

Coap and SUS Regionalization: the various implementation patterns in the Brazilian states

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Abstract *This paper analyzes the implementation process of the Public Action Organizational Contract (Coap) and its impacts on state agendas of SUS regionalization, comparing the different institutional reactions of the states to the strategy proposed by Decree 7.508/11. The comparison of developing dynamics of state agendas took as reference a normative baseline structured in eight strategic political-institutional moments in the implementation of the Coap in accordance with the logic defined in Decree 7.508/11. We collected data through a questionnaire containing 35 questions (1 open, 25 closed and 9 mixed) and extensive documentary research in 2013 and 2014 in all states, except for the Federal District. Results showed that state agendas were distributed around three differentiated developing patterns: six states maintained greater distance from the national agenda established by Decree 7.508/11, engaging in a very fragmented way; 12 states engaged in the Coap agenda, selectively focusing on specific moments or stages, strengthening the process they have been developing; and 10 states maintained greater performance regularity during the eight moments of the Coap implementation cycle.*

Key words *Unified Health System, Federalism, Decentralization, Regionalization and Coap*

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Introduction

The decentralization of the SUS carried out throughout the 1980s and 1990s transferred to the subnational entities a large part of management and implementation of policies and programs^{1,2}. As this process developed, the success of national strategies for the organization of care networks, aimed at reducing fragmented health actions and services and promoting regionalization of the SUS, depended heavily on the political-institutional contexts of each federative unit³.

Marked by significant differences in supply capacity, financial resources, levels of political conflict, institutional and managerial capacity, these contexts can influence the direction and pace of the state decision-making process and can produce very diverse responses to the policies proposed by the sphere for the organization of health care networks⁴.

The impact of these diverse contexts has been a fundamental factor in the implementation process of the Public Action Organizational Contract - COAP, a legal-executive device introduced in the normative framework of the SUS by Decree 7.508/11 aimed at clearly delimiting the responsibilities of each state in the integration of health actions and services in the health regions⁵.

At the national level, debates related to the regulation and implementation of the COAP promoted a renewal of the sectoral policy agenda on important issues such as regionalization, intergovernmental relations, organization of health care networks, comprehensiveness, financing, among others. This agenda involved intense debates and agreements between the Tripartite Interagency Committee (CIT) between the Ministry of Health (MS), the National Council of State Health Secretaries (CONASS) and the National Council of Municipal Health Secretaries (CONASEMS), among other stakeholders, which resulted in important decisions (Law 141/12) and the definitions of comprehensive standards of the agenda of actions and services (RENASES) and drugs (RENAMES) of the SUS, among others.

However, after more than four years of publication of Decree 7.508/11, only the states of Ceará and Mato Grosso do Sul signed the COAP. The remaining states, despite not having signed the contracts, maintained a minimally productive dialogue with the national agenda of implementation of the COAP, displaying very different patterns of development.

This process has acquired unique contours in each case, marked by movements of progress,

stagnation and setbacks, indicating that the states build legal and institutional responses adapted to their specific contexts in their relationships with national policies. Issues such as how diverse these responses may be and what factors may influence this dynamic are essential for the design of future federal coordination strategies in the SUS.

Thus, this paper shows an analysis of the implementation process of the Public Action Organizational Contract (COAP) and its impacts on the state agendas of regionalization of the SUS, identifying the moments of progress and stagnation of the implementation process in each Brazilian state and discussing the different institutional and legal reactions to the regionalization strategy promoted by the publication of Decree 7.508/11 and the corresponding legislation. The identification of the different implementation patterns of the contract can contribute to the definition and implementation of actions that minimize obstacles to regionalization and the creation of care networks.

Research methodology

We monitored COAP's implementation process in the Brazilian states from a baseline study of state regionalization agendas, with emphasis on initiatives developed by state health secretariats in response to the strategy established in Decree 7.508/11. This is a cross-sectional study aimed at identifying how far each state has progressed toward the implementation of the COAP, taking as reference a standardized set of markers or monitoring variables.

Research was developed in 4 (four) steps: (1) the baseline design, which reproduces the main stages of the full COAP implementation cycle; (2) the development of instruments to standardize data collection at the national level; (3) the systematization of the data collected in a monitoring panel, in order to allow the comparison of the stages of evolution of the COAP in each state; and (4) the classification of state agendas according to development patterns and the comparative analysis of the research results. These four steps of the research are described in detail in the following sections.

Baseline design: COAP's implementation moments

We structured the baseline building on strategic political-institutional and legal moments

of COAP's implementation process. We defined these moments based on the detailed analysis of the legislation corresponding to the COAP, in particular Decree 7.508/11⁶ and CIT's regulations providing for the implementation of the COAP by the states. Technical documents of the Ministry of Health prepared by the Department of Federal Articulation, Strategic and Participatory Management Secretariat, Ministry of Health (DAI/SGEP/MS), an organizational unit responsible for monitoring COAP's implementation at the national level, were also consulted^{7,8}.

