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Regionalization in the SUS: implementation process, challenges and perspectives in the critical view of system managers

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Abstract *This article examines the regionalization process in the Brazilian Health System, identifying frameworks and challenges of this process from critical dialogue on the subject, contextualized by the experience of the management system and in the light of an established theoretical debate in the last decade. We used the thematic content analysis of legal and documentary surveys of the regionalization process in SUS, collated by elements of the historical and political context in the period. As evidence, it appears that the regionalization process has been incremental decentralization/deconcentration of management and health actions and services. There are important challenges, particularly in relation to ensuring access and system governance structure, which contributes to critical thinking and construction of new perspectives by those who lead their implementation.*

Key words *Regionalization, Unified Health System, Management of the SUS, Interfederative articulation, Health policy*

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Introduction

As established in the Brazilian Federal Constitution, health actions and services are of public relevance and should be made available to the population in a regionalized and hierarchical way, with comprehensive care provided to people across the Brazilian territory, both in preventive and care actions. This system should be managed in decentralized fashion and with a unique direction in each government sphere of, establishing a system based on community participation in its development and implementation process[1].

The Health Organic Law published in 1990 as part of the normative framework that underpins the SUS and deals with its principles and guidelines, identifies as part of the process of political-administrative decentralization the regionalization and hierarchization of the health services network, established at levels of increasing complexity and that can be complemented by private services through the need to ensure these principles in full[2].

Santos & Andrade[3] say that the SUS is the ultimate example of cooperative federalism, where interests are common and inseparable and should be harmonized on behalf of local, regional, state and national interests. In SUS federalism, all should be holders of the interests underlying the public health issue and must ensure the single direction of the system, while preserving its autonomy. Paim & Teixeira[4] mention that the system management's institutionalization process can be characterized as a decentralization / centralization pendulum movement governed by the effort to implant the federative pact incorporated into the Federal Constitution of 1988.

This process, basically initiated in 1991 with the publication of the basic operational standards (NOB)[5-7], progressively established the strategies for the organization and functioning of the system through a process of political-administrative decentralization, whose emphasis was on different modalities of qualification of states and municipalities, types of services and modalities of financing, paving the way for the introduction of the health care operational standard (NOAS)[8] in 2001, whose main organizational contribution to the system was the establishment of rules for the regionalization process of health actions and services.

As of the 2000s, with the need to advance the consolidation of population access to health services and actions of greater complexity, the regionalization of services becomes imperative. The launching of the Health Pact[9] in 2006, with its developments for states and municipalities, and the enactment of Decree No. 7.508[10], of June 28, 2011, however, resume regionalization from the point of view of political agreements between managers in the organization of the system and provide a scale-up of this agenda in the management agenda, expanding the role of the Interagency Commissions[11] at the regional level and strengthening the logic of integrated planning, embodied through the Public Action Organizational Contract (COAP) and the Health Region as an effective setting for its operationalization[11,12].

Decree 7508/11, among other things, complies with the constitutional determination that the SUS should be established by a regionalized and hierarchical network and that its "health regions" should organize themselves to provide at least PHC, urgent and emergency care, psychosocial care, specialized outpatient and hospital care and health surveillance actions[10], explaining the complementarity between these actions to ensure, at a minimum, comprehensive care in a timely manner.

Among the set of relevant aspects of the Decree, the definition of primary care as the priority gateway of the system can be highlighted from the organizational point of view; and the establishment of new SUS planning devices, understood as bottom-up and integrated, guided by health needs and availability of resources, inducing the organization of care networks[11], favoring the main lines of care that sum up the efforts of states and municipalities to ensure a regionalized access to health[13-17].

Carvalho et al.[18], analyzing the highlighted process, explain that the recent construction of the Health Pact and its improvement with the enactment of Decree 7508/11, which regulates aspects of Law 8080/90, is based on respect for the constitutional principles of the SUS, with emphasis on the health needs of the population, which implies the simultaneous exercise of the definition of articulated and integrated priorities aiming at improving access to health services and actions, strengthening regional planning with the consequent definition of care networks in the health regions, the improvement of governance mechanisms and the qualification of tripartite pacts[19].

