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Dodging the Bullet of Patronage:

Professionalism and Autonomy in Brazil's Ministry of Health

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Abstract

Executive bureaucracies can be used by presidents in multi-party systems to leverage legislative support. What are the identity and capabilities of these political appointees? Why are some executive departments able to cultivate autonomy to innovate in a fragmented political regime, while others are not? We analyzed the Ministry of Health in Brazil, a desired political post in an extremely divided presidential system, examining nominees' biographies and their autonomy in three different policy areas. We find that health professionals have been remarkably savvy in maneuvering patronage in their favor and occupying strategic managerial posts. Nevertheless, their autonomy plays out differently across departments, which is explained by the ways they have built legitimacy and alliances to support their preferences. These findings challenge theories of political control of the bureaucracy and recent studies of governance that depoliticize the analysis of bureaucracies, contributing to how we conceptualize appointees and the resources available to them.

1. Bureaucratic autonomy and capabilities

At the forefront of the debate in contemporary democracies is an increase in directly elected presidents and an escalating fragmentation of the party system, demanding minority presidents to form cross-party support to be able to maintain a good relationship with Congress (Chaisty, Cheeseman, & Power, 2018). To form coalitions, presidents can, among other actions, provide cabinet seats to their political allies. Political appointments allow the incumbent party to implement policies that are important to their constituencies but are also a powerful bargaining tool (Mainwaring, 1993). Presidents wishing to reward, punish, or gain legislative support may use cabinet nominations. The strategic use of the presidential portfolio allocation is well documented in the literature but contrasts starkly with the lack of public

administration studies of the consequences of this process for capacity and autonomy of the bureaucracy. We ask two simple questions that have not been explored in these contexts: What are the identity and capabilities of these political appointees? Why are some executive departments able to cultivate autonomy to innovate in a fragmented political regime, while others are not?

In multiparty presidential regimes, cabinets might be often reshuffled and can be divided among different parties, or even become larger than necessary (Martinez-Gallardo, 2010; Mello & Spektor, 2018; Stein, Tommasi, Spiller, & Scartascini, 2008). To a worse extent, fragmentation can erode accountability controls and entrench social dynamics that are more typical of non-democracies (Mello & Spektor, 2018). In these contexts, particularly in developing countries, political appointments are assumed to be an inefficient patronage.[1] Therefore, cabinet allocation in multiparty systems can be an important laboratory to study the capabilities and autonomy of appointed bureaucracies. Deadlocks posed by coalition presidential regimes lie at the heart of the politicians' dilemma (Geddes, 1996) and speak directly to more recent literature about executive branches and their governance (Fukuyama, 2013; Lodge & Wegrich, 2012).

Governance scholarship has long emphasized that bureaucratic autonomy — independent policymaking power — is a crucial feature of modern states (Carpenter, 2001a). It allows actors the ability to innovate, propose, and implement policies. The influential (and controversial) work of Fukuyama (2013) proposed the concept of *capacity*, as an approach to measure governance. That is, the resources and degree of professionalization of bureaucrats, which can be measured by their level of education and professionalism. Replacing incompetent patronage appointment with economists, engineers, and even doctors would partially solve this

[1] We opted to use the expression "political appointment" to avoid misunderstanding with clientelism or predatory patronage that have historically been associated with cabinet allocation in these contexts.

problem given the normative beliefs entrenched in these careers since they would less prone to misbehavior given the ethos of their vocations. He also considered *autonomy*, which is the extent to which government officials are independent of partisanship, meaning that the fewer number of mandates leads to greater autonomy from its political principal. This approach has been useful for scholars interested in comparative studies of bureaucracy (Bersch, Praça, & Taylor, 2017; Holt & Manning, 2014). However, this literature has received criticism for depoliticizing the analysis of bureaucracy and ignoring the ability of different actors to work together within a larger perspective about state-society relations.[2] In this article, we take a different approach and analyze the politics of political appointments in a multiparty presidential system by investigating capacity and autonomy in-depth.

When choosing whom to appoint, presidents and parties can nominate political allies, personal connections or even noted professionals to advance their interests. There is growing literature about the politics of political appointments, particularly about concept development and large comparisons of portfolio allocation (Martinez-Gallardo & Schleiter, 2015; Panizza, Peters, & Larraburu, 2018). See, for instance, the innovative taxonomy proposed by Panizza et al. (2018) in this journal, which classifies portfolio allocation according to the degrees of institutionalization of party systems compared to the types of connections between political actors and voters. These are important advancements, but we still need in-depth, qualitative analysis of political appointment's capabilities to complement and test these analyses. Alongside this literature, some scholars have observed the role of economists, scientists, and health professionals engaging with politics from within the state (Coats, 2001; Dargent, 2014; Harris, 2017; Rich, 2013). Important scholarship has recently called attention to professional movements occupying positions within a bureaucracy to advance their policy agendas (Harris,

[2] See the Governance Blog for diverse comments on Fukuyama's approach: https://governancejournal.wordpress.com

2017). Usually, these authors are concerned with explaining reforms promoted by progressive bureaucrats and the resources provided by the state to push their agenda forward, and not as much about how these specialists exploit cabinet allocations to gain seats in the bureaucracy.

In terms of autonomy, the delegation literature has taught us that nominees are not always loyal to their political principals and conflicts between presidents and ministers, even those from the same party, are not uncommon (Martinez-Gallardo & Schleiter, 2015). Therefore, principals could apply different mechanisms to manage agency loss, including monitoring through junior ministers (Martinez-Gallardo & Schleiter, 2015; Pereira, Batista, Praça, & Lopez, 2017) or using administrative procedures to oversight bureaucrats (McCubbins, Noll, & Weingast, 1989). The problem with this principal–agent literature, where presidents/legislators are principals and the bureaucrats are agents, is that it leaves little room for autonomous office-holders (Ames, Carreras, & Schwartz, 2012).

