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Inter-municipal Health Consortia and the Challenges of Cooperation: An Analysis of the Experience in the Zona da Mata Region of Minas Gerais, Brazil

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Abstract

Objective: To examine the role of Inter-municipal Health Consortia (IHC) in the Zona da Mata region of Minas Gerais, Brazil, in fostering joint action among public entities.
Method: A thematic categorical content analysis was conducted on 33 documents, including protocols of intent, statutes, program and apportionment contracts, from the nine IHC members in the Zona da Mata region. Additionally, 10 interviews were carried out with executive secretaries, administrative managers, and mayors.
Results: This study highlights the presence of instruments for mutual adjustment, arenas for technical debate, and joint deliberation, along with controls that position IHC as a governance structure capable of overcoming obstacles to cooperation, limiting opportunistic actions, and facilitating conflict resolution.
Contributions: The findings shed light on how cooperation functions within IHC. The analysis reveals characteristics and models of the federalist system and public administration, alongside the risks of opportunistic behavior. While actors display utilitarian tendencies, their objectives also converge in the management of IHC.
Keywords: Federalism; Cooperation; Municipal associations; Governance.

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1 Introduction

Inter-municipal Health Consortia (IHC) are public structures designed to promote cooperation among state entities to implement medium- and high-complexity health policies (Diniz Filho, 2014). This study examines the conditions within consortia that facilitate joint action among municipalities, even under adverse circumstances such as pronounced socioeconomic disparities, the complexity of state apparatus, and differences across federative levels (Union, states, and municipalities) (Affonso, 2000; Filippim & Abrucio, 2016).

IHC break away from the traditionally isolated structure of Brazilian public administration by incorporating the need for action at the regional level (between state and municipal levels) and driving a transformation in public management. In this context, IHC are established as cooperative institutional arrangements within a framework of competitive federalism and self-governing municipalism (Abrucio & Sano, 2013).

Establishing a consortium alone does not ensure consensus on municipalities' actions, which could render consortium little more than a good concept. For instance, Teixeira *et al.* (2003) note that while mayors may initially be incentivized to participate in consortia to improve and expand health services in secondary and tertiary care, they may not sustain their commitment to the partnership over time.

Therefore, it is essential to establish a process for constructing common objectives—through contracts, agreements, and the formalization of a structure—and to develop instruments that facilitate the implementation of actions in pursuit of IHC's public purpose (Galvão, 2020). Generally, the structure of IHC can be understood as arrangements designed to foster cooperation, coordinate activities, and establish agreements to resolve conflicts.

In addition to their bureaucratic and organizational structure, consortia are established and operate based on four main agreements: the protocol of intentions (the initial agreement among public authorities to establish the consortium), the statute (which defines general rules for operation, structure, and relationships among participants), the program contract, and the apportionment contract (agreements specifying financial contributions and the provision of medium- and high-complexity health services between the consortium and each municipality). Therefore, Inter-municipal Health Consortia (IHC) embody agreements formalized through governance instruments. Reis and Diehl (2015) identified these elements as key components of good governance in the IHC of Rio Grande do Sul.

However, IHC continue to face challenges inherent to the structure of Brazilian public administration, where the personal and political interests of individual actors often take precedence. Analyzing this public institutional arrangement underscores the fundamental conditions required to promote cooperation among these actors. Such cooperation necessitates the creation of rules and agreements that depart significantly from the isolated bureaucratic practices of municipal authorities and the conventional federative dynamics between state and municipal levels (Diniz Filho, 2013).

Based on the above, this study aims to understand the role of the IHC in the Zona da Mata region of Minas Gerais, Brazil, in facilitating joint actions among public entities. To this end, the governance instruments formalized by the IHC in this region were analyzed. The Zona da Mata mesoregion was chosen due to the highly heterogeneous nature of its municipalities, which presents significant challenges to the implementation of collective public policy strategies (Sachs, 2008).

Some elements justify this study and its objective: (i) previous studies (Morais & Chaves, 2016; Lui *et al.,* 2020; Lui *et al.,* 2022) have predominantly focused on describing the content or strategies of agreements signed between entities of the Federation. This study, however, emphasizes relationships, particularly the sharing of attributions and responsibilities for the provision of public health, with a focus on the perspective of stakeholders—highlighting how public consortia interact across various management instances; (ii) in addition to documentary analysis, the study captured the perceptions of individuals involved in the governance of IHC, recognizing that relationships and management involve people who must be heard; and (iii) as discussed by Lui *et al.* (2022), research in this field lacks critical reflections on how public consortia communicate (relationships) and whether managers find cooperation adequate. This context in Minas Gerais served as the foundation for this investigation.

This study provides significant contributions, particularly regarding establishing cooperation relationships in IHC. The findings reveal a perception of autonomous municipalism, competitive federalism, bureaucratic public administration models, heterogeneity among municipalities, and the risk of opportunistic behavior. These factors suggest that actors in the management of IHC exhibit both utilitarian behaviors and a degree of convergence toward shared objectives.

After the introduction, this study comprises four sections structured as follows: First, it presents the theoretical foundations that form the basis of the research. Next, it outlines the methodological approach used and the analysis results. The discussion follows, offering insights into the findings. Finally, the study concludes by emphasizing its contributions and providing recommendations for future research.

2 Theoretical Framework

2.1 Public consortia: collective action and governance in health

Public consortia are structures that allow participating municipalities to address the demand for the provision of public goods. In this way, the shared needs of consortium municipalities are recognized and addressed through collective actions (Gerigk & Pessali, 2014; Amaral & Blatt, 2011; Nascimento *et al*., 2021).