The reading of the legislation and the technical documents elaborated by the Ministry of Health resulted in an identification of eight strategic moments that allowed to identify the development stage of each state COAP implementation agenda, as shown in Figure 1.

We can see that, in the normative rationale of Decree 7.508/11, the COAP implementation process was conceived as a cycle, ranging from the first debates on the possibilities of membership

in each unit of the federation to formalization of the commitment in a concrete legal and executive instrument.

Once moments of the implementation cycle were established, it was necessary to define the variables that would indicate, in each state, the extent to which they had been achieved, in order to assess how much the respective regionalization agendas had advanced in COAP's implementation process at a particular point in time. Chart 1 shows and describes the set of these variables.

Elaboration of the questionnaire and data collection

Once we identified the variables, the next step was to investigate their behavior in each of the 27 states. Thus, we elaborated a 35-question questionnaire, with one open question, 25 closed questions and nine mixed questions. We first implemented this questionnaire in November 2013, producing a baseline of COAP's implementation

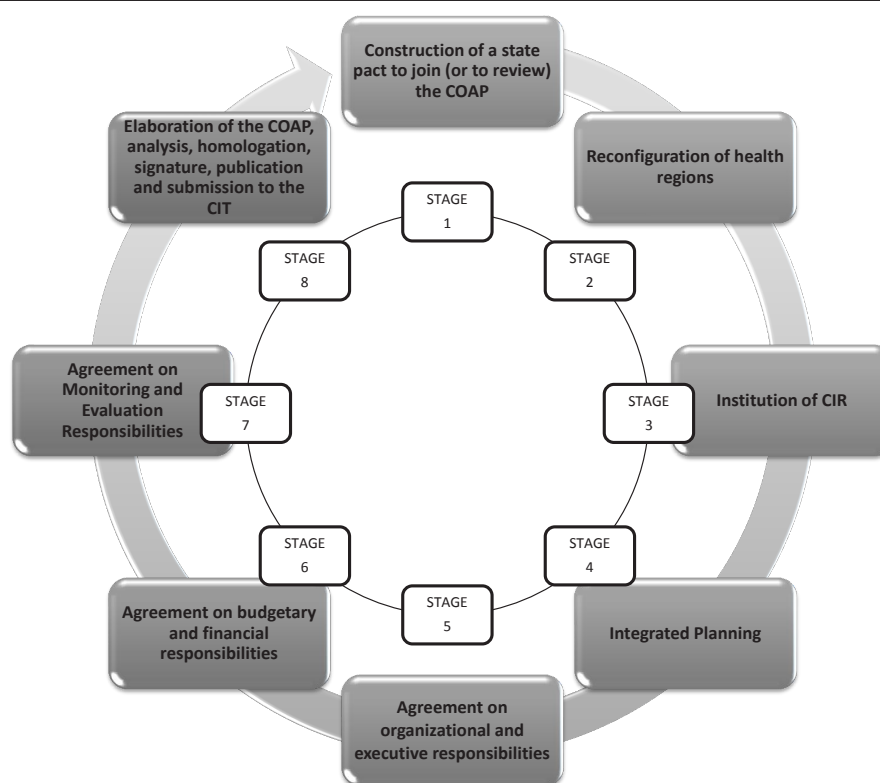


Figure 1. Coap implementation cycle.

Source: Authors' elaboration.

Chart 1. Key Institutional and Legal Moments of the COAP Implementation Agenda.

Moments	Variable		Description of variable
Construction of a state COAP covenant	Formalization of COAP SG	1	There is a steering group established through a formal and legal instrument
	Operation of COAP SG	2	The steering group has periodic meetings
	COAP Regional Meetings	3	There were meetings of presentation and discussion of the COAP in the health regions
	COAP's Formalization at SGEP	4	The SES held a formal meeting and/or presented a document to the SGEP Secretary stating its intention to sign the COAP
	COAP Agreement in the CIB	5	There have been official debates on the state agenda for the implementation of COAP in the CIB
Reconfiguration of Health Regions	Reconfiguration of Health Regions	6	The SES conducted a process of evaluation and improvement of the design of health regions
Establishment of CIRs	CIRs Internal Rules	7	CIRsinternal rules available
	XIR Structure	8	Executive secretariats and technical chambers / working groups in place in the CIRs
Integrated Planning	Health Map	9	Conducting discussions on the health map in CIB
	State Health Plan	10	State health plan for the period 2012/2015 available
		11	State health plan for the period 2012/2015 approved by the CES
	Integrated and Agreed Agenda	12	Discussion and definition of agreed and integrated program in CIB
	Annual Health Agenda	13	SES concluded the preparation of the 2014annual health program
		14	The 2014 annual health program has been approved by the CES
Guidelines, Objectives, Targets and Indicators Agreement	15	Significant volume of municipalities that completed the process of agreeing the goals, according to national guidelines, objectives and indicators, in the period 2013 and 2014 (regions accompanied by the sponsors)	
Executive Responsibilities	Discussion of COAP in the CES	16	The COAP was discussed at a CES meeting
	National Health Card	17	Discussion about SUS national card is ongoing in CIB
	Access Regulation Policy	18	State policy of access regulations discussed and agreed in the CIB in place
	Thematic Networks	19	Ongoing meetingsdiscussing plans for the implementation of thematic networks in CIB
Budgetary-Financial Responsibilities	New Investments: discussion in the CIB	20	Presentation of discussion in the CIB about the need for new investments by the state manager
Monitoring and evaluation Responsibilities	Monitoring and evaluation Strategy	21	A policy to monitor and evaluate the goals agreed by state and municipal managersis in place
Processing and Signing the COAP	Signing the COAP	22	Procedure and signature of the COAP by a set of regions in the State