Here we define autonomy in terms of the ability of bureaucrats to take actions according to their own preferences and innovate even against the interests of the politicians who nominated them (Carpenter, 2001a; Dargent, 2014; Groenleer, 2009). Note this is different from authors that see this as resulting from the credentials of political appointees (partisan or non-partisan) or their distance to the president, party or position on an issue.

To investigate bureaucratic autonomy, we will depart from the mechanisms proposed by Carpenter. Bureaucratic autonomy grows from political legitimacy, that is, the understanding by authorities and citizens that agencies can deliver benefits, plans, and solutions to the country's most pressing needs. If politicians appear to oppose popular or highly regarded policies, they could suffer electoral defeat. Bureaucrats thus focus on forging appropriate alliances with professionals and civil society, although, at times, they are primarily politicians, promoting policies they favor. The political foundation of bureaucratic autonomy is policymaking power, that is, the office holder's ability to build alliances that channel

innovative policies (Carpenter, 2001b).[3] Reputational alliances transcend ideological, partisan, and class labels. For this reason, legitimacy and the ability to form a strong community of support are two key mechanisms to understanding autonomy. Bureaucrats use legitimacy – built out of expertise, efficiency, or moral safeguards, and through ties with organized interests and the media – to convince politicians to accept their agenda, even if the government officials would prefer other policy choices. For instance, usually a Minister of Justice would have little autonomy on most issues, but Minister Sergio Moro, Brazil's most famous graft-buster and media-adept judge (The Economist, 2019), naturally enjoys more autonomy to advance his preferences as he is a moral figure with the strong support of part of the judiciary system, some congressmen, and large part of Brazilian society. As defined, autonomy cannot be misunderstood as the isolation of policy from politics. These entrepreneurs are embedded in politics. Therefore, this investigation is aligned with the understanding that the "role of politicians and bureaucrats are inherently blurred, involving both administrative (bureaucratic) and 'political' tasks" (Lodge & Wegrich, 2012, p. 216).

To investigate professionalism and autonomy in multiparty presidential systems, we explore the context of Brazil; a country that has received a great deal of attention from scholars interested in understanding cabinet allocation as the country is one of the most fragmented presidential systems in the world (Bersch et al., 2017; S Praça, A Freitas, & B Hoepers, 2011).

Particularly, we will focus on the example of the Ministry of Health (MoH). There are several reasons to believe that the health cabinet would be a crucial case to investigate the capacity and autonomy of the bureaucracy. Ministries of health "are platforms for individual politicians, who want to accumulate power, gain visibility, or shed difficult dossiers – and they are therefore useful for prime ministers [or presidents] who want to shape the careers of allies

[3] Carpenter refers to these as coalitions, but to avoid misunderstanding with party-coalition, we opted to use alliances or network of support to define this mechanism.

and rivals" (Greer, 2010, p. 115). Thus, it is a desired post for political bargain. In addition, health bureaucracies are often engaged in the provision and regulation of health politics (e.g. pharmaceutical industries and private healthcare providers) than other areas (Carpenter, 2012). This means that politicians can use appointments to reward or manipulate powerful lobbying interests. Thirdly, sectoral analysis can be an important tool to improve the quality of largescale studies on the relationship between elected politicians and their appointed bureaucrats. Narrowing down the concepts of capacity and autonomy can wash out relevant information. Sectoral analysis can improve the quality of any data analysis. Finally, in Brazil, healthcare is a paradoxical case; despite this exposure to partisanship politics, authors suggest that the MoH has been governed by an expert health bureaucracy, promoting important policy innovation from within (Harris, 2017; Rich, 2013). Therefore, it could provide valuable insights into how these progressive actors achieved power and gained independence to promote innovative policies -- or when they are limited in their actions.

This article is organized as follows: the next section will discuss the research design and methodological choices. The third section maps out nominations since the 1990s, considering the first elected administration after the military government. This exploratory, demographic description of bureaucrats' capabilities is relevant as we know very little about the appointees of this crucial executive branch. The fourth section investigates autonomy in three policy areas: food and drug regulation, science & technology (S&T) policies, and HIV/AIDS response. These illustrate the extent to which professional bureaucrats are autonomous to promote necessary policy innovations, and when and why their independence is limited.

2. Research design and methods

The first step of this study was to investigate the identity and capabilities of political appointments to the MoH. We considered the nominations to the MoH post (health minister) and its second echelon. Given their strategic role and visibility, these are the desired appointments for party coalition bargaining. For the health minister post, we culled information between 1990 and 2018. We searched for professional background information about all ministers (including professional, academic, and political history). For the second echelon, who are staff directly related to the health minister, information was available only for the period between 2003 and 2018. For the sake of brevity, we opted to focus on four key offices out of seven: S&T, health surveillance, healthcare, and the executive secretariat.[4] These are offices have more than 10 years of history, they deal with strong interest groups, and have a high potential for visibility. Here too we searched for nominated-bureaucrats' biographies, including professional, academic, and political history.

The second step of this investigation analyzes bureaucratic autonomy. The comparative analysis rationale is illustrated in Box 1. We selected three policy areas that have opposing results in terms of bureaucratic autonomy, despite the presence of highly skilled bureaucrats (vectors of control). The case selection was based on the concept of "most-similar analysis", that is, cases differ in main independent variable of interest (legitimacy and supporting alliances) and in the outcome (Seawright & Gerring, 2008). All three cases analyzed in this study happened during the democratic period (post-1985). We controlled for institutional context, as one of the assumptions of an alternative explanation is the relationship between capacity and autonomy: "If an agency were full of incompetent, self-dealing political

[4] The others are the Special Secretariat for Indigenous Health (created in 2010), Secretariat of Labor and Education Management in Health, and Secretariat for Strategic and Participatory Management.

appointees, one would want to limit their discretion and subject them to clear rules" (Fukuyama, 2013, p. 360). On the other hand, organizations with highly-educated officials would require less control to encourage innovative behavior. Our cases happened within the same institutional environment, meaning that all departments were subjected to a relative number of controls and mandates. In fact, the AIDS program is located at the third level of the hierarchy, while S&T and food and drug regulation are at the second. Therefore, the empirical test would be harder on the former. All departments were staffed, at different moments, with healthcare professionals who had an equivalent background.

