# Explaining Institutional Change

*Ambiguity, Agency, and Power*

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This book contributes to emerging debates in political science and sociology on institutional change. Its introductory essay proposes a new framework for analyzing incremental change that is grounded in a power-distributional view of institutions and that emphasizes ongoing struggles within but also over prevailing institutional arrangements. Five empirical essays then bring the general theory to life by evaluating its causal propositions in the context of sustained analyses of specific instances of incremental change. These essays range widely across substantive topics and across times and places, including cases from the United States, Africa, Latin America, and Asia. The book closes with a chapter reflecting on the possibilities for productive exchange in the analysis of change among scholars associated with different theoretical approaches to institutions.

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# Infiltrating the State

## *The Evolution of Health Care Reforms in Brazil, 1964–1988*

Tulia G. Falleti

> Policy in Brazil changes by accretion rather than by substitution.
>
> Schmitter 1971, 256

In the last two decades, Brazil's health care system has undergone two major transformations: *universalization* and *municipalization*. Prior to 1988, the administration of the health care system was centralized in the federal government. The member states and the municipalities had a minimal role in the management and delivery of health care. National funding was channeled, via contracts, to the private sector, and inequalities in the provision of services were pervasive. A large portion of the population did not have access to health care, either because they were uninsured or because there were no health facilities in the areas where they lived.

Two decades later the system has been radically reconfigured. In the new health care system, coverage is universal, access is free, public

services are integrated, and the delivery of health care is decentralized. The private sector continues to exist alongside the public sector, but its importance as a contractor for the public system has diminished significantly. The Brazilian states and some of the large municipalities are responsible for high-complexity health services, and all of the municipalities – more than fifty-five hundred in total – deliver basic health care services.

This development is puzzling in light of existing theories that all point to insurmountable political barriers to universalization in a context such as Brazil. Several features of the previous system should have dampened efforts in this direction. In particular, the fact that a sizeable portion of the public enjoyed private-sector coverage should have narrowed the political coalition for reform. In addition, the initial national public insurance programs were focused on "residual" populations, who lacked the political clout to push for the extension of such programs. Moreover, since 1964, the military government had made great strides in building a private medical industry. From a comparative standpoint, the political barriers to universalization of health seemed insurmountable (see Hacker 1998, 127–128).

Why and how did Brazil achieve universalization of health care despite the prior institutional evolution of its health care system? Most scholars invoke a critical-juncture explanation, identifying political "break points" or economic crisis as having provided the solvent that unhinged the old system and opened the door for something new. The most prominent such account points to the constitutional reform of 1988, in the midst of Brazil's democratic transition after a two-decade-long military regime (1964–1985) (Kaufman and Nelson 2004, 44). According to this approach, the health care reforms were possible when the political opportunity structure changed; this occurred during an exceptional period of political opening that led to the relaxation of the institutional and political constraints set in place by the prior development of the health care system. In this interpretation, the constitutional convention of 1987–1988 was one of these rare and short-lived episodes when the opportunities for fundamental change of so-called locked-in institutional arrangements occurred. Another group of scholars locates the origins of the reforms in the economic crisis of the early 1980s, which created incentives to restructure the economically troubled social security system that provided health

services (Draibe 1994, 276, 285; Lewis and Medici 1998, 270). Similar to the prior account, this explanation considers the economic crisis to be the critical juncture that produced the institutional changes.

These explanations are shortsighted, however. In this chapter, I show that the health reforms introduced in Brazil's 1988 constitution and implemented throughout the 1990s were not the result of a critical juncture (either political or economic). Instead, they were the result of gradual changes – beginning long before the transition to democracy – through which actors on the periphery of the existing system were able to introduce incremental changes through processes of what the editors of this volume call "layering." The crucial opening for the strategies of these "subversives" was provided by the military, which in the 1970s introduced health care reforms that were designed to solidify authoritarian rule by extending the state's presence to the countryside. The military was interested in the state's territorial expansion to the peripheral areas of the North and Northeast, where it had practically had no presence. The regime was also interested in taming the social and political demands of an increasingly active rural movement. In an effort to legitimate its domination and co-opt rural activists, the military government extended health care to those employed in the informal economy (the majority of the rural population) and to the unemployed.

These efforts provided an opening for leftist health care organizations, those of the *movimento sanitário* (henceforth, the sanitarista movement), to put in practice on a broader scale models of preventive and public social medicine that they had been promoting in isolated pockets, mostly southern municipalities ruled by the opposition. In short, the penetration of society by the authoritarian state facilitated the infiltration of the state by reformist elements in society. Moreover, strengthened by a gradual process of political opening and democratization, the sanitarista movement increasingly imprinted its ideological orientation in the health reforms that unfolded after 1976. The reforms of 1985 merely revealed – but also codified and institutionalized – the principles of universalism and decentralization that had already been promoted to dominance by the actions of these "subversives" who were able to operate on the periphery and within the logic of the existing system, although in ways that gradually altered its trajectory.

## Penetrating Society: The Military Integration of Health Services and the Extension of Coverage

Prior to 1988, health care services were organized in three subsystems: the private sector, the public sector, and the social security sector. The private sector covered 20 percent to 30 percent of the population through medicine groups, cooperatives, self-management plans, or private health insurance. Most important, however, the social security subsystem contracted the private health sector to provide services (expensive hospitalizations, in particular) to their members. In the public sector, health had evolved as a responsibility of the central government, focused on vaccination campaigns and the control of epidemic outbreaks. The National Ministry of Health, created in 1953, was poorly funded and was only responsible for preventive and some chronic care (Lobato and Burlandy 2000).