Recent studies[20-26] developed with the perspective of analyzing the regionalization of the SUS demonstrate that this process has been constructed, from a technical and political point of

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view, with the effective participation of state and municipality managers, while focused on the induction of the Federal Manager and developed in complex and often conflictive institutionality and governance processes, established through relations between the different levels of government and between these and citizens and the various segments of society, of public or private nature.

It can be seen that in this process, among other things, tools and mechanisms for planning, managing and financing health actions and services have been built over time, aiming at the provision and organization of a regionalized system[27-31], indicating as a starting point the identification of demands and health needs of the population, as well as the establishment of care flows of services for the establishment of care networks, built from reference potentials and distinct typologies[32-34].

A perspective of integration of governmental activities is also perceived in the areas of health care, economy and social policies, aiming at mitigating regional inequities in the process of formulating and implementing sector policies[13,35,36].

Hence, while being influenced by socioeconomic dynamics, the regionalization process is also influenced by the cycles of implantation / implementation of policies and the level of articulation / cooperation among the social stakeholders that are components of the sector's governance spaces. There is a self-referential process that relies on the theoretical references, interests and projects in which they are involved and active[4], based on these stakeholders' capacity to generate consensus on shared responsibilities and to build regional designs that aim to ensure access to health services and actions[20-23,37].

Even with the specific features of the SUS, the trends of the Brazilian health regionalization follow the processes established in different countries regarding the need for coordinated management of actions and services, especially in terms of governance, planning and programming, personnel qualification and training, the development of professional networks, as well as exercises of mutual coping in the event of catastrophes and the operation of urgent/emergency services, including access to high-cost technologies and drugs[38-40]. According to these studies, this has allowed for a more efficient use of resources and better coordination and progress of the sector in comparative analyzes[41].

Considering that the problem of regionalization in the SUS implies understanding the challenges and possibilities found by managers in relation to the new responsibilities planned in the construction of this process, it is necessary to further expand knowledge in its conceptual and evolutionary aspects in the scope of the SUS management.

Therefore, we worked on the construction of this paper identifying aspects related to the establishment of frameworks and limits of the health regionalization process, using as a starting point the test of a critical dialogue on the subject and, finally, a first approximation to the experience lived in the management of the System during the period 2010-2015, which ensued this work, aiming to contribute in pointing out some still pending challenges.

Methodology

We used thematic content analysis[42] for normative and documentary surveys on the process of regionalization in the SUS, collated by historical and political contextualization elements in the period, allowing to aggregate knowledge about the object studied and its relations beyond what may be explicit. It should be noted that this technique has its limitations, among which we highlight the potentially contaminated view of the observer, with its "preconceptions", biasing the results. However, the study aimed to highlight the views of managers, which could somehow contribute to the progress of the regionalization process in the day-to-day management.

The main data sources were restricted circulation documents of the Department of Interfederative Articulation of the Strategic and Participatory Management Secretariat (DAI/ SGEP/ MS)[43,44], with institutional authorization to use for study purposes.

The first document[43] concerns the consolidated report of a cycle of debates produced at the time of transition from the Health Pact process[9] to Decree 7.508/11[10], whose objective was to understand the concerns related to the management processes linked to the system's regionalization and which brings about the views of state and municipal technicians and managers; representatives of all the State Health Secretariats (SES) and all Municipal Health Secretariats (COSEMS) were invited in each State, in five different moments, within one month. Guests should show the state of the art of the regionalization process in their states, from the reference to its importance, as a structuring guideline of decentralized

actions and services; the parameters that guided the configuration of the regions and the establishment of the respective regional management collegiates; how to ensure "governance" of a health region, given the federalist characteristics of the country; and concerns and challenges regarding the process.

The second document[44] addresses the report of an institutional survey conducted in 2014, based on a selected sample of national technicians, managers and advisors, composed of five members from the federal, state and municipal levels, directly linked to the national pacts process, aiming at elaborating a diagnosis about the process of regionalization in the SUS from the perspective of governance, in order to point out ways for its qualification and improvement. Individual interviews, guided by a previously prepared script, were applied to five members of the National Health Council, leaders of five secretariats of the Ministry of Health; five members of the National Council of Health Secretariats (CONASS) and the National Council of Municipal Health Secretariats (CONASEMS); and three focal groups, composed of technicians and advisors of the managers to the process of national agreement.