Box 1. Comparative analysis rationale

Policy areas	**X^1**	**X^2**	**X^3**	**Y**
	Legitimacy and supporting alliances	Health professionals in key bureaucratic positions	Democratic, universal healthcare context	Bureaucratic autonomy
AIDS (1980s-2018)	1	1	1	1
S&T (2000-2018)	1	1	1	1
Drug/Food regulation (1980s-1998)	0	1	1	0

X^1 = theoretical variable of interest, X^{2-3} = control vectors, Y = outcome of interest

Since these are well-documented policy areas, including studies conducted by the authors themselves, we relied upon mostly documentary research (primary and secondary data). Sources included data from documents, such as scholarly literature, legislation and regulations, especially, ministerial decrees, which are publicly available on the government's website, and from media coverage. The list of appointees was provided by the MoH through the Citizen Information Service. Professional background information about these nominees was culled from the internet, through consultations with former and current bureaucrats working at the MoH (and other health specialists), and through their curriculum vitae (Brazil has a public database (http://lattes.cnpq.br) that collects information from all academics registered in the country).

3. Unpacking the technical-political bureaucracy of the Ministry of Health

In Brazil, competitive salaries and working conditions created an incentive to attract qualified professionals to the federal bureaucracy. However, high-level managing positions, defined as the director and advisor posts (DAS, *Portuguese acronym*) are appointed, just as ministerial positions. The president has the discretion to appoint ministers, and then ministers are free to appoint top managerial posts. During the 1970s, health academics and professionals began to organize and seek opportunities to work together to influence the healthcare policymaking process at the federal level. There is a consensus about the role of this movement, known as the *sanitaristas*,[5] in reforming the health system from within the state (Falleti, 2010; Harris, 2017). However, this organized movement dispersed after the redemocratization process (Escorel, 1999). In addition, since the political system in Brazil was leaning towards a coalition presidential regime it would be expected, for the reasons discussed in the first part of this article, that MoH posts would be highly contested. Table 1 demonstrates that the number of nominated posts in the MoH has steadily increased from 1,267 appointments in 1993 to 1,927 posts in 2015, increasing the opportunities for political allocation of seats.

Tale 1. Number of Higher Director and Advisor (DAS) and Gratification Posts (FG) of the Ministry of Health between 1993 and 2015.

Year	No of Nominees	Presidential Decree No
1993	1267	809
1998	1907*	2477
2000	1460	3496
2003	1407	4726
2010	1879	7336
2013	1927	8065
2015	1927	8490

Source: Presidential Decrees Nº 809 (April 24th, 1993), Nº 2.477 (January, 28th 1998), No 3.496 (June 1st, 2000), Nº 4.726 (June 9th, 2003), Nº 7.336 (October 19th, 2010), Nº 8.065 (August 7th, 2013), Nº 8.490 (July 13th, 2015).

[5] The *sanitarista* movement included medical professionals, leftist politicians, and scholars.

*Included relocations from other government departments as part of the State Reform

Between 1991 and 2018, Brazil has had 17 health ministers. Data from Table 2 provides three important pieces of information.

First, our data suggest that medical credentials are not the only criteria for health ministers' nominations, but it is a necessary condition. A politician with a healthcare background, coming from the president's political party or from a key party ally to the government's coalition, has a greater chance of becoming health minister. These are party-professionals that combine partisan trust and professional competence (Panizza et al., 2018). However, we cannot immediately assume that the MoH would suggest nominations based on career identity. Other ministries with a strong technical identity, were occupied by professionals with different credentials than their cabinets. For instance, in 1994, the sociologist Fernando Henrique Cardoso was the finance minister that promoted a famous economic stability plan, then diplomat Celso Amorim became the defense minister, and, more recently, economist and politician José Serra was appointed to the Ministry of Foreign Affairs.

Second, Cardoso was the only president who did not bargain with the MoH's highest post, saving it for his own party; while Presidents Lula and Dilma Rousseff (*Partido dos Trabalhadores*, Worker's Party, PT) alternated the health ministry cabinet between their own party and the Brazilian Democratic Mobilization Party (PMBD), their key coalition ally. However, it is relevant to mention that José Gomes Temporão, one of the longest running ministers in the history of the health cabinet, was originally affiliated with the communist party. Anecdotal information suggests that President Lula encouraged his affiliation to PMDB months before his nomination so he could be included in the quota of the coalition (Folha de Sao Paulo, 2007). Therefore, health professionals can make instrumental use of political affiliation to reach influential managerial posts.

Third, among the 17 health ministers in the contemporary democratic government, only four did not have previous experience within the health sector, and only two were not affiliated with any political party (Adib Jatene and Agenor Silva), but each occupied the post for only a year. In, 1998, Cardoso, for the first time in decades, nominated a politician, instead of a health-oriented professional to the MoH. This created tension with coalition parties that also claimed the rights to appoint non-specialists to key ministers (Folha de Sao Paulo, 1998a). Serra's nomination was sighted at the 2002 election (Folha de Sao Paulo, 1998b). More recently, President Michael Temer, who took the post after Dilma's controversial impeachment, promised to nominate only noted professionals but instead appointed two extremely unpopular politicians for the MoH who did not last long.

