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Management problems and strategies: The vulnerability of small-sized municipalities

Elisangela Pinafo (https://orcid.org/0000-0002-7553-7588) [1]
Elisabete de Fátima Polo de Almeida Nunes (https://orcid.org/0000-0002-5873-7561) [1]
Brígida Gimenez Carvalho (https://orcid.org/0000-0003-3850-870X) [1]
Fernanda de Freitas Mendonça (https://orcid.org/0000-0002-3532-5070) [1]
Carolina Milena Domingos (https://orcid.org/0000-0002-7725-1831) [1]
Camila Ribeiro Silva (https://orcid.org/0000-0001-9297-4838) [1]

Abstract *The decentralization process has a strong impact on the finances of small-sized municipalities (SSMs), which are the most vulnerable entity of the Federative Republic of Brazil. This paper aims to analyze the main problems and management strategies used by SSMs to address the inequalities resulting from the decentralization process. This qualitative research is developed through operative groups with 55 workers from the management teams of SSMs in the northern macroregion of Paraná. A comprehensive and interpretative analysis was conducted using the Social Game Theory as a theoretical reference. Among the problems examined are the insufficient capacity to manage municipalities and provide comprehensive health care to citizens. The formation of Intermunicipal Health Consortia, the purchase of services through parallel contracts with private providers, and the adhesion to state and federal programs are strategies to address the problems, but they trigger problems of their own. To minimize the vulnerability of SSMs, it is necessary to empower the municipal manager, implement processes of listening to the SSMs, and foster a culture of facing problems in a collective and shared way among the federated entities to create interfederative management.*

Key words *Decentralization, Health management, Public Health System, Small-sized municipalities*

[1] Programa de Pós-Graduação em Saúde Coletiva, Universidade Estadual de Londrina. Av. Robert koch 60, Vila Operária. 86039-440 Londrina PR Brasil. elisangelapinafo@uenp.edu.br

Introduction

Most Brazilian municipalities are small, many of them created after the enactment of the Federal Constitution of 1988. With the Federal Constitution, the municipalities became subnational entities with political and tax autonomy and became recipients of distributed resources through intergovernmental transfers[1].

Small-sized municipalities (SSMs), i.e., those with a population of fewer than 20,000 inhabitants, despite representing approximately 70% of the municipalities in the country, are the most vulnerable subnational entity. Most of these municipalities combine limited healthcare offerings and management capacity conditions to respond to the public policies assigned to them through the healthcare decentralization process[2]; little autonomy for the management of municipal budgets[3]; lower tax revenue capacity, and consequently, lower allocation of budget resources[1,4]; and limited decision power of municipal managers in governance spaces[5] and difficulty retaining medical professionals[6].

In addition, with the creation of the National Health System (*Sistema Único de Saúde* – SUS) in 1988, there was political-administrative decentralization of healthcare and transferring of responsibilities, particularly to municipalities, for the management of healthcare actions and services. This management process is complex due to the effects either of social and epidemiological determinants on the disease process of the population or to technical, political, and economic factors[7].

In SSMs, the SUS manager, in addition to being responsible for primary care to residents, must also provide the population with access to other levels of care through agreements with other municipal and state managers and the contracting of private services[5] to provide full healthcare to the population, even if it does not take place within the municipality's territorial limits[8,9]. In this sense, SUS managers face the task of managing a heterogeneous and noninstitutionally integrated network of services with insufficient provision of services at the medium and high complexity (MHC) levels[10].

In this context, the analysis conducted by Teixeira et al.[11] shows that although municipalities have benefited in the decentralization process from the distribution of resources, they continue to present great fiscal vulnerability. If, on the one hand, their sources of resources have increased, on the other hand, the decentralization of public functions has had a strong impact on their finances. Given this difficulty, the implications arising from the decentralization process have had a highly unequal impact on these municipalities compared to larger municipalities.

Considering the scenario experienced by SSMs, the question arises: What are the problems faced by the management team in municipal healthcare management? What management strategies are used to address these problems?

