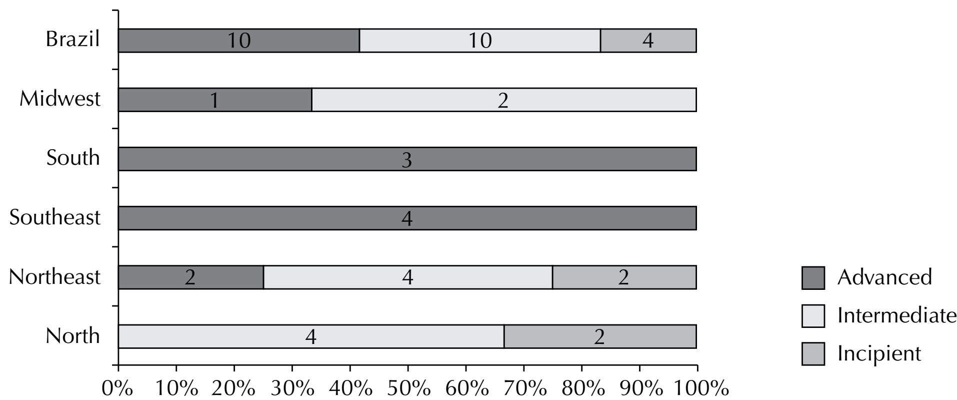

Figure 1. Distribution of the Bipartite Committees in health care in different states, according to the level of institutionality and regions. Brazil, 2007-2010.

institutional capabilities of governments, and the specific trajectory of each BIC).

An advanced level of institutionalization was associated with the maturity and solidity of this body as a space for negotiation and intergovernmental decision on health care policies and was indicated by the existence of clear rules, regular, participatory and dynamic character of plenary meetings, and realization of preliminary meetings between state and local representatives. In states where regular technical groups existed, debates on specific topics and joint decisions were more consistent.

The representativeness of states and municipalities was also relevant to the BIC classification. When an advanced level of institutionality was present, the representatives of State Secretariats of Health were the technical-political elements responsible for managing strategic areas of health care, whereas the municipal representatives were selected during discussions sponsored by the Board of Municipal Health Secretaries, considering the intrastate diversity. Another variable that allowed the assessment of differences in the health care system was the creation of regional committees.

The adequate organization and technical and political dynamism of the committee's executive secretariat were associated with the level of institutionality but were not isolated determinants. The trajectory of each committee; existence of clear, solid, and agreed operating rules; profile of representatives; and their political legitimacy for the health authorities were more important factors. In the states with incipient levels of institutionality, the fragilities in the operation of the executive secretariat seemed to derive from limitations in these variables.

The second category analyzed was the scope of intergovernmental negotiations in Bipartite Committees, which indicated an overall positive profile for all states. In the 24 states studied, the scope of the negotiations was diverse and involved various fields and subjects related to the health care policy. Despite the predominance of topics related to the organization of the health care system, topics on health surveillance (primarily epidemiological surveillance), health care education, specific policies, and management (finance, information systems, and evaluation) were often discussed.

Topics related to regionalization, emphasized on the national agenda, were common in most states. However, this topic was more frequent in states with a tradition of health care regionalization, including the prior existence of regional committees. In one-third of the states studied, regionalization was barely discussed by the committees, which may reflect differences in the regionalization processes and stewardship.

In addition to the diversity of topics, in 21 states, the content of the negotiations in the committees applied to the state reality, although the federal agenda influenced the debates. Accordingly, in most states, Bipartite Committees promoted the discussion of topics of regional importance and attempted to adapt national guidelines to state, regional, and local contexts. This led to the diversification of the foci of discussion among commissions and the consequent regional diversity. For instance, in the north region, the topics of greater importance involved the control of endemic diseases and the direct provision of health care services, including the transfer of health care units and professionals. In the southern states with a strong presence of the private sector associated with SUS, relevant topics involved the regulation of health care providers (contracts, budgetary limits, health care coordination, and measures to be taken in cases of noncompliance with contracts and agreements). In only three states, Bipartite Committees operated exclusively under national guidelines.

