Overcoming Decentralization's Defects: Discovering Alternative Routes to Centralization in a Context of Path Dependent HIV/AIDS Policy Devolution in Brazil

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In a context of poorly designed health policy decentralization processes and constitutional commitments to decentralization, what can national governments do to overcome sub-national policy inefficiencies and respond more effectively to health epidemics, such as HIV/AIDS? Examining the case of Brazil, this article argues that within these constraining political contexts, national AIDS programs can devise approaches to what the author calls "indirect centralization". That is, by creating new conditional fiscal transfer programs based on sub-national government adherence to national policy mandates while at the same time working with local AIDS NGOs to monitor sub-national AIDS policy performance, thus increasing local government accountability to the center, the national AIDS program can sustain its centralized influence within a decentralized context. The case of Brazil provides an example of what other nations can achieve in order to ensure that decentralization continues to work effectively in response to AIDS and other diseases.

INTRODUCTION

Since the 1970s, governments in Latin America pursued decentralization and community development as a means to enhance the provision of social services, especially healthcare services. Within authoritarian political regimes, decentralization also provided a means to increase the government's legitimacy while facilitating the gradual transition to democracy.[1] In Brazil, for example, this strategy was pursued. Military and opposing political elites quickly invested in decentralization as a way to open up the political system, while civic movements demanding healthcare as a human right gradually infiltrated the highest echelons of the Ministry of Health and Planning. This further solidified the government's commitment to decentralization. In the end, a path dependency process of increasing returns as well as policy-feedback[2] generated unwavering political commitment to decentralization.

By the late-1980s, however, the 1988 constitution's immediate devolution of health financing and administrative responsibilities to the municipalities constrained the government's ability to immediately respond to health epidemics, such as the HIV/AIDS epidemic. Bereft of resources, municipal health departments did not have the adequate infrastructure and medical treatment needed to effectively respond, while the national AIDS program did not provide sufficient support. In this article, it is argued that while decentralization provided the most efficient means to democratize, in the end, decentralization provided the most inefficient policy means for an aggressive response to HIV/AIDS.

When confronted with decentralization's defects, what can governments do to overcome these limitations? In Brazil, given the government's pre-existing constitutional commitment to healthcare decentralization through SUS (*Sistema Único*

de Saúde), reversing decentralization through an official re-centralization of health financing, administrative, and expenditure responsibilities was certainly not an option. Operating within these constraints, Brazil's government pursued an alternative path, one that I call *indirect centralization*.

Conceptually, indirect centralization combines the central government's creation of fiscal policies[1] for a particular disease, such as HIV/AIDS, along with partnerships with civic organizations, such as AIDS NGOs, to increase the national AIDS program's on-going influence over sub-national policy implementation. Indirect centralization is different from fiscal re-centralization in that sub-national fiscal autonomy is not reduced through a reduction in fiscal transfers and limits on spending and borrowing through hard budget constraints. During a process of indirect centralization, federal fiscal transfers, often through the constitution, for healthcare and other social welfare policies persist; moreover, in this process the central government creates new fiscal policies that augment its authority without interfering with existing fiscal transfer arrangements to the states. More specifically, indirect centralization is achieved through the provision of conditional-based grant assistance to state and municipal health departments as long as they comply with the national program's policy mandates. This is designed not to reduce sub-national fiscal autonomy and capacity, as typically envisioned in a fiscal re-centralization scheme, but rather to augment sub-national fiscal revenues in a conditional, controlled manner. In addition to fiscal policy, indirect centralization entails the national HIV/AIDS bureaucracy working closely with NGOs to monitor sub-national governments and report their initiatives back to the national program. These two strategies provide fiscal incentives for sub-national governments to maintain the national AIDS program's policy interests while increasing sub-national accountability to the national program.

The national AIDS program pursued indirect centralization in order to maintain its centralized control over AIDS policies, which by the year 2000 was devolved to the municipalities. This initiative reflected the national program's lack of confidence in both decentralization and sub-national governments' ability to effectively implement policy. When combined with constitutional and political commitments to a universal and effective response to AIDS, as well as eventually having an international reputation for an aggressive policy response, by the early-2000s this motivated the national program to indirectly intervene.

Brazil's indirect centralization strategy provides a unique inter-governmental response to AIDS policy sustainability, one that has not been adequately examined in the literature. As the conclusion of this article explains, federations seeking to overcome decentralization's defects through indirect centralization will need to learn how to combine fiscal innovations with the national health bureaucracy's strategic usage of partnerships with civil society. Moreover, the case of Brazil shows that indirect centralization does not equate to a gradual reversal of decentralization. Rather, indirect centralization emboldens decentralization processes while kindling new civic commitments to holding local governments accountable and meeting healthcare needs. Therefore, indirect centralization may eventually rekindle confidence and commitment to health policy devolution.

[1] It is important to note that those fiscal policies used for indirect centralization are new and separate from existing fiscal policies supporting health policy legislation, such as automatic fiscal transfers from the constitution.

METHOD

The method employed in this article is based on a qualitative, single case study research design. Two qualitative methodological goals were pursued: First, to use a single case study in order to illustrate and confirm existing theories in path dependency, such as increasing returns and policy-feedback processes, as well as to show the potential effectiveness of a new concept, indirect centralization, that could eventually be turned into a generalizable theory.[3] The intended theoretical contribution of this paper, then, is to introduce a new concept and to illustrate its potential for not only explaining complex inter-governmental processes in response to HIV/AIDS but also its potential for eventually becoming a generalizable theory applicable to a large universe of cases. Indeed, it is the author's hope that this concept will be eventually measured and quantified for a large number of cases, which, as explained later in the paper, can be achieved through particular social science methods.

My methodological approach in this article comports with the *analytic narrative*[4] enterprise in comparative case study research. This approach is different from a historical description of a case study because the goal is to use in-depth historical evidence to show the elegance, sophistication, and efficacy of a concept or theory and its ability to explain complex causal processes, where several actors (often at different levels of analysis, e.g., domestic and international), preferences, and strategies combine to yield a particular outcome.[5] Concepts and theories that are typically employed are often abstract and illustrated through formal modelling, though as this article and other scholars maintain, this need not be the case.[6] Furthermore, this approach emphasizes that theory linked to data is more effective than studies using either data or theory alone.[7] In this approach, empirical case studies are not used to test for the broader generalizability of theory, [8] which entails a Large-N statistical (cross section) analysis or an in-depth within-case analysis proving the presence of a particular causal variable or series of variables.[9] This is mainly because the causal variables considered in an *analytical narratives* (as well as small-n) approach are often too complex to be adequately conceptualized and measured at a broader level.[10]

Nevertheless, if one were to take the extra step of empirically testing the concept of indirect centralization for the purposes of creating a generalizable theory applicable to a large universe of cases, one would have to first devise the following theoretical hypothesis: in response to the shortcomings associated with a decentralized response to HIV/AIDS, governments create new fiscal transfer programs for sub-national governments as well as employ HIV/AIDS NGOs to monitor state and local government commitments to using fiscal transfers effectively as well as adequately implementing policy. One can then employ qualitative research methods, such as *fuzzy sets analysis*,[11] which uses qualitative evidence, such as interviews, articles, and book publications, to code several developing nations based on the presence of this complex, two part hypothesis. In so doing, one is able to examine if and to what extent these causal conditions are present and if they lead to the outcomes of interest: that is, indirect central government control over HIV/AIDS policy implementation. However, such a theory-building enterprise is not the goal of this study.

Second, the case of Brazil was used to analyse current theories discussing the preconditions associated with health policy centralization. This was done in order to

reveal the limitations associated with these approaches, while providing an empirical example of alternative indirect centralization processes. Yet it is important to note that the goal was not to test established theoretical frameworks in order to devise a new generalizable theory about the preconditions necessary for indirect centralization to take place.[2] Rather, the goal was to express why Brazil was unique from other nations, where direct centralization took place, while providing an in-depth case study as an example of how indirect centralization worked in Brazil.