The social security sector was the largest of the three subsystems. It had originated in the 1920s, when the first social insurance funds were formed by industry and provided invalidity, retirement, and survivors' pensions, as well as medical assistance and funeral aid for industry workers. In 1953, Brazil's populist president Getulio Vargas envisioned the social security system as one of the three main pillars (together with the unions and the labor courts) of the state-corporatist arrangement. To this end, he merged the proliferating industry funds into seven social security institutes organized by sector of the economy. These institutes were funded through compulsory contributions from employers and employees, and although the state was supposed to contribute funds as well, state contributions over time did not amount to much more than the administrative costs of the institutes (Malloy 1979, 70, 127, 135–136).[1]

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[1] The social security institutes were autarchic public entities under the supervision of the Ministry of Labor, Industry, and Commerce. They were managed by a president appointed by the President of the Republic and a council, of four to eight members, where employers and employees were equally represented. After 1953, the resulting Institutes of Retirement and Pensions (Institutos de Aposentadorias e Pensões, IAPs) were the institute of workers in railway and public services (IAPFESP), of banking workers (IAPB), of commerce (IAPC), of industry (IAPI), of maritime (IAPM), of transport and hauling (IAPETC), and of civil servants (IPASE) (Malloy 1979, 97–98).

Despite prior corporatist inducements, the social security sector covered only 7.4 percent of Brazil's population in 1960, and 9 percent in 1970 (Malloy 1979, 68, 95; Weyland 1996, 89). The rural sector, the urban self-employed, and the intermittently employed remained uninsured (Malloy 1979, 68; McGuire forthcoming, ch. 6). High inequalities in the provision of health services plagued the system, both in the type and the quality of services provided by the different institutes, as well as in the services available to the populations of different regions of the country.[2]

There had been prior attempts to extend social security coverage and reduce inequalities. In the 1940s, inspired by Britain's Beveridge Report, technocrats of the industrial workers' institute (IAPI) had called for equal and universal social protection (Oliveira and Teixeira 1986, 172–180; Weyland 1996, 90). The politicians' incentives to modify the system, however, were quite low, since literacy restrictions on the vote (in place until 1985) rendered much of the rural population and the urban poor irrelevant for electoral purposes.[3] In 1945, Vargas tried to unify the entire social security system, but the health institutes' bureaucracies and the unions opposed the measure, which was never implemented (Oliveira and Teixeira 1986, 157; Luna and Klein 2006, 203).[4] The social insurance institutes had become important

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[2] The system was set up such that the institutes would provide their members with medical services *only* after other obligations had been met. Hence, the funds with higher per capita income members and fewer claims for sickness and invalidity could support better medical schemes. Large numbers of those workers often employed in unhealthy and dangerous jobs received the worst system of health care. Thus, the IAPB (banking sector), with about 153,000 affiliates in 1960, provided the best medical care, whereas the IAPI (industrial workers), with over 2.1 million affiliates, had the worst (Malloy 1979, 102, 110–111). These inequalities were compounded by the regional distribution of all the health services and facilities (public, social insurance, and private), which favored the urban areas of the Southeast, where physicians and hospital beds were concentrated at considerably higher per capita rates than in the rest of the country. In 1970, for example, there were 7.4 doctors per 1,000 inhabitants in the Southeast, compared to 2.3 and 2.4 doctors in the states of the North and Northeast, respectively. Similarly, there were 5.4 hospital beds per 1,000 inhabitants in the Southeast, compared to ratios of 2.8 in the North and 1.9 in the Northeast (Malloy 1979, 111).

[3] The political support of traditional rural bosses, or *coroneis*, was sufficient for the delivery of rural votes (on *coronelismo*, see Nunes Leal 1997, 275–287).

[4] It was decree-law No. 7526 (*Lei Orgânica dos Serviços Sociais do Brasil*) that tried to unify all the social security health institutes (IAPs) and replace them with the Institute of Social Services (Instituto de Serviços Sociais do Brasil, ISSB).

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sources of power both for politicians linked to organized labor and for union leaders, who wanted to preserve the institutes' current structure (Malloy 1977, 198–199; 1979, 73). Also opposed to the integration of the social security system were the managers and technocrats of the other social security institutes, who had historically been committed to a contributory system of financing (i.e., services provided only to those who contribute) and were concerned that it would be financially unviable to cover the large mass of the poor (Weyland 1996, 90).

The health system remained little changed until the military regime came to power in 1964. Under the military, the social security subsystem was integrated and coverage was extended, privileging contracts with the private sector whenever possible. As a means of reducing the power of organized urban labor, General Humberto de Alencar Castelo Branco (1964–1967) unified all the social security institutes in a single institute, the National Institute of Social Insurance (Instituto Nacional de Previdência Social, INPS), and replaced their "political" presidents and councils with "apolitical" technocrats. In doing so, the military regime cut one of the labor movement's most vital institutional pillars of power. This reform, which had been tried in democratic periods but had failed because of the unions' opposition, was, from the standpoint of services, an equalizing reform. All workers in the private urban economy would have the same social security and health benefits. However, inequalities persisted: the public servants and military personnel remained in separate funds with higher levels of privileges, and the poor in the informal sector of the economy remained excluded (Malloy 1979, 134; Weyland 1996, 90).