It was also observed that in two-thirds of the states, the agenda was defined jointly by states and municipalities, which were equally important in defining the discussion

topics. In one-third of the states, significant power inequality was observed between states and municipalities when proposing agendas and during the debates. In these cases, the state level assumed increased importance.

Four groups of states were identified, with regard to the agenda of intergovernmental negotiations in the Bipartite Committee, which involved the diversity of topics, applicability of the discussions to the state reality, and degree of sharing for the established guidelines (Figure 2).

The first group consisted of 14 states (59.0% of the total), where the committee's agenda was diverse, adapted to the state reality and defined jointly by states and municipalities. This group comprised the Southern and Southeastern states (except one), two states in the Midwest region, four states in the Northeast, and two in the North.

The second most significant group (29.0% of the total) was formed by seven states, where the agenda was diverse and adapted to the state reality; however, its definition was not balanced between the state and municipalities. This group consisted of three states in the North, three in the Northeast, and one in the Southeast region.

In the North, a Bipartite Committee with a peculiar condition was identified: the agenda was diverse, and its definition was shared between state and municipalities, but it was eminently tied to federal guidelines and therefore not adapted to the state reality.

Another group was formed by two states, one in the Northeast and one in the Midwest, where the agenda was diverse but did not apply to the state reality, and its definition not shared. These limitations restricted their capacity of operation as intergovernmental coordination bodies by reinforcing power asymmetries between the three government levels and differences in the institutional capacity of states and municipalities, rather than mitigating these differences.

The third category involved analysis of the political processes in Bipartite Committees, considering the nature and scope of intergovernmental relations. Overall, the "cooperative and interactive" profile predominated in 13 states (54.0%). The second most common type of profile was the "cooperative and formalist", observed in four states. These two groups accounted for over two-thirds of the states located in various regions of Brazil. The first group had a more favorable condition for intergovernmental coordination, whereas in the second group, despite the predominance of a cooperative profile, the formalist character of intergovernmental relations limited the committee's role to compliance with federal regulations, such as the adherence to specific strategies.

The "conflictive-formalistic" profile and "cooperative-conflictive and restricted" profiles were observed in a few states in the north and northeast regions. In the north, the limited relations between health care managers are partly explained by historical-structural factors (long distances, difficulties in travelling, strong dependence on the Union for the states that were federal territory until the 1980s), and political-institutional factors (limited institutional capacity and political instability).

Notably, the prevalence of cooperative relations does not mean complete absence of intergovernmental conflicts. In many states, such conflicts occur but can be resolved using formal and informal channels (plenary

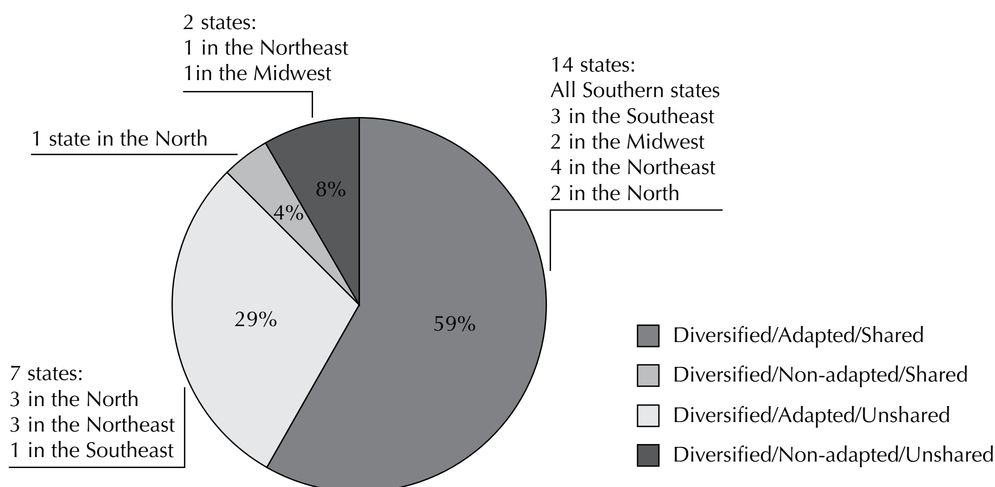

Figure 2. Distribution of the Bipartite Committees in health care, according to the agenda of intergovernmental negotiations. Brazil, 2007-2010.