Indeed, politics were not the only criterion for a health minister nomination, as the vast majority of ministers were also healthcare professionals or from the president's personal network (Machado, 2007). However, there is a saying in Brasilia, the capital of Brazil: a strong politician without technical support and a skilled professional without strong political support, does not go far out (Cantanhede, 1998). Executive appointees with technical credentials must be proficient in the "politics game", whilst it is imperative for politicians to specialize in the areas in which they govern (Loureiro, 1998). That can explain why despite the intense turnover at the MoH, only three ministers remained in power during full presidential terms: Serra, Temporão, and Alexandre Padilha. All three were savvy policymakers (managers with politicians' skills), but also enjoyed strong support from the public health community.

Table 2. List of Health Ministers by period and political party, Brazil, 1990-2016.

Health Minister	Period	Political Party	Profile	Presidential Term
Alceni Guerra	1990-1992	PFL	MD, P, HM	Fernando Collor de Mello (PRN)
Adib Jatene	1992-1992	-	MD, A, HM	
Jamil Haddad	1992-1993	PSB	MD, P	Itamar Franco (PMDB)
Henrique Santillo	1993-1995	PP	MD, P	
Adib Jatene	1995-1996	-	MD, A, HM	Fernando H. Cardoso (PSDB)
Carlos Albuquerque	1996-1998	PSDB	MD, HM	
José Serra	1998-2002	PSDB	Economist, P	
Barjas Negri	2002-2003	PSDB	Economist, P, HM	
Humberto Costa	2003-2005	PT	MD, P, HM	Luiz I. Lula da Silva (PT)
José Saraiva Felipe	2005-2006	PMDB	MD, P, HM	
José Agenor A. da Silva	2006-2007	-	Biochemist, HM	
José G. Temporão	2007-2010	PMDB	MD, A, HM	
Alexandre Padilha	2011-2014	PT	MD, P, HM	Dilma Rousseff (PT)
Arthur Chioro	2014-2015	PT	MD, A, HM	
Marcelo Castro	2015-2016	PMDB	MD, A, P, HM	
Ricardo Barros	2016- 2018	PMDB	Civil engineer, P	Michel Temer (MDB, former PMDB)
Gilberto Occhi	2018-current	PP	Lawyer	

Source: (Machado, 2007; Machado & Baptista, 2012) and author's compilation
Description:
MD- Physician
A-Academic or with PhD degree
P-Politician
HM- Experience with health management

We turn now to investigate the second echelons of the MoH. Data available from the secretariats (second echelon of the MoH), between 2003 and 2018, suggest that the majority of appointees had a professional background in the health sector (Table 3). In these four key secretariats, the vast majority of policymakers had a medical degree (MD), academic background (masters or PhD) and/or experience in health administration. Scholars investigating cabinet politics in Brazil suggest that political nominations diverge among ministers, but Health and Finance are cabinets with lower levels of partisanship appointments

(Bersch et al., 2017; S Praça, A Freitas, & B Hoepers, 2011). The authors speculate that this is because these are consolidated institutions, when compared to younger agencies such as the Urban Affairs Ministry that do not include a large group of career bureaucrats.

In addition, the delegation theory suggests that a junior minister (executive secretariat) acts as a watchdog for the coalition, representing the preference of presidents within in the ministry; but in practice, they are responsible for assisting with decision-making, budget allocation, and other key tasks. In Brazil, this strategy is used when there are ideological differences within coalition parties (Pereira et al., 2017). However, our data imply that the MoH, executive secretariats are academics and specialists in healthcare management, some of them with strong ties to the health movement such as Gastao Wagner and Macia Mazzoti. Overall, appointments to second command posts at the MoH are highly specialized, less likely to be unskilled patronage, and more policy-oriented.

Table 3. Political appointments in four secretariats of the MoH (2003-2016)

Departments/Appointment	Year	Profile
Health Care Secretariat		
Jorge Solla	2003 - 2005	MD, A, P, HM
José Gomes Temporão	2005 - 2007	MD, A, HM
José Carvalho Noronha	2007 - 2008	MD, A, HM
Alberto Beltrame	2008 - 2011	MD, A, HM
Helvécio Miranda Magalhães Junior	2011 - 2014	MD, A, HM
Fausto Pereira dos Santos	2014 - 2015	MD, A, HM
Lumena Almeida Castro Furtado	2015 - 2015	Psychologist, HM
Alberto Beltrame	2015 - 2016	MD, A, HM
Francisco de Assis Figueiredo	2016 current	B.A. Business and HM
Public Health Surveillance Secretariat		
Jarbas Barbosa da Silva Júnior	2003 - 2006	MD, A, HM
Gerson Oliveira Penna	2007 - 2011	MD, A, HM
Jarbas Barbosa da Silva Júnior	2011 - 2015	MD, A, HM
Antonio Carlos Figueiredo Nardi	2015 - 2016	Dentist, A, HM
Adeilson Loureiro Cavalcante	2016 - 2018	MD, HM
Vacant		
Executive Secretariat		
Gastão Wagner de Sousa Campos	2003 - 2004	MD, A, HM
José Agenor Álvares da Silva	2005 - 2006	MD, HM
Jarbas Barbosa da Silva Júnior	2006 - 2007	MD, A, HM
Marcia Bassit Lameiro da Costa Mazzoli	2007 - 2010	Economist, A, HM
Márcia Aparecida do Amaral	2010 - 2014	MD, A, HM
José Agenor Álvares da Silva	2015 - 2015	MD, HM
Antonio Carlos Figueiredo Nardi	2016 - 2018	Dentist, A, HM
Adeilson Loureiro Cavalcante	2018 current	MD, A, HM
SCTIE		
José Alberto Hermogenes Souza	2003 - 2004	MD, A, HM
Luiz Carlos Bueno De Lima	2004 - 2005	Political appointed
Moises Goldbaum	2005 - 2007	MD, A, HM
Reinaldo Felipe Nery Guimarães	2007 - 2011	MD, A, HM
Carlos Augusto Grabois Gadelha	2011 - 2015	Economist, A, HM
Jarbas Barbosa da Silva Júnior	2015 - 2015	MD, A, HM
Adriano Massuda	2015 - 2015	MD, A, HM
Eduardo de Azeredo Costa	2015 - 2016	MD, A, HM
Marco Antônio Fireman	2016 current	B.A. Business