In general, collective actions are understood as social and economic interactions among individuals within the same group who share common interests (Wolfart *et al*., 2014). Despite the shared understanding of collective actions, various approaches and authors explore this topic from different perspectives. Olson (2015), for instance, argues that collective action can be beneficial depending on certain variables, such as the size and behavior of groups of actors. Conversely, Hardin (1982) and Ostrom (2005) focus on collective action in the context of managing shared resources often referred to as "commons." In this view, groups tend to unite when they recognize that resources—whether natural, such as water or air, or otherwise—are scarce and require coordinated management.

In the public sector, Feiock and Scholz (2009) emphasize that collective action among local governments is essential for addressing issues that transcend municipal boundaries, such as natural resource management and economic development. They highlight that the effectiveness of these collaborative networks largely depends on local contexts, including the history of interjurisdictional cooperation and the unique incentives present in each region.

Therefore, there are no consistent patterns of collective action; in other words, the actors (network members) do not behave uniformly in every situation, nor is it possible to identify homogeneous groups within society. As Carlos (2015, p. 84) affirms, corroborating Dagnino *et al*. (2006), "there is no homogeneous pattern or unitary model of action that represents societal actors and that serves as a paradigm for the action of social movements, given the complexity and heterogeneity of civil society." (Free Translation)

Similarly, Bimber et al. (2005, p. 366) argue that it is crucial to examine whether contemporary examples of collective action align with theoretical frameworks and whether the theory itself aligns "with the rich set of collective actions now present in public life." Therefore, the analysis of IHC understood as a form of collective action, must effectively address its intended focus—specifically, the characteristics of behaviors and agreements in the interrelationships among municipal authorities.

Collective action in HCI, in this context, serves as a significant strategy for understanding cooperation among municipalities. In a Brazilian context characterized by pronounced regional inequality and challenges in managing public resources, HCI enable municipalities of varying sizes and administrative capacities to collaborate in delivering health services more efficiently and equitably, thereby overcoming individual limitations. This form of collective organization facilitates, for instance, the expansion of access to medium- and high-complexity healthcare services, cost reduction through economies of scope, and enhanced negotiating power with suppliers of inputs and services through economies of scale (Arretche, 2010; Flexa & Barbastefano, 2020).

However, collective action in HCI encounters significant challenges and relies on various institutional and contextual factors. Among the primary challenges are the coordination among participating entities and the sustained commitment of municipalities. The diversity of interests and disparities in the financial and administrative capacities of municipalities can undermine the cohesion, cooperation, and efficiency of the consortium. Regarding institutional and contextual factors, the governance of HCI must be adaptive, enabling flexible management that addresses local needs and responds swiftly to changes in the political, economic, and social landscape. Moreover, building trust among municipalities is crucial for the success of collective action, as it facilitates cooperation and minimizes the risks of conflicts and inefficiencies (Domingos *et al.*, 2019; Martins *et al.*, 2020).

In this context, the literature (Ostrom, 1990; Feiock, 2007) on collective action emphasizes the importance of governance mechanisms that promote cooperation and reduce the risk of opportunistic behavior, such as "free-riding." In the HCI environment, this occurs when some municipalities benefit from the consortium's advantages without adequately contributing to the agreed-upon distribution (Teixeira *et al.*, 2003). The institutional design of consortia, including clear rules for membership, cost sharing, monitoring, and enforcement mechanisms, is crucial for the success of these initiatives.

Studies (Grin *et al.*, 2018; Ventura & Suquisaqui, 2020) indicate that consortia often invest in developing technical and administrative capacities while fostering organizational learning among participants. These efforts are vital for ensuring the long-term sustainability of HCI and creating an environment that encourages innovation and the continuous improvement of services. Consequently, collective action not only enhances the efficiency of service delivery but also strengthens local and regional governance, amplifying the positive impacts of public policies.

In this study, we aim to explore the role of HCI, as a form of collective action, in enabling public health services. Governance is a central aspect of this analysis, as it forms the foundation for understanding the agreements and standards that facilitate collaborative efforts to deliver medium- and high-complexity healthcare. However, the focus is not on the elements or motivations behind the formation of inter-municipal public consortia but rather on analyzing the relational dynamics that define responsibilities and guide the planning of service provision. Specifically, this study examines how collective action in HCI takes place and how it overcomes contextual barriers within Brazilian public administration. Additionally, we identify factors hindering more efficient collective action and analyze how these obstacles manifest, as discussed in the following sections.

3 Theoretical elements that influence the performance of IHC: federalism and public management models

Public organizations embody characteristics from various models, paradigms, and systems (Klumb & Hoffmann, 2016). Specifically, HCI are shaped by the dynamics of the Brazilian federal system (Diniz Filho, 2013) and by influences from patrimonialism, bureaucratic, and managerial models (Denhardt & Catlaw, 2017; Fabriz, 2017; Lui & Schabbach, 2020; Mathias & Oliveira, 2019).

Regarding the Brazilian federal system, it is important to highlight the coexistence of two models: competitive and cooperative (Elazar, 1987). The competitive model originates from the Applied Economic Theory of Decentralization, first presented in a seminal work by Tiebout (1956). This model emphasizes that governments should focus on enhancing public sector efficiency. In contrast, the cooperative model proves more viable in contexts marked by regional inequality (Ismael, 2018).

HCI emerged in Brazil in a specific context: a) on the one hand, municipalities are encouraged to become autonomous in managing their health policies; b) on the other hand, they face difficulties mainly regarding limited capacity and resources and see cooperation as a way to implement health actions (Abrucio et al., 2013). Thus, when structured, HCI enable joint coordination between municipalities to offer these services and carry out collective purchases, optimizing resources and expanding healthcare coverage. These consortia have proven to be fundamental in overcoming the limitations imposed by regional inequalities and managing difficulties and scarcity of resources (Domingos *et al*., 2019; Martins *et al*., 2020).