Table 2. Dynamic of the Bipartite Committees according to regions and states. Brazil, 2007-2010.

Dimension/ Region-state	Level of institutionality	Agenda of the intergovernmental negotiations	Political process/ Intergovernmental relations	Capacity of operation of Bipartite Committees
North				
Acre	Intermediate	D+A+S	Cooperative and interactive	High
Amapá	Intermediate	D+NA+S	Cooperative and interactive	Low
Amazonas	Incipient	D+A+US	Cooperative-conflictive and restrictive	Low
Pará	Intermediate	D+A+S	Cooperative and formalist	Moderate
Rondônia	Intermediate	D+A+US	Cooperative-conflictive and formalist	Low
Roraima	Incipient	D+A+US	Cooperative-conflictive and restrictive	Low
Northeast				
Alagoas	Incipient	D+NA+US	Cooperative-conflictive and formalist	Low
Bahia	Intermediate	D+A+US	Cooperative-conflictive and interactive	Moderate
Ceará	Advanced	D+A+S	Cooperative and interactive	High
Paraíba	Incipient	D+A+S	Cooperative-conflictive and formalist	Low
Pernambuco	Intermediate	D+A+US	Conflictive and formalist	Low
Piauí	Intermediate	D+A+US	Cooperative and interactive	Moderate
Rio Grande do Norte	Intermediate	D+A+S	Cooperative and formalist	Moderate
Sergipe	Advanced	D+A+S	Cooperative and interactive	High
Southeast				
Espírito Santo	Advanced	D+A+US	Cooperative and formalist	Moderate
Minas Gerais	Advanced	D+A+S	Cooperative and interactive	High
Rio de Janeiro	Advanced	D+A+S	Cooperative and interactive	High
Sao Paulo	Advanced	D+A+S	Cooperative and interactive	High
South				
Paraná	Advanced	D+A+S	Cooperative and interactive	High
Rio Grande do Sul	Advanced	D+A+S	Cooperative and interactive	High
Santa Catarina	Advanced	D+A+S	Cooperative and interactive	High
Midwest				
Goiás	Intermediate	D+NA+US	Cooperative and formalist	Low
Mato Grosso	Intermediate	D+A+S	Cooperative and interactive	Moderate
Mato Grosso do Sul	Advanced	D+A+S	Cooperative and interactive	Moderate

D: Diversified; A: Adapted to the state reality; NA: Not adapted to the state reality; S: Shared; US: Unshared

meetings, technical meetings, contacts between managers and technicians), which favor the creation of agreements and the obtaining of minimum consensus.

Furthermore, the nature of intergovernmental relations varies, depending on the agenda topics. For example, cooperation predominated in discussions related to professional training, whereas conflict was common in debates about funding. In some states, intense conflicts were observed between State Secretariats of Health and managers of state capitals, where many health care services are concentrated.

The fourth dimension of analysis was the committees' capacity of operation in policy formulation and implementation, intergovernmental coordination, and organization of the health care system. Nine committees had a high capacity of operation, seven had a moderate capacity of operation, and eight had a low capacity of operation. Furthermore, regional differences were observed, such that Bipartite Committees of all southern states and most southeastern states exhibited a high capacity of operation, whereas many committees in the North, Northeast, and Midwest had a low capacity of operation.

Finally, it was found that this capacity of operation was dependent on other dimensions (Table 2). In the presence of the first three favorable dimensions, Bipartite Committees showed a high capacity of operation in eight states (with one exception). The reciprocal relation corroborates the hypothesis: all the committees with a high capacity of operation had the other three dimensions favorable; the only exception had two favorable dimensions and one dimension with an intermediate classification.

On the other side, the four committees with incipient levels of institutionality had a low capacity of operation. Moreover, half the committees with a low capacity of operation presented an incipient level of institutionality. The remaining half had intermediate levels of institutionality, accompanied by one or two other unfavorable dimensions.