Despite the relevance of this topic, the scientific literature on the dynamics of SUS management in SSMs, with the analysis of the management problems faced and management strategies employed, is scarce[12,13]. In this sense, the objective of the study was to analyze the main management problems and strategies used by SSMs to address the inequalities arising from the decentralization process, in light of Carlos Matus's Social Game Theory.

Methodological-theoretical framework

For Carlos Matus, the social system is a large, complex, nebulous game composed of several other interlocking individual games. These games are simultaneous and coexist in the same time and physical space, have their own dynamics and particularities, and internally reproduce other games in a subordinate form. The social game is divided into overlapping game logics with a dominant intersection[14].

Matus[14] describes the existence of nine power games: political, economic, macroorganizational, personal, everyday life, nature, communication, values, and science. However, those that stood out in the analysis of the present study – in the context of SUS management in SSMs – were the political, economic, and macroorganizational games.

The political game disputes and distributes political, civil, and military power, the function of which is to create, concentrate, and distribute social power. The economic game functions to produce goods and services demanded by the population to meet their needs, distribute income, and distribute the ownership of economic goods[14]. In turn, the macroorganizational game produces organizational action, which is a collective human action capable of materializing institutional production in the service of any of the other games. Organizational action is a game of struggle for the distribution of governance and organizational power[14].

For Matus[14], living in society brings out problems that are common to any type of social prac-

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tice. However, the complexity of social problems grows at a rapid pace, while the personal or institutional capacity to govern these problems grows increasingly far from overcoming them.

Social problems are, above all, according to Matus[14], almost structured problems because they are more complex, are usually multicausal, have causes that it is not always easy to identify, and do not always have consensual proposals for their solution. Therefore, when actors try to solve problems, an exchange of problems occurs that benefits some people but, at the same time, can harm others. For the author, the problem depends on the point of view and the place occupied by the "actor," by which he refers to the person who experiences the problem and plays a role.

Strategy, in turn, is a category of the possible as a function of the necessary[15]. Strategy is a moment dedicated to how to accomplish something, where paths are built to achieve the objective image – a moment involving the science of making the goal possible, of reducing uncertainties and accumulating strengths[16]. Strategy is the way of dealing with other players in situations where objectives and interests are divergent, and the circumstances surrounding the social game become conflicting[17]. Matus[14] distinguishes three planes of characterization of a strategy: the plane of its administration, or the actor's internal direction; the plane of the paths chosen to deal with the other; and the plane of the purpose's content, in relation to individual interest or social collective interest (Figure 1).

According to its form, a strategy can be open or closed. There are numerous possible strategic means. It is possible to follow the path of imposition, of negotiation, of persuasion, of coercion, of court trials, of deterrence, of confrontation, and of war. In turn, the strategy, given its content and purpose, is privileged by conciliatory action or strategic action, two types of action that are not compatible with each other[14,18].

Given the above, it is understood that the participants in the great social game – in this case, the healthcare system – develop a constant struggle for power because power is both a means and end, and it is gratifying to have it or use it. For some participants, power as a means is more rewarding than power as an end. This power struggle is channeled through competition for the supremacy of one of the games over the others or competition for dominance in each game[14].

The field of SUS management in SSMs is permeated by social problems arising from the needs of individuals and communities, and, based on the analysis of the social situation and the reality faced by the healthcare service, the social actors represented by the management team can use several alternative solutions and/or management strategies to address these problems[12].

In the present study, the actors who interpret these problems are members of municipal management teams, including the municipal health secretary. Each one, within their social context and faced reality, holds power and has a role in the social game of SUS management in the search for coping with problems arising from the individual or collective needs of users of this system.

Methods

This research is a qualitative study conducted with workers who make up the SSM management team from the northern Paraná macroregion, which includes the 16th, 17th, 18th, 19th, and 22nd Health Regions (HRs). In this macroregion, 84.5% of the municipalities are classified as small-sized, and in Paraná, of the 399 municipalities, 312 (78.1%) are SSMs.

A total of 55 representatives of the management teams who stood out in the development of management activities, obtained by a convenience sample of each HR, were selected based on interviews with key informants from the HRs. Data were collected from April to June 2015 in five operative groups (one per HR) composed of 10 to 18 people per region, in which the selected participants participated. The operative groups were conducted based on a script containing questions that addressed the types of problems present in the municipalities and the management strategies used to address them.