Nascimento et al. (2021) emphasize that HCI enable the sharing of resources, infrastructure, and technical knowledge, helping mitigate regional healthcare delivery inequalities. These arrangements allow smaller or resource-limited municipalities to access services they would otherwise be unable to provide independently. However, the authors also highlight challenges related to the coordination and governance of consortia, including the need to align the interests of different municipalities and the complexities of collective decision-making. Additionally, they stress that the political, economic, and social characteristics of each region significantly influence the success and functionality of these cooperative arrangements.

Fernandes *et al.* (2020) demonstrate that the formation of inter-municipal consortia can enhance municipalities' operational efficiency by enabling the sharing of costs and resources. Additionally, according to the State Department of Health of Minas Gerais (2021), such consortia offer several advantages, including cost reduction, improved dialogue among municipalities within the same region, resolution of regional issues, and joint planning for implementing health policies.

However, they emphasize that local factors—such as geographical proximity, a history of cooperation among municipalities, and local socioeconomic characteristics—are crucial for the formation and effectiveness of consortia (Nascimento *et al*., 2021; Fernandes *et al*., 2023).

In this context, the management and governance of HCI encounter several challenges, particularly in coordinating the diverse federated entities and ensuring long-term financial sustainability. Integrating health policies within consortia demands effective governance that can align the interests of various municipalities while ensuring transparency and accountability in the use of public resources (Martins *et al*., 2020; Souza, 2023).

Regarding elements of public administration, Julião and Oliveri (2020), in their study of public consortia in Ceará, Brazil, emphasize the roles of politicians and bureaucrats. According to the authors, bureaucracy was particularly evident through the state government's initiatives and the actions of managers involved in public administration, who played a key role in the strategy to establish consortia in that state. Similarly, Nuske *et al.* (2018) highlight bureaucratic elements—such as organizational structures, rules, and deadlines—already present in municipal public administration and now integrate these new forms of action.

According to Flexa and Barbastefano (2020), several challenges inherent to municipal management persist even after the establishment of HCI. Examples include low qualifications among public servants, scheduling conflicts, planning deficiencies, bureaucratic hurdles, and limited or inefficiently allocated resources. Consequently, forming consortia becomes essential to address the difficulties many municipalities face in providing public services (Marroni *et al*., 2021; Lui & Schabbach, 2020; Silva *et al.*, 2017). Once these new entities are consolidated, many municipalities can overcome the primary challenges of delivering medium- and high-complexity health services, enhancing effectiveness through managerial practices.

Studies on the performance of HCI have also highlighted the importance of evaluating and analyzing the users of the health services provided by these entities, as well as the role of social control (Fabriz, 2017; Mathias & Oliveira, 2019). HCI are not solely focused on service delivery but also on addressing the broader needs of society.

It is important to emphasize that, in addition to being public structures aimed at achieving social outcomes, HCI are also understood as new entities formed through municipal cooperation. Their organizational structure includes actors—such as the assembly, president, executive secretary, and fiscal council—who interact in situations that may not always be cooperative and can sometimes involve conflict (Gerigk & Pessali, 2014).

4 Methodological Procedures

According to the Minas Gerais State Health Department (SES-MG), in 2021, there were 74 active HCI, of which 64 were generalist and 10 thematic (linked to the Mobile Emergency Care Service - SAMU), encompassing more than 90% of the state's municipalities and serving a population exceeding 20 million inhabitants. In April of the same year, according to SES, nine inter-municipal health consortia were operating in the Zona da Mata mesoregion, eight generalists and one thematic.

This study analyzed 134 municipalities associated with HCI in Minas Gerais' Zona da Mata mesoregion. This mesoregion was selected because it reflects a key characteristic of the state of Minas Gerais: the heterogeneity among its municipalities.

Thirty-three contracts (including memorandums of understanding, bylaws, apportionment agreements, and program contracts) were analyzed to comprehend the governance structure of the aforementioned HCI. These documents were obtained from consortia websites or via telephone or email requests between January and March 2021.

Ten interviews were held with managers from eight of the nine HCI in the Zona da Mata region of Minas Gerais to understand these agreements and the contextual factors shaping Brazilian public administration that may influence municipal cooperation. Among the respondents, six were executive secretaries, two were administrative managers, and two were mayors. The interviews, conducted in July 2021, followed a semi-structured script. A literature review on consortia was also performed to support the data analysis.

This study was authorized and registered with the hosting Institutional Review Board through the Certificate of Presentation of Ethical Appreciation (CAAE) under No. 39277220.9.0000.5153.

Data analysis and interpretation were conducted using categorical content analysis with a mixed grid (Bardin, 2011). Predefined categories were established based on the theoretical framework, while additional categories emerged from the empirical analysis (Table 1).

table 1
Categories of Analysis

Contextual Factors	Incentives for cooperation	Potential benefits of joint action, characteristics of the federative pact, incentives from government levels (state and federal) and models of personalistic or bureaucratic public administration	Kissler and Heidemann (2006), Abrucio et al. (2013), Diniz Filho, (2013), Filippim and Abrucio (2016), Bevir (2017), Silva et al. (2017), Ismael (2018), Flexa and Barbastefano (2020), Lui and Schabbach (2020), Marroni et al. (2021), Nascimento et al. (2021), Fernandes et al. (2020), Fernandes et al. (2023), Domingos et al. (2019)
	Obstacles to consortium	Self-governing municipalism, risk of opportunistic behavior, managerial public administration model, heterogeneity among participants.	
Consortium structure and instruments	Structure	Set of bodies and positions r elated to the consortium's governance	Kissler and Heidemann (2006), Denhardt (2012), Capano et al. (2015), Martins et al. (2020)
	Instruments and rules	Contracts, standards and rules for accountability	
	Deliberation	Forms of deliberation and participation of those involved	
	Relationships	Forms and means of communication of the IHC and between the consortium municipalities	
Actors	Functions and responsibilities	Identification of the responsible actors and what roles they perform	Kissler and Heidemann (2006), Denhardt (2012), Capano et al. (2015), Martins et al. (2020)
	Involvement	Mode of participation and level of engagement	

Source: developed by the authors.