In 1971, during its most repressive phase (the presidency of Emílio Médici, 1969–1974), the military government granted social security and health coverage to the rural population, the unemployed, and the self-employed through the Assistance Fund for Rural Workers (Fundo de Assistência ao Trabalhador Rural, FUNRURAL). Responding to pressure from a radicalized rural movement (Erickson 1977), a program with the same name had been created under President João Goulart (1961–1964), but, lacking significant funds, that program was never implemented (Malloy 1979, 120, 200–201). The military now financed FUNRURAL with sound taxes on agricultural wholesalers and on urban firms' payrolls. Almost overnight, the proportion of the population legally covered by social insurance increased from 9 percent

to 90 percent (McGuire forthcoming, ch. 6). To be sure, the quality of the services and pensions for the rural population was significantly lower than that of the urban population. And the total resources of FUNRURAL were still only one-tenth of the resources of the preexisting system of social insurance for organized urban labor (INPS), even though they served populations of roughly equal size (Malloy 1979, 134). Nonetheless, FUNRURAL was "the most important redistributive change ever made in Brazilian social security" (Weyland 1996, 91). Furthermore, as McGuire explains, "FUNRURAL was the first Brazilian social insurance program to break with the [contributory] principle that benefits depended on contributions" (forthcoming, ch. 6).

Why did the most repressive government of the military period advance such an important redistributive reform? Two reasons are apparent. On the one hand, the military regime implemented this reform as a means of taming and co-opting rural activism. In the early 1960s, political turbulence and organization proliferated in the rural areas, particularly in the Northeast.[5] This mobilization was perceived as a populist challenge on behalf of former President Goulart. FUNRURAL was meant to stem social discontent among the rural population and to slow down the worrying trend of rural-urban migration.[6] In the classic state-corporatist tradition, the military regime co-opted the moderate National Confederation of Workers in Agriculture (Confederação Nacional dos Trabalhadores na Agricultura, CONTAG) and entrusted the administration of FUNRURAL to this organization, while quashing the radical elements of the rural movement.[7]

On the other hand, the military sought to use FUNRURAL to extend the presence of the nation-state in the remote rural areas of the North and Northeast, deemed necessary for national security reasons. The military was informed by a comprehensive doctrine of national security, which linked the full realization of the nation's human and

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[5] Independent rural organizations, the so-called peasant Leagues, had formed in the 1950s and 1960s, aided by either the Catholic Church or the Communist Party (Flynn 1978, 261). Some of the Leagues radicalized to the point of becoming involved in guerrilla warfare.

[6] In 1960, 55% of Brazil's population lived in rural areas, but by 1980 this percentage had decreased to 32% (Houtzager and Kurtz 2000, 402–403).

[7] Of all the northeastern organizations, the radical peasant Leagues suffered the greatest number of prisoners and political murders after the coup of 1964 (Moraes 1970, 496; Malloy 1979, 131).

economic potential to the primordial quest for military security and national grandeur (Stepan 1971, 131; Malloy 1979). By creating a system of social insurance coverage for the agricultural population, and conferring its administration on an organization (CONTAG) that it could control, the military aimed to extend the reach of the nation-state in the North and Northeast and at the same time penetrate and co-opt the rural workers' organizations.

However, in its move to integrate and expand the health care system, the military regime privileged the private health sector. The extension of health coverage largely took place through the expansion of private health services (Lewis and Medici 1998, 281). Whereas in 1960, 14 percent of all hospital beds were in the private sector, by 1976 this percentage had increased to 73 percent (Lobato and Burlandy 2000; McGuire forthcoming, ch. 6). Moreover, when emergency treatment was extended to the uninsured in 1974, the number of "emergencies" treated by private hospitals grew beyond all expectations (Weyland 1996, 96–97).[8]

The promotion of the private health sector was further facilitated by a social security reform introduced in 1977, in which the military separated the pension and the health care components of social security. The National Institute for Medical Assistance in Social Security (Instituto Nacional de Assistência Médica da Previdência Social, INAMPS) was created to coordinate the health care services of the social security system, and this organization instantly became one of the main channels for the transfer of public resources to the private sector.[9] Above all else, INAMPS institutionalized a high-cost, specialized, curative, hospital-based health care system concentrated in the profitable regions of the country (Arretche 2004, 161; McGuire

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[8] In 1978, the president of INPS recognized that there had been six hundred thousand unnecessary hospitalizations in the four years since emergencies had become covered by the Ministry of Social Insurance and Welfare (Escorel 1999, 55).

[9] The INAMPS reimbursed doctors on a fee-for-service basis. Because office visits were reimbursed at a lower rate relative to cost than were diagnostic tests and hospital stays, there was an upsurge in hospital stays and unnecessary medical procedures. The INAMPS practice of paying higher fees for cesarean births, for example, led to an estimated 186,000 unnecessary cesarean deliveries in 1979. In 1986, 32% of all births in Brazil, and 64% among high-income groups in São Paulo, were by cesarean section—compared to the 10 to 15% rate recommended by the World Health Organization (McGuire forthcoming, ch. 6).

forthcoming, ch. 6). Since the creation of this new overarching institution superseded and absorbed FUNRURAL, President Ernesto Geisel (1974–1979) passed the reform over the opposition of the organization of agricultural workers (CONTAG) that the government had previously co-opted to administer the rural program.

By the late 1970s, then, despite the integration of the social security institutes and the extension of coverage to a large portion of the population, the institutional conditions were inauspicious for universalization and municipalization. First, as in the United States, a system of national health insurance had not been enacted but a sizeable portion of the population was serviced by the private sector. Second, the first nationalized insurance program, FUNRURAL, reached a substantial portion of the population but it represented less than one-tenth of the social security subsystem – existing as it did alongside the previous industry-based programs for the urban working population. In this sense, it was a "residual" portion of the health care system. Finally, as they expanded coverage to the informal workers and the unemployed and universalized emergency treatment, the military governments made great strides forward in building a private medical industry.