Source: Authors' elaboration.

in Brazil. In order to validate the responses obtained in the field, we also collected documents to confirm the behavior of variables.

In July 2014, the research team went back to the field, implemented the same instrument and proceeded to collect documents. Thus, we collected data for all states, with the exception of the Federal District. The absence of the Federal District in the research is justified by the impossibility of obtaining data through the questionnaire and the collection of documents. In both moments of implementation, respondents of the questionnaire were DAI/SGEP/MS technicians responsible for direct and constant monitoring of the COAP implementation process in the Brazilian states, and were, therefore, strategic informants of this process.

The two implementation dates allowed COAP implementation monitoring from the end of the first year immediately after the end of the process of regulation of the regionalization model defined by Decree 7.508/11 to halfway through the subsequent year. The discussion and approval of CIT's normative instructions and decrees of the Ministry of Health that regulated Decree 7.508/11 occurred between June 2011 and June 2013.

We collected documents in the period from November 2013 to July 2014 with the purpose of ratifying the information collected through the questionnaire and further analyzing the understanding of the dynamics of COAP's implementation in the states. Thus, it was necessary to establish a standardized list of documents that would cover at least all the relevant variables in the baseline design.

Thus, corresponding documents were collected for each of the variables of Chart 1, which allowed to obtain another source of information in relation to the own perception of field researchers. The pace of document collection in the states varied significantly, influenced by the very dynamics of COAP's implementation and the level of access granted by the state bodies of the SUS (SES and CIB). Despite this, it was not possible to collect documents in only three states: Paraná and Rio Grande do Sul, in the south, and Piauí, in the northeast.

Data systematization: the construction of COAP's monitoring panel

We organized collected data into a COAP's implementation monitoring panel in the form of a double-entry spreadsheet: we arranged states in the rows and the moments of the normative cy-

cle were sequentially aligned in the columns. The panel format allowed both breaking down the development of the agenda in each state along the normative cycle and comparing the dynamics of COAP's implementation between federated units.

We entered data in the panel in two steps. In the initial stage, data collected in the first application of the questionnaire (November 2013) were plotted, facilitating the visualization of which states responded immediately to the national COAP implementation agenda. Document collection started shortly thereafter and provided more consistent information to ratify questionnaire's data and update the baseline. This update showed over the following months which states maintained the initial activities and developed new initiatives or renewed old processes of the regionalization agenda.

Finally, in the second stage, data from the second application of the questionnaire (July 2014) were inserted, aiming to build the implementation framework resulting from practically two years of national implementation of the COAP. We collected new documents on a timely basis to ratify the information and to conclude the panel. Based on this new information, a new national setting for COAP's implementation unfolded, from which the analyses of this paper were produced.

Information analysis: State agendas development patterns

The information plotted in the panel was analyzed from a classification typology of implementation agendas developed specifically to analyze COAP's implementation dynamics in the Brazilian states. We considered three types of implementation agenda, namely:

- *Advanced agendas*: marked by advances in all stages of the COAP's baseline, with more significant consistency and sequencing;
- *Bureaucratic agendas*: defined by state responses concentrated in groups of sequenced moments from the implementation agenda. This concentration can be, in general, in the three initial moments (Initial pact construction, reconfiguration of health regions and establishment of regional Bipartite Interagency Commissions (CIR)) or in regional planning;
- *Incipient Agendas*: characterized by state responses restricted to advances in very specific and dispersed processes along the baseline, including only parts of the moments.

- To qualify this analysis, it is necessary to construct a theoretical framework that articulates policy implementation with federalism.