A comprehensive and interpretive analysis was performed on the empirical material produced. First, horizontal and exhaustive reading of the texts produced was performed. This initial exercise, also called "floating reading", allowed us to grasp the central ideas of the social actors, the key moments, and their positions on the subject[19]. Second, the material was read transversally to identify units of meaning and to understand their connections[20].

After this phase, a synthesis of this classification was performed, grouping the units of meaning into empirical categories to understand and interpret what was most relevant[20]. The analysis was performed using Carlos Matus's Social Game Theory as a theoretical framework.

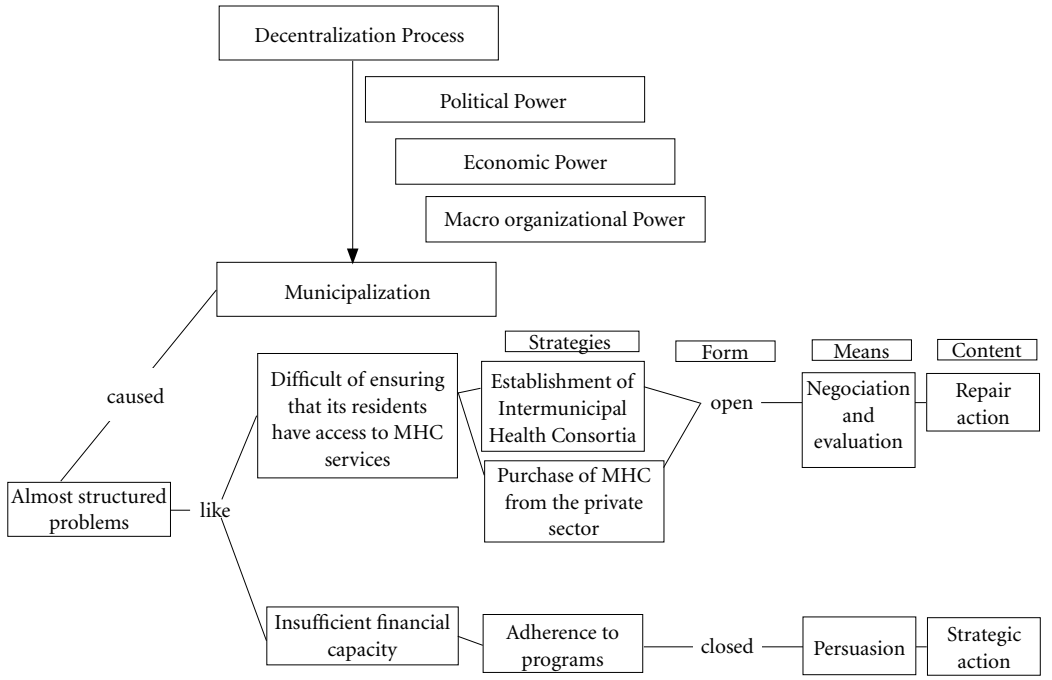

Figure 1. Management problems and strategies of SUS in PMS.

To guarantee the participants' anonymity, the responses were coded using letters and numbers. First, the groups were designated by the letter "G", and then by the first letter of the HR to which they belonged (A, C, L, J, I), and the responses were numbered sequentially as they were offered (1, 2, 3, 4...).

This study is part of a larger project titled "SUS work management in small-sized municipalities in Paraná from the perspective of the management team." The study complied with the norms for research involving human subjects, according to Resolution n. 466/2012[21] of the National Health Council, and was submitted and approved by the Research Ethics Committee of the university with which the researchers are affiliated on 09/14/2012.

Results and discussion

The presentation of the results of the operative groups is organized into two empirical categories: one related to the problems and the other to the strategies (Figure 1). Two problems were analyzed in the first category and three strategies in the second category. Management problems and strategies of SUS in PMS.

Problems

The decentralization of SUS management was the main way to make the system universal. The way decentralization was undertaken for the municipal entity, called "municipalization", was problematic because it did not provide for the sharing of system functions and management competencies among subnational entities[22]. Thus, there was a strong attribution to municipalities regarding the technical provision of healthcare actions and services in their territory[23], a factor that highlighted the vulnerability of small municipalities in particular.