However, as we shall now see, these moves by the military toward integration of the health system and the extension of free coverage to previously peripheral constituencies were consequential to later reform proposals. Moreover, the military regime's efforts at penetrating society in order to control it paradoxically rendered the authoritarian state more permeable and easier to infiltrate by a reformist movement.

### Infiltrating the Authoritarian State: The Sanitarista Movement's Reorientation of Health Care Reforms

During the military regime, a well-organized and leftist reformist health care movement was able to penetrate the state bureaucracy, build on the reforms introduced by the military, and redirect those reforms toward new objectives. Like the military, the reformist movement promoted integration of the health system and extension of coverage. However, unlike the military, the movement sought to strengthen the public sector and decentralize the delivery of health services to the municipalities. Aided by the federal structure of Brazil's government, members of this leftist sanitarista movement were able to occupy

key positions in the health sector: in municipal opposition governments, in some national health offices, and in the Panamerican Health Organization (Neto 1997, 63). From those positions, they either built on existing programs or promoted new ones, guided by the movement's ideology, this is to say, by the movement's definitions of public health goals, by their conceptions of bureaucratic and political means, and by their policy agendas. In a sense, the sanitarista movement acted as an "ideological guerrilla," as part of a "subversive elite," "one whose members share[d] beliefs about the nature of politics and economics which differ[ed] from those usually defined as belonging to the [power] elite" (Adler 1986, 704–705).

The sanitarista movement originated in the developmental period of the early 1960s, during the left-leaning government of President Goulart. The movement stressed preventive over curative care and understood health to be a universal human right tied to citizens' socioeconomic living conditions. Health, the sanitaristas claimed, could not be disentangled from access to decent housing, education, and employment (CEBES 1980; Ministério da Saúde 1986a). Unlike the *sanitarismo campanhista* (the rural sanitarista tradition) of the pre-1930 "Old Republic" (Paiva 2006), the developmentalist sanitarista movement opposed centralization of resources and decision making, and advocated for municipalization of health. Municipalization, the sanitaristas argued, would bring basic health care to remote rural areas, where not even the state-level offices reached at the time (Ministério da Saúde 1992 [1963], 187–205; CONASS 2007, 28).[10]

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[10] In the 3rd National Health Conference of 1963, the representatives of the developmentalist sanitarista movement demanded that health care be devolved to the municipal level and recommended the creation in all the municipalities of a basic sanitary structure that would include water and sewage infrastructure, supervision of food establishments, vaccination against contagious diseases, provision of basic health care, protection of pregnant women and children, sanitary education, and collection of vital statistics (Ministério da Saúde 1992 [1963], 183, 239–240). The municipalization of health demand notwithstanding, the proliferation of municipalities was a concern at that time. The creation of new municipalities responded – apparently – to the electoral incentives of local leaders and to the economic incentives created by Law 395 (July 18, 1948), which distributed the *imposto de rendas* (income tax) in equal parts among all municipalities (Ministério da Saúde 1992 [1963], 179). Thus, according to the Brazilian censuses, the number of municipalities increased from 1,889 municipalities in 1950; to 2,766 in 1960; 3,952 in 1970; 3,991 in 1980; 4,491 in 1991; and 5,507 in 2000.

The military coup against President Goulart in 1964 was clearly a setback for the developmentalist *sanitarista* movement, which had been close to Goulart's administration. However, even if the institutional and political configuration at the national level doomed any efforts at seeking outright national reform, the *sanitaristas* continued to pursue their goals at other levels and through alternative channels. For example, a 1968 reform mandating the creation of preventive medicine departments in Brazilian universities opened a door for the institutionalization of the reformist movement (CONASS 2007, 33). *Sanitarista* doctors taught in these departments and gained organizational strength (Escorel et al. 2005, 63). In 1976, the *sanitarista* association the Brazilian Center of Health Studies (Centro Brasileiro de Estudos de Saúde, CEBES) was created. In the pages of its influential journal *Saúde em Debate*, CEBES opposed the health policies of the dictatorship (Escorel et al. 2005, 67).[11] Similar to the role of the scientific and technological elite that at about the same time was developing a domestic computer industry in Brazil, CEBES "became the home for an ideologically assertive group – a 'guerrilla headquarters' of sorts – that set itself up to sell ideas, raise consciousness, and use political power to achieve its goals" (Adler 1986, 691).[12] In fact, many of the members of the *sanitarista* movement were militants belonging to the banned Brazilian Communist Party (Neto 1997).

The International Conference on Basic Health Care, organized in 1978 by the World Health Organization in Alma-Ata under the slogan "health for everyone in the year 2000," gave additional strength to the progressive demands of the *sanitarista* movement (CONASS 2007, 35–38; Weyland 2007). The following year, another influential *sanitarista* organization, the Brazilian Graduate Association in Public

[11] The importance of CEBES has not declined over the years. In a study of the diffusion of the local Family Health Program (*Programa Saúde da Familia*) in more than 200 Brazilian municipalities, Sugiyama (2008) finds that affiliation with CEBES led to an increase in the probability of adopting the program.