**Theoretical framework:
the implementation of policies
in federative contexts**

In the traditional view of public policy, the implementation process was an almost immediate consequence of the diagnostics and strategies defined in the early stages of the policy cycle. This was because it was sustained that the state consisted of a monolithic stakeholder led by central authorities, with significant level of independence within the political system, with legitimacy to impose own perceptions, with sufficient expertise to determine the best solution to the problems that emerge on the governmental agenda and with control of the strategic resources required to implement the policies⁹.

Gradually, this view has given way to policy analysis conceptions in which the implementation is portrayed as a multidetermined process and marked by expressive levels of uncertainty and constant political disputes¹⁰⁻¹². This change is due, in particular, to changes in the environment of public policy management driven by privatization, production deterritorialization, expanded role of multilateral organizations, fragmented corporate entities representing interests, expanded social and environmental awareness movements, among others.

In the area of intergovernmental relations, this process has been driven by decentralization movements brought about by state reforms over the past three decades, which have transferred resources and roles to local and regional governments, strengthening federations and creating a new policy implementation context in the Government's sphere.

Federations are an arrangement of political-territorial organization that gathers minor political communities within a more comprehensive system through the distribution of power between the federal government and the constituent units, so as to protect the existence and the authority of both the national domain and subnational entities, both of which share the general processes of decision-making and execution of governmental actions^{13,14}.

Keeping the balance between the autonomy of constituent entities, preserving their original constitutionally defined sovereign rights, and sustaining the interdependence required to

achieve common goals are concomitant and inherent challenges to the federative rationale. This tension between competition and cooperation involves both horizontal relations between subnational entities of the same nature (states with states and/or municipalities with municipalities) and vertical relations (between municipality, state and Federal Government).

Joint governmental action between the federation entities cannot be achieved vertically with the imposition of the Federal Government nor should it be left to the free game of informal political negotiations. In the first case, the situation may lead to discouragement of local innovation or the emergence of boycotts and refusals of cooperation, while in the second case there would be possible predatory competitive dynamics, convergence voids, decision blocks and lack of accountability.

The horizontal character of intergovernmental relations in a federation imposes a commitment of interdependence and autonomy that requires the presence of a sophisticated political-institutional architecture of federative coordination to regulate the extreme centrifugal and centripetal tendencies, imposing limits to the exercise of power of the Federal Government (or national government) and of the subnational federated entities so that they do not exceed their prerogatives¹⁵.

Thus, in federative countries, the implementation of national policies is very different from that in unitary countries, where subnational entities are the offshoots of the federal government. In this case, it is enough to deconcentrate activities and resources and the design of organizational structures and functionally articulated clinical and managerial routines. In federations, the implementation of the health policy, for example, is not only a matter of adequate clinical, managerial and financial design, but also fundamentally a political and institutional challenge that must be faced with consistent federative coordination strategies.

The diversity of regional contexts implies, for the most part, different responses from federation units to policies and strategies drawn from the central level. Even in federations where the policy-making process is defined jointly between the federal, regional, and local authorities, through constant shared decision-making processes, we note that each subnational authority produces differentiated responses in terms of pace and quality of the implementation process^{16,17}.

Therefore, the reaction of subnational entities, even in the face of well-defined national

strategies, can vary widely. In more virtuous contexts, the emphasis placed by the federal sphere on a public policy issue may encourage political elites, administrators, and local interest groups to mobilize efforts to adhere to the national agenda, since such movement may represent access to financial incentives, provision of financing lines, technical support, etc.¹⁸.

In addition, the federal sphere's entry can reduce the costs of regional governments to arbitrate conflicts in their jurisdictions, enact their own legislation and employ resources from their budgets, which would enable those governments to focus on other relevant public policy issues, achieving a double gain of agenda. Likewise, triggering debates and building national programs can help to break down resistances of regional stakeholders and increase confidence levels in shared solutions.

The availability of national forums with consistent discussion agendas can generate incentives for the entry of new players with entrepreneurial capacity at a regional level, motivated by access to strategic political and economic resources and by the expectation of changes in the power pacts.

States that have already developed legislation and policies with management and public service delivery structures and professional bureaucracies can also leverage these existing initiatives through specific partnerships with the federal government to increase coverage, create new programs, train staff, qualify the management and expand the infrastructure, etc.¹⁹.

This convergence framework would also be an incentive for regional politicians and administrators to spearhead such federal initiatives in their states, in view of impending political gains. In addition, adherence to a federal government initiative can strengthen cooperation ties and allow access to financial and technical resources available in other national policies and programs²⁰. Under these conditions, federal initiatives can both foster new public policies on emerging issues and agendas in states and redirect and qualify existing service delivery programs and structures.

However, underlying these situations of synergy in intergovernmental relations is always a calculation of risks and returns of adherence of subnational entities to federal initiatives. Their legal and institutional responses always take into account the possibilities of increasing gains and minimizing the costs of engaging in processes of vertical dissemination of public policy innovations. This is exactly when structure, dynamics

and trajectory specificities of each state become a decisive factor for the success of the federal initiatives. Different formats of relations between the federal sphere and each subnational entity lead to different lines of action²¹.