Individual interviews sought to approach from the understanding of the regionalization process in the organization of the health system to future perspectives for the governance process, in a context of shared management, perception regarding the incorporation of health needs and management in the planning process; relationship among agreement bodies and with the institutionalized social control bodies.

The focal groups were also guided by a set of issues where it was possible to approach the perception about the process of health regionalization and its governance-oriented institutionalization mechanisms; the relationships of the various stakeholders in the development of governance in the SUS: interagency commissions, social control bodies and other social participation mechanisms; the governance process and decision-making in integrated regional planning, with the consequent agreement of healthcare responsibilities among the federated entities, the regional challenges and, finally, the future prospects of this process.

The findings with respect to these two processes, induced by the federal manager, were systematized in two analytical matrices, whose discoveries summarize the findings until then (Matrix 1), as well as the limits and perspectives (Matrix 2) of this process, before the system managers' take on the subject at hand. The matrices were guided by four thematic categories synergistically linked to the concept underlying the idea of health system regionalization, as a structuring guideline for the decentralization of actions and services in the SUS; to its actual implementation, identifying mechanisms and instruments that guide daily practice through the configuration of regions and the establishment of the regionalized service network, governance structure and the role of managers in the regionalization process of the SUS; and, finally, the perspectives that open possibilities in the reading of concerns and challenges before the established regionalization process. The split into two matrices aims at establishing a time frame, in order to make challenges to be faced in the process of regionalization more visible, as a structuring guideline of the SUS.

Ethical issues were also observed, in accordance with CNS Resolution n. 196/96, as well as those relating to authors' conflicts of interest.

Results and discussion

From the perspective of the leading figures of the system management, captured from the *Cycle of Debates about the Regionalization Process in the context of Interfederative Management of the SUS*[43] and the *Institutional Survey on Regional Governance in the SUS*[44], the following matrixes were elaborated.

Based on Chart 1, it is evident that regionalization can be considered as a structuring guideline for the decentralization of health actions and services in the SUS, based on the perspective of ensuring the right to health through resolute and equitable access of the population to health actions and services provided by the health system[23,25,36]. This is a process in progress since the Organic Health Law, encompasses the operational norms and the Health Pact and is not something that begins or is even renewed a priori with Decree 7508/11[18,26].

It is worth noting the various interpretations of which Decree 7508/11 implying the development of contradictory or even ambiguous strategies, especially the Organizing Contract for Public Action (COAP), which has had a very localized development in the country, evidencing deficiencies in the basic instruments and tools linked to the SUS planning and evaluation process[31,44].

Even with the normative advances and the efforts of the managers in the system, regional-

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Quadro 1. Evidências temáticas do processo de regionalização, segundo os achados da análise documental.

Thematic category	Cycle of Debates	Institutional Research
Regionalization as a structuring guideline for the decentralization of actions and services in the SUS	• To ensure the right to health, promoting equity and contributing to the reduction of social inequalities; • To reduce care gaps; to organize health care actions and services in a care network; to ensure resolving access; to direct investments; • To allow a solidary, cooperative management, sharing responsibilities; to strengthen the process of decentralization and the role of the state and municipalities and intensify negotiation and agreement among managers.	• The regionalization is legally based in Law 8.080/1990, developed by means of Operational Norms and Decree 7.508 2011 and its complementary devices; • Regionalization is not yet in the effective agenda management of the system; • It must be considered that some States have advanced in the issue of the regionalization of care, and that there are different movements in the country. • The health regionalization model has been constructed in a detached way from the other processes of regionalization; • It is only possible to progress in the regionalization process by re-discussing the SUS financing model.
Configuration of the regions and establishment of the regionalized service network	• The aspects taken into account to configure the regions were population; scale and scope; care flows; territorial contiguity; road network (transport network); communication network; accessibility; sufficiency of basic care and accomplishment of part of the medium complexity; socioeconomic and cultural profile; and epidemiological profile.	• The managers' interest in shaping the regions is not based on users' needs; its establishment occurred due to administrative rather than health issues; • Municipalities with greater capacity have no interest and / or incentives to materialize the principle of solidarity; • SUS norms do not consider the regional specificities, which are strictly done for non-existent ideal municipalities; • A party-political bias is hampering the process of regionalization.
Structure of "Governance" and the role of managers in the regionalization process of the SUS	• To institutionalize CIR, promoting the creation of technical chambers subsidizing the construction of agreements between regions in the CIB; • Ensure greater participation of the state manager, strengthening the continuity of regional projects by CIR members; • Increase the participation of other actors in the regional governance process (Health Councils, social movements, private initiative, etc.), establishing partnerships between SES, State Regional Administration and COSEMS; to rely on field sponsors; public consortia and ombudsmen in place.	• The bureaucracy has defined the actions of the CIR; the spaces of negotiation and decision of the SUS managers in the health regions are fragile; and the lack of technical groups that advise managers in the CIR weaken these decision settings; • The low technical qualification and the personnel deficit in the municipal and state structures compromise the management of the system; • The normative "fury" of the SUS has disrupted the original functions of negotiation and decision-making spaces of the system; The implementation of the programs ends up becoming unfeasible by party interests and disputes; • Political /party issues directly interfere with federative relationships, with negative impacts on the health sector.