[12] An important difference between the groups is that whereas the scientific group developing the domestic computer industry was working inside the state, in the Commission for the Coordination of Electronic Processing Activities (CAPRE) in the Ministry of Planning, CEBES was part of civil society. Nonetheless, like the scientists in CAPRE, the health reformists would also penetrate the state and promote progressive health programs. For more information on the fascinating development of the domestic computer industry in Brazil during the years of the military dictatorship, see Adler (1986).

Health (Associação Brasileira de Pós-Graduação em Saúde Coletiva, ABRASCO), was formed.

In the late 1970s, the *sanitarista* movement had a three-pronged strategy: (1) to produce and disseminate its progressive reform proposals, (2) to occupy positions of power whenever possible, that is, to *infiltrate* the state, and (3) to lobby Congress (Rodriguez Neto et al. 2003, 34–35). In 1979, as a result of the pressure exerted by the *sanitarista* movement, the Lower Chamber of Congress held Brazil's first symposium on national health policy (Escorel et al. 2005, 71). In a position paper presented at the symposium, the *sanitarista* association of health studies called for the creation of a decentralized unified health care system (CEBES 1980). The process of political opening at the local and later state levels (Samuels and Abrucio 2000; Falleti 2007) afforded the members of the movement the opportunity to occupy local government positions.[13] They slowly infiltrated the public bureaucracy from the bottom up.

### The Gradual Institutional Evolution of Brazil's Health Care System

Unlike other contemporaneous Marxist or national-populist movements in Latin America, the reformist doctors in Brazil did not conceive the state as a monolithic apparatus that represented solely the interests of the dominant class and that had to be overthrown from the outside. Instead, since the early 1970s, the *sanitarista* doctors affiliated with the preventive care and communitarian health movement aimed to occupy positions of power in the public health bureaucracy (Escorel 1999, 24). In effect, these doctors sought to exploit the room for maneuver that existed as a result of their ability to exercise discretion from within a bureaucracy not of their own making. From the perspective of the military, the *sanitarista* movement's proposals of communitarian medicine were inexpensive solutions to the increasing demand for health and sanitation services that the years of the "economic miracle" had generated (Escorel 1999, 23, 29, 49). The bureaucratic-authoritarian regime thus created research and sectoral institutions that emphasized technical knowledge and administrative modernization. Those institutions were soon occupied by members

[13] Interviews with Luiz Carlos Pelizari Romero (Rio de Janeiro, August 4, 2005) and Gilberto Hochman (Rio de Janeiro, August 15, 2005).

of the sanitarista movement and became the main generators of the health reform proposals to be analyzed here (Escorel 1999, 43–44). In addition, and beginning with the presidency of Geisel, which initiated a process of political liberalization (*abertura*, or "opening"), the Ministry of Health became even more "permeable" to new ideas and actors.

Federalism also facilitated the infiltration of the bureaucracy by health reformist leaders, particularly at the local level. To maintain the appearance of a vertical and horizontal division of power, the military allowed the continuation of some elections. All legislative posts (at the national, state, and municipal levels), for example, were elected. With few exceptions, mayors were also elected, as were state governors, beginning somewhat later, in 1982. Thus, thanks to the vertical division of powers characteristic of the federal arrangement, the opposition won elected posts at the local level first. Elected local officials in turn opened the doors of their municipal secretaries of health to the members of the reformist sanitarista movement. The municipalities of Campinas (São Paulo), Londrina (Paraná), Vale do Jequitinhonha, Montes Claros (both in Minas Gerais), and Niteroi (Rio de Janeiro) experimented with progressive local programs during the 1970s (Cordeiro 2001, 324; Rodriguez Neto et al. 2003, 36, 45).[14] The Montes Claros project, which integrated health services in the north of Minas Gerais, became an important institutional model for a more extensive and ambitious program (for a detailed analysis of the Montes Claros program, see Escorel 1999, 143–154).

In 1976, a group of sanitarista doctors from a prestigious government think tank (Instituto de Planejamento Econômico e Social, IPEA) and the Ministry of Health designed a health program called Program of Internalization of Health and Sanitary Actions (*Programa de Interiorização das Ações de Saúde e Saneamento*, PIASS), which consisted of a network of mini health sanitary stations in localities of low-density population (Tanaka et al. 1992). The network was designed to provide preventive care and sanitation to the population of poor and small towns in the nine states of the Northeast and in Minas Gerais. The program called for the integration of health services at the local

[14] In the case of Niteroi, local officials copied the family health doctor model adopted in Cuba (Weyland 2007). At the time, in fact, it was quite common for sanitarista doctors to travel to Cuba or Italy to study the local community health programs in those nations.

level, under the coordination of the state secretaries of health. Private health providers did not operate in these poor and remote areas, so the private health sector did not oppose the reform. However, because the program would tap into social security resources, the technocrats in the social security national bureaucracy (INAMPS) did oppose it. But Northeast politicians (most of them from the ruling military party) exerted enough pressure on the national government that the program was implemented.