Source: Part of the information was given by the Ministry of Health under the Service for Citizen's Access and part was the author's own compilation

Description:

MD- Physician

A-Academic or with Master or PhD degree

P-Politician

HM- Experience with health management

This section shows that nominees in the first and second echelons of the MoH, despite the high rotation, were most often professional individuals favoring experts in public health management and health policy scholars.[6] We can also discern that many of the 1980s healthcare reformers (and now their acolytes) were successful in maintaining posts in the federal bureaucracy, regardless of their political party affiliation. That is, physicians and health scholars in Brazil have demonstrated a remarkable ability to use their professional expertise as a means to occupy policymaking positions within the federal bureaucracy.

On one hand, this is good news to those concerned about the possibility of unskilled high-level cabinet holders and the lack of career bureaucrats in the federal bureaucracy (Alberto, Machado, & Teixeira, 2011; Nunberg & Pacheco, 2016). On the other hand, one could question the organized power of the medical profession in capturing posts at the federal level. We recall that the influence of such groups and how they interact with the bureaucracy differs according to domestic political institutions (Immergut, 1992). Unlike the United States (U.S.), where physicians are usually credited for blocking efforts to introduce national insurance, in Brazil these individuals were the agents of reform and the health social movements (Harris, 2017). In Brazil, the organization of the medical profession is distributed among different associations, which has historically lowered the capacity of physicians to organize a common political agenda (Labra, 1993).[7] Thus, the political engagement of doctors is usually linked to health movement associations such as the Brazilian Center for Health

[6] Nevertheless, there are records of activists complaining about the suitability of some appointed health bureaucrats. For instance, the appointment of the executive secretariat Adeilson Cavalcante, who might serve the interests of private hospital groups given his former position as director of a hospital association (https://saudenodfblog.wordpress.com accessed on Sept 20, 2018).

[7] Labra (1993) speculated that fragmentation in the medical profession association is a product of state corporativism in Brazil; the organization of the healthcare system that is, historically, divided between public health/social security/private insurance; and is a heterogeneous market for physicians who usually have different professional affiliations.

Studies or the Brazilian Association of Collective Health. These institutions are historically engaged with the expansion of universal healthcare coverage.

4. Case studies

We have seen so far that these political appointees come from a medical professional background, are highly educated, and have experience with public sector management. Now we consider how autonomous they act to promote their preferred policy agenda. The following section explored autonomy.

4.1. The semi-autonomous HIV/AIDS program

Since the mid-1980s, one of the remarkable achievements of the MoH in Brazil has been its response to the HIV/AIDS epidemic. In the early days of the crisis, when international agencies were skeptical about the viability of supplying treatment to patients in developing countries, Brazil innovated by combining prevention with treatment, revolutionizing the guidelines on AIDS care worldwide. There has been enormous research that examines Brazil's experience, citing the key role of the federal bureaucracy (Flynn, 2013; Nunn, 2008; Rich, 2013). These progressive bureaucrats were able to provide innovative strategies to respond to AIDS when there was no established knowledge about how best to deal with the growing epidemic.

The National AIDS Program's (NAP) bureaucracy has been remarkably stable. Over a period spanning 23 years (1985-2018), the program has had only nine directors. They are located in the third echelon of the MoH, responding to the Public Health Surveillance Secretariat. These directors have been highly skilled and noted health professionals, mainly

physicians with previous experience with AIDS care or management, which not only highlighted their capacity to deal with such a pressing public health issue, but helps in explaining why they were well received by the HIV/AIDS community. Building up such a successful strategy at the national level is not a trivial managerial task. Given the uncertainty that surrounded the AIDS disease in its initial years and the stigma associated with it, delineating a national response, securing funds, and engaging politicians and other government departments were key challenges for this government department. In 1986, the first appointee to the AIDS program was a health professional, Lair Guerra, MD who was strategically nominated given her experience at the U.S. Center for Disease Control, her connections with the Pan American Health Organization and the political party affiliated with President José Sarney (Barros & Vieira-da-Silva, 2016; Nunn, 2008). Initially, the AIDS response focused on regulating the blood supply, which had until then been controlled by powerful interests; developing prevention practices, and increasing the number of hospital beds in institutions that previously refused to treat patients with AIDS. As treatment options evolved and Congress approved a law guaranteeing access to AIDS medicines, health bureaucrats developed creative strategies to secure a stable supply of affordable drugs.

Political legitimacy and building a supporting network were crucial steps to allowing AIDS bureaucrats to gain autonomy within the MoH. NAP bureaucracy was historically formed by civil society activists, health professionals, and patients with AIDS, in sum, invested individuals with a stake in the national policy response. They gained access to the program as NAP directors invited them to collaborate in the design of the national response. This definitely facilitated their dialogue with civil society more broadly, which by turn, supported bureaucrats' decisions (Rich, 2013). For instance, in 1997, the increasing number of patients and the rising price of HIV/AIDS drugs raised concerns within the MoH about exorbitant program costs. The minister of health, Carlos Albuquerque, MD announced he was concerned "that 10% of Health

Ministry expenditure was going to 0.1% of the population, adding that it was unjust that the government was obligated to spend $428 million reals on a disease that only affects 55,000 people" (Nunn, 2008, p. 99). NAP leaders used the media and formed an alliance with non-governmental organizations (NGOs) to hold politicians and the MoH accountable for providing a stable supply of drugs. These were risky political decisions as the program responded to the secretariat and the health minister, but their moral statements and the support of the AIDS community were safeguards for their actions (Nunn, 2008).