The categories were selected because they align with the study's objective: to understand the role of IHC in Minas Gerais's Zona da Mata region in facilitating joint action between municipalities. In this context, analyzing the factors that drive the formation of IHC and those that influence the dynamics of their relationships is crucial, as these factors may highlight the dichotomy between cooperation and competition within the public sphere (Abrucio *et al.*, 2013). Additionally, the analysis may reveal the system of checks and balances that limits opportunistic actions through participation and control mechanisms. Structural and compositional elements of IHC are also essential for understanding management and governance, as they shed light on the presence of various actors, each with distinct roles and responsibilities (Denhardt, 2012).

4.1 Results and Discussion

4.1.1 Incentives and obstacles to public consortium

The responsibility municipalities assume for healthcare delivery originates from the Federal Constitution of 1988, which pressured municipal management to secure resources and establish structures despite the centralization of revenue collection by the states and the Union. IHC emerged as a strategy to mitigate these challenges (Report 1).

> Consortia are actually the primary means for solving municipal problems today. Currently, we have a federal pact that exonerates the municipality in terms of responsibility and relieves it in terms of taxes [...]. So, consortia appear to be an instrument for strengthening negotiations as a whole (Report 1).

If the federative pact pushes municipalities to form consortia out of necessity, it also does so through political incentives. Incentives for forming consortia include those from federal and state governments (Teixeira & Dowell, 2002; Leal et al., 2019), gains in efficiency and scale (Amaral & Blatt, 2011), and the feasibility of providing services in contexts where a municipality alone would be unable to fulfill its constitutional obligations (Flexa & Barbastefano, 2020).

Leal *et al.* (2019) analyzed the factors driving the increase in the number of IHC in the State of Pernambuco, Brazil. Similar to Minas Gerais, the focus of this study, the authors highlight that the expansion of consortia in Pernambuco is primarily attributed to the need to enhance efficiency in health service delivery, address resource constraints in smaller municipalities, and promote equitable access to health services across different regions of the state.

Since 1995, consortia have been encouraged in Minas Gerais. In 2003, the relationships among stakeholders were regulated (SES/MG Resolution No. 0353/2003), and in 2009, the State Program for Strengthening Inter-municipal Health Consortia in Minas Gerais (Procis) was consolidated (Diniz Filho, 2013).

These factors encourage cooperative municipalism and promote regionalized action by local authorities. As noted in Report 2, consortia achieve results that would be unattainable through the isolated efforts of individual municipalities, particularly smaller ones.

> The consortium is crucial, particularly for small municipalities, you know […] providing adequate healthcare in a small municipality is challenging without being a consortium member. We consider a consortium to be a highly important tool due to its inherent logic you know. See, bringing together multiple municipalities allows for purchasing in larger volumes at reduced costs. It is different when a single municipality makes individual purchases instead of several municipalities buying together. So, we can access procedures at significantly lower prices (Report 2).

Although larger municipalities with large populations and high revenues could provide such services independently, the additional benefits of collective action, such as reducing idle capacity (scale gains) and offering specialized services (scope gains), encourage the formation of consortia. These benefits serve as incentives for establishing and maintaining cooperation, aligning with the suggestions of Flexa & Barbastefano (2020) and as outlined in Report 3.

> I think that the consortium represented progress on several fronts. First, it increased the number of exams, consultations, and procedures performed. Second, it reduced costs by enabling regular product acquisition through the consortium. Additionally, investments led to a greater and improved number of devices, resulting in more accurate diagnoses (Report 3).

Supply management is also undertaken by the IHC, alleviating the burden on municipal governments while generating benefits in specialization and management. These advantages align with the managerial discourse promoted by the *Nova Administração* Pública [New Public Administration]. The adoption of this school of thought, particularly by mayors, can facilitate the establishment of consortia and influence their operational dynamics. The influence of New Public Management principles—economy, efficiency, and flexibility—is evident in documents such as statutes and protocols of intent, where business-oriented terms like "efficiency," "economy," and "establishment of partnerships" are explicitly emphasized.

Similarly, Galindo *et al.* (2014) observed that the organizational policy of the Inter-municipal Health Consortium of Sertão do Araripe, Pernambuco (Cisape) was in transition, reflecting management-focused characteristics in its structure. These included a reduction in the sphere of control through empowerment and a concentration of authority within a hierarchy of competencies.

Thus, the characteristics of the Brazilian federative pact—decentralization of responsibilities combined with the centralization of revenue collection—and the initiatives of the state of Minas Gerais, along with the potential benefits of consortia, promote the establishment of these structures. Nevertheless, there remain challenges to their creation and sustainability.

Although IHC operate cooperatively, they may also involve competition, as each municipality seeks independence and autonomy—characteristics typical of autonomous municipalism. As a result, contextual incentives for the creation of IHC may be insufficient to sustain cooperation or may limit it to a merely formal level.