With the governors' support, the new regional program had by 1980 established small health outposts operating in 700 municipalities (56% of the total of the Northeast and Minas Gerais). These clinics served a population of seven to eight million people, about 20 percent of the northeast region's population at the time. In the states of Minas Gerais, Bahia, Pernambuco, Rio Grande do Norte, and Alagoas, the program was operating well. In Ceará and Paraíba, despite its implementation, this basic health and sanitation program had not reached all the necessary localities. Finally, in Maranhão, Piauí, and Sergipe the program was still in an initial phase (Hermógenes de Souza 1980, 84). By 1980 a total of 1,250 health posts (each about 40 square meters in size) had been built in villages with populations of less than 2,000. In towns of up to 6,000 inhabitants, 650 health centers had been built (40 to 150 square meters in size). The health posts and centers were directly connected to higher-complexity medical facilities in the larger nearby state cities or state capitals. The program had a sanitary component, through which 172 systems for provision of water and 22,000 latrines were built. Moreover, PIASS recruited and trained health agents from the targeted regions, most of them young people without formal medical training who would not be prone to professional biases. In the first three years of its operation this program trained 3,700 health agents, eighty percent of whom had only an elementary education.[15]

This health and sanitation program (PIASS) had important policy effects for the universalization and municipalization of health care. First, it fostered interministerial coordination. The Ministries of Health, Social Insurance and Welfare, and Interior were all represented in the interministerial executive group, along with a secretary of the

[15] Subsequent successful health programs in the Northeast would have similar practices of personnel recruitment and training (see Tendler 1997, 21–45).

presidency. PIASS was one of the first programs (if not the first) to bring together all these national ministries in a single health program. Second, the program promoted intergovernmental coordination, as the aforementioned national ministries and the state secretaries of health and sanitation were all part of the coordination and supervision group. The financing of the program also connected the national, state-, and local-level governments. PIASS thus constituted the first systematic attempt at vertically coordinating the actions of municipalities, states, and the national government for the staffing, financing, delivery, and supervision of public health services. Third, PIASS strengthened the position of state health secretaries vis-à-vis the once all-mighty representatives of the national social security health bureaucracy. This proved important a few years later, when another decentralization program appealed to the state secretaries of health. Finally, PIASS led to the creation of the National Council of State Secretaries of Health (Conselho Nacional de Secretários de Saúde, CONASS) in February of 1982 (Escorel et al. 2005, 71), just a few months before the first direct gubernatorial elections were scheduled to take place.

The PIASS health and sanitation program and the subsequent proposals to extend public coverage to other regions (such as the program *Prev-Saúde*) were not embraced by all the relevant actors. As it developed, the program encountered increasing opposition in the private sector and in parts of the national bureaucracy (Tanaka et al. 1992, 4; Rodriguez Neto et al. 2003, 37–38), to the point that it could not longer be sustained (Escorel 1999, Escorel et al. 2005, 70–71). Nonetheless, as the financial situation of the social security system worsened, the president commissioned a study for the comprehensive reform of the health care system. In 1982, a national advisory board proposed a plan that combined streamlining and efficiency measures.[16] The program, known as the CONASP Plan after the name of the advisory board, sought greater articulation among the federal, state, and municipal health sectors, along the lines pioneered under the PIASS program (Rodriguez Neto et al. 2003, 44).

A year later, a leader of the sanitarista movement, Eleutério Rodriguez Neto, was appointed director of the Planning Department

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[16] The national advisory board was named the Consultant Council of Administration of Social Security Health (Conselho Consultivo de Adminstração de Saúde Previdênciária, CONASP).

of the national bureaucracy. It was one of the first appointments of a high-level sanitarista doctor to a strategic position in the social security health administration (Rodriguez Neto et al. 2003, 47). Rodríguez Neto used the CONASP Plan as a vehicle to deepen health care reform. Based on that proposal, he advanced a wholesale reorganization of the public and social security health sectors that had a strong decentralizing component. The reform program was called Integrated Health Actions (*Ações Integradas de Saúde*, AIS).

To neutralize internal opposition at the national level, Rodríguez Neto engaged the state secretaries of health. In his own words, he sought to promote "bottom-up" pressures (Rodriguez Neto et al. 2003, 47) – albeit paradoxically, from the top. Thanks to the prior political opening that had started at the municipal and state levels, Rodríguez Neto strategy's worked: "The greater legitimacy and autonomy of the governments elected in 1982 and in power since May of 1983, especially in the states where the opposition won, gave the [reform] pressures such a strength that it was possible to sign AIS [Integrated Health Actions] agreements 'in chain.' Starting with São Paulo, Rio de Janeiro, and Minas Gerais, by May of 1984 all the states had signed, and it was officially recognized that the AIS constituted the federal strategy to restructure the national health policy" (Rodriguez Neto et al. 2003, 47).

The AIS program proved quite effective. It integrated the health services of the Ministry of Health and the Ministry of Education and Culture, and it coordinated the different levels of government in a decentralized administration (Paim 1986, 172; Tanaka et al. 1992, 5). As recalled by José da Silva Guedes, former secretary of health of the city of São Paulo, "The AIS represented an increase of 30% of the secretary budget. It was not earmarked to pay salaries, debt, or new construction. Instead, it was intended to improve and expand the [health care] system. In the city of São Paulo, for example, it allowed for the creation of a third work shift in all the sanitary units and to have general-practice doctors in them" (quoted in CONASS 2007, 53, author's translation). Rodriguez Neto was removed from his post in 1984, but his removal did not affect the process of decentralization that was already underway. As he said, by 1984 "the AIS were irreversible" (Rodriguez Neto et al. 2003, 48, author's translation).

After 1985, during the civilian government of José Sarney (1985–1990), the reformist movement occupied more posts in the national

bureaucracy and sought to implement equity-enhancing reforms (Weyland 1996, 159–164). The main opposition to health care reform came from the private sector. Meanwhile, the sanitaristas proposed an even more encompassing health reform: the Unified and Decentralized Health System, which was guided by the principles of universal coverage, equity, decentralization, regionalization, articulation of levels of government, and communal participation. This program would transfer authority, resources, and personnel from the social security health bureaucracy to the state and municipal secretaries of health. State and municipal actors would be the main managers of health care. Although the program was never implemented, it was an important antecedent for the implementation of the Single Health System (Sistema Unico de Saúde, SUS) that fully integrated Brazil's public health sector (Cordeiro 2001, 324).