This alliance with NGOs successfully directed public opinion to adhere to "treatment for all people living with HIV/AIDS" agenda (Galvão, 2002). NAP engaged in heated price negotiations with multinational drug companies and shepherded an international campaign to clarify the connections of intellectual property protection to public health. However, there were moments, when these bureaucrats had their independency challenged by their hierarchy. An exemplary moment was in 2005, during the price negotiations of lopinavir/ritonavir, an important drug in AIDS treatment protocol at that time. While activists and NAP officials strongly advocated for a compulsory license (CL) that would allow other firms to supply these drugs without permission of the patent holder, the secretariat of the Public Health Surveillance Agency and the minister of health opted for a close door agreement with Abbott Laboratories, the original supplier. This created tension and NAP feared for its autonomy (Revista Veja, 2006), but this did not last long and two years later they were able to issue a CL for efavirenz after an unsuccessful price negotiation with Merck & Co.

From 2016 to 2018, Brazil went through a severe political crisis that caused much debate between the executive and legislative politicians. The NAP could have been included as a bargaining chip to gain the support of the evangelical caucus, one of the most powerful groups in Congress and highly critical of progressive AIDS prevention campaigns; yet the structure of the department remained unaltered. No recent health minister has ever opposed the

spending on modern AIDS medications and conservative politicians who have tried to gain access to the reins of NAP have faced a strong backlash (Fonseca & Bastos, 2017). The costs of opposing NAP became too high thanks to the autonomy gained by the bureaucrats.

4.2. Science and technology (S&T) and health: scientists as bureaucrats

In the MoH, the Science, Technology and Strategic Inputs Secretariat (SCTIE) has been responsible for procuring high-cost drugs and health technology assessments that define which drugs will be supplied by the healthcare system. Those are decisions that define winners and losers in the powerful pharmaceutical and device industry. Its bureaucrats have dedicated their careers to studying the health industry and have been pushing forward their progressive health industry agenda backed by the strong support of the public health community and healthcare suppliers (Centro Brasileiro de Estudos de Saúde, 2014; Valor Economico, 2016). Industrial policies are often controversial because they can favor particular economic groups and policies could be traced back to personal connections between elites and government actors. However, SCTIE has promoted novel policies for technology transfer agreements between multinational drug companies and local laboratories (national and multinational), among other policies. Gaining the trust of these different partners and being able to promote partnership in such a competitive environment can be connected to these bureaucrats (Flynn, 2015; Fonseca, Shadlen, & Bastos, 2017).

In 2000, the MoH established the Department of S&T to respond to environmental contamination in the state of Rio de Janeiro. Its first director was a physician and epidemiologist, who had recently concluded her doctoral studies in the U.S. A few years later, SCTIE was created, after an organizational reform promoted by the government. This elevated the relevance of S&T to the second echelon of the MoH. All nominees appointed to SCTIE

(secretariat and its directors) resemble the high skilled pattern observed in the AIDS example and some were notable participants of the 1980s-public health movement.

One of SCTIE's major policy innovations was an ambitious agenda to promote public-private partnerships for technology transfer of drug development. By committing to purchasing products from the consortium, SCTIE was able to convince public laboratories and drug companies to engage in this partnership. A consortium between multinational and local drug companies to develop medicines for the health system was a policy innovation never seen in the country before.

This policy was first promoted by the Health Minister Temporão (2007-2011) himself. Temporão was one of the key leaders of the health movement during the 1980s. He appointed several health scholars from his home institution, Fiocruz (Latin America's largest biomedical institution) to SCTIE. These bureaucrats were guided by progressive beliefs in the role of the healthcare system to promote economic and scientific development (Gadelha, 2001; Temporão, Carvalheiro, Homma, & Higashi, 2005). Their reputation was key to legitimize the heath industrial policy and gain the support of public health advocates, who historically refused any partnership with the private sector.[8] By using normative phrases such as "reduce Brazil's dependency on foreign capital", they won public opinion and surfed the wave of industrial policies that had been promoted by the Ministry of Industry, Foreign Trade and Services since 2003. If SCTIE bureaucrats had not counted on the acquiescence of the public health community and the private sector, it is less likely that SCTIE would have been able to implement and maintain such a progressive agenda.

However, in 2014, news media denounced a possible political influence at the SCTIE to benefit a particular local drug company (Valor Econômico, 2014). The Brazilian Association

[8] For instance, see Hesio Cordeiro's book on the pharmaceutical industry and the health system in Brazil is highly critical of the pharmaceutical industry (Cordeiro, 1980).

of Collective Health (Abrasco), the most influential public health associations in the country, expressed its support for SCTIE bureaucrats, "Health innovation cannot stop!" Vouching for their capacity and honesty:

> "Carlos Gadelha, [head of the SCTIE], has excelled for his competence, devotion, and civil service duty in leading a national policy for science, technology and health innovation (…) Abrasco express its full confidence [in SCTIES officials] (…) highlighting the relevance of maintaining an industrial policy aligned with the health needs of the Brazilian population".[9]

In other circumstances, the head of the secretariat would have been resigned, but given the strong support he received, Gadelha remained in power. These bureaucrats formed alliances with public health advocates, healthcare industries, and academics to push forward an agenda of fostering the research and development of strategic drugs important to the healthcare system. The Permanent Joint Forum for Articulation with Civil Society within the Executive Group of the Health-Industry Complex facilitated dialogue with different government agencies, the private sector, and civil society (Flynn, 2015). These are a clear instance of legitimacy and embeddedness that underpin the autonomy of SCTIE's officials.