A relevant problem mentioned by the management team refers to the difficulty of ensuring that its residents have access to MHC services. Given the lack of provision of these services in the SSMs, they highlighted the challenge of ob-

taining services of this type: "*If the municipality wants to resolve [the problem], it ends up paying; otherwise, the line for surgery moves*" *(GC5);* "*Orthopedics is chaos, despite lawsuits; the consortium has an agreement with hospital B in city D but the municipality pays for the agreement*" *(GA2).*

The conditions for decentralization to ensure guaranteed access and comprehensive care, according to the needs of the population, were not safeguarded, especially because the diversity of the reality of the Brazilian municipalities was not considered[2,24]. The way decentralization proceeded, with great emphasis on municipalization, led to the creation of various isolated local systems. In such systems, with regard to MHC services, fragmentation and disorganization of healthcare services is observed. For these authors, this fragmentation occurs because the decision-making spaces of managers are permeated by local interests at the expense of ensuring universal access[25].

For Silva et al.[13], a factor that contributes to the problem of access to specialized services in SSMs not having a short-term solution is that legal mechanisms, such as the Organizational Contract for Public Action (*Contrato Organizativo da Ação Pública* – COAP), proposed to make the organization and provision of MHC services in the region viable were not effective. According to these authors, this failure is due to the growing distancing of federal and state bodies from their attributions with regard to both the funding and the management of the system.

In an attempt to ensure access to specialized care, SSM managers have taken over the development of actions for MHC services that surpass those agreed upon by them and, as a result, have invested more than advocated by Law 141/2012 for healthcare spending[13]. These same authors indicate that in 2014, in the SSMs of the Paraná region, the average spending of own resources for healthcare expenditure, relative to the total spending in this segment, corresponded on average to 69.7%, ranging from 57.2% to 81.8%[13]. The high percentage of municipal budget resources invested in healthcare demonstrates the great weight of the responsibility that falls to municipalities.

As reflected by the above facts, the gain of autonomy by municipalities was also accompanied by increased responsibility for funding healthcare actions and services. This situation can be illustrated by analyzing the increase in public spending on healthcare in the period between 2008 and 2015, in which the expenditures of federal and state governments increased by 40.4% and 49.4%, respectively, while that of municipalities increased by 71.6%[26].

When analyzing the social game[14] present in the problem under consideration, it is possible to infer that the macroorganizational, political, and economic powers were exercised by the federal entity over the municipalities.

The macroorganizational power was characterized by the organization of the decentralization process, in which the federal government, exercising power based on bureaucratic and institutional resources, transferred greater responsibility for management and provision of healthcare in their territories to municipalities[14], even though the SSMs did not have the conditions necessary to meet the demands for their residents' comprehensive care.

From the perspective of Matus[14], this situation could be considered a quasistructured problem. This type of problem, even if it has a technical dimension, always covers the sociopolitical sphere and becomes a multifaceted challenge because the solution given to the problem (in this case, the purchase of MHC services) generates another problem (financial and responsibility overload on SSMs), and the two are connected because the system is continuous.

Corroborating this statement, the study participants highlighted insufficient financial capacity as another problem in SSMs: *The demand grew too much, all without planning, because nobody planned (GC8).* Because they did not have a service structure with the capacity to provide comprehensive care to residents, SSMs' expenses increased considerably: *...what we receive from other entities is very little, it depends on the per capita of each municipality (GI2); We pay for everything (GA8); The municipality bears everything (GC4).*

As already mentioned, decentralization was governed by a characteristic of power deconcentration, in which greater political power[14] was designated to municipalities, linked to autonomy in the conduct of healthcare actions. However, this power required greater expenditure of financial resources by the municipality, accompanied by expenditure containment by the federal government.

Arretche and Marques[27] indicate that the financial burden experienced by municipalities is due to the decentralization of the actions taken, mainly outpatient actions, which are the actions that most increased the healthcare expenditures for these entities.