Pereira *et al.* (2020) highlighted elements that align with the discussion presented here. In their analysis of health regionalization in Minas Gerais, the authors emphasized that, while regionalization is considered a vital strategy for improving the organization and delivery of health services, numerous challenges undermine its effectiveness. Chief among these obstacles are the difficulties in coordination between different levels of government and among the municipalities themselves.

Ribeiro and Costa (2000) also identified obstacles arising from "typical problems of governability," such as the appropriation of political benefits, which increases the risk of opportunism (e.g., by mayors). These challenges include conflicts among members, lack of commitment to the consortium, and other difficulties associated with "autonomous municipalism." Reports 4 and 5 highlight similar situations observed in IHCs in the Zona da Mata region of Minas Gerais:

> Clearly, municipalities have very different interests regarding the consortium. In 2021, several mayors were not reelected, bringing a political framework different from that before 2020. As people start to actively participate in the consortium and fully understand its purpose and role, their perspectives begin to shift. However, there is still a noticeable difference in how many of them approach it (Report 04).

> During elections, municipalities often want to [...]; one might aim to become the president, leading to disagreements [...]. Following the elections, the newly elected president may attempt to interfere in the consortium's actions—often in ways that shouldn't involve political influence, such as appointing allies to positions or favoring certain individuals. This is a common issue in municipalities, and sometimes this mindset carries over to the consortium. They may view the consortium as a tool for their own benefit, rather than focusing on the broader perspective. We, however, maintain a more comprehensive outlook, considering the whole rather than just the needs of a single municipality. Municipalities often prioritize actions that serve their own interests, seeking visible results or media attention, and this political approach can sometimes clash with the consortium's broader objectives (Report 5).

Thus, certain factors may work against the essence of IHC formation—uniting efforts and fostering partnerships for the joint provision of health services—and instead promote isolation or non-cooperation. Differences in political influence, municipality size, contribution amounts, and inter-federative relationships can lead to individual municipalities' particular interests and needs taking precedence over shared goals (Nascimento *et al.*, 2021) (Reports 6 and 7):

> **Have you ever witnessed divergent interests in a consortium?**
> Yes, when a new member joined the consortium and political influence prevailed (Report 6).

> To be quite honest, when (NAME OF MUNICIPALITY HIDDEN) manages the consortium [...], even because (NAME OF MUNICIPALITY HIDDEN) represents 58% of the resources here and the population is much larger. But when he manages the consortium, he takes a stand like he deserves more, you know? (Report 7).

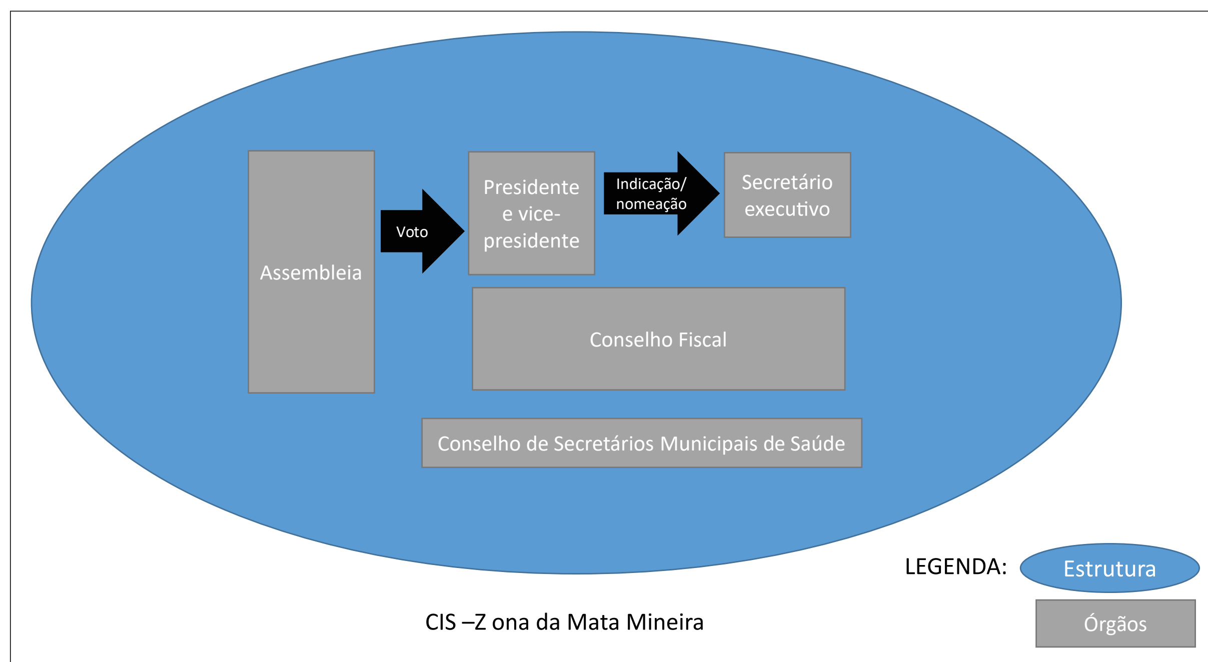
As political actors, mayors may be incentivized toward opportunistic behavior, such as using the consortium to increase regional influence or strengthen their position within their municipality by directing the consortium's actions to serve their interests (Report 7). However, for cooperation to succeed, it is essential to address these challenges by establishing structures and mechanisms that ensure participation and control. Such safeguards are necessary to prevent mutual trust from deteriorating otherwise the cost of maintaining cooperation may become unsustainably high.

Effective governance is essential to address these differences and ensure the continuity and viability of the consortium (Nascimento et al., 2021). This governance must respect heterogeneity and promote robust internal management. Accordingly, the agreements must account for each municipality's specific characteristics, ensuring equitable treatment and accommodating their demands while acknowledging their limitations.