Thus, in the face of a proposed legislation or a specific national program, smaller states with a more limited budget and a reduced service network may be able to join more easily than a larger state, with more fiscal resources and a larger service network. The impact of federal aid may be a much greater stimulus for the former and may still be interpreted, in some cases, by the larger states as a possible reduction of their autonomy, especially if there are significant differences in content and orientation between federal proposals and state.

On the other hand, even states with a greater propensity to adhere to national policies because of the increase that the corresponding resources may mean in their budgets will always tend to consider the relationship between the volume of resources and the extent of the additional responsibilities that they will have to assume. The decision to adhere will only occur if this relationship is favorable and associated with the assurance of constant flows of intergovernmental financial transfers.

In the case of strategies for regionalizing health care, as is the case, regional specificities take on more intense contours and may have a more significant impact on states' decision to adhere or not to federal proposals. In general, three orders of factors can expressly influence the likelihood of subnational entities to adhere to federal regionalization strategies: structural, institutional and political factors.

Structural factors refer to the domain and distribution of economic and productive resources and can influence the level of regional cooperation. States with health regions predominantly characterized by high levels of socioeconomic development, municipalities with high fiscal autonomy, with an expressive domain of health resources and a high flow of internal exchange of health actions and services will tend to display greater potential to expand the scope of regional relationships and will show less dependence vis-à-vis other health regions, the state and the Federal Government. This configuration tends to generate more consultative patterns of federalism with lower degree of verticalization and greater need for constant rounds of negotiation, but there is also a greater capacity to produce regional schemes with a greater capacity to provide comprehensive care²²⁻²⁴.

In turn, the institutional factors are those related to the ways in which rules that set the possibilities of relationships between the federative entities and other relevant stakeholders (health professionals, private providers, etc.) are established.

Thus, the possibilities of leading regionalization further will be greater in states composed, for the most part, of health regions with a favorable history of cooperative relationships among the federated entities, with a well-structured agreement body system with clear and negotiated rules, regular and quality functioning, significant capillarity and adequate interconnection between the forums (Bipartite Interagency Commissions (CIB), Regional Bipartite Interagency Commissions (CIR), State Health Councils (CES), Municipal Health Councils (CMS), etc.), among others.

There will be an ever greater likelihood of furthering regionalization in states and their health regions with good operational structures of policy implementation covering organizational units specializing in promoting regional cooperation, qualified and committed managers, compatible information systems, clinical coordination mechanisms (Electronic records, care protocols, multi-professional groups, etc.), clear methodologies for allocation of funding and investment resources, among others²⁵⁻²⁷.

Finally, the political factors are those related to the nature and development of the power dynamics established between the main players of the health system and the way in which such dynamics influences the decision-making on the health policy's major directions.

Thus, there will be a greater possibility of progression in regionalization in states and respective health regions where state and municipal directorates of the policy (commanding offices of state and municipal health secretariats) have a consistent regionalization strategy, are committed to regional health integration policies and mobilize to garner support from stakeholders who have strategic resources in the political arena (state's governor, partisan leaders, senators, representatives, etc.).

The possibilities of furthering regionalization around a more systemic design are amplified if there is the commitment with the defined strategy for the state and its respective regions of health by the institutions of the civil society and traditional collective health academic movements (associations of users, associations of researchers in the field of health, etc.), state and municipal

managers (CONASS and CONASEMS), as well as entities of health professionals and private and philanthropic providers.

Overcoming defensive stances and constructing a joint strategy that materializes a solidarity regionalization depend on a certain minimum convergence between the main players of the health field in each state, something that is intrinsically related to the sectorial political history^{28,29}.

Due to all these implementation factors, the strategy proposed by Decree 7.508/11 were a bold challenge to the SUS regionalization agenda, considering that the decentralization process that occurred throughout the 1990s and 2000s had significantly increased the role of states and municipalities in the financing and management of the SUS.

While the NOBs sought to induce the transfer of attributions and resources to states and municipalities, Decree 7.508/11 proposed two major challenges to create a post-decentralization agenda: to define goals for health actions and services and to clarify the responsibilities of each state. These goals and responsibilities should be expressed in the Public Action Organizational Contract (COAP), in state.

These two new challenges put the Federal Government, the states and the municipalities before the need to take on new responsibilities in health, with high financial costs, in a sectorial situation of insufficient financing and judicialization. In the following section, the patterns of response to COAP's implementation agenda in each state are shown and discussed, highlighting the observed advances and hurdles.