Compared to medium and large municipalities, SSMs have unique characteristics because

they are generally situated in more isolated geographic regions, with situations of greater social and economic vulnerability[28].

Calvo et al.[29] conducted a study that evaluated the presence of categories favorable to healthcare management, related to the demographic characteristics, funding capacity, and purchasing power of the population. The results revealed an important contrast between large and small municipalities. While 77% to 100% of large municipalities presented favorable factors for healthcare management, only 10% to 17% of the small municipalities did so.

Some researchers claim that the strategic nature of intervention in the economy prevailed in this decentralization process, with a reduction in the role of the federal government and economic stability in which, by transferring responsibility to municipal entities, the guarantee of users' universal access to healthcare services was not prioritized. Thus, the decentralization of the healthcare system served the purpose more of decreasing the role of the federal government and containing its expenses than of expanding the system. In other words, municipalization represented another strategy of shifting responsibility for social spending to subnational spheres, which in general are not in a position to take on such burdens[2,30]. In this context, the use of political and economic powers stands out[14].

Strategies

This section analyzes the management strategies used by the management teams to address the problems related to the difficulty of ensuring access to MHC services and SSMs' insufficient financial capacity.

In the regions studied, the strategy used by all municipalities to provide access to MHC care was the establishment of Intermunicipal Health Consortia (*Consórcios Intermunicipais de Saúde* – CIS) to administer and provide specialized and diagnostic support services with higher technological density to the population of the consortium municipalities.

According to the interviewees, by entering into a consortium, the municipality contributes a monthly per capita value to use the services of the CIS, thus gaining access to a stipulated number of monthly visits and exams. If necessary, it is possible to expand the purchase of exams and visits by paying an extra charge called the "extra quota".

The results of this study corroborate the findings of several studies that CIS are a strategy that increases access to specialized medical care and MHC services and which act as one of the instruments for the regionalization of SUS management[31-33].

In the state of Paraná, public consortia are exclusively intermunicipal and have autonomy to manage regional policies within the scope of action; their collective interests are deliberated by councils of mayors[33].

In the studied regions, the existing CIS seek to contract services with the private sector by negotiating the actions and services through an addendum to the SUS table in an attempt to obtain the ability to purchase the necessary services. However, the proposed values do not always meet the interests of the private sector, i.e., there is not always adherence to the value proposed by the CIS, which causes difficulties related to the contracting of services and specialized professionals for provision to the municipalities.

It was also found that the situation of the consortia is not uniform in the regions studied. In some regions, according to the managers' reports, the CIS ends up exercising the mere function of negotiating the contracting of MHC services with the private sector and cannot play a role that goes beyond the purchase of services. Thus, they do not play a role in integrating healthcare among the various points of care, resulting in insufficient supply or even lack of supply in some areas. The consortium's lack of effectiveness in these regions reflects the challenges and weaknesses regarding MHC services and directly affects the quality and continuity of healthcare to residents.

This situation compels many managers to use another strategy, the purchase of MHC care actions and services directly from the complementary private sector:

Enters into an agreement with private clinics (GL5);

At clinic Y, it pays for pays for visits and exams (GA3);

There is clinic X, where I pay for visits when it cannot be done through the consortium, or it is urgent and it cannot be resolved; there they also provide colonoscopy, endoscopy, and endovaginal ultrasound (GC3).

It is observed that the municipality ends up bearing the financial burden and responsibilities to meet the needs of users that extend beyond primary care in an attempt to provide access to healthcare services and thus *ends up spending their primary care resources to resolve [problems with] medium- and high-complexity care (GJ1)*.

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The management team tries to confront the problem, in practice, based on planned operations such as the use of its economic power because it has control over its budget. In an attempt to meet its needs, it redistributes the municipal budget with greater spending on healthcare resources, and within the health area, it ends up allocating more resources to the demands of MHC care, which are not organized in the region and which are more difficult to resolve by the municipality. In this sense, primary care actions do not receive the investment that they should or that would enable a change in the services landscape at this level of care.