With regards to data, this article relied on primary and secondary qualitative evidence in the form of journal articles, newspaper articles, university theses from Brazil, interviews with national AIDS officials, and government documents from Brazil. Because of the dearth of peer-reviewed articles and documents discussing indirect centralization processes, especially Brazil's *Política do Incentivos, Fundo-a-Fundo* program and partnerships with NGOs, this article employed a triangular method of using several different pieces of qualitative evidence in order to confirm that this process in fact occurred.[12] This method underscores the fact that this is a new topic in health policy research and that scholars need to employ as much qualitative evidence as possible when discussing unique causal phenomenon.[13]

And finally, what the case of Brazil is and why it was selected needs to be addressed. First, Brazil was chosen because it represented a lot of the challenges that other developing nations, both within and outside of Latin America, faced during their initial response to HIV/AIDS. For example, federalism and in particular healthcare decentralization has posed challenges to nations' ability to immediately respond to HIV/AIDS,[14] especially when one considers the fast paced timing of decentralization without ensuring that local governments have adequate resources and experiences, sub-national corruption and lack of political commitment.[15] Second, Brazil submits a case study of a unique, successful, and on-going national government response to HIV/AIDS, where it has engaged in a process of incessant policy learning and timely adaptability, such as through the introduction of indirect centralization shortly after devolving more authority for HIV/AIDS policy implementation, in order to ensure effective policy sustainability.[16] Consequently, Brazil can and should be treated as a unique case study that other scholars and policy-makers can learn from.

In the next section, I address recent theories about the benefits and inefficiencies associated with health policy decentralization. This is done in order to illustrate limitations within the existing literature accounting for why decentralization has failed while incorporating the path dependency literature in political science and sociology as an alternative way to understand these limitations. I then address the recent literature discussing health policy centralization as a strategy pursued by other nations to overcome decentralization's defects, while underscoring the limitations of this approach based on its failure to address binding historic federalism and

[2] One will note that in the theoretical section, I lay out possible pre-existing conditions for indirect centralization to take place, such as the historic presence of political federalism, the historic presence of suppressive military regimes failing to provide adequate healthcare, and sustaining reputable public health programs. Yet these prepositions are introduce not to create a generalizable theory, but to specify some possible reasons why the case of Brazil – and other Latin American federations – were different from Western Europe, where direct centralization occurred. This is why these prepositions are not discussed at length in the body of this article.

constitutional commitments to decentralization. This is followed by an introduction to *indirect centralization* and how this process works.

DECENTRALIZATION AND INDIRECT CENTRALIZATION

In recent years, a consensus has emerged suggesting that the decentralization of health policy is the most effective means for rendering public health services, especially in response to HIV/AIDS. Decentralization is defined here as entailing two processes: a de-concentration and devolution of health policy. De-concentration entails the central government's transfer of policy responsibility to sub-national administrative units that are not autonomous in their ability to make fiscal, administrative, or policy decisions but instead abide by the central government's policy preferences.[17] De-concentration also entails a central bureaucracy's direct financing as well as management of sub-national bureaucrats, which in turn helps to avoid corruption and inefficiency.[18] Devolution, on the other hand, entails the transfer of all administrative, financial, and policy decisions to state and municipal governments, with the management and financing of personnel controlled by sub-national governments.[19] In this scenario, state and local governments are often subject to capture by political elites, which in turn leads to corruption and inefficiency in the provision of health and other social services.[20] This study is mainly concerned with health policy devolution, however, given that this is the type of system found in Brazil as well as most public health systems in large federations, such as Russia, China, and South Africa. Of course, there are federations that exhibit a more de-concentrated form of public health and other social welfare policies, such as India.[21] With the exception of perhaps India, this often has to do with the smaller geographic size of the nation as well as having a long and continued history of centralized political and bureaucratic control, as seen in several southeast Asian nations, Africa, and Latin America, e.g., Mexico and Chile.[22]

In the academic literature, it is often argued that health policy devolution motivates citizens to become more involved in designing AIDS prevention and treatment policies,[23] while increasing local government accountability.[24] In addition, some argue that devolution leads to greater economic efficiency through the containment of health costs, as spending and program development can be better targeted.[25] This is especially the case when the center decides to devolve complete autonomy and choice in how to design policy and manage hospitals,[26] in turn providing opportunities for AIDS policy innovation.[27] And finally, some claim that local politicians have incentives to receive healthcare responsibilities, as this provides an opportunity to demonstrate leadership and AIDS policy innovation, thus garnering more political support.[28] It is important to note, however, that decentralization and devolution's benefits in particular have been perceived to go beyond the health sector, strengthening the policy-making and administrative capacity of local governments in Latin America.[29]

Recent re-evaluations of the benefits of health policy devolution reveal some limitations to its efficacy, however. Some note that in Latin America, sub-national incapacity and corruption continue to undermine local governments' ability to provide AIDS prevention and treatment policy.[30] Incapacity emerges when governments lack the human resources, technical knowledge, and experience needed to combat AIDS.[31] Incapacity also emerges when the timing of health devolution is too fast, imposing a host of responsibilities onto municipal health departments lacking managerial

experience and infrastructure.[32] And finally, corruption breeds inefficiencies. This occurs when local politicians are not held accountable to the center, have short-term horizons, and reallocate resources for health to other programs providing greater payoffs.[33] Recent scholars suggest that because of these problems, when it comes to responding to health epidemics, decentralization may not be the most efficient policy means for implementing prevention and treatment policies.[34]

This article comports with these views. For it posits that the hasty devolution of policy responsibility may not provide the most advantageous approach to responding to AIDS and other epidemics. Nevertheless, while the aforementioned literature emphasized sub-national incapacity, poor timing, weak infrastructure, and corruption as reasons for why health policy devolution failed, this article emphasizes how pre-existing political elite commitments to democracy and the unwavering belief that devolution is part and parcel of this process leads to a substantially delayed national government responses to helping municipalities respond to HIV/AIDS.

Paul Pierson's notion of policy feedback affects captures this dilemma nicely. Policy feedback occurs when political elites, guided through their ideological views and interests, invest heavily in policies (in this case devolution) while building coalitions that sustain this process.[35] This, in turn, locks in policy and its supporting institutions. These coalitions build on health devolution processes and commit more resources to it. This contributes to high sunk costs and an unwillingness to alter policies even when there is a perceived need to do so.[36] Institutional change, such as policy centralization, is not pursued because the perceived political costs associated with institutional change greatly outweigh its benefits.[37]

The timing of devolution is also accelerated whenever political elites invest heavily in it. While initially the decision to devolve may entail a substantial amount of inter-elite negotiations, given differences of opinion of whether or not to do so,[3] the decision to devolve is eventually predicated on their belief that decentralization advances democracy, being, in other words, the most democratically efficient means for rendering health services. This belief, when combined with the government's relationship with like-minded, well organized civic movements infiltrating the health bureaucracy, further motivates elites to quickly devolve policy to municipalities. And this occurs even when politicians and bureaucrats know that municipal health departments are unprepared to handle these responsibilities and respond to epidemics. This reflects what Smoke, Gómez, and Peterson[38] call *precocious decentralization*, where political interests often lead to a hasty devolution of authority without ensuring that local governments have the capacity to take on such responsibilities.

Alternative Routes to Centralization

But what can Ministries of Health do to overcome the path dependent inefficiencies associated with poorly designed, devolved healthcare policies? There are

[3] In Brazil, for example, initially the decision to decentralize was not guided by unanimous political consensus. During the military regime, those favoring decentralization, such as the *sanitarista* movement in civil society, confronted resistance from those that were more aligned with INAMPs and hospitals, which preferred centralization; this generated incessant negotiations, leading to gradual decentralization, first to the states, then suddenly to the municipalities in 1988; for more on this note, see Weyland (1996); Arretche (2005).

several choices that can be pursued. First, Ministries of Health can engage in a formal process of policy centralization. Centralization (or re-centralization, if policy has already been decentralized) entails the national government's decision to decrease sub-national government fiscal, administrative, and policy autonomy through various means. Fiscally, this entails either the elimination of automatic fiscal transfers, such as from the constitution, the imposition of new taxes, and the imposition of borrowing and expenditure constraints.[39] With regards to policy-making, centralization entails the central government's decision to reduce state and local government policy-making autonomy as well as responsibility in implementing policy.[40]

With regards to centralization in health policy, this process often entails directly altering a nation's constitution in order to claw back financial and policy-making autonomy from sub-national governments; second, they can combine this centralization with a limited decentralization process, such as policy de-concentration or delegation;[41] or third, they can find indirect, alternative routes to centralization by combining fiscal policies, such as new fiscal transfers that are conditional, based on sub-national policy performance, as well as partnership strategies with civic organizations. Which one of these strategies a government pursues is often a product of their unique history of federalism, pre-existing constitutional commitments to decentralized universal healthcare, and a successful reputation - as well as social expectations - for maintaining an effective public health program.

