Ciência & Saúde Coletiva
cienciaesaudecoletiva.com.br
ISSN 1413-8123. v.29, n.9
DOI: 10.1590/1413-81232024299.07052023EN

Implementation of public health consortiums and regional polyclinics in Bahia state, Brazil

Daniela Gomes dos Santos Biscarde (https://orcid.org/0000-0001-8758-2645) 1
João Vitor Pereira dos Santos (https://orcid.org/0000-0003-4472-3529) [1]
Vitória Oliveira Santos (https://orcid.org/0000-0001-6369-2970) [1]
Nilia Maria de Brito Lima Prado (https://orcid.org/0000-0001-8243-5662) [2]
Patty Fidelis de Almeida (https://orcid.org/0000-0003-1676-3574) [3]
Ana Paula Chancharulo de Morais Pereira (https://orcid.org/0000-0003-1940-5254) [4]
Adriano Maia dos Santos (https://orcid.org/0000-0001-9718-1562) [2]

Abstract *Public Health Consortiums (PHC) in Brazil represent a strategy to enhance regionalization in the Public Health Care System (SUS in Portuguese) and State/interstate/intermunicipal cooperation. The establishment of regional polyclinics aims to improve access to services with greater technological concentration and closer to users' homes. This study specifically aims to analyze the process of creating PHC and regional polyclinics in Bahia State, based on documental analysis, identifying aspects related to entering the political agenda that facilitate and hinder, the role of state administration, specificities of the composition of these PHC and regional polyclinics. A documental analysis was carried out of the minutes of the Comissão Intergestores Bipartite (CIB-BA) [Bipartite Administrative Commission] from 2015 to 2018 and of constitutive documents of the consortiums established in this state. The Ceará State experience inspired the creation of consortiums in Bahia, especially the structuring of polyclinics. Municipal administrators demonstrated a favorable position regarding the potential of consortiums with cooperation among municipalities. The role of the state government proved to be a facilitating condition, whereas the maintenance of the municipal counterpart in finance constituted a hindering element. The consortiums contributed to the regionalization of health in the state as well as expansion of access to specialized care.*

Key words *Health consortium, Health administration, Regional health planning*

[1] Escola de Enfermagem, Universidade Federal da Bahia. R. Basílio da Gama 241, Canela. 40231-300 Salvador BA Brasil. dbiscarde@ufba.br
[2] Instituto Multidisciplinar de Saúde, Universidade Federal da Bahia. Salvador BA Brasil.
[3] Universidade Federal Fluminense. Niterói RJ Brasil.
[4] Universidade do Estado da Bahia. Salvador BA Brasil.

Introduction

The establishment of the Public Health System (SUS) in Brazil was conditional upon many aspects of the coordination of public policies. These aspects were of a politico-institutional nature, typical of the federal and historico-structural arrangement linked to socio-spatial inequalities. As these limited the articulation and performance of the governments, it was essential to develop strategies and coordination instruments with multiple actors and decision-making scales for policy implementation, and comprehensive, integrated action[1].

Public Health Consortiums (PHC) are considered strategic to make public action viable as a network, uniting and integrating autonomous federal entities in carrying out activities and projects of common interest[2]. Organizational arrangements realized through PHC promote cooperation and sharing in the provision of health care among federal entities, fostering access and interaction among municipal public services, aiming to facilitate local planning and administration[3] to meet regional needs with quality and cost rationality[4].

The first experience of vertical health consortiums occurred in Ceará State. It demonstrated factors favorable for vertical cooperation in the state: (i) the trajectory of Ceará's health policy; (ii) the performance of the state government as a coordinating entity in the regionalization process; (iii) the existence of political entrepreneurs and cohesion in the bureaucracy; and (iv) the overlap between the institutional design of the consortiums and the decision-making structure of the SUS[5].