DISCUSSION

The present study investigated Bipartite Committees of 24 states, corroborated previous research results, and helped elucidate their dynamics, constraints, and possibilities. The role of these committees in the coordination of health care policies at the subnational level is relevant but vary among the federation states.

The differences in Bipartite Committees involved the level of institutionality, agenda, and political processes of negotiation. The configuration of these three dimensions, in turn, influenced their capacity of operation in the formulation of policies and intergovernmental coordination of health care.

Concerning the level of institutionality, the presence of technical and political channels of negotiation among the states and municipalities favored the establishment of cooperative intergovernmental relations and thereby favored their capacity of defining policies. The recognition of the relevance and legitimacy of these commissions by senior officials of the State Secretariat of Health was expressed in their participation in meetings, ability to dialog, and respect for the agreements established. Furthermore, the existence of a politically and technically strong Board of Municipal Health Secretaries facilitated the intergovernmental coordination through Bipartite Committees. In the absence of these conditions, their operation was limited to the performance of monthly plenary meetings in which state and municipalities conducted administrative procedures, with limited impact on policy making.

With regard to the intergovernmental negotiation scope, a significant finding was the diversity of topics and issues addressed by each committee. On the other hand, variations in the capacity to adapt policy agendas to each state and in the political power balance between state and municipalities were observed.

The importance of national guidelines and topics was reported by other authors[9] and confirmed in the present study, particularly with regard to the adherence to national programs and the receipt of federal funding. However, in agreement with a previous study,[16] we found that in most states, Bipartite Committees favored discussions of the consequences of national policies in state health care systems, establishment of local policy agendas, and more appropriate distribution of responsibilities for health care management among the states and municipalities. In few states, Bipartite Committees' debates were solely guided by national concerns. With regard to power equality between federative entities, there were many cases in which state and municipal authorities played a similar role in defining the agendas.

Another important finding concerns the recent importance given to regionalization in Bipartite Committees' debates, which suggests the importance of these commissions in regional processes in the states, which are very diversified.[7] The present study was conducted during the implementation of the Health Care Pact and indicated that these committees were important in the strengthening of regional intergovernmental committees, regional planning, and establishment of health care networks. In 2011, after the study was concluded, a presidential decree added responsibilities to Bipartite Committees, defined the Regional Committees as a space for the establishment of agreements for the formation of health care networks, and proposed the "organizational contract" among governments as an instrument for the reinforcement of regional strategies.[14,b]

With regard to the political processes, the cooperative and interactive nature of intergovernmental relations predominated in Bipartite Committees, which reiterated their potential to resolve conflicts at the federal level and promote partnerships between states and municipalities. In contrast, in cases of conflicting or restrictive relations, their capacity of operation in the establishment of health care policies was limited.

Regional differences were observed. Committees with advanced levels of institutionality and a high capacity of operation predominated in the South and Southeast, whereas committees with incipient or intermediate levels of institutionality and a low or moderate capacity of operation predominated in the North and Northeast. Committees with an intermediate situation predominated in the Midwest. This result suggests the influence of historical-structural conditions (socioeconomic development, geographic barriers, characteristics of the health care system) in the ability of coordination of health care policies at the state level. However, some states did not have a predominant profile, indicating the possibility of overcoming structural problems through institutional and political changes.

The presence of inequalities among Bipartite Committees indicates that the strengthening of their institutional capacity should occur on an individual basis throughout the country. In addition, their strengthening may require

[b] Brasil. Decreto nº 7.508, de 28 de junho de 2011. Regulamenta a Lei nº 8.080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde - SUS, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências. *Diario Oficial Uniao* 29 Jun 2011 [cited 2013 Feb 20]:1. Available from: http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2011/decreto/D7508.htm

various strategies, including the expansion of novel communication technologies in states with geographic barriers, support for the establishment of permanent technical intergovernmental groups, changes in Bipartite Committees' representativeness (to contemplate strategic segments of the State Secretariat of Health and the diversity of municipalities), and strengthening of regional committees.