In Western Europe, recent government preferences have been to move away from complete healthcare devolution in favour of a combination of fiscal centralization amidst administrative devolution in healthcare management and policy, where local governments retain limited administrative and managerial autonomy while the Ministry of Health finances and creates policy. In fact, recent scholars argue that healthcare devolution is currently only one of several options that governments have pursued in several Western European countries.[42] While still acknowledging the benefits of devolution for certain aspects of hospital management and administration, governments have combined this process with the centralization of fiscal and policy-making powers, in turn providing a combination of fiscal and policy-making centralization with administrative devolution.[43] Some maintain that devolution and centralization processes can therefore complement each other, and that effective inter-governmental relationships require finding the appropriate mix of both processes.[44]

Western Europe's unique political history also helps to account for the emergence of these hybrid systems – that is, a combination of fiscal centralization and devolution. With the exception perhaps of Italy and Spain, where federalism, local government autonomy, and civic participation has a long history,[45] other European nations – especially in the Eastern region – do not have such histories. The absence of historic federalism, political, and social expectations of devolution and local autonomy has facilitated countries such as Norway, Sweden, and France's ability to subsequently reverse decentralization policy decisions established in the 1990s. [46] Other countries exhibit similar conditions. In India, for example, the absence of a tradition of federalism and healthcare devolution, as well as social expectations of this process, has facilitated the Ministry of Health's ability to maintain and justify the control of program funding and fiscal transfers to the states for public health programs, such as HIV/AIDS.[47] This, in turn, has been viewed as an effective way to implement HIV/AIDS and other health policies while responding in a timely manner.[48]

Other studies note that nations have followed a more centralized approach to health policy implementation, especially in response to disease, in order to ensure more a more timely and effective response. For example, work by Constance Nathanson[49] maintains that a successful policy response to HIV/AIDS and maternal infant mortality in France depended on the immediate centralization of policy-making autonomy, receptivity to scientific evidence and consulting, as well as a pre-existing political proclivity for centralization.[50] The benefits of policy centralization have motivated others to argue that when providing infant immunization and HIV treatment, non-democratic and/or highly centralized states are more effective than representative democracies in rendering these services.[51]

Yet another factor facilitating the centralization process in these nations is the absence of supercilious, unjust military regimes that did not provide equitable universal healthcare. Consequently, transitioning European democracies, as well as in India, did not see the political 'backlash' effects that other nations experiencing these unjust processes did, such as Brazil, Chile, Argentina, South Korea, Thailand, and Taiwan.[52]

In contrast to Western Europe, however, when it comes to social policy, most Latin American governments have not moved away from de-concentration or devolution.[53] There are two major reasons for this: First, federalism's rich political history and constitutional commitments, inspired by recent transitions to democracy. Latin American nations – especially in Brazil and Argentina – have had a long history of federalism and decentralization.[54] Consequently, a deep legacy of state government control over health and other social welfare sectors has persisted. Second, several nations went through transitions to democracy and as a result of civic and political pressures, produced constitutions guaranteeing universal access to healthcare as a human right.[4] Decentralization was seen as the primary and legitimate vehicle for delivering healthcare services.[55] Thus, and as mentioned earlier, notwithstanding innumerable sub-national financial, administrative, corruption, and managerial inefficiencies, issues that prompted several European nations to re-centralize financial and policy responsibilities,[56] deep historical legacies and constitutional commitments have motivated Latin American governments to maintain a decentralized provision of healthcare.

Yet another factor distinguishing Latin America from other nations is the fame that some decentralized health sectors have achieved, as well as the international and domestic pressures and expectations that such programs continue. One health sector that stands out in this regard is HIV/AIDS. As the case of Brazil illustrates, international notoriety and fame for having a successful response to HIV/AIDS, as well as its well-known decentralized approach to health services provision, can motivate governments concerned about their international reputation to maintain a decentralized approach to HIV/AIDS prevention and treatment.[57] In part because the prevalence of HIV/AIDS was not as high, European and Asian nations have not received as much notoriety, thus generating few incentives for leaders to sustain decentralized approaches. In Africa, on the other hand, some have argued that successful country responses, such as Uganda, and international acclaim has helped maintain a decentralized approach to AIDS prevention and treatment in Uganda.[58]

[4] Recent work by James McGuire (2010) also notes that has also been the case in East Asia, such as in Thailand, Taiwan, and South Korea.

Because of continued international recognition, civic organizations and even international donors continue to expect that a decentralized provision of AIDS programs is pursued. As the case of Brazil shows, civic movements and on-going social expectations of a decentralized universal healthcare approach to AIDS, through SUS (*Sistema Único de Saúde*) treatment persists, while recent major loan packages from the World Bank have been designed to strengthen SUS and local government capacity.[59] These social and international expectations has essentially forced Brazil to formally maintain a decentralized approach to AIDS policy, even when it has several reasons to formally centralize some aspects of it.

In contrast to other nations, then, Latin America's history of federalism, constitutional commitments, and domestic and international expectations has not provided the Ministries of Health with the resources and policy tools needed to pursue fiscal centralization, or even a hybrid of fiscal centralization and devolutionary strategies. Given these constraints, governments must find alternative, indirect routes to centralization.

I argue that a form of *indirect centralization* can be achieved when governments establish processes of central government policy influence without adjusting constitutional inter-governmental fiscal arrangements with the states. The national AIDS program can, for example, can create new conditional fiscal transfer programs that are distinct from existing fiscal policies supporting healthcare and that are designed to supplement decentralization processes while motivating municipal health agencies to comply with the national AIDS program's policy interests. Acting as a form of aid conditionality, fiscal transfers, in the forms of grants, are based on municipalities' adherence to national AIDS policy goals and the efficient use of financial and administrative resources to achieve them. In a context of heath policy devolution, this strategy indirectly increases the national AIDS program's influence over local health departments and the policy implementation process by making the latter more accountable to the former.

In addition, indirect centralization entails the national AIDS program's strategic relationship and usage of civic organizations, such as AIDS NGOs, to further increase the accountability and performance of municipal health departments. NGOs under contract with the national program achieve this by monitoring and reporting municipal policy inefficiencies back to the national office. This not only holds municipal officials accountable, but it also provides national AIDS officials with the information needed to more accurately assess municipal policy performance.

In order for *indirect centralization* to take place, then, health sector specific fiscal transfer programs and partnerships with civic organizations must be present. Yet the presence of either of these conditions is insufficient for indirect centralization processes to unfold. While governments may introduce new fiscal policies for the AIDS sector, without civic organizations reporting information back to the center, national AIDS officials' access to information is limited, thus complicating their ability to effectively monitor municipal government performance. This can be problematic in scenarios where municipalities are distant from the nation's capital and where geographic terrain makes it difficult for national health officials to travel to remote localities. At the same time, proactive civic movements in the absence of fiscal disciplining mechanisms will not lead to sufficient pressures and municipal accountability to the center and local constituents. This is especially the case when municipal officials have a pre-existing

history of not being accountable to constituents and where processes of political elite capture motivate local officials to favour some constituents over others.