The reduction of regional inequalities is highlighted as one of the potential advantages of PHC, as they enable an equitable supply of services for the benefit of municipalities with different population sizes in the same health region[6]. Consortiums can favor decentralization of services and greater rationality in the implementation of public policies, which, from a territorial view of development, means regional issues must be dealt with jointly[7].

Regarding processes of input acquisition and contracting of services, PHC have better performance as compared to individualized processes by each federal entity[4,8]. In other situations, the strategy provides for adequacy and improvement of hospitals and other health units offering high-tech care[3]. However, the organization of flows and regional care integration still persist in a fragile state[9,10].

The specificity of the Brazilian federal arrangement, along with profound territorial inequalities and political conflicts in government are revealed as conditions for federal coordination, showing the need for command structures, sharing of responsibilities and administrative skills among federal entities, and the improvement of mechanisms for intergovernmental cooperation through strategies and instruments that favor alignment of government efforts and actions directed to common objectives[1].

In this sense, PHC are presented as an alternative to promote intergovernmental cooperation to meet the needs for high-tech services and achieve a greater degree of solution of health issues on the part of SUS, especially in regions with smaller municipalities that, in isolation, would not be able to offer a great diversity of services.

PHC strengthen integrality, expand provision and access to specialized services[11,12]. Thus, it is possible to infer that this strategy, together with the establishment of regional polyclinics, is important in the context of regionalization and equity in the distribution of health services among municipalities and regions, which, traditionally, have smaller populations, less installed capacity, lower tax revenue, administration lacking skill, compounded by the territories being far from major urban centers, facing great difficulties in access to health services, as well as deficiency in terms of SUS effectiveness.

The regionalization process in Bahia has been increasing since the 1970s[13], although it is possible to infer that this strategy, together with the establishment of regional polyclinics, has relevance in the context of regionalization and equity in the distribution of health services, even though, only throughout the 2000s, has it gained momentum due to strong action on the part of the state government[14]. In Bahia, the formation of vertical PHC is a strategy adopted by the government to set up regional health polyclinics to expand access to specialized care for different health regions, including patient transport[12].

This article aims to analyze the process of establishment of PHC and regional polyclinics in Bahia, based on documental analysis, identifying facilitating and hindering aspects related to entry into the political agenda, the role of state administration, and the specificities of territorial composition in the state.

Methodological aspects

This research is conducted by documental review[15], which produces and reworks knowledge from a research corpus consisting of 99 documents. The minutes of 36 CIB-BA meetings were analyzed, as well as 4 CIB-BA activity reports, 23 PHC statutes, 16 PHC meetings' minutes, 19 polyclinic apportionment contracts and the Regionalization Master Plan (RMP) (Chart 1). Data collection and analysis occurred between November 2019 and May 2021, conducted by scholars and the research team approved by CAAE: 79452117.5.0000.5556

Between November 2019 and January 2020, the minutes of the CIB-BA meetings from 2015 to 2018 were obtained. From January to March 2020 and in May 2021, statutes and implementation minutes, available on the website of the Bahian Regionalization Observatory (BRO) were consulted, in order to understand the chronology of the creation of PHC and regional polyclinics. In October 2022, March and August 2023, BRO was consulted again to update the PHC creation scenario.

The RMP was consulted to identify the composition of the health regions, comparing them with the composition of the PHC and the territorial scope of the polyclinics. Additionally, CIB-BA reports from April to May 2021, identified convergences and divergences about content, number and monthly frequency of meetings held by members of the Bahia State Health Secretariat (SESAB) and the Bahia State Council of Municipal Health Secretariats (COSEMS).

The analytical process was initiated by reading minutes and identification of content related to the objective of the research. There was organization and systematization of content from two analytical matrixes: 1) general characteristics of the meetings (type, frequency, periodicity, and participation of Bipartite Administrative Commission members); 2) content related to the thematic reference units (regionalization, finance, PHC and regional polyclinics). Next, by means of triangulation of documental evidence from different sources, other documents were analyzed to expand and validate the information obtained from the minutes.