Results and discussion: differentiated evolution of state agendas for the implementation of the COAP

Construction of initial agreement, reconfiguration of health regions and establishment of CIR

As can be seen in Chart 2, 18 states (69.2%) formalized the establishment of a steering group and 15 (57.7%) conducted meetings, workshops and seminars on the subject in their respective health regions, officialized the agenda at the SGEP/MS and held official discussions in the CIB.

In this initial moment, the main gap observed in the state agendas for the implementation of the COAP was the regular functioning of the

steering groups, since only seven states (26.9%) maintained a regular schedule of meetings and activities.

This national pattern showed some regional variations. In the northern and southern regions, it was possible to observe more difficulties to keep the regular functioning of steering groups. Only Tocantins in the north sustained a regular steering group. In the south, none of the three states advanced on this subject.

In the northern region, there were also more hardships for regional discussions and seminars on COAP, which may be a result of the region's specific territorial features, characterized by extensive land extension and difficult access and transportation. By contrast, in the Northeast, virtually all states held regional discussions. Also in this region, proportionally, a greater volume of states that officialized the implementation agenda at the SGEP/MS and held official debates in the CIBs was noted.

In 17 states (65.4%), the SES conducted evaluation and improvement processes in the health regions, aiming to adapt the previous configuration to the new requirements of Decree 7.508/11.

Resolution CIT 01/2011 defined minimum criteria for the qualification of health regions, in particular the need for a basic agenda of health actions and services, inducing states to re-evaluate the existing territorial formats at the time. This territorial reconfiguration process was more intense in the Northeast and less in the Midwest.

Decree 7.508/11 also established a change in regional local governance bodies through the establishment of Regional Interagency Committees (CIR), an amendment that had significant adherence in practically all states. Nineteen federal units (73.1%) established CIRs with internal rules, and in 18 states (69.2%), these collegiate bodies had minimum administrative structures, such as executive secretariats, working groups and/or technical chambers to discuss relevant issues. The spread of these innovations was more expressive in the North, Northeast and Midwest.

CIR integrated planning

As also shown in Chart 2, although the integrated planning system characterized by the definition of joint goals and specific health responsibilities has not been implemented, states have made significant moves to renew their regional planning routines, since 21 states (80.8%) submitted a state health plan for the period 2012-2015 approved by the respective health council.

Similarly, as can be seen in Chart 3, 18 states (69.2%) had discussed or were in the process of discussing the Agreed and Integrated Agenda (PPI) with municipal managers in the CIB, which is a significant dissemination in the national territory.

However, this agenda for the renewal of planning processes was not so comprehensive when considering the other variables analyzed. Just 14 states (53.8%) carried out activities to discuss health maps in the respective CIBs and progressed in the agreement of guidelines, objectives, goals and indicators (Chart 2). Likewise, only nine states (34.6%) had completed the respective annual health program (PAS) for 2014 and approved it in the state health council.

Regional variations are also more intense when compared to the other stages of integrated planning. The discussion of the health map was conducted by more than two-thirds of the states in only two regions of the country (South and Midwest), a level obtained only in the southern region when considering the conclusion and approval of the PAS.

This suggests that barriers to the institutionalization of the regionalization model established by Decree 7.508/11 began to surface more intensely as the implementation agenda moved towards the processes of definition of federative attributions around goals and responsibilities of each manager.

The differences in response from the state agendas to the time of integrated planning compared to earlier moments may indicate a difference in adherence costs between the two steps, since planning activities involve minimally the opening of the debate between the federal, State and municipal levels on the contribution of future financial resources, which may imply the beginning of distributive conflicts.

Agreement on organizational and executive, budgetary-financial and monitoring and evaluation and signature of the COAP responsibilities

As can be seen in Chart 3, in the more advanced stages of the implementation of the COAP, there has been a tendency to reduce the response dynamics of the state agendas already observed in activities related to integrated planning. Besides the fact that only 2 states (7.7%) signed the COAP (Ceará and Mato Grosso do Sul), most had difficulties in progressing in the process of qualification of their executive, monitoring and evaluation responsibilities.

Chart 2. Evolution of COAP Implementation in the States - Construction of a state pact to join the COAP, Re-configuration of health regions, Institution of CIR and Integrated Planning – Regions and States

Regions	States	Construction of a state pact to join the COAP					Reconfiguration of health regions	Institution of CIR		Integrated Planning (cont.)		
		1	2	3	4	5	6	7	8	9	10	11
N	TO											
	PA											
	RR											
	AM											
	RO											
	AP											
	AC											
NE	RN											
	PE											
	CE											
	AL											
	BA											
	SE											
	PB											
	PI											
	MA											
MW	MS											
	GO											
	MT											
SE	ES											
	RJ											
	MG											
	SP											
S	SC											
	PR											
	RS											

Source: Authors' elaboration.