In sum, the strategic usage of AIDS-specific conditional fiscal transfers as well as civic networks can allow national AIDS programs to increase their centralized influence in a context of health policy devolution. Nevertheless, it is important to note that indirect centralization by no means constitutes a reversal of healthcare devolution. Instead, it can strengthen devolution by filling in lacunas where it has failed while motivating civil society to collectivize, monitor, and hold municipal governments further accountable. When striving to sustain and strengthen national programs focused on on-going epidemics, such as HIV/AIDS, this strategy can be extremely helpful. As others have argued, supplementing decentralization with innovate fiscal programs can also illustrates a government's on-going concern about effective AIDS policy implementation and finding the best strategies needed to sustain effective programs.[60]

To the author's knowledge, with the exception of Brazil, indirect centralization as a strategy for strengthening decentralized approaches to AIDS and other health policy sectors has not been pursued in other nations. In-direct centralization therefore appears to be a new concept that emerges from the case of Brazil and may in fact be unique to this country. This concept is unique for two primary reasons: first, the national government's simultaneous creation and usage of new conditional fiscal transfer policies for HIV/AIDS as well as the contractual hiring of AIDS NGOs to monitor municipal performance in using funding effectively and implementing HIV/AIDS policies. Second, most nations either do not create conditional fiscal programs specifically for HIV/AIDS at subsequent points in time, and/or they do not strategically employ and use AIDS NGOs to work for the national AIDS program as monitoring agents. There are certainly nations that have created national vertical fiscal and policy programs for HIV/AIDS, often with the assistance of the international community,[61] as well as additional, innovative fiscal programs design specifically for HIV/AIDS, such as in the United States in the early 1990s with Ryan White Care.[62] But it is important to note that these fiscal programs were created at the beginning of the HIV/AIDS epidemic, while no subsequent fiscal programs for HIV/AIDS were implemented in order to sustain and strengthen the government's on-going response.[63] This finding confirms recent scholars' claims that the national AIDS program in Brazil is perhaps unique and unwaveringly committed to continuously strategizing about how to strengthen its approach to eradicate HIV/AIDS.[64]

Second, when compared to Brazil, many nations either do not have as close of a partnership with AIDS NGOs, with many NGOs that are unemployed and in search of work, or are contracted by the national AIDS program to work in partnership with it to monitor sub-national policy performance. When compared to India, China, Russia, and South Africa, i.e., the other emerging federations, scholars note that this is indeed the case.[65] When compared to most developing nations, moreover, Brazil's government provided prevention and universal ARV treatment at an earlier point in time, which left many AIDS NGOs satisfied, less confrontational and in need of work;[66] this, in turn, incentivized AIDS NGOs in Brazil to work in partnership rather than in opposition to the national AIDS program, thus providing the latter with a bountiful supply of civic organizations that could be used to monitor sub-national performance.[67] However, because the other emerging and developing nations have not achieved this, there is little evidence that this kind of partnership between the state and civic organizations is

present. Rather, these nations are either still not committed to working closely with AIDS NGOs, or they are still developing close ties with them and meeting needs.

Despite the fact that there is no similar case to Brazil, the new concept of indirect centralization is important because it provides an example of what can work – and may perhaps be working – in other nations; it is important, moreover, because the concept and evidence from Brazil can provide an example of what nations need to do when confronted with the on-going institutional and policy challenges of poorly designed and implement decentralization – both de-concentrated and devolutionary – processes. Indirect centralization represents a novel attempt by the national government to induce sub-national political commitment to meeting the needs of HIV/AIDS victims as well as avoiding the common problems associated with health policy devolution, such as corruption, lack of accountability, and administrative inefficiency. Furthermore, indirect centralization is a novel concept and approach that has been inducted from the case of Brazil, a nation that has been well known for sustaining and deepening its national commitment to combating HIV/AIDS.[68] While the concept may only be applicable to Brazil at this time, this should motivate scholars and policy practitioners to work together in discovering if it is present in other nations, and if not, if they have the potential and need for responding in this manner in the future.

In the next section, I introduce the case of Brazil. I begin with an analysis of health policy decentralization and its on-going inefficiencies. I then discuss the emergence of indirect centralization processes, and how this strategy has been vital for sustaining and strengthening Brazil's world famous national AIDS program.

DECENTRALIZATION AND INITIAL GOVERNMENT RESPONSE TO AIDS

In Brazil, the decentralization of health policy went hand in hand with the transition to democracy. Democratization in Brazil was a gradual process that started towards the end of the authoritarian military dictatorships, which began in 1964 and ended in 1985. While the first few years of authoritarianism was marked by a high degree of political centralization, economic modernization, violation of human rights and the suppression of leftist political movements,[69] by the early-1970s, a decline in economic performance (due mainly to underperforming state-own enterprises), increased social unrest and international pressures convinced the military that the government was going to inevitably transition back to democracy.[70] Realizing this, both in an effort to maintain its political legitimacy and survival, given its hopes to remain influential after the transition back to democracy,[71] by the early-1980s the military began to allow state and municipal elections in 1982, the election of federal deputies and senators in 1974, 1978, and 1982, and mayors in 1982 before the first democratic election and president was installed in 1985.[72] Some of the most affluent and important states, such as Sao Paulo, saw the election of governors from the major opposition political party, such as the election of Franco Montoro of the opposition PSDB (Brazilian Social Democratic Party) in 1983, who was committed to electoral competition, human and social rights, as well as the provision of social services and healthcare.[73]

In addition to gradually allowing for the provision of federal, state, and local elections, the outgoing military also introduced health policy innovations in order to increase its political legitimacy, survival, and thus influence after the democratic transition. In response to heightened civic pressures, especially from the *sanitarista*

movement, which arose during the 1960s as a leftist political movement composed of doctors, medical practitioners, academics, and activists pressuring the military for universal access to healthcare as a human right, as well as equating this to the need for democracy and decentralization,[74] the military began to work closely with this community and to pursue health policies that would appease the rural poor, who were often excluded from the Ministry of Health and INAMPS (*Assistencia Medica da Previdencia Social*), which was a social security-funded and contributory healthcare system created in 1978 and mainly for the employed.[75]

The military also began to allow *sanitarista* members to obtain prominent positions within government. In so doing, pro-democratic forces from civil society could design healthcare policies that were more democratically based, inclusive, equal, and effective in meeting needs. For example, in 1983 Dr. Eleutério Rodriguez Neto, a famous leader of the *sanitarista* movement, became Director of Planning in the Department of Social Security – which administered healthcare through INAMPS.[76] This movement advocated for years that the government push for decentralization, social control of health policy through municipal civic participation, and that it was the government's responsibility to provide high quality healthcare.[77] While serving, Rodriguez Neto succeeded in introduced AIS, and more broadly, building a sub-national coalition of governors and mayors (mainly in the pro-democratic southern states) that agreed to AIS and further pushed the military for decentralization.[78] Netto's movement was also aided by the presence of a host of *sanitarista* members that infiltrated health and departmental agencies in south and even the northeastern states, where the military had expanded its services through FUNRURAL (*Fundo de Assistência ao Trabalhador Rural*) to increase its legitimacy and control of potential subversive groups.[79]

Thus in sum, the democratization process in Brazil saw the need to introduce political and healthcare innovations that would increase the military's legitimacy while at the same time facilitating the transition to democracy. Realizing that the end of their reign was near, military officials viewed political and healthcare experts as the primary way they could remain popular enough to have some degree of influence after the democratic transition occurred.[80]

In terms of healthcare decentralization, in 1982, just three years before the transition to democracy in 1985, the outgoing military decided to decentralize – rather, de-concentrate - the provision of all healthcare services, management, and policy regulation to the governors. For the outgoing military, health policy decentralization was perceived as an innovation that could essentially kill two birds with one stone: on one hand, it could substantially reduce the cost to the federal government of providing health services, while on the other hand it demonstrated its commitment to democratic deepening by increasing the participation of civil society in the policy reform process, in turn enhancing the quality of policy provisions.[81] Decentralization thus reflected the interests and motivation of the Brazilian government, not international pressures.

The first set of decentralization measures introduced was called the AIS (*Acões Integradas de Saúde*), or Integrated Health System. In response to hyperinflation and in an effort to prune expenditures, in 1982 the government quickly sought to delegate these responsibilities to the states.[82] The primary mission was to create, for the first time, a unified (universal) healthcare system, managed and controlled by the states, with an emphasis on primary care provision, an increased reliance on underutilized public rather than private facilities, a greater control over high-cost medical procedures

and contracted service costs.[83] Until that point, these responsibilities were controlled by the Ministry of Social Welfare, through INAMPS (Instituto Nacional de Assistencia Medica da Previdencia Social).

Even more discretion was decentralized. In 1987, two years after Brazil's transition to democracy, the Jose Sarney administration implemented the Unified Decentralized Health System (SUDS). SUDS carried over the principles of the AIS, while giving the state health secretariats more control over administration and management. Furthermore, and this is key, for the first time it gave the state health secretariats complete discretion over how much financial and administrative autonomy should be decentralized to municipal health agencies.[84]

This set the stage for the complete and fast-paced devolution of health financial and administrative authority to the municipalities in 1988.[85] That year, the Congress voted and agreed to implement the Unified Health System (SUS). This was Brazil's first ever completely decentralized universal healthcare system. In contrast to AIS and SUDS, it was completely decentralized to municipal health agencies. Once again, the goal was to increase efficiency in healthcare provision, to increase the access and availability of health services (and this is important, given Brazil's 5,043 municipalities), and to reduce costs by giving mayors more discretion over how much they should spend.