During the analytical process, factors related to the availability of documents made it difficult to obtain complete information. Of the 23 PHC established in Bahia, seven did not have any minutes available in the BRO during the 2020 data collection period. In this study, the date of creation of the consortiums was considered as the date corresponding to the first assembly, and, in the absence of this, the date of protocol of the consortium's most up-to-date statute. As for the period the polyclinics were established, the date of the work order stated in the apportionment contract was adopted.

The health regions of Bahia were defined by CIB Resolution No. 275/2012[16], and updated by subsequent resolutions considering the municipalities' requests to transfer to another region. Currently, the Regionalization Master Plan has 28 health regions (Figure 1).

For analysis of the data gathered, Kingdon's perspective (1997)[17] was utilized, from which the decision-making process in public policies was represented by the confluence of three major dynamic currents: the problems (*problems*), the proposals or alternatives (*policies*) and political aspects (*politics*). Thus, the thematic units in the CIB decision agenda were identified, correlating them with the problem of access to specialized care in the state, the strategic actors and actions to promote the PHC proposal in the government's political agenda, and aspects of the political, administrative and legislative context favorable to the creation of the PHC. It was based on the content of the CIB-BA minutes, later complemented by the other documents described in Table 1.

Chart 1. Documents analyzed and their sources.

Documents	Total	Sources
Minutes of CIB-BA meetings	36	CIB-BA portal http://www5.saude.ba.gov.br/portalcib/
CIB-BA activity report	4	
PHC statutes in Bahia	23	Bahian Regionalization Observatory (BRO) https://obr.saude.ba.gov.br/
PHC minutes in Bahia	16	
Apportionment contracts for regional polyclinics	19	
Regionalization Master Plan	1	Bahia State Health Secretariat site (SESAB) http://www1.saude.ba.gov.br/mapa_bahia/indexch.asp

Source: Authors.

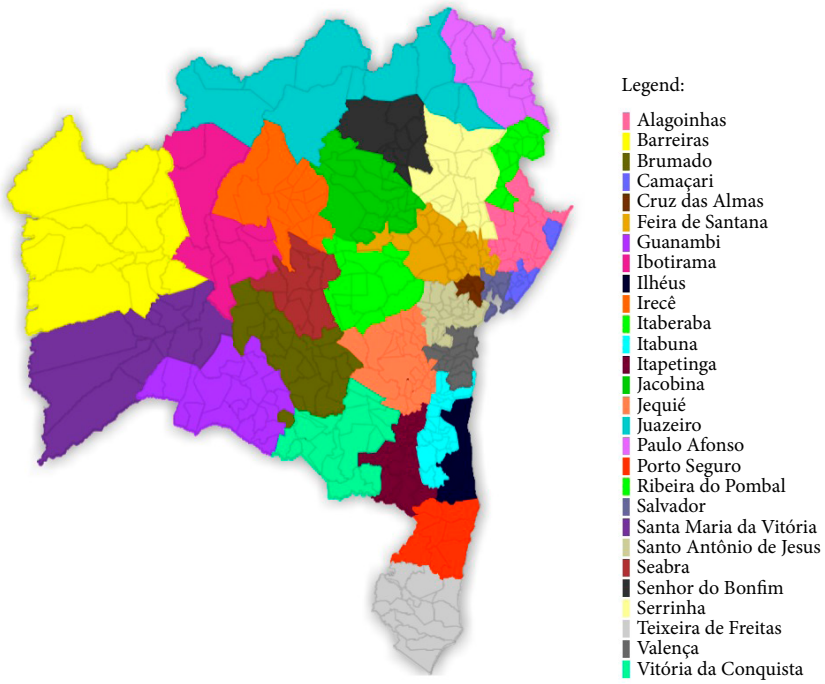

Figure 1. Health regions in Bahia State.

Source: Adapted from the map of the Bahia State health regions (http:www1.saude.ba.gov.br/mapa_bahia/indexch.asp).