In the first case, only 12 (46.2%) states had discussed the COAP with their health councils and defined a state policy for access regulation, and only nine (34.6%) had discussed the implementation of the national SUS card in the CIB. In addition, regional variations were also extremely expressive, and only the southern region showed little more regularity at this stage. In the North-east and Midwest, it was also possible to observe

a good spread of the discussion movements on the COAP at the state health councils.

The only exception, at this stage, was the implementation of the thematic networks of health care (“Rede Cegonha” (*Stork Network* – a mother and child care program), Urgent and Emergency Care Network, Psychosocial Care Network, Diseases and Chronic Conditions Care Network, etc.). In 23 states (88.5%), it was possible to iden-

Chart 3. Evolution of COAP Implementation in the States - Integrated Planning (continuation), Organizational and Executive Responsibilities, Budgetary and Financial Responsibilities, Monitoring and Evaluation Responsibilities and Signature of COAP – Regions and States

Regions	States	Integrated Planning				Organizational and Executive Responsibilities				Budgetary and Financial Responsibilities	Monitoring and Evaluation Responsibilities	Signature of COAP
		12	13	14	15	16	17	18	19	20	21	22
N	TO											
	PA											
	RR											
	AM											
	RO											
	AP											
	AC											
NE	RN											
	PE											
	CE											
	AL											
	BA											
	SE											
	PB											
	PI											
	MA											
MW	MS											
	GO											
	MT											
SE	ES											
	RJ											
	MG											
	SP											
S	SC											
	PR											
	RS											

Source: Authors' elaboration.

tify implementation plans for at least two thematic networks at different development stages. This significant adherence of states can be explained by the contribution of federal financial resources and by the emphasis conferred by the summit of the Ministry of Health in its dissemination.

The discussion of the need for new investments for the health services network among state and municipal managers was also one of

the points that mobilized the state agendas over the period analyzed. In 18 states (69.2%), it was possible to identify the presence of debates in the respective CIBs related to the contribution of additional resources, especially the demands for increased ceiling of federal transfers.

The extension of this demand may suggest that most of COAP's regionalization and implementation progress possibilities were condi-

tioned to increased financing base of the SUS, with emphasis on the expanded federal contribution of resources.

Finally, only 11 (42.3%) states showed some strategy for monitoring and evaluating the goals agreed between the state health secretariat and respective municipal secretariats in the official planning documents (state health plan, agreed and integrated agenda and annual health program). In the Northeast, Southeast and Midwest, the lack of these procedures was more expressive than in others.

In addition, it was possible to identify that the development of state COAP's implementation agendas evidenced erratic dynamics, marked by moments of progress, stagnation and regression. As shown in Graphic 1, few states have developed only a few more fragmented and dispersed processes (incipient agendas), showing greater distance from the national agenda established by Decree 7.508/11.

Most states engaged formally in COAP's agenda (bureaucratic agendas), focusing on the specific moments or stages, following the national agenda emphasized by the Ministry of Health, which allowed the follow-up of the national debate in a productive way without having to increase the costs of adherence ensued by the closer commitment to the formal signing of contracts. Thus, some states such as Roraima, Paraíba and Mato Grosso focused initially their activities between the establishment of an agreement to discuss the COAP and the implementation of the CIRs. Others, such as Minas Gerais, São Paulo and Paraná focused their efforts on renewing their integrated planning routines.

Finally, a substantial group maintained significant regularity throughout the various processes activities that characterized the implementation of the COAP in the analyzed period. These states have sustained a broader agenda that has allowed in most cases the opening of the implementation debate, reconfiguring health regions more rationally, establishing new regional governance bodies (CIR), renewing and refining integrated planning routines and advancing the discussion of new investments, among others.

The central question is to analyze which factors may help to explain the differences in COAP's implementation patterns observed among Brazilian states. As can be seen in Graphic 1, in general, extreme situations of combination of political-federative complexity (number of municipalities) and structure of the health services network (number of health facilities) have