The proposal to create the Single Health System had been drafted at the 8th National Health Conference that met in Brasília in March 1986. The conference was described by President José Sarney as the preconstituent assembly of the health sector (Ministério da Saúde 1986b, 31). More than four thousand people attended, among them one thousand delegates who were equally divided between government and civil society representatives.[17] Among the government delegates, 50% were from the federal level, 22% from the state level, 18% from the municipal level, and 10% from Congress. Of the five hundred civil society delegates, 15% represented the private health sector, 20% belonged to professional health entities, 30% represented unions and urban and rural workers, 10% belonged to dwellers' associations, 20% represented community groups, and 5% were from political parties (Escorel and Bloch 2005, 118). Among the nondelegate participants, there were federal, state, and municipal authorities; health practitioners; health care consumers; and academics. Medical professionals, local health authorities, and left-wing health experts represented the sanitarista movement. The conference was organized into 135 working teams, 37 of which were formed by delegates and the rest by participants (Ministerio da Saúde 1986b, 1). The working teams discussed

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[17] For comparison purposes, it is worth noting that the 5th National Health Conference of 1975 counted 217 delegates and 77 nondelegate participants and the 6th Conference had 405 delegates and 29 observers (Ministério da Saúde 1975, 15).

three issues: (1) health as a right, (2) the reformulation of the national health system, and (3) the funding of the health care sector.

By the time this conference was convened, the sanitarista movement had used its position within the existing system both to forge networks across localities and to position itself as a highly credible voice in health care reform. It is thus not surprising that the final conference report expressed the views of the reformist sanitarista movement in every issue. Health was conceived as a right to be guaranteed by the nation-state. The health system had to be public, free, integrated, and decentralized. Popularly elected municipal and state health councils had to be created to facilitate citizens' participation and the implementation and control of health programs. The fiscal strengthening of states and municipalities was demanded, and the decentralization of health care had to target the municipalities (Ministerio da Saúde 1986a; 1986b).[18] This was the template that health reform followed in Brazil from 1988 onwards.

The same networks and expertise also meant that the sanitarista movement emerged as a strong voice with a well-shaped reform proposal in the constitutional convention of 1988 – possibly the best-organized sector (Rodriguez Neto et al. 2003, 48–52). The movement's demand for universal coverage was adopted in the reformed Constitution with the creation of the Single Health System. The demand for a fully public health care system did not succeed owing to the lobbying of the private health sector, thus both public coverage and private coverage were included in the Constitution. Soon after the constitutional reform, the National Council of Municipal Secretaries of Health (Conselho Nacional de Secretarias Municipais de Saúde, CONASEMS) was created. Coordinating the action of subnational authorities, this new council of municipal health authorities worked with the preexisting council of state authorities; together they played an important role in the negotiations over the regulation and implementation of the nation's health system from 1990 onwards. Also stemming from this reform, a process of decentralization of health care was set in motion, such that

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[18] According to the annals of the conference, only one mayor, Ubaldo Dantas, of Itabuna, Bahia, expressed any caveats regarding the municipalization proposal. He considered municipalization a possible threat to the integration of the health system (Ministério da Saúde 1986a, 161).

by 2000, 99 percent of the municipalities delivered basic health care services in Brazil.

## Conclusion

This chapter explains the remarkable transformation of the Brazilian health care system – from centralized but narrow to decentralized and universalistic. This change did not occur, as was commonly assumed, abruptly, at the moment of democratic transition in Brazil, but unfolded gradually and under the noses of (indeed, within the very infrastructure set up by) the military regime of the 1970s and 1980s. The analysis here calls into question accounts of institutional change that focus too squarely on critical junctures (see also Capoccia and Keleman 2007; Falleti and Lynch 2009), as well as analyses of institutional stasis that place unwarranted emphasis on lock-in effects (see also Thelen 2003; Streeck and Thelen 2005). The study of health care reform in Brazil shows that three main components were necessary to ensure institutional change: subversive actors, infiltration, and expansion.

A well-organized subversive group of health practitioners was essential to bringing about this institutional change. Facing a national context that featured a particularly strong veto player in the authoritarian governments of the day, leftist reformers were nonetheless able to infiltrate a bureaucratic apparatus that had been set up by the military for its own reasons, and use this structure as a platform for introducing more subtle changes on the margins, which pushed the system in directions more consistent with their own ideology and goals. Even if they characterized the state as a capitalist, bourgeois, or authoritarian apparatus, the sanitaristas pursued a strategy of change from *within* the public health institutions, rather than advocating for change from outside the system, as other leftist movements did (Weyland 1995, 1700; Neto 1997, 63). For the sanitarista movement, infiltration was an effective means by which to take advantage of small openings. Those small openings arose first at the local level, where the political opposition was winning mayoral posts, and then at both the territorial periphery of the country and the functional periphery of the health care system, where the power holders were not invested and where local actors could operate beyond the scrutiny of the military.

In fact, it is difficult to determine the extent to which the power holders noticed the ongoing process of infiltration and either tried or cared to reverse it. It appears that the military allowed the process of infiltration by reformists in the health care sector, just as they had in Brazil's technology sector (see Adler 1986). In the Northeast, the reformists' preventive health care plans constituted an inexpensive solution for national health problems. Moreover, by placing the administration of a part of the health system (FUNRURAL) in the hands of the opposition (CONTAG), the military also tried to co-opt mobilized groups and appease social discontent.