When analyzing the motives of the municipality to use its own resources as a way to intervene in this problem, Mendes[34] notes that although there are mechanisms for the equitable allocation of resources via transfers from the federal government to the municipalities, as established in Law 141/2012, criteria based on healthcare needs have not yet been defined. Moreover, the participation of state governments in the transfer of resources to municipalities remains highly incipient.

Regarding the purchase of MHC services, it is found that this strategy has not been adopted to complement primary care or even to increase resolution at this level of care. Rather, such purchases are specific, isolated actions that often reflect a relationship of clientelism between the user population and the manager because *the citizen lives in the municipality, so they know everyone, the secretary, the mayor, and they will knock on the doors (GJ1)*.

This strategy also denotes the dependence of the municipality on the private sector, which in most cases has no link or coresponsibility for the continuity, comprehensiveness, and resolution capacity of care. Instead of promoting change, the private sector reinforces the biomedical care model, which remains hegemonic. In the relationship between public managers and private care providers in SSMs, power asymmetries, interests, and benefits prevail, in addition to clientelist and hierarchical practices[5].

In this type of strategy, a relationship of exchange or permutation of problems is masked. The problem, which was previously the insufficient supply of MHC services, eventually gives way to the low effectiveness of the adopted strategy, given the low resolution of these actions or the increase in expenses for the municipality, which is also reflected in the reproduction of the biomedical model of healthcare. In this sense, all exchanges of problems are conflicting because they refer to values that are differentiated according to each problem, which can be intensified or mitigated.

The management team uses strategies that are considered open in their form or administration; that is, there is a decentralization of decisions regarding their fulfillment, leaving a wide scope of freedom for the use of creativity and information at the moment[14]. In other words, if at that opportunity or moment it is feasible to enter into an agreement with a clinic, the municipality will adhere to this strategy; if this is not possible, this alternative will be discarded. In this sense, the management team have a certain flexibility to make this decision according to the requirements of circumstances at the time.

An analysis of the employable strategic paths demonstrates that in most cases, the management team uses evaluation and negotiation to find the means or ways to obtain a positive result. For this purpose, the manager initially evaluates the situation, analyzes the ways to intervene, and then tries to negotiate how to use the contracted services to provide a particular type of care to the user.

Contentwise, the strategies used are part of conciliatory action, in which the purpose and motivation of the actors are related to the community[14]. In this sense, the management team strives to the greatest extent possible to ensure access to healthcare services.

Given these game strategies and tactics, the economic game remains the type of power that stands out in the presented situations and dominates over the other types of games.

To confront the problems related to insufficient financial capacity, the management team referred to adherence to programs offered by the state and federal governments. Adherence to the More Doctors Program (*Programa Mais Médicos* – PMM) was reported by most municipalities in an attempt to solve the difficulty of retaining doctors in their territories as well as to defray the salaries of these professionals. Under the program, expenses with doctors were borne by the federal government, which alleviated to some extent the budgetary pressure on small municipalities.

Adherence to other programs was also indicated by the management team to expand the financial resources transferred from other entities to the municipality and thus improve healthcare services: the Family Health Strategy (*Estratégia de Saúde da Família*), Program for Improvement of Primary Care Access and Quality (*Programa*

de Melhoria do Acesso e da Qualidade da Atenção Básica – PMAQ-AB), Health Surveillance Qualification Program (*Programa de Qualificação da Vigilância em Saúde* – VIGIASUS), Program for Support and Qualification of Public and Philanthropic Hospitals of the SUS (*Programa de Apoio e Qualificação dos Hospitais Públicos e Filantrópicos do SUS* – HOSPSUS) and Program for Primary Care Qualification in the SUS (*Programa de Qualificação da Atenção Primária no SUS* – APSUS) as well as adherence to healthcare networks.

The APSUS was highlighted by the team as a trigger for changes in the work process of the services, mainly due to the actions of permanent education in health (*educação permanente em saúde* – EPS), which provided improvement in the service as a whole. Some municipalities highlighted the HOSPSUS in the execution of contracting or agreement with some hospitals through referral flows, which facilitated the entry and care of the user in the hospital.

The benefits provided by the APSUS and HOSPSUS, which constitute state strategies, although they have a closed form of administration, are strategies with content that constitutes conciliatory action, with the purpose of improving healthcare[14].