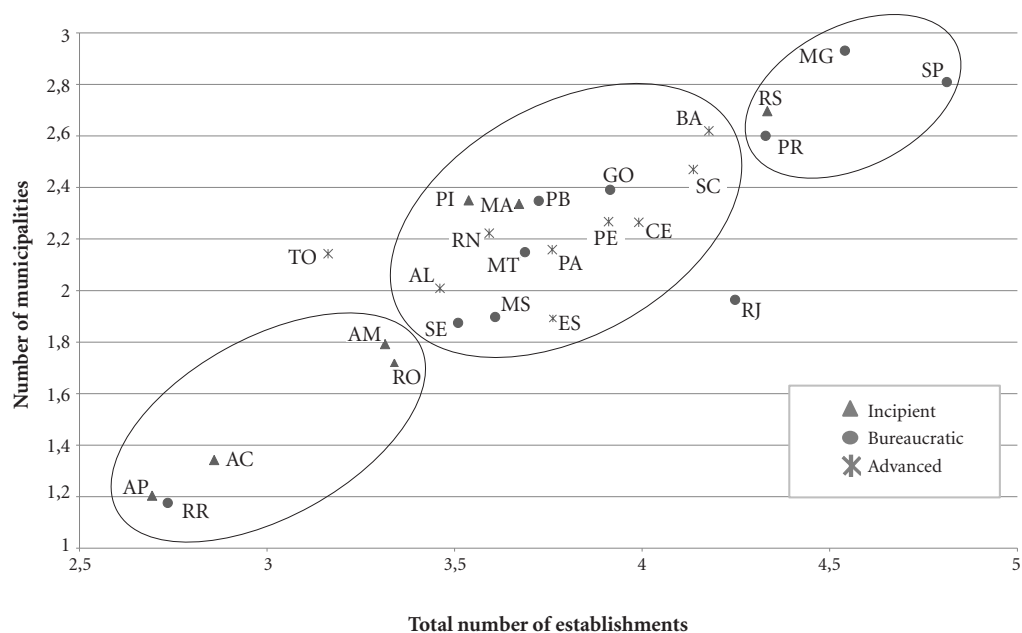
resulted in greater difficulties in advancing the agenda of implementation of the COAP.

The states that showed the greatest progress (in green) were those characterized by intermediate combinations, which suggests that the COAP implementation strategy was not sophisticated enough to consider the diverse Brazilian regional contexts. This indicates that smaller states may have succumbed to the low capacity of their service supply structure and the fragility of their municipal network, as well as the difficulties of technical quality of bureaucracy, less potential for investment, contract transaction costs, etc., resulting in less regional cooperation capacity to comply with COAP's obligations. On the other hand, states with diversified networks and with more municipalities have, on the one hand, greater capacity to meet the demands for service and, on the other hand, have to deal with a more complex context of federative relations, hindering and delaying contractualization, not to mention the fact that they have the most specialized high complexity services of national reference, which significantly increases the costs of adherence.

However, even among the set of states with intermediate combinations, there is an expressive group of states with incipient and bureaucratic agendas, making the COAP implementation a policy with high failure rate and pointing to constraints that are beyond the diversity of regional contexts and were not included in the national strategy. This scenario indicates a depletion of the SUS regionalization strategies in the face of the current structural limits imposed by a limited national political pact, eroded over the last decades, and a fragile funding base, in addition to the access bottlenecks resulting from significant distribution inequalities of the installed capacity of Brazilian health services. Overcoming such limits requires a national pro-SUS reform agenda, otherwise the implementation of the COAP and other regionalization strategies that succeed it will be missed and unfinished agendas.

Conclusion

It is concluded that, although only two states signed the COAP, the very dynamics of discussion and partial implementation initiated by Decree 7.508/11 stimulated a movement to renew the state agendas of regionalization that resulted, minimally, in the reconfiguration of the health regions, the implementation of new governance



Graphic 1. State Agendas Response Patterns by Size of Health Services Network and Number of Municipalities (totals by state for July 2014 in base log 10).

Source: Authors own elaboration from DATASUS (2015).

spaces in health regions and the improvement of integrated regional planning routines.

Thus, the Federal Government's initiative has proved important in order to promote the sectoral debate on regionalization at the national level and to stimulate state and municipal managers to produce movements to renew their structures and processes that support the joint work of subnational entities in the health regions.

These positive impacts were not uniform nor were they maintained with the same intensity throughout the COAP implementation cycle. In general, it was possible to identify two distinct phases in the general reaction of the agendas of each state in relation to the federal agenda of the COAP.

Until the stage of discussion and definition of agreed and integrated programming (stage 12 of the COAP cycle), the political-institutional response of state agendas proved to be significantly more homogeneous and intense than in the subsequent stages. In this first phase, between half and 80% of the states evidenced positive respons-

es, minimally dialoguing with the Federal COAP agenda, with the exception of the functioning of COAP's steering groups. The stages of this phase cover processes of a formal nature and related to the organizational and administrative structuring of health regions. Such processes, while requiring the mobilization of state and municipal managers, can be considered financially less costly than the later stages, involving a more expressive level of federative accountability.

In general, COAP cycle's next steps include the commitment of managers with concrete goals in terms of health actions and services and, consequently, the most significant contribution of funding. Therefore, adherence of subnational entities has a cost and implies a more explicit commitment to health goals that are explicit in contracts and can be claimed judicially.

Issues related to the definition and approval of the annual program of health actions and services, the national health card, the regulation of access and the evaluation of goals were highlighted in only less than half of the states. Thus,

it is worth highlighting, in this second phase, that greater states' mobilization to organize plans for the implementation of thematic networks, linked to federal funding, and to discuss in the CIB the inclusion of new state investments was noted.

Collaborations

AM Ouverney, JM Ribeiro and MR Moreira participated equally in all stages of preparation of the article.

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