For the government, devolving responsibilities to the municipalities was perceived as a solution to Brazil's health problems. For it was believed that decentralization would increase efficiency through greater state and especially municipal government accountability. Decentralization also provided what civil society wanted: that is, more control and participation in the policy-making processes. Through municipal health councils, which were launched in the 1988 constitution through SUS, citizens could vote on the provision of financial resources and healthcare planning,[86] thus giving them more social control.

But a closer examination of how decentralization worked revealed its defects. First, it was perceived that decentralization was done too quickly. That is, the SUS immediately landed into the laps of several municipal health agencies that were insolvent due to their repeated inability to secure funding from state health secretariats,[5] which, in turn, made it difficult to respond to crucial diseases, such as AIDS and TB.[87] The municipal health departments also lacked human resources, such as doctors, nurses, and lab technicians.[88] And finally, several municipalities lacked basic health infrastructure, such as beds and x-ray machines.[89]

This engendered a decentralized system that was anything but prepared for the AIDS epidemic. To make matters worse, with the exception perhaps of São Paulo, which historically had more autonomy in health policy when compared to other states, from 1982-88 most of the governors opposed decentralizing resources to the municipalities.[90] Full control over health policy meant access to resources, justification for money, loans, and notoriety. This threatened to take away the governors' access to resources, their political popularity, and thus political influence.[91] Consequently, there were major disincentives for the governors to support municipal health secretariats at the height of the AIDS epidemic.

[5] This is not to say that all municipalities in Brazil are insolvent and incapable of rendering services in an effective manner. Some cities have done a good job of financing and providing health services, such as some cities in the state of São Paulo and Curitiba (Matzuda et al, 2008).

The key question to ask here is where was the federal government during the first few years of the AIDS epidemic? What happened to the government's rich tradition of intervening rapidly in order to ensure that local governments had the financial and technical resources needed to respond to epidemics?[92] What happened to the tradition of building and/or modernizing a centralized bureaucratic agency that would immediately assist municipal health departments whenever new epidemics emerged? It should be kept in mind that this was a tradition going back to the 1920s and was maintained and even expanded under several military and democratic regimes until the re-emergence of the military government in 1964.[93] Why didn't the government respond in a similar manner when the AIDS epidemic emerged?

Path Dependency and Decentralization's Authoritarian Drive

Answering these questions first requires a brief discussion of the path dependency elements motivating the government to maintain its commitment to decentralization, notwithstanding its knowledge of the inefficiencies associated with it. As noted earlier, Pierson's[94] notion of policy-feedback helps us understand this process. This occurs when political beliefs in the legitimacy of a particular institutional design not only leads to policy but also on-going political coalitions in support of such policies; politicians and bureaucrats benefit from sustaining these policies, thus creating few incentives to reform institutional designs.[95]

This policy-feedback process was present in Brazil. As mentioned earlier, for example, the outgoing military government's commitment to decentralization, reinforced by its perceived association with the democratization processes and political legitimacy,[96] generated perceptions among the military elites that the AIDS epidemic could be more effectively handled by a de-concentrated form of local government response.[97] Because it was widely assumed by the president and senior health ministers that decentralization was already the most efficient policy means for responding to epidemics and other health ailments,[98] based mainly on the expected benefits of increase electoral accountability, transparency, and civic participation in the policy-making process, there was no interest in decelerating the government's commitment to de-concentration and immediately helping local governments respond to AIDS.[99]

A lack of interest in pursuing an alternative approach to de-concentration, such as a more vertical, centralized approach, was also the product of political coalitions that sustained the de-concentration process. Notwithstanding the suggestions of some reform-minded HIV/AIDS officials that the MOH should immediately create a national AIDS program that could create policy while providing resources to the states, such views were ignored by the military.[100] Instead, by the early-1980s, the military and *sanitarista* members that had infiltrated key positions in the Department of Planning and MOH had created a coalition of support that made it too difficult – and indeed, politically risky – to reverse the decentralization process. Indeed, when commenting on this, specifically on the need to balance the federal budget amidst the military and subsequent democratic government's healthcare and other social welfare policies, Vilmar Faria writes that the: "social protection system inherited from the past is part of the problem, not the solution. Its corporatist and fragmentary structure, together with its high cost and operational inefficiency, the host of interests developed around it (politicians, bureaucrats, suppliers, and clients) and its regressive structure of benefits

has given rise to a set of acquired rights and privileges, especially by segments of the middle class well placed in the judicial, political, bureaucratic and military structures of the country."[101]

In addition, and as mentioned earlier, the military's receptive affiliation with the pro-democratic *sanitarista* movement - as evident with the military's allowance of this group to penetrate key position within government - through new de-concentrated health reform efforts furthered the military's belief in decentralization, in turn strengthening its coalition with this civic group. In 1976, the *sanitaristas* proposed the creation of PIASS (Programa de Interiorização das Ações de Saúde e Saneamento), which was a network of sanitation outposts and mini-stations in low-density populations. Concentrated mainly in the northeast of Brazil and in the state of Minas Gerais, PIASS was designed to provide a state-run program replete with doctors that believed in decentralization and preventative care.[102] Though hesitant to immediately agree to working with the *sanitaristas* on this project (mainly out of fear that it did not have the Social Security revenues needed to finance it), eventually INAMPs agreed to the program, as it complemented its efforts to extend coverage to the poor through the FUNRURAL (Fundo de Assistência ao Trabalhador Rural) program.[103] Because PIASS was composed of *sanitaristas*, ardent advocates of decentralization and community participation in the policy-making process, this relationship with INAMPS revealed that the military agreed with decentralization processes.[104] Finally, and as mentioned earlier, the strategic infiltration of the *sanitarista* movement in the national bureaucracy also helped to further solidify the military's belief and support for decentralization.

The military government's belief in decentralization was made evident through its inaction and excessive reliance on local governments during the first few years of the AIDS epidemic. Prior to the military's withdrawal from power in 1985, it relied entirely on state and local health departments to respond to the epidemic.[105] State-run INAMPS hospitals were extensively relied on to administer treatment to the HIV positive.[106] The absence of sufficient resources, however, underscored the fact that the center expected the states to fend for themselves.[107] The military therefore believed that there was no sense of urgency, no need to immediately intervene, both through the provision of financial resources and infrastructural assistance, such as beds and other medical equipment.[108] The only assistance that the municipalities received from the Division of Hansenaise and Dermitology (Divisao de Hanseniase e Dermatologial Sanitaria [HDS]) was information on how to monitor the disease and how to establish a telephone hotline in order to answer questions about its spread.[109]

The authoritarian government's inaction prior to the transition to democracy in 1985 highlighted its unwavering belief in decentralization. AIDS historians note that during this period there was no evidence illustrating the military's interest in intervening in order to help the municipalities combat AIDS.[110] The government's belief in federalism and decentralization reigned, and it was expected to provide a more effective response to AIDS when compared to policy centralization, which had dominated public health policy up to that point.

As pressures from civil society increased and the epidemiological data about the spread of AIDS became impossible to ignore (c. 1987), the national government began to respond. In 1985, the Ministry of Health created a new federal agency, the *Programa Nacional de DST/AIDS* (PNDST/AIDS) (henceforth, national AIDS program). However, it was poorly constructed, lacked sufficient funding, political support, and was distant

from the gay and intravenous drug (IDU) community.[111] In essence it was perceived to be a cosmetic institution: that is, it was built to give the impression that the government was amassing an aggressive response, while in reality it was not.[112] Officials in the national AIDS program barely, if ever, met with the gay or the IDU community. It provided little advice to municipal health secretariats. And even at the height of the epidemic in 1991, one of its former directors not only decided to skip the yearly carnival festivities in Rio, but he also refrained from ordering his staff to go and distribute condoms.[113] Meanwhile, access to antiretroviral medication, such as AZT, was at a minimum, while the government had very little money and interest in helping local governments finance prevention and treatment programs.[114]

To the government's credit, it did do a fairly good job of discussing the new disease in public and it did implement a fairly aggressive AIDS awareness campaign.[115] Nevertheless, by the late-1980s, it became very clear to many that a) the national AIDS program was very ineffective and b) that most of the municipalities were lacking the resources needed to respond to AIDS. During this period a host of municipal governments had implemented their own anti-AIDS programs.[116] Yet most local governments were lacking basic health infrastructure, such as beds, clean needles, and surgical tables.[117] Under these conditions, the AIDS virus continued to spread. In the end, the proud, nascent democracy, grounded in the tenants of human rights, equality, and universal access to healthcare had done barely anything to help municipal health agencies respond to AIDS. Yes, democratic decentralization was achieved … but to what end?