Of particular interest in the process of state-society transformation that took place during Brazil's authoritarian period is that the military's intention to penetrate society and extend the nation-state to the territorial periphery made the state bureaucracy more permeable and easier to infiltrate. Like other authoritarian regimes of the right (Bismarck in Germany, for example), the Brazilian military advanced "progressive" social reforms as a means of co-opting and controlling the population and avoiding radicalization. The sanitarista movement seized those opportunities and reoriented the reforms toward new goals.

Brazil's federal institutions aided the sanitarista movement's infiltration in several interrelated ways. First, federalism made local- and state-level public health positions available to the members of the reformist movement, facilitating the reform of the state from the bottom up. Second, and similar to the Canadian case discussed in Hacker (1998, 101), federalism created opportunities for political parties sympathetic to health care reform to gain power at the local and state levels. Governors and mayors thus became potential political allies of the health care reformist movement in the negotiations with the national-level bureaucracy, the national deputies and senators, and the military. Third, federalism allowed for the implementation of innovative programs in politically distinctive and territorially bounded regions and municipalities. Changes in the periphery did not pose a serious threat in the eyes of military rulers and private health providers, whose interests were focused on the hospitals of the Southern region, which constituted the economic core of the health care system. Finally, during both the military and democratic periods in Brazil, federal transfers to states and municipalities were oriented (at least partially) by a criterion of fiscal

equalization among the subnational units.[19] As in Hacker's (1998, 73) analysis of Canada, this feature of Brazilian federalism permitted the poorer subnational units to play a leadership role in health care reforms, a role that their limited fiscal resources would have otherwise precluded.

Expansion was the last crucial element needed to achieve universalization and municipalization. Changes institutionalized in one area of the health care sector prompted changes in other areas, both territorially and functionally. Territorially, health reform programs scaled up from the local to the regional and national levels. Public health reforms first adopted in a few municipalities (Niteroi, Montes Claros, Londrina, etc.) were later implemented in the states of the Northeast and in Minas Gerais. Such programs, in turn, led to other national health reform programs, such as the Integrated Health Actions (AIS). Functionally, changes in one area of the health system prompted changes in other related areas, such as in the case of the expansion from AIS, which coordinated only the Ministries of Health and Education, to the Single Health System, which integrated the whole health system.

In this interpretation of the evolution of the health care sector in Brazil, "choice points," "branching moments," or "critical junctures" have little (if any) relevance in the causal narrative. Although radical changes in the health sector were codified in the Constitution of 1988, they only brought to light changes that had been percolating beneath the surface and been nurtured at the local level for more than a decade. By the time the constitutional conventionalists ruled on health care, the sanitaristas had already established both the networks and the expertise that put them in a position to exercise strong influence, so that the codification and institutionalization of the practices they had perfected over the years of military rule were politically feasible.

A final word is in order regarding the substantive policy outcomes of the institutional reforms analyzed here. The life expectancy of Brazilians increased from 67 to 72 years between 1991 and 2005; infant mortality decreased from 32 to 22 deaths per thousand infants

between 1997 and 2004; and the number of health care professionals increased from 1.1 to 1.4 per thousand people between 1990 and 2005 (Ministerio da Saúde 2006). Public opinion polls conducted in large cities such as São Paulo and Salvador show that people in the bottom 40 percent of the population – those who rely the most on the public sector for health services – have positive opinions about the current public health system.[20] Although Brazil's continental size and immense regional and social inequalities leave statistics based on national averages largely wanting, as McGuire argues in a cross-national study of policy reforms and their impact on health indicators, thanks to health care reforms that "revolutionized social policy in favor of the poor... [b]y 2005, Brazil had some of the most well-designed, encompassing, innovative, and pro-poor social policies in Latin America" (forthcoming, ch. 6). It is indeed very likely that universal health coverage and a decentralized structure that is funded with guaranteed federal transfers and that promotes users' participation in health councils are largely responsible for the improvement of Brazil's health outcomes. The evolution of health care reforms in Brazil shows that it is possible to break away, in a gradual and incremental manner, from the historical institutional preconditions that preclude universalization of health. They also appear to indicate that such institutional evolution leads to significantly better public health outcomes.

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[19] During the military period, this strategy was pursued for national security reasons (Stepan 1971) and also to build political support for the official ARENA Party in the North and Northeastern regions, which were historic bastions of political conservatism.

[20] See the public opinion data in Figueiredo et al. (2005, 135; 2007, 72).

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3

# The Contradictory Potential of Institutions

## *The Rise and Decline of Land Documentation in Kenya*

Ato Kwamena Onoma

I wanted a [land] document because it is like a marriage certificate for a woman. It gives you [the husband] confidence that no one will ever bother you.

> An old farmer in Taita Taveta, Kenya, in a 2005 interview with author

[Land titles] are mere pieces of paper.

> William ole Ntimama, minister of local government, Kenya, "The Indigenous and the Natives," *Weekly Review* (Nairobi), July 9, 1993.

## Introduction

The gradual decline of institutions that secure property rights presents us with an interesting puzzle. These institutions have a number of features that should display positive-feedback effects and ensure their continued strength. Land documentation systems, which constitute key components of these institutions, can aid informed and well-connected members of society in acquiring swathes of land, giving these actors an incentive to perpetuate such documentation systems (Scott 1998, 48).