ization is not yet in the priority agenda of the system, unless we consider the aspects related to the healthcare organization of health services, such as the care networks initiative built in this perspective in recent years.

It is necessary to highlight the effort towards establishing a more solidary and cooperative management, with greater sharing of responsibilities, although, in practice, issues related to system financing and infrastructure of the service network colonize the management agenda and is a hindrance to the full establishment of the regionalization process[19,23,25], although, in fact, criteria for allocating resources regarding the provision of services in health regions and the directionality of shared investments have not been clearly established, and a wide discussion about the sector's financing model is necessary[43,44].

There is an expressed need for normative simplification since the legal-institutional framework of the system makes it complex, ambiguous and difficult to apprehend on the part of the management teams[30,44]. Hence, it is necessary to construct new normative schemes that support the development of the SUS and the professionalization of management and that clearly stipulate responsibilities and limits for each of the federative entities, such as a Health Responsibility Law[4,25,30,45].

There is also a discrepancy between the health regionalization model and other regionalization models of public policies, particularly social policies, a factor that brings instability to its implementation process[33,34,44]. In addition, the federal level economic power has determined the development of policies and programs in municipalities and states, distorting the establishment of health needs-based actions [35,36,43,45].

It is clear that the regionalization process institutionality is therefore still incipient and lacks the necessary means and support for its consolidation, given the undefined roles and functions of political stakeholders, the complexity of some processes, shortage of resources, as well as the changes brought about by political cycles[25,30,44].

Managers reinforce that the care model cannot advance unrelated to the management model; on the contrary, regional governance is based on a clearly defined care model shared by all and strengthened in a robust health networks co-management process in the territory[44].

Finally, both the situation involving the role of the Federal Government and the State, together with the organizational difficulties of municipalities are challenges for the establishment of the regional framework and the consolidation of governance agreements around COAP[44,45]. As it is also noted that, to some extent, the State competes in health care with municipalities rather than providing technical and financial support to them, which generates tensions and, consequently, weaknesses in the scope of SUS management.

Regarding the concerns expressed in Chart 2, it is clear that, for the construction of the regional designs, the instruments/tools are used inadequately, limiting managers' ability to conceive/understand the regions in their expressions and health needs, given the top-down centralism of collective decisions (tripartite and bipartite interagency commissions)[43-45].

Added to this is the fragile process of operation of the interagency collegiates, particularly the regional ones, where there are still no technical chambers and there is a low availability of technically qualified personnel in many health areas, which makes these settings lacking the necessary regional "authority", hampering the process of regional planning based on local health needs[4,30,31,44,45].

The approaches point to the need to take into account the internal particularities and specificities of the system, since some of the weaknesses identified are due to centralized and homogeneous definitions in the operationalization of the actions inherent to the planning process, regional organization and its historical and cultural differences. From the standpoint of planning, the interagency "top-down" and disconnected movement brings considerable damage to the implementation of locoregional policies[43-45].