In 2011, as a result of the protagonist role played by the SCTIE, the Ministry of Industry transferred to the MoH the responsibility for implementing the health section of the industrial policy (*Plano Brasil Maior*) proposed by President Dilma Rousseff (2011-2016). This consolidated the leadership of SCTIE in health, S&T, and industrial policies. However, as with the AIDS example, despite the political instability in Brazil, the autonomy of SCTIE is likely

[9] https://www.abrasco.org.br/site/outras-noticias/institucional/abrasco-lanca-nota-de-apoio-a-carlos-gadelha-e-eduardo-oliveira/1916/ (accessed in February 15, 2019)

to persist. For the first time in Brazil, associations between the multinational pharmaceutical firms and local drugs companies, as well as two of the most important think-tanks of public health advocates, the Brazilian Center for Health Studies and the Brazilian Association of Collective Health, issued a statement of support to SCTIE's policies and its bureaucrats. The actions of skilled bureaucrats working within the MoH, and in particular their ability to gain autonomy to engineer policy innovations, provides solid evidence to support the independence of this agency in promoting health, S&T, and industrial development. Their decisions are too entrenched and they have strong support from multiple stakeholders, therefore it would be too costly to reverse them.

4.3. Food and drug regulation turns to public disgrace

While, in the other offices, bureaucracies are examples of impressive autonomy, the regulators of food and drugs throughout the 1980s and 1990s were also health professionals with expertise in this area. However, their decisions scored little achievements and these officials positioned themselves far from collaborations that could have brought them needed political capital. Even the pharmaceutical industry, which could have been an important ally, did not want to get involved with the regulators' proposals. Exploring this case will be helpful to gain insights into conditions where autonomy is less likely to emerge.

In the 1980s, as health reformists gained positions within the federal government, there was an opportunity to reform pharmaceutical surveillance and to improve regulatory standards of food and drug registration. Consumer organizations, health professionals, and scholars demanded adequate regulatory standards along with qualified human resources (Costa, Fernandes, & Pimenta, 2008). The 1986 National Conference on Consumers' Health was a crucial venue for fostering communication between government officials, consumers, and

academics. Therefore, AIDS and food & drug regulation began under a similar institutional context and with similar bureaucratic capabilities.

However, between 1990 and 1992, during the term of President Fernando Collor, small advancements made during the 1980s suffered major setbacks. Many official documents disappeared, and policy decisions were made without appropriate consultation in regards to the regulated sector or society in general. In addition, a desire to catch up with the enormous backlog in drug registrations led the MoH to adopt a fast-track process without including any technical analysis. This decision ended up flooding the market with many potentially unsafe products, which later had their quality and efficacy questioned (Costa, 2004). This created administrative chaos, which continued during President Itamar Franco's term. These top-down decisions, having little engagement with the regulated sector or with the *sanitarista* movement, deeply affected the legitimacy of actions taken during this period. Therefore, key attributes of autonomy see in the other cases, were absent here.

Another instance, in an effort to organize health surveillance, the health minister appointed, in 1992, Dr. Roberto Chabo, a respected physician with strong ties to the healthcare reform movement. Chabo revoked the fast-track process for drug registration arguing it was dangerous to public health. In a controversial effort to reduce the price of drugs, he mandated the exclusion of brand names on all pharmaceutical products. This unilateral decision led to strong opposition and a legal action from the pharmaceutical industry, generating additional suspicions towards decisions approved by the National Secretariat of Health Surveillance (SNVS, *Portuguese acronym*).

A year later, after a cabinet reshuffle, President Franco appointed Dr. Henrique Santillo, a physician and representative of the Progressive Party (PP), as health minister. Evidence suggests that there were serious misconducts at SNVS by Santillo himself. An investigation conducted by the Federal Police and extensive media coverage suggested that Santillo lobbied

for drug registrations in response to a request made by a politician in exchange for industry support during his campaign (Folha de Sao Paulo, 1994b). In this context, the head of the SNVS, Dr. Joao Martinelli, tried to expand health surveillance, but he was unsuccessful. He confiscated more than 200 drugs from the market, restricted the level of impurity allowed in wheat flour – suffering strong opposition from congressmen who represented wheat mills (Folha de Sao Paulo, 1994a). Despite Martinelli's efforts, Santillo replaced him with a military officer who triggered strong disapproval from health professionals (Folha de Sao Paulo, 1994a).

Thus, these SNVS bureaucrats acted without even minimal dialogue with the regulated sector and specialists, often creating instability in the market or relaxing norms that could have endangered public health. If these officials had created transparent and continuous channels of communication and considered the opinion of consumer groups and the industry seriously, it is more likely that they would have been able to form a consensus about their actions. If the ability to form a political diverse network and gain political legitimacy is crucial attributes for autonomy, the health surveillance office did not cultivate them.

The election of President Cardoso in the mid-1990s represented another effort to bring health surveillance expertise into this office with the appointment of another renowned physician, Dr. Elisaldo Carlini (1995-1997). Carlini developed a strategy to inspect 600 registered laboratories, subsequently closing down 53 due to their poor conditions (Costa & Rozenfeld, 2000). Despite these efforts, in 1997, the federal government was accused of being negligent in regulating the blood supply, which led to more than 40,000 patients being affected by contamination related to HIV and other blood-borne infections (Folha de Sao Paulo, 1997). Also, several women became pregnant after using ineffective birth control pills (Revista Veja, 1998). During these crises, President Cardoso decided to appoint Serra as Minister, who dismissed the entire team of the SNVS and advocated for the creation of an independent

regulatory agency (Piovesan & Labra, 2007). Serra explained his decision to shut down the SNVS permanently in 2000: “If you wanted to point out corruption practices in Brazil, it was there [in the SNVS]. It was famous for lengthy decisions about everything. Can you imagine that even to change the name of a bleach product, you had to get approval from SNVS?” [personal communication]. Therefore, the reputation of SNVS was completely ruined. The blood mafia and fake medicines crises propelled the SNVS into public disgrace, which led to its full termination.