INDIRECT CENTRALIZATION

Faced with an on-going AIDS epidemic and a poorly decentralized healthcare system, the national AIDS program eventually needed to find a way of allowing healthcare devolution to function while at the same time increasing its centralized control and influence over the implementation of sub-national policy. However, as mentioned earlier in the theoretical section, it is difficult to centralize national policy control when nations have a long history of federalism, social expectations of decentralized universal healthcare, and constitutions guaranteeing this as a human right.[118] In contrast, it was argued that the absence of these historical and institutional conditions facilitates centralization. But when faced with the former constraints, how can nations achieve this? As this section explains, this can be achieved when the national AIDS bureaucracy creates conditional fiscal policies while at the same time contracting AIDS NGOs in order to monitor municipal government performance in using fiscal resources and implementing AIDS policy. In so doing, Brazil shows that nations can maintain their political and constitutional commitments to healthcare devolution while at the same time maintaining their centralized influence in order to ensure that policy is effectively implemented.

But why did the national AIDS program in Brazil pursue this strategy? The answer to this question is rather simple. After years of devising and controlling AIDS policy from above, implementing highly vertical prevention and treatment policies,[119] and after recognizing healthcare devolution's on-going policy defects, the national program was not ready to completely let go of its control and influence.[120] This reflected the national program's lack of trust in SUS and municipal governments' lack of

incentives and capacity to provide effective prevention and treatment policies. Although the national program devolved greater financial and administrative responsibility for AIDS policy in 2000, reports and research suggested that for the reasons mentioned earlier, policies were still not being adequately implemented, especially when it came to harm reduction and AIDS treatment.[121] In response, the national program reasoned that it needed to maintain and strengthen its capacity to ensure effective policy implementation.

In addition, the Ministry of Health had long been committed to providing a de-concentrated form of universal healthcare (beginning with AIS and SUDS). As mentioned earlier, there was a long history of bureaucratic, political, and civic commitment to rendering universal prevention and treatment policy through SUS, both for AIDS and other diseases. This incentivized the national program to help ensure that devolution and the national AIDS program was sustainable and effectively working.[122] In addition, by the late-1990s, the national program developed a very strong international and domestic reputation, as a program unwaveringly committed to widespread prevention campaigns and universal, equal access to ARV medication.[123] In 2001, the AIDS program's leaders and Minister of Health, Jose Serra, had worked with India and other developing nations to declare the right to produce generic versions of ARV medication in times of public health emergency.[124] When combined with receiving the Bill & Melinda Gates foundation award for having the best national policy response to AIDS in 2003 and standing as a "model response" for other nations (Bill & Melinda Gates Foundation, 2003), this bolstered the AIDS program's reputation all the more. Thus, as more evidence emerged indicating that decentralization was not yielding the best policy results, the national AIDS program had incentives to do whatever it could to strengthen sub-national policies, permanently curb the spread of AIDS, and maintain Brazil's – and the national program's - international reputation.[125]

Brazil's national AIDS program quickly discovered that the only way to sustain and strengthen its influence while ensuring that sub-national policies were effectively implemented was to indirectly centralize control through two primary means: the creation of a conditional fiscal transfer program incentivizing municipal governments into compliance with national policy mandates; and second, by establishing close partnerships with NGOs to monitor sub-national policy performance, compliance to national program standards, and thus increase municipal government accountability to the national program.

The Strategic Usage of Fiscal Policy

The first strategy, the strategic usage of conditional fiscal policy, occurred shortly after the national AIDS program devolved financial and administrative responsibilities to the states in 2000. However, because of the various shortcomings associated with the decentralization of health policy, and because of the national AIDS program's fear that SUS and municipal AIDS programs would not have adequate financial support, in December 2002 the MOH released its Ministerial Ordinance No. 2313, *Política do Incentivos, Fundo-a-Fundo* program. Through this program the national AIDS program provides fiscal grant transfers to state and municipal health departments, through SUS's system of financial disbursements. There are several reasons why the national program created this conditional fiscal transfer system. First and foremost was the fear that state

and especially municipal health departments would not have the financial wherewithal needed to sustain SUS and finance AIDS prevention and treatment policy.[126] Therefore, The *Fundo-a-Fundo* (henceforth, *Fundo*) program ensured that the states have adequate financial resources and that the national AIDS program's policy interests can be sustained.[127]

But this in turn revealed what others and this author view as the national AIDS program's primary intention: that is, to strengthen the national AIDS program, ensuring that its policy interests and mandates were institutionalized at the state and municipal level.[128] By providing fiscal transfers to municipalities in dire need of assistance, and by establishing a very elaborate system of monitoring sub-national capacity and commitment to policy implementation,[129] the national AIDS program could essentially guarantee that despite the presence of formal healthcare devolution through SUS, it could maintain its influence and essentially guarantee its policy interests.[130] In addition to ensuring a steady flow of fiscal resources, the program was also designed to increase sub-national commitment to establishing policy goals and implementing them, effective managerial capacity, thus incorporating an element of local responsibility and autonomy.[131] It was also designed to motivate local governments into ensuring its commitments to incorporating the participation of civil society into the policy-making process.[132]

The best way that the national AIDS program could achieve its objective, however, was to devise a conditional-based fiscal program. That is, not every state and municipality was guaranteed *Fundo* assistance; they first had to meet specific basic requirements for assistance, followed by subsequent policy commitments. When it came to qualifications, the following conditions needed to be met:

1) A high incidence of HIV/AIDS, demarcated at a minimum of 50,000 cases, as well as the high velocity of its spread; [133]

2) A local government's participation in the first two World Bank loans (1994-98 and 1999-2003), which in turn signalled financial and infrastructural needs, as well as a history of compliance and cooperation with the national program;[134]

3) Budgetary evidence that sub-national governments were already committed to acquiring technical equipment and managerial capacity.[135]

But in order to qualify for a grant, the national AIDS program also required that state and municipal health departments specify several policy commitments. The following is what the national AIDS program was looking for:

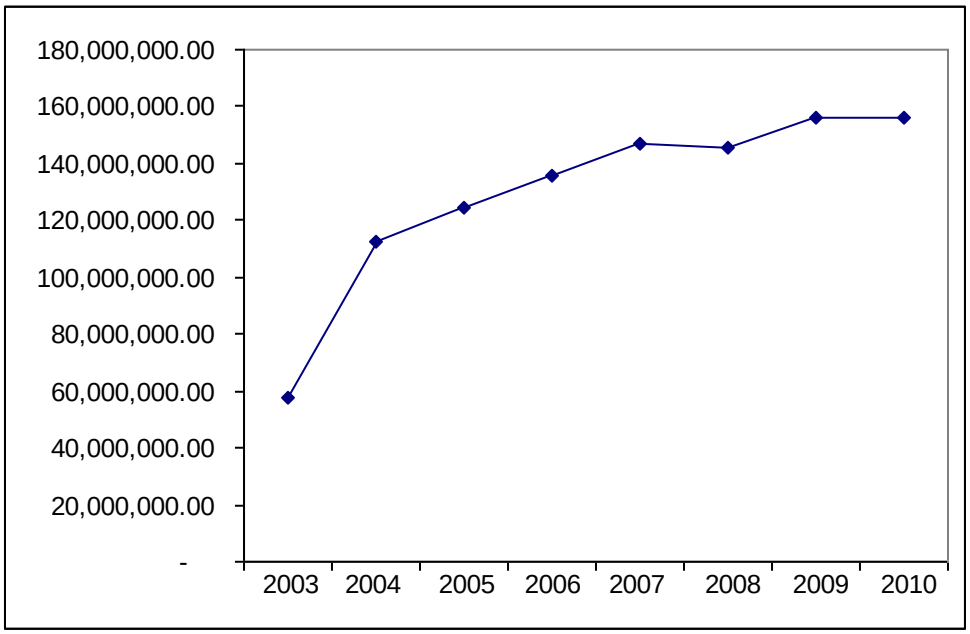
1) Commitments to building the institutional, infrastructural, and managerial capacity to effectively implement prevention and treatment policy;[136]
2) Commitments to ensuring that high quality prevention and medical treatment was available to all HIV and AIDS victims;[137]
3) The establishment of an agreement that municipalities receiving *Fundo* assistance would provide support to those municipalities that did not receive grant assistance but needed it in time of emergency;[138]
4) Commitment to transparency, rigorous policy monitoring, data evaluation, as well as using *Fundo* resources appropriately;[139]
5) Commitment to strengthening civil society's participation in monitoring and policy-making;[140]
6) A promise to ensure that health departments purchase and distribute ARV (antiretroviral) medicine for all in need;[141]