Thus, managers point out that the municipal and/or state weaknesses regarding planning tools and instruments, as well as the undefined role of the State in many occasions, translate into hardships linked to the determination, by the Federal Government, for example, with regard to the source of funds that should be applied and managed at the regional level, hampering integrated and bottom-up regional planning.

Finally, another outstanding approach concerns the performance of health councils and citizen participation in the system, where a number of negative situations were pointed out, such as the marked presence of particular interest groups in the Health Councils, producing a progressive bureaucratization in them, and, consequently, causing resistance on the part of the Interagency Commissions to Social Control[43-45].

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Chart 2. Concerns and challenges before the established process of regionalization, according to the documentary analysis findings.

Thematic category	Cycle of Debates	Institutional Research
Concerns and challenges before the established process of regionalization	• To develop a solidarity culture among the federated entities, as well as to define the real healthcare responsibilities of each one; to comply with agreements between managers in the health area; to strengthen the CIR; • To ensure agreement between intra-state and interstate health regions; to overcome the hurdles of access and movement in the territory; • To consolidate PHC as coordinator of the health care network; to deconcentrate health services; to increase the decentralization of medium complexity services; to increase installed capacity; • To provide adequate financing; to implement a regulatory process; to regulate private providers; to avoid interference of political-partisan factors; • To articulate health and administrative regions of the State; to build interstate health regions; to qualify health managers and servants; to internalize and establish professionals; • To establish monitoring and evaluation processes; to use planning and management tools; • To ensure social participation and control.	• The fragmentation of national information systems still persists; • Instruments / tools are used improperly, • States have no access to municipal information passed on to national databases; • Bottom-up planning that does not materialize and is not aimed at meeting the health needs of the population, since the economic power of the federal government is what has defined the local priorities; • Municipal and state health conferences that still function as stages for the national conference are losing the ability to guide local / regional agendas; • The deliberations of the conferences, especially those of the national event, are not incorporated into the SUS agenda; • The spaces of social control are seized by "corporate" interests, distancing themselves from the interests of the population.

Final considerations

The current debate on the issue of regionalization in the Brazilian health system has been gaining new ground in the last fifteen years, both due to the federal manager's editing a dense normative framework on the issue, and to the significant number of studies on the subject developed, mainly, from the establishment of the Unified Health System (SUS).

It is becoming increasingly clear that there is a need to think about policies with a regional focus, adequate to a reality that respects historical and cultural aspects of the management processes, allowing the consolidation of the equitable development of the SUS. Hence, it is important to emphasize the improvement of the planning processes and the monitoring and evaluation practices; for this purpose, it will be necessary to invest in people who operate the system, especially in training processes that make it possible to professionalize the management of the system.

On the other hand, the health approach must be intersectoral; thinking about health means implying other sectors that influence the health sector and that are mostly unaware of their challenges, potentialities and processes. From the viewpoint of interfederative articulation, considering the Brazilian federative regime, it is also evident that it will be necessary to step up the relationship between the Federal Government, States and Municipalities regarding their commitments and responsibilities in the regionalization process.

This will require an effort to obtain greater precision as to the role of each federative entity in the organization of the system, particularly the role of the State, in coordinating the establishment of networks and identifying the supply of health services and needs, as well as in coopera-

tion with its municipalities. In order to do so, it is necessary to invest in the transition from the supply-based model to a model based on health needs and that, in view of the services provided, this process should be focused on the implementation of preventive and health promotion strategies.

It is clear that these weaknesses inherent to the regionalization process are historical and have been trailing since the onset of the system and that only by overcoming these weaknesses can we strengthen regional governance, whose implementation speed will rely on political will and ability and will be different throughout the country.

Finally, it is worth highlighting the complexity of the topic and the need to further study the aspects discussed here in later studies, with a view to unveiling hurdles and indicating strategies in the health sector that can strengthen regionalization as a dynamic process in the implementation of public policies, consolidating the SUS as an expression of an inclusive social policy.

Collaborations

ALB Carvalho and IMVB Senra participated in the elaboration of this paper, outlining the theme and constructing the text, its rationale and development; WLA Jesus carried out the systematic review and identification of the bibliographic reference, also contributing to its development and the adjustment of the final version.

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