Results and discussion

Entry in the CIB-BA agenda and the incentivation role of the state administration

Between 2015 and 2018 (Chart 2), an average of ten CIB meetings were held per year. Most were of an ordinary nature, only two being extraordinary. Judging by the number of minutes available in the CIB-BA electronic portal and data from the Commission's activity report, there was a divergence regarding the number of meetings during the period under analysis.

The meetings took place mostly in the auditorium of the Union of Bahian Municipalities (UPB), but some were in the auditorium of the Bahia State Legislative Assembly. They were composed of municipal and state administrators, representatives of COSEMS and SESAB[18]. Regarding attendance, there was a constant presence of CIB members. There was also an assiduous presence of those representing the capital, and this participation was noteworthy. However, there was low attendance of State Health Council representatives.

During the period analyzed, it was identified that discussions among administrators in CIB generally involved regulation and the health care network. The theme of regionalization also arose linked to actions and indicators about health surveillance, along with discussions conducted by the Health Surveillance and Protection Superintendency (SUVISA) and Bahia State Epidemiological Surveillance Directorate (DIVEP).

In 2015, there was great emphasis on the theme of Public Health Consortiums and regional polyclinics, this being associated with the strengthening of the decentralization and regionalization of the SUS. On the other hand, in the 2016 minutes, there were no references to PHC, a fact also evidenced in the CIB-BA activity report.

In 2017, the analysis of minutes showed emergence of discussion involving regional polyclinics highlighting their influence on access to specialized care in small municipalities. Furthermore, there were discussions related to agreements among municipalities, within and outside

Chart 2. Characterization of the CIB-BA meetings from 2015 to 2018.

Year	Meetings		Mean attendance of members at the meetings*	
	O[1]	E[2]	COSEMS	SESAB
2015	9	2	6.9	6.2
2016	9	0	5.5	6.5
2017	10	0	5.7	5.9
2018	10	0	5.8	6.5

Source: Portal of the Bipartite Administrative Commission – BA. Accessed: May/2021. Available at: http://www5.saude.ba.gov.br/portalcib/index.php?option=com_content&view=article&id=445&itemid=188. * Arithmetic mean calculated from the number of members present at each meeting based on CIB-BA activity reports, 2015 to 2018. 1 O – ordinary meeting. 2 E – extraordinary meeting.

the same health region. In 2018, there were discussions about the increase in the incidence of diseases, such as diabetes, prostate and breast cancer, correlated with the action of regional polyclinics in the face of such problems.

Due to the PHC and polyclinics, with the perspective of strengthening the interdependence relationships among municipalities, it was recognized there was greater possibility of integration and strengthening of the health region. Thus, especially in 2017, it was possible to notice narratives of the SESAB directive team about strengthening the SUS through the regional health care organization, a guideline that enabled a more refined view of the health regions' singularities.

Between 2015 and 2018, of the 36 CIB-BA minutes, the PHC were referred to in 8; 2015 having the highest frequency (4), followed by 2017 (3) and 2018 (1). The matters dealt with at the meetings were restricted to presentation of the proposal to the plenary, the state administrator acting as rapporteur. This situation demonstrated the protagonism of the state administration in conducting such a strategy and the absence of discussion at the municipal/regional level. It was assumed that the conduct of this agenda by SESAB, resulting from the fact that such strategy entered the composition of the Government's Chief Executive Participation Program (PGP) at the time, in its Eixo 1 [Axis 1], which established in its list of actions the establishment of regional health polyclinics. Protagonism on the part of the state was observed in the process of establishing consortiums and other health care units, such as the polyclinics[19].

The government agenda followed a process characterized by: 1) emergence or recognition of a problem affecting society in general; 2) existence of ideas and alternatives to be conceptualized - originating from specialists, researchers, politicians and social actors, among others; 3) a political, administrative and legislative context favorable to the development of action[17].