4.1.2 Ensuring cooperation: consortium structure and instruments to resolve conflicts and strengthen the common objective

The governance elements reflect the identification of the entities and agents within the IHC that must collaborate to enable collective action. Understanding their roles and responsibilities reveals an initial "layer" of structure aimed at safeguarding cooperation from opportunistic behavior and aligning activities with the intended purpose—promoting medium- and high-complexity healthcare services in municipalities.

Documentary analysis revealed a common structure within the IHC in the Zona da Mata region of Minas Gerais, which includes an assembly, a president, an executive secretary, a fiscal council, and a council of municipal health secretaries (comprising the health secretaries from the consortium's municipalities) (Figure 1).



Translate: Assembly; Vote; President and Vice-President; Nomination; Executive Secretary; Fiscal Council; Council of Municipal Health Secretaries

Source: developed by the authors

Figure 1. Actors/bodies that form the basic structure of the IHC in Zona da Mata – MG

The assembly (formed by the heads of the Executive Branch of each of the consortium members) is responsible for the main decisions of the IHC, including electing, by vote, the president and representatives of the fiscal council, approving the appointment of the executive secretary, deliberating on changes to regulations (bylaws, contracts) and the accounts of the IHC. The president (a member of the assembly elected by peers) is responsible for representing and responding to the consortium in various instances, in addition to seeking partnerships and appointing the executive secretary, who (appointed by the president and approved by the assembly) acts as the manager of the IHC, based on the demands of the assembly, the president and the councils. The fiscal council (composed of members of the assembly elected by peers) monitors and supervises the IHC, obtaining information on the accounts and the decisions of the president and secretary.

Report 8 describes the structure from the perspective of an interviewee.

> The CONSORTIUM has its own councils; we follow a rule, a general line for consortia, through a council of municipal health secretaries and a fiscal council. As I already mentioned, the Council of Municipal Health Secretaries dictates the policies to be followed by the consortium—the fiscal council, which exercises control *per se*. Moreover, the Council of Mayors (assembly) is a legal body that gives legality to our acts. It creates resolutions similar to a city council that creates laws, you know, and votes on laws. So, to be more precise, our council [assembly] approves the bylaws and statutory changes to the protocol of the public consortium contract. In short, it issues the resolutions. This is the consortium's line, and, as far as we know, it is very similar to most of them (Report 8).

The existence of the secretaries' councils is noteworthy, as it provides a platform for technical discussions aimed at both guiding the assembly and overseeing the consortium's management.

Communication methods also serve to reduce information asymmetry and facilitate decision-making. Document analysis revealed that traditional channels, such as bulletin boards and e-mail/fax, were initially used. However, reports indicated the existence of synchronous and informal communication channels. In most of the IHC (seven of the eight analyzed), communication now incorporates web systems and platforms: "There, through the WhatsApp group, and published in the official gazette, the website... (Report 9)."

As reported by one of the representatives in an IHC (Report 10), more significant informal interaction can help strengthen ties and, through mutual knowledge, increase social capital, avoid communication problems, and promote learning. It is worth noting that the managers are the organizers of the meeting, which reveals the convergence with the consortium's collective nature, which can contribute to favoring regional integration beyond its purpose in health.

> We have a monthly and itinerant assembly with mayors, which is always held on the last Friday of each month. So, each month, we go to a different municipality, and then we start with breakfast, hold a meeting, and end it with lunch. It is a get-together, a time to exchange ideas, a connection between them, which significantly strengthens joint actions, the exchange of help, you know? So we have this practice here; it has been our peculiarity since the beginning of the consortium's foundation (Report 10).

Participation, deliberation, and accountability must also be considered structure elements.

Participation in the consortium entities primarily occurs through voting, with each member entitled to a vote. All protocols and statutes reference the rights and duties of consortium members, as established in Art. 4 of Law No. 11,107, dated April 6, 2005 (*Lei de Consórcios Públicos*). The accountability system, requiring the executive secretary and the president to report to the assembly, with oversight by the fiscal council, serves as a mechanism to mitigate political influence and opportunistic behavior.

However, voting does not necessarily guarantee effective equity (Shleifer & Vishny, 1997), particularly given disparities in resource capacity and health service demands. While voting is a fundamental mechanism in democratic processes, it may fail to achieve genuine equity and balance in complex contexts such as public consortia (Gerick & Pessali, 2014).

Even though IHC differ from private structures—where shareholders invest with the expectation of returns proportional to their shares—there may be instances where those contributing more may demand even greater access to services, potentially affecting the relationships within the consortium. This heterogeneity among municipalities, particularly the dominance of larger municipalities or those with more decisive political leadership over smaller ones or those lacking political capital, poses a risk of imbalance and a source of opportunism.

Instruments are required to balance participants' demands and capacities. Two key tools stand out: apportionment agreements and program contracts, which help resolve conflicts over which services will be offered. These agreements are established between the IHC and each participating entity to determine each municipality's financial contribution to the consortium and the specific actions contracted with the IHC. As such, these contracts serve as mechanisms to equalize differences, enabling the adjustment of varying demands through tailored approaches.

Interviews revealed that in six consortium members, apportionment contracts are determined based on the number of inhabitants (municipal population) or the Municipal Participation Fund coefficient. This approach aligns contribution capacity with receiving resources from the federative pact rather than the municipality's revenue. On the other hand, program contracts are tailored individually for all eight members, considering the medium- and high-complexity health services each municipality deems necessary for its population. Each municipality contracts only for the services it will utilize.

The protocols of intent and statutes of the consortia are also noteworthy for emphasizing partnerships, which can be understood as municipal governments' collective objectives to achieve contracting flexibility beyond the constraints of direct public administration. Reports confirmed that IHC can establish outsourced partnerships (Report 11).