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Although all three health departments had expert bureaucrats appointed to their bureaucracies, under similar institutional context, not all of them were able to cultivate autonomy. Public sector managerial expertise and professionalism will help in gaining a seat in the highest echelons of the MoH bureaucracy; but if nominees do not have the ability to cultivate trustworthiness and form alliances, professional credentials and holding fewer principals, will not guarantee autonomy. Clearly, the SNVS did not have these attributes.

5. Conclusion

This article analyzed political appointments in Brazil. Despite the common practice of appointing political party members for coalition management, nominations to the MoH have not been exclusively influenced by partisanship. Most ministers have been affiliated with political parties, but we show that, historically, higher posts of the MoH have been filled by physicians with expertise in health service administration and academics. Health bureaucrats,

some of them remaining from the 1980s-health movement, have demonstrated a remarkable ability to maneuver partisanship and remain in power through different administrations, regardless of which political party or coalition was running the country.

However, the autonomy of health bureaucrats played out differently in the three examples analyzed. The cases of HIV/AIDS and S&T show that federal bureaucrats have been capable of advancing remarkable health policy innovations, which can be attributed to their credibility and capacity to forge alliances with civil society and specialists. Neither the HIV/AIDS nor the S&T innovative policies were generated by the legislative side, the president's agenda, or from organized interest groups' lobbying. Instead, they were developed through alliances forged by health bureaucrats, which included normative frames and moral arguments, such as 'access to medicines as a human right' and 'local production of medicines as social, technological and economic development', and their network capacity. Eventually, these bureaucrats gained support from the president and other ministries and those who opposed their policies were unable to interfere with them. In the case of HIV/AIDS, activists built an impressive network of NGOs that supported the NAP. In the S&T and health policy, the SCTIE successfully mobilized multinational and local pharmaceutical firms to adhere to its ambitious project for technology transfer. The reputation of their offices endured to the point that even after leaving power and with cabinet reshuffles, the NAP and SCTIE sustained their earlier policy choices.

On the other hand, the case of the SNVS suggests that professionalism and fewer mandates alone are not sufficient to guarantee autonomy. Increasing the number of experts might not generate desirable policy effects if not accompanied by legitimacy and an ability to form alliances. The combination of decisions with little discussion with stakeholders facilitated political interference. Santillo's example illustrates well the concepts of theories of delegation. As both pharmaceutical companies and consumers are important constituencies, complaining

about the missteps of SNVS in the context where the health minister, a savvy congressman, acted as to terminate the department and delegate its responsibility to an independent agency. This sort of strategic design of the organizational structure was only possible because the SNVS did not provide efficient accomplishments nor gather a supporting network around their programs and proposals.

We recognize that the generalizability of these findings is limited. Bureaucracies are often diffused and heterogeneous (Ames et al., 2012) and Brazil has one of the most fragmented party systems in the world. Nevertheless, even in such an extreme institutional environment, bureaucrats can be talented and independent. If that can happen in an extreme case such as Brazil, it is likely that can prevail in other contexts with a similar or less divided multiparty presidential regime.

Understanding the conditions by which bureaucrats gain autonomy and promote far-reaching innovations in multiparty presidential regimes can inform future debates about executive bureaucracies and governance studies. We are still building a cohesive understanding about the profile of bureaucrats in coalitional presidential regimes and which tools they can successfully deploy to gain authority and innovate (Martinez-Gallardo, 2010). In addition, in Latin America the study of political appointments is essential given the considerable resources available to the executive branch and its record of administrative inefficiency, but it is yet under developed (Hecimovich & Alejandro Trelles, 2016; Panizza et al., 2018). Here we argue that even under highly unsatisfactory institutional conditions, this kind of bureaucrat can still obtain a large amount of autonomy.

Our contribution to executive politics' theories is nuanced. First, bureaucracies are more independent than assumed by the theories of a principal-agent, which, nowadays, tend to be the core in studies about multiparty presidential regimes, particularly in Latin America. Appointed government officials, despite their ascension to power through the hands of

politicians, have the means to promote and perpetuate progressive public policies. To better understand how this process unfolds, a deeper look inside the cabinet is mandatory. This assertion might seem conventional since studies such from Geddes (1996) and Carpenter (2001a) pointed this direction at the turn of the century. Yet, scholars of public administration have focused too much on promoting theories and explaining public sector reform/performance to pay attention to these internal dynamics of the executive government. We hope this exploratory analysis of Brazil's health cabinet can inspire other scholars to investigate governance beyond the narrow definitions of capabilities and autonomy and add to the growing literature about the politics of bureaucracy and comparative public administration (Dargent, 2014; Lodge & Wegrich, 2012).

Second, studying bureaucratic autonomy through the lens of reputation and alliance formation was a difficult test to Carpenter's (2001a) approach. The Brazilian executive government is far more sensitive to partisanship than American agencies given their need to manage heterogeneous political coalitions. Nevertheless, mechanisms of legitimacy and autonomy are apparently well equipped to study bureaucracies in Latin America but should be put to the test in other contexts as well.

From an applied perspective, our study informs public administration practitioners in the global south that in spite of the constraints imposed by a coalition presidential regime, appointed bureaucrats might not be as limited or unskilled as a first impression might give. Even in less favorable conditions, such as countries with a high level of cabinet turnover, savvy bureaucrats can still cultivate independence if they are able to build political capital through an accomplishment-oriented reputation for their offices and forge supporting networks.

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