These conditionalities clearly specified what the national AIDS program expected from those state and municipal health departments asking for *Fundo* assistance. One of the advantages of this conditional fiscal program was its specificity, transparency, and clarity. Indeed, in Ministerial Ordinance No. 2313, the national AIDS program clearly specified the following federal, state, and municipal responsibilities during the grant implementation process: at the federal level, the national AIDS program was to devise and finance *Fundo* policies, as well as coordinate, monitor, and regulate sub-national compliance with aid conditionalities in order to ensure that the latter were meeting their policy goals;[142] at the state-level, governments were to help analyse the spread of HIV/AIDS, as well as helping devise plans, methods, strategies, and monitor municipal compliance to *Fundo* mandates;[143] and at the municipal level, grant recipients were to achieve all of the aforementioned policy conditionalities and commitments.[144] But this specificity also unmasked the national AIDS program's seriousness and commitment to making sure that its policy interests was maintained and that there were sufficient sub-national resources to ensure this.

The manner in which the *Fundo-a-Fundo* program was implemented also revealed the national AIDS program's centrist intentions. Since the beginning, the national program dispatched technical consultants to sub-national governments to ensure that they were implementing the national program's technical norms and policy mandates.[145] All technical publications, materials, and planning procedures were designed by national officials.[146] This suggests two things. First, that the national program wanted to indirectly decrease sub-national autonomy and, second, that it had no confidence in sub-national governments' technical, planning, and policy-making capacity. But perhaps more importantly, what this revealed was the national program's unwavering commitment to monitoring and controlling sub-national policy through the *Fundo* implementation process.

Since it creation in 2002, several states and municipalities have received *Fundo* funding. Since 2003, most of the grant money has gone to the southern states, which to this day still has the highest incidence of HIV/AIDS. Some analysts report that the municipality of São Paulo, which is the largest metropolitan city in Brazil, has received the most grant assistance, totally 33.4% of all grants dispersed since 2003.[147] To this date, 26 states and 489 municipalities have received *Fundo* assistance.[148]

Graph 1.1 - Spending for the Fundo-a-Fundo Program (R$ Reais million)



Source: Ministry of Health, 2010

The national AIDS program has also been committed to consistently providing funding for the *Fundo* program. As Graph 1.1 illustrates, spending for the program continues to increase. And this has occurred despite the arrival of a new World Bank loan, signed in December 2008, which explicitly provides funding for SUS and sub-national AIDS programs.[149] This provides further evidence of the national program's commitment to the *Fundo* program and more importantly, that it has no interest in decreasing its funding commitments despite the presence of yet another round of World Bank loans.

In sum, since 2002 the national AIDS program has strategically used the creation of a new conditional fiscal program to indirectly maintain its centralized control over sub-national AIDS policy. It has strategically done this under the guise of seeking to sustain and strengthen SUS and sub-national AIDS policies. Yet since its inception, it has gradually become clear to scholars and policy-makers that the national program's overall intention has been to strengthen the national AIDS program and its core principles. What this in turn suggests is that the national AIDS program is doubtful that decentralization will work and that it needs to find ways of indirectly intervening in order to ensure that it does.

National Bureaucratic Usage of Civic Organizations

The creation of new fiscal policies is not the only element to indirect centralization processes. For it also entails working with and strategically using non-governmental organizations (NGOs) to monitor local governments in order to increase

sub-national accountability to the national AIDS program while encouraging NGOs to incessantly apply pressure on municipal health departments. Because the national AIDS program is limited in is ability to monitor municipal performance, they must rely on AIDS NGOs to achieve these outcomes.

The prospect of achieving this approach to indirect centralization increases when there is a large pool of NGOs to work with. In sharp contrast to other health sectors, such as TB, malaria, cholera, and dengue, there is essentially an overabundance of NGOs working on AIDS in Brazil. This growth emerged in the mid-1990s, when the national AIDS program, along with multi-lateral donor organizations, such as the World Bank, began to work with and support NGOs.[150] By the year 2000, the year in which the national AIDS program devolved complete financial and administrative responsibility to municipal governments, hundreds of AIDS NGOs were present, yet many of them were unemployed and searching for work.[151] With the national AIDS program providing most of what the AIDS NGOs lobbied for during the 1980s and 1990s, such as universal access to ARV drug treatment, condoms, and prevention through public campaigns and awareness, by the 2000s NGOs now had less work to do, thus leading to fewer employment opportunities and even an identity crisis.[152] Add to this the gradual decline in funding and competition with other NGOs for scarce funds, by 2000 NGOs were eager to find any work and willing to work with instead of oppose the national AIDS program.[153]

Viewing this shift in NGO views towards the government, the national AIDS program began to seek out and work with these organizations, but this time for an alternative reason: to monitor and obtain information on municipal health department performance in policy implementation, with the end goal of increasing sub-national accountability to the national AIDS program. One of the ways the program achieved this was by national AIDS bureaucrats' frequent interaction with NGOs through participatory governance institutions, such as local municipal AIDS policy committees, otherwise known as the *Commissions for Articulation with Social Movements* (CAMS). Through CAMS, national bureaucrats meet with and obtain information from NGOs about municipal government commitment to effectively implementing AIDS prevention and treatment policy, share experiences in working with municipal officials, and devise plans to continuously monitor municipal performance.[154] Research conducted by Jessica Rich (2010)[155] finds that after analysing meeting notes and interviewing officials at twenty-one CAM meetings, national bureaucrats obtained information from NGOs about the problems associated with decentralization and municipal health agencies' poor implementation of prevention and treatment policies. In addition, at these meetings AIDS officials' often raised questions about how NGOs can better monitor municipal health departments and mayors and how NGOs can apply pressure on these officials in order to maintain their policy commitments.[156]

In addition to helping build trust between national AIDS officials and NGOs, the transfer of information has also increased municipal health agency's accountability to the national AIDS program.[157] In a context where the national AIDS program is basing transfers of conditional grant assistance through the *Fundo-a-Fundo* program, which as mentioned earlier is based on the national program's evaluation of municipal commitment to policy, information sharing strengthens sub-national accountability to the national program all the more. This is because municipal health and political officials often have incentives to obtain as much money as possible for their programs.

At the same time, national bureaucrats have pursued contact and information sharing about national policy mandates with AIDS NGOs. These partnerships between national bureaucrats and NGOs often emerge when officials pay regular visits to NGO leaders in all twenty-six states; by attending local CAM meetings, public awareness events, and training seminars, national officials develop a strong partnership with NGOs.[158] In fact, some AIDS officials claim that establishing contacts and partnerships provides an important supplementary source of information for monitoring sub-national AIDS policy implementation.[159] By visiting civil society groups and bureaucrats in local environments, national bureaucrats can personally observe the problems that were highlighted at policy meetings at the national level.[160] At the same time, national AIDS bureaucrats claim that their contact with civil society leaders in the less formal setting of local events strengthens the personal ties forged in more formal arenas, such as national meetings in Brasília – e.g., through the National AIDS Commission.[161]

Finally, the national AIDS program has provided funding to engage civil society groups as public advocates for progressive policy reform. The national program has a track record of disseminating grants to explicitly politicize NGOs and other grassroots groups; this funding often goes towards NGO lawsuits filed against local governments,[162] to organize rallies and expand activist networks. In 2006, for example, the national AIDS program provided NGOs with approximately US$807,000 to develop legal aid projects, US$118,300 for advocacy projects, and US$84,600 for strengthening civil society networks.[163] The scholar Jessica Rich notes that according to AIDS officials, one of the most critical roles played by NGOs is to apply public pressure for AIDS policy advancement.[164] AIDS bureaucrats help to sustain outside pressure by using NGOs as a key complement to pressure from the national program for reform, squeezing sub-national politicians into compliance with national policy guidelines.[165] This political interpretation of these government grants for AIDS NGOs contrasts with the traditional view of government grants as apolitical "outsourcing" contracts to administer social services, intended primarily to reduce state expenses.[166]