> There is a requirement for the professionals hired, the specialists, to have a degree. High-quality outsourced services are hired to offer countless procedures, whether in gastroenterology, ophthalmology, imaging, resonance, tomography, and many other imaging exams, which are countless. So, we seek these partners to perform outside the walls, which is what we do not have to offer here (Report 11).

4.1.3 Actors' actions: mayors, executive secretaries, and health secretaries

For cooperation to endure, consortia must effectively capitalize on potential benefits and continuously adapt their dynamics. This section delves into accounts of the everyday functioning of IHC, extending beyond their structure and instruments.

The documents (statute, apportionment agreement, and program agreement) emphasize control as a means of safeguarding the interests of the IHC and its stakeholders while limiting opportunistic behavior. Interviews revealed that this control is underpinned by trust among peers and is primarily grounded in a technical perspective from municipal health secretaries' councils. Notably, differences in how consortia activities are monitored can be observed across the following structures: the assembly (comprising all mayors), the fiscal council (composed of a subset of mayors), and the council of health secretaries.

Mayors, including those serving on the fiscal council, often lack a deeper understanding of the IHC's decisions, suggesting room for improvement in the oversight process. However, this also indicates a degree of trust in the relationships within the consortium. In some cases, the fiscal council was described as underdeveloped, with meetings functioning more as a statutory formality than as a meaningful oversight mechanism, as noted in Report 12.

> The fiscal council rarely meets. Getting the mayor to review the accounts is very difficult, even though it is mandatory to present an accounting report every six months. We call it an accounting report, where we show the council what is happening. We present the balance, the expenditures, the commitment notes, and all the procedures that need attention (Report 12).

It is important to emphasize that delegation—decentralizing decision-making to municipal health secretaries—does not imply negligence or invite moral judgment. One of the key benefits of the consortium is its ability to absorb part of the responsibilities of the municipal executive structure, effectively "freeing" mayors to focus on their roles as heads of the municipal executive.

Mayors, primarily through the assembly or, in some cases, the fiscal council, tend to play a more peripheral role, generally endorsing regulations, opinions, and decisions made by the council of secretaries. This indicates a "delegating behavior" that is less participatory, with mayors focusing more on political actions within the IHC.

Delegating behavior also highlights a focus on isolated political actions, underscoring that while consortia represent an effort to break away from the individualistic paradigm, they remain insufficient to extend into other dimensions and overcome the challenges posed by heterogeneity, competitive federalism, and autonomous municipalism.

The Council of Municipal Health Secretaries is regarded as a technical body focused on health-related decisions, such as hiring physicians, purchasing equipment, and assessing the feasibility of offering new specialties. The interviews revealed that these councils are active and must be consulted before any deliberation in the assembly, which typically unanimously approves the recommendations made by the municipal health secretaries (Report 13).

> We have a council of municipal health secretaries that also meets monthly, and, actually, all the health guidelines we have are included in the council of secretaries. [...] So, the council (of health) is the one that deliberates on health actions and gives us the direction of what we need to develop, hire, undo hiring, or modify. So, the guidelines are really theirs. (Report 13).

Regarding the objective of this study, the closer involvement of the council of secretaries compared to that of the mayors highlights key elements of the dynamics within the IHC.

The greater involvement of health secretaries, coupled with the relative distance of mayors and their limited engagement in key technical decisions, reflects the managerial character of IHC. This "delegating behavior," even if unintentional, reinforces the health sector's technical specificity while diminishing the consortium's political nature. The fiscal council's focus on technical decisions and oversight highlights the mayors' more specific and limited participation, primarily during assemblies.

The nature of delivering health services through collective action was most prominently reflected in the protocols of intent and statutes. As foundational agreements of the consortium, these documents outline the objectives, functions, and representational intentions of the IHC (Abrucio *et al.*, 2013; Gerigk & Pessali, 2014). Interviewees corroborated these elements, emphasizing responsibility, the pursuit of collective objectives, and the importance of partnerships.

The unique characteristics of each municipality, as previously noted, are accommodated through apportionment and program contracts. Additionally, representatives emphasize that this heterogeneity is acknowledged, and disregarding it could jeopardize the feasibility of cooperation.

We asked whether any municipality held greater influence over others within the IHC. While some cases in the reports suggested such instances, the predominant finding was that no municipality had a greater influence within the consortium. Managers (executive secretaries) expressed a clear commitment to maintaining the consortium as a collective entity, ensuring that all municipalities contribute equally to the IHC while preserving its collaborative nature (Report 14).

> Interviewee: No, we have never allowed this [difference between municipalities] to happen. In the assembly, votes have the same weight, and the location of the headquarters is chosen for strategic reasons. It is not the largest municipality; it is one of the largest; it is a hub, but it is not the largest. And it is always like this when there is an election... one of the largest municipalities or the headquarters municipality, the new manager [president] usually thinks he is the master of the situation, but later, he realizes he is not. So, we always take this political issue very seriously, ensuring everyone has the same weight within the consortium. We have experience much interference or problems with this (Report 14).

Mayors, health secretaries, and executive secretaries play distinct roles within the consortia's structure, each contributing to its legitimacy in specific ways. Mayors provide institutional legitimacy, health secretaries bring technical expertise, and executive secretaries ensure collective interests are respected.

4.1.4 Summary Report

The structure and instruments designed to ensure cooperation are not self-operating. On the contrary, their effectiveness depends on adherence to functions and rules to ensure that "institutions function." One report encapsulates these concerns (Report 15).