Despite having adhered to such programs as a way to obtain resources to improve the care of the population, for some municipalities of the given health region, the management team reported that the federal and state governments use the incentive of financial resources derived from these programs as a way to attract the municipality to adhere to such programs.

They are bait, they put these programs as bait for us to want the program and fall into the illusion that everything will improve. They offer the program and an incentive for us, they offer funds (GI1);

In fact, this incentive does not pay even half of the cost of the program, so they want the municipality to participate in them, but the municipality ends up having to bear the rest of the expenses because the funds that are actually given do not cover the expenses of the programs (GI8).

Given this situation, municipalities are faced again with the situation in which adherence to a program that helps cope with a problem ends up generating another problem, which is related to spending to maintain this strategy.

Given the presented situation, the federal programs become strategies of the federal government with closed characteristics. Programs arrive ready for the municipality, which must execute them in the way the federal government conceived, thereby characterizing a strategic action to fulfill a federal government interest and not conciliatory action to meet healthcare needs. The execution of a strategy is a move, and the actor must consider that the social game combines direct and transparent actions with disguised actions, i.e., there is the possibility of double-dealing[14].

The political and economic powers can be seen in the struggle for control of the healthcare system, in which the federal entity, which has the largest volume of resources, financially induces the municipalities' adherence to programs and strategies.

Final considerations

Based on the analysis of the management problems and strategies that emerged from the understanding of the dynamics of the management of SUS in SSMs, it is highlighted that the main challenge faced by managers is to make the SUS, proposed by the constituent, happen in the reality of healthcare services through changes in the care model. This challenge becomes greater for the SSMs because, unlike medium and large municipalities, they combine the lower technical capacity of the management team, lower population density and purchasing power of the population and insufficient financial capacity to meet the challenges of managing the healthcare system.

Although some guidelines offer a foundation for changing the care model, the biomedical model is so hegemonic that managers, when facing management problems, are unable to perform other types of actions or strategies other than to expand the supply services. However, they recognize that such actions are insufficient to ensure an effective path as a permanent route; the problems are recognized, but the strategies adopted (consortia, purchase of services, adherence to programs) do not have the power to resolve them.

The way decentralization was implemented left the SSMs in a situation of greater vulnerability compared to other entities, especially financial vulnerability. The macroorganization and economic powers were predominant in triggering these problems.

The strategies adopted to confront the initial problems end up triggering other problems, which Matus calls problem exchange, and end up increasing SSMs' vulnerability. Given these

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game strategies and tactics, it is perceived that the economic game remains the type of power that stands out in the situations presented and that dominates over the other types of games.

Constitutional Amendment 95, approved in 2016, which freezes the federal government's expenditures on healthcare for a period of 20 years and establishes unfavorable limits to correct the funding of this same sector[35], further compromises the capacity of the municipal sphere to manage local public policies efficiently. Thus, it is even more necessary to reorganize the decentralization process so that the state entity assumes a position of effective coordination and coparticipation in the formation of networks and in the process of regionalization, with sound funding.

It is also necessary to foster the empowerment of municipal managers, i.e., to expand their political and social powers by strengthening their skills. To accomplish this task, it is fundamental to implement processes of listening to the needs of smaller municipalities in regional governance spaces and to create a culture of coping with problems in a collective and shared way among subnational entities, thus promoting interfederative management. In this sense, the Regional Intermanagerial Commissions and the Bipartite Intermanagerial Steering Commissions should create spaces for discussions or working groups to build effective practices to help SSMs overcome their problems.

Such mobilization includes the joining of forces of all managers, healthcare workers, organized society, and the population to defend the public healthcare system – a coalition that, in the more than 30 years of the health system's existence, has not yet been able to materialize due to the blows suffered during dismantling.

Collaborations

All authors participated directly in the planning, execution, or analysis of this study, as described: E Pinafo, EFPA Nunes, BG Carvalho, FF Mendonça, and CM Domingos equally participated in the development of the manuscript, its discussion and writing, and the revision of the text. CR Silva collaborated in the discussion and final revision of the text. All authors read and approved the final version submitted.

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