Through these strategies, the national AIDS program has been successful in increasing its influence while avoiding ongoing sub-national inefficiencies. In several cases, with the guidance of national officials, AIDS NGOs have protected the quality of AIDS policy by consistently applying public pressure to correct local policy failures,[167] by working with local courts to protect against human rights abuses,[168] and by mobilizing the legislature to pass progressive local laws and block discriminatory local legislation.[169] At the same time, NGO successes in strengthening municipal policy implementation appears to be concentrated in the states in which NGOs was already mobilized around AIDS before the national AIDS bureaucracy stepped in to offer support.[170] Nevertheless, strong channels of communication with NGOs have also enabled national AIDS officials to focus their efforts on municipal problem areas. Although the national AIDS program does not have the authority to intervene in sub-national governance issues, national AIDS officials have successfully averted a number of local AIDS policy crises through mediation between key local players such as AIDS patients, clinical directors, bureaucrats, and politicians.[171]

CONCLUSION

There is now a brewing consensus in the literature that healthcare devolution is not the best answer to providing healthcare services. This article and other scholars have shown that devolution's defects can hamper initial government response to health epidemics, such as HIV/AIDS, in turn seriously questioning devolution's effectiveness. By applying path dependency and institutional change theory, this article has shown that in Brazil, early political and civic investments in healthcare de-concentration led to a fast pace devolution of health policy responsibilities under SUS to municipalities that were anything but prepared to respond to HIV/AIDS. High levels of political support, reinforced by political and social coalitions, incited the federal government to maintain its commitment to devolution yet at the crucial expense of providing assistance to the states. The end result was a lackluster government response to HIV/AIDS.

Nevertheless, eventually the national AIDS program's interest in maintaining its centralized presence and ensuring that devolution worked effectively motivated it to overcome devolution's defects through *indirect centralization* processes. Indirect centralization occurs when national programs create new conditional fiscal transfer programs in order to motivate sub-national governments into compliance with the national AIDS program's policy interests; moreover, it entails the national AIDS program working closely with AIDS NGOs to monitor local government policy performance, report back to the national program, and thus increase sub-national accountability to it. When combined, the case of Brazil shows that indirect centralization can strengthen national bureaucratic influence and efforts to sustain effective public health programs despite ongoing national government commitment to healthcare devolution.

Yet it is important to note that indirect centralization does not constitute a reversal of healthcare devolution and democracy. For several decades many have viewed decentralization, especially its devolutionary aspects, as synonymous with sub-national political development and civic participation, key ingredients for democratization to unfold.[172] Despite its appearance, the findings in this article suggest that indirect centralization *reinforces* health policy devolution and deepens civic participation and accountability. Indirect centralization establishes processes by which national bureaucrats can increase sub-national government accountability to the center while motivating civic organizations to remain active in holding local governments accountable for effective policy implementation.

Brazil's response to HIV/AIDS also shows that in order for healthcare devolution to work effectively, especially within large federations troubled by poorly implemented devolutionary processes and hard to reach areas, governments may need to periodically engage in indirect centralization in order to ensure the sustainability and effectiveness of HIV/AIDS policies. To date, scholars have not considered how indirect centralization enhances national and especially sub-national state capacity in implementing HIV/AIDS policies within challenging federal contexts. Future research will need to closely examine how national HIV/AIDS officials in other large federations, such as the United States, Russia, India, and China, can strategically partner up with and use extensive networks of AIDS NGOs as yet another arm of the state intervening to ensure that devolution yields positive results.

The benefits of indirect centralization suggest that especially within large federations, more research will need to go into carefully assessing the national government's role in time of health crisis, and if central intervention should be pursued under these conditions. The findings in this article suggest that devolution's defects in times of epidemic crisis require indirect centralization. Doing this may nevertheless instigate political resistance from mayors and governors seeking greater political control and recognition. But in time of health crisis, are sub-national politicians willing to forgo some of their policy autonomy and allow federal intervention?

This article, as well as the recent work of Jessica Rich[173] and Eduardo J. Gómez,[174] seems to suggest that sub-national politicians may indeed be willing to allow this. Moreover, within constraining historical and constitutional commitments to devolution, the findings in this article suggest that there is a specific *type* of federal intervention that sub-national politicians are more likely to accept. If it is indirect centralized assistance and control, and if this entails the transfer of financial resources, then perhaps mayors will be willing to periodically adhere to central agency preferences and mandates; but if intervention equates to complete policy reversal towards the center, as seen in Western Europe, then perhaps not. Future research will need to compare and contrast federations' attempts at both processes to see if indeed sub-national politicians are more willing to accept indirect versus direct centralization processes.

Future work will also need to explore the political conditions under which sub-national politicians are willing to periodically allow for indirect centralization. As seen in Brazil, perhaps it is a combination of ongoing health epidemics, inequalities, and pre-existing constitutional commitments to universal healthcare that encourage mayors to permit the national AIDS program's intervention, even if it is perceived to be a threat to mayoral autonomy. Moreover, perhaps under these conditions the political payoff for mayors to work closely with federal agencies is greater than trying to respond to epidemics on their own, given the high degree of electoral accountability at the municipal level and mayors' fiscal constraints in ensuring that they can guarantee universal access to healthcare. Addressing these questions provides a fruitful area of research for those scholars interested in analyzing how national bureaucrats' and sub-national politicians' interests intersect to strengthen healthcare devolution's efficacy in response to epidemics.

Does all of this mean that other nations can and should pursue a hybrid of direct or even indirect centralization along with de-concentration or devolution? Perhaps. The work of Richard Saltman (et al)[175] suggests that because of the limits to decentralization in several Western European nations, combining a re-centralization of fiscal authority with decentralized administrative management can render more effective health services.[176] While achieving these outcomes is more challenging for some European federations, such as Spain and Italy, which have a longer history of federalism, regionalism, and local fiscal autonomy,[177] there is nevertheless a realization in Western Europe that health policy devolution has failed and that hybrid systems are needed.[178]

But this begs the following question: why, then, are some federations, such as Brazil, better able to introduce hybrid systems while others are not, such as Spain and Italy, considering that they share with Brazil a long history of sub-national political and fiscal autonomy? While the states in Brazil certainly have a long history of sharing social policy responsibilities with the national and municipal governments,[179] these

cooperative constitutional arrangements are different from the politics surrounding a national agency's decision to indirectly intervene. For such processes require unique political histories and incentives motivating national health agencies to find innovative interventionist strategies strengthening their position as well as decentralization. While Brazil certainly shares with Italy and Spain a long history of federalism, authoritarian rule, and transitions to democracy, Brazil also saw a radical political backlash against years of suppressive authoritarianism failing to provide adequate universal healthcare. When combined with the infiltration of well organized, pro-democratic civic movements in the national bureaucracy, such as the *sanitarista* movement, believing in the need to sustain and deepen these universal commitments through decentralization, this provided the additional incentive and impetus for national AIDS bureaucrats to indirectly intervene in order to sustain its influence and eventually ensure that devolution work effectively. This political impetus and civic infiltration was absent in Spain and Italy, and has yet to be found in other countries having a rich tradition of federalism and sub-national autonomy.

But does this mean that indirect centralization strategies are unique to Brazil? This may certainly be the case. To the author's knowledge, in response to HIV/AIDS and other health epidemics, no other nation has subsequently introduced new conditional fiscal programs explicitly for HIV/AIDS while simultaneously working closely with AIDS NGOs in order to monitor local governments and increase their accountability to the center. In the United States, Brazil's closest federal, political, and geographic counterpart in the Western Hemisphere, in response to HIV/AIDS the US has not subsequently created new conditional fiscal programs or worked closely with AIDS NGOs to increase the CDC's AIDS program and ensure that local governments have the resources and incentives to successfully implement policy.[180] In other emerging nations, such as India, China, or even Thailand (a nation that others consider most closely resembles Brazil's successful national response to AIDS), to the author's knowledge, none of these nations have pursued indirect centralization strategies.

Despite the absence of similar indirect centralization processes, Brazil's success in sustaining an effective national and sub-national AIDS program suggests that scholars and policy-makers continue to conduct comparative research and discover if other nations are pursuing similar strategies. As the defects of healthcare devolution continue to unfold throughout the developing world, and as international and social pressures for more effective sub-national policy intervention increase, perhaps other nations will begin to follow Brazil's alternative path to centralization and will begin to see the fruits of HIV/AIDS policy decentralization unfold.

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