> So, in the previous administration, when the mayor of (NAME OF MUNICIPALITY HIDDEN) took office, he joined the consortium thinking that it was part of (NAME OF MUNICIPALITY HIDDEN). He thought the consortium belonged to (NAME OF MUNICIPALITY HIDDEN). He had no idea that it was only headquartered here and that it belonged to all municipalities. He thought it was just his. So, he wanted to be president at any cost, but the mayors did not accept it. And then he wanted to leave the consortium; he did not contribute for a while, he got angry [...], until he found out about it, came back, contributed, you know, participated in the consortium, and continued to be a member of the consortium for the first year. In the second year, he wanted to be president, and then, in a meeting, they accepted that he would be president, but he practically broke the consortium within almost six months. For the first time, the consortium could not meet all its commitments at the end of the year because, in less than six months, it practically went bankrupt precisely because he brought the political dimension into the consortium. We held a meeting [...] in the middle of the year. Look how important meetings are! We held a meeting, and I, as executive secretary, showed the consortium's financial situation. I said we were going bankrupt and would go bankrupt by the end of the year. The mayors decided and fired many people, people who had joined but were useless, for political positions, and so on. The consortium barely made it to the end of the year. So, what happened? He wanted to be reelected. But, the members did not accept his reelection. As the president, he did not even accept that meeting to finish, the meeting was closed right there and then. We were left without a president. As the executive secretary, I held a meeting. I called a meeting because the statute allowed me to. In that meeting, we unanimously elected a new president – without the current president's consent, he was still president— for the next term. So a new president was chosen because the assembly is sovereign, the president has power, but his power lasts until the end of the year, and the assembly is even more powerful than the president because the members are all the owners of the consortium, you know, all the municipalities. So that was done; a new president was appointed, and he simply cooled off and removed the municipality from the consortium. (Report 15).

The case describes an instance of opportunistic behavior by a mayor who repeatedly attempted to take over the presidency without fulfilling the municipality's financial obligations to the consortium. After eventually being elected president, the mayor distorted the consortium's purpose, leading to serious financial issues for the IHC. The response came from the executive secretary (as an agent) and the assembly, which dismissed individuals hired for political reasons. Subsequently, due to the president's resistance to a new election, the executive secretary, acting by the statute, convened a new assembly where a new president was elected and sworn in.

In summary, the institutions (statute, assembly, and executive secretariat) operated as checks and balances to deter opportunistic behavior and provide mechanisms for conflict resolution, thereby ensuring cooperation. Opportunistic actions were curtailed by the response of a structure designed to uphold collective action. From this perspective, the role of the manager was also highlighted. With extensive experience at the IHC and a clear understanding of his responsibilities as executive secretary, the manager took the initiative and implemented measures to prioritize the collective interest, effectively acting as a guarantor of the IHC's objectives.

Still considering the characteristics and contextual elements in which IHC are formed, these structures represent public arrangements that potentially reflect patrimonialist, bureaucratic, and managerial models (Fabriz, 2017; Lui & Schabbach, 2020; Mathias & Oliveira, 2019). The patrimonialist model is evident in the inherent duality of interests (public and private) embedded within the arrangement. The bureaucratic model is reflected in the presence of formal structures and regulations. Meanwhile, the managerial model is characterized by efforts to develop a flexible structure to achieve results, particularly in delivering medium- and high-complexity public health services (Denhardt & Catlaw, 2017).

Thus, consortia can be understood as:

- a forum and agent to promote integration between consortium members and other actors with a view to institutional development and regional development in the health sector; and
- guided by efficiency and economy of resources (human, financial, and material), in addition to acting to obtain resources via partnerships with public and private entities for investments of regional interest in the health sector.

5 Final Considerations

This study aimed to understand the role of IHC in the Zona da Mata region of Minas Gerais, Brazil in facilitating joint action among public entities. To establish a foundation, elements of the federative pact, autonomous municipalism, and public management models were examined. An analysis of empirical data from documents and interviews revealed factors that both promote and constrain cooperation, the institutions that shape IHC (structures and standards), and accounts of situations where these mechanisms curbed opportunistic behavior and enabled the potential benefits of consortia.

Although designed as instruments to facilitate the provision of medium- to high-complexity public health services and to overcome local barriers, IHC in the Zona da Mata region of Minas Gerais still face challenges that hinder cooperation. These challenges include autonomous municipalism, competitive federalism, bureaucratic public administration models, heterogeneity among municipalities, and the risk of opportunistic behavior. While the IHC members in this mesoregion strive to mitigate these risks and phenomena, they have not yet fully overcome them. To reduce the risk of opportunistic behavior and conflicts that could weaken cooperation, IHC have implemented mechanisms such as instruments for mutual adjustment (apportionment and program contracts), arenas for technical debate (council of health secretaries), and joint deliberation platforms (assembly), along with oversight controls like the fiscal council. The actions of executive secretaries (managers) demonstrated significant dedication to preserving the collectivist nature of the entity.

In summary, inter-municipal health consortia are governance structures aimed at integrating participants whose dynamics and managerial logic prevail. They are institutionally legitimized by the participation of local executives. Although no spillovers to other areas of joint action at the regional level have been observed, the health consortia of Zona da Mata in Minas Gerais illustrate an institutional form of cooperation between public entities of direct administration.

Limiting factors include the reliance on documents that have already been formalized and entities that are already established. Studies focusing on the creation process could uncover challenges specific to the formative stages and the initial phases of operation.

As a means of improvement and future studies, we suggest a debate on greater participation by civil society (democratic public governance) and the importance of considering the dynamics of IHC in terms of management and relationships at the regional level. Comparative studies between health consortia and other sectors and between different states can reveal relevant aspects for a broader understanding of cooperation in the public sphere.

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