Problems regarding inequality of access and utilization of health services, installed capacity and lack of welfare facilities in different regional territories of Bahia, generating large displacements of population seeking care, above all in the Salvador metropolitan region, were already reported by the mainstream media, by other studies[20], in administrative spaces, social control and election campaigns. Therefore, recognition of the problem about the difficulties of access to secondary and tertiary care levels was linked to inequality in the health macroregions, given the structural and financial heterogeneity, especially the east macroregion with its greater amount of services of medium to high complexity. Thus, restructuring the health network was necessary to strengthen and distribute resources to overcome such impasses[21].

There are conditioning aspects of a political nature: development programs privileging the capital and surroundings, and/or areas disassociated from the local and regional characteristics; and also structural aspects: high financial dependence on municipal government transfers (Municipal Participation Fund, ICMS, National Health Fund); lack of specialized professionals, great dependence on the private sector, and poor infrastructure for the health facilities. Both, results of the historical process of occupation of the Brazilian territory, had privileged the coastal zone, and the model adopted by Brazil's central government for financing health action and services was based on installed capacity, thus consolidating inter and intraregional inequalities.

Therefore, it was evidently imperative that there be reorganization of the health care network, based on population needs, financial mechanisms that would mitigate the inequalities of supply among the regions, and the strengthening of regional governance spaces. It was urgent to foster creative, innovative strategies that would strengthen solidarity and cooperative intergovernmental relations, overcoming impasses in the implementation of health policy.

The insertion of PHC into the CIB meeting agendas was the initiative of the state government, and the first record of discussion of this

theme was in the February 2015 meeting, in which there was a presentation by the state health secretary of the proposal for consortiums in Bahia. He addressed planning for the establishment of regional specialty polyclinics, based on the structuring of State/interstate/intermunicipal health consortiums (CIS).

CIB minutes indicated that the PHC agenda was raised at meetings amid a scenario of access problems and the need for cooperation among municipalities with different typologies and realities. In this context, the discussions emphasized municipal and regional strengthening through the PHC, which was with a view to improving the regionalization of the SUS, and, above all, rationalizing the utilization of resources in the health regions.

[...] through the consortiums what the SUS advocates on paper would become real: cooperation among municipalities and the real apportionment of expenditure – Minutes of 2015.

[...] the process of regionalization and decentralization started in Bahia stimulates each region to decide what to do with the MAC resources, thus heading towards strengthening the region, and, consequently, strengthening the municipalities – Minutes of 2017.

It is possible to identify the motivation for insertion of the PHC theme into the CIB agenda, given its function as a mechanism capable of fostering federal cooperation in the health region, aiming to improve state response to the population's health needs, at the same time decentralizing the decision-making process at regional level, and sharing responsibilities, resources and expenditure.

In addition to the recognition of the problem, there were analyses by experts in the academic field, administrators and technicians in health planning who already enjoyed a successful record in PHC establishment in different Brazilian states, demonstrating their potential to promote federal cooperation and strengthening the regionalization of the SUS.

The Paraná State CIS was outstanding due to the staff, their employment conditions and the visible regional improvement in the expansion of specialized services[22]. Study of the PHC in Pernambuco State revealed a democratic, regionalized administrative strategy focused on results[23]. Consortium experiences in Minas Gerais and Paraná States were outstanding in terms of state government commitment[4].

Rio Grande do Sul State[8] created consortiums to meet demands for access to health services and relief for financial weakness in small municipalities. Mato Grosso State achieved satisfactory results in improving the regional health situation after establishing consortiums[10]. In Ceará State, the establishment of PHC, aimed at guaranteeing and expanding specialized services, resulted in a successful experience[24].

Analysis of the minutes showed that the experience of the Ceará State PHC was the main reference for creation of this strategy in Bahia, including the physical structure of the units. The architectural plan and technical construction design of the Ceará State polyclinics were replicated in Bahia. In this process, there was consultation of the Ceará health administrator who had participated in the process of creating the consortiums and polyclinics.

Regarding the political, administrative and legislative context for creating the government agenda focused on the creation of PHC in Bahia, the content of the minutes also pointed out that there was a facilitating scenario[17]. There was a notable alignment between the governor and the state health secretary in order to decentralize and extend reference services to the state health regions. Evidence obtained in the minutes revealed that "*the governor's banner for the health area has, from the very first moment, always been regionalization, decentralization.*" Such ideas coincided with the state health secretary's perspective, as stated in the minutes.

This alignment and expansion of services denoted the prospect of increasing the installed capacity, access and regional determination, thereby favoring the regionalization process. Since the Labor Party mandates in control of the State Government (2007-2014), initiatives for establishment of public consortiums as a strategy for territorial development in Bahia occupied the government agendas, with emphasis on multipurpose consortiums[25] (Figure 2).

There was a Bahia State government decision regarding the adoption of the PHC strategy to establish regional polyclinics as of 2015. Thus, a political process was triggered, with strong determination on the part of the state executive, through negotiations with mayors and articulations with the legislature (ALBA and Municipal Councils) in order to enable approval of the law to regulate the PHC in each subnational sphere. It is noteworthy that, in September 2015, State Law No. 13,374 was passed[26], which addressed the participation of the state in the State/interstate/intermunicipal health consortiums (CIS), aiming at technical cooperation among federal entities, the

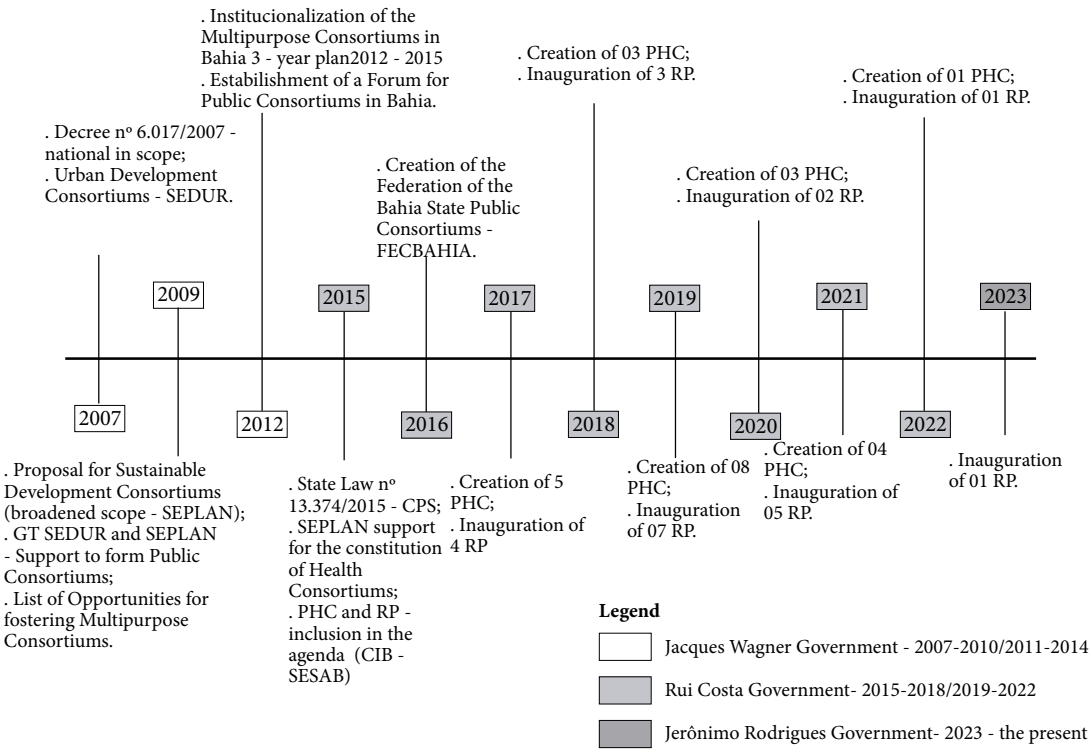

Figure 2. Creation of Public Health Consortiums (PHC) and Regional Polyclinics (RP) in Bahia 2015 - 2