The main limitation of the present study was the lack of information about the operation of regional intergovernmental commissions inside the states that experienced changes during the study period because of the adherence to the Health Care Pact, with implications for Bipartite Committees and the regionalization process.[7]

Finally, the formulation of national policies and the creation of federal investments according to regions or states are crucial to overcome the persistent structural inequalities in Brazil, which affect the political institutions and the operation of intergovernmental committees. The operation of Bipartite Committees is a step forward; however, strengthening their ability to coordinate health care is crucial for the regional organization of the health care system in the Brazilian states.

REFERENCES

1. Abrucio FL. A coordenação federativa no Brasil: a experiência do período FHC e os desafios do governo Lula. *Rev Sociol Polit*. 2005;24:41-67. DOI:10.1590/S0104-44782005000100005
2. Arretche M. Federalismo e relações intergovernamentais no Brasil: a reforma de programas sociais. *Dados*. 2002;45(3):431-58. DOI:10.1590/S0011-52582002000300004
3. Dourado DA, Elias PEM. Regionalização e dinâmica política do federalismo sanitário brasileiro. *Rev Saude Publica*. 2011;45(1):204-11. DOI:10.1590/S0034-89102011000100023
4. Elazar DJ. Exploring federalism. Tuscaloosa: The University of Alabama Press; 1987.
5. Levcovitz E, Lima LD, Machado CV. Política de saúde nos anos 90: relações intergovernamentais e o papel das Normas Operacionais Básicas. *Cienc Saude Coletiva*. 2001;6(2):269-91. DOI:10.1590/S1413-81232001000200002
6. Lima LD. A Comissão Intergestores Bipartite a CIB do Rio de Janeiro. *Physis*. 2001;11(1):199-252. DOI:10.1590/S0103-73312001000100005
7. Lima LD, Viana ALD, Machado CV, Albuquerque MV, Oliveira RG, Iozzi FL, et al. Regionalização e acesso à saúde nos estados brasileiros: condicionantes históricos e político-institucionais. *Cienc Saude Coletiva*. 2012;17(11):2881-92. DOI:10.1590/S1413-81232012001100005
8. Lucchese PTR. Descentralização do Financiamento e Gestão da Assistência à Saúde no Brasil: a implementação do Sistema Único de Saúde - Retrospectiva 1990/1995. *Planej Polit Publicas*. 1996;14:75-156.
9. Miranda A. Processo decisório em Comissões Intergestores do Sistema Único de Saúde: governabilidade resiliente, integração sistêmica (auto) regulada. *Rev Polit Planej Gestao Saude*. 2010;1(1):117-39.
10. Obinger H, Leibfried S, Castles F. Federalism and the Welfare State. Cambridge: Cambridge University Press; 2005.
11. Peterson PE. The Price of Federalism. New York: Brookings; 1995.
12. Pierson P. Fragmented Welfare States: Federal Institutions and the Development of Social Policy. *Governance*. 1995;8(4):448-78. DOI:10.1111/j.1468-0491.1995.tb00223.x
13. Ribeiro JM. Conselhos de Saúde, comissões intergestores e grupos de interesse no Sistema Único de Saúde (SUS). *Cad Saude Publica*. 1997;13(1):81-92. DOI:10.1590/S0102-311X1997000100018
14. Santos L, Andrade LOM. Redes interfederativas de saúde: um desafio para o SUS nos seus vinte anos. *Cienc Saude Coletiva*. 2011;16(3):1671-80. DOI:10.1590/S1413-81232011000300002
15. Silva IF, Labra ME. As instâncias colegiadas do SUS no estado do Rio de Janeiro e o processo decisório. *Cad Saude Publica*. 2001;17(1):22-41. DOI:10.1590/S0102-311X2001000100017
16. Viana AL, Lima LD, Oliveira RG. Descentralização e federalismo: a política de saúde em novo contexto - lições do caso brasileiro. *Cienc Saude Coletiva*. 2002;7(3):493-507. DOI:10.1590/S1413-81232002000300008
17. Viana AL, Machado CV. Descentralização e coordenação federativa: a experiência brasileira na saúde. *Cienc Saude Coletiva*. 2009;14(3):807-17. DOI:10.1590/S1413-81232009000300016
18. Watts R. Comparing Federal Systems in the 1990s. Kingston: Queens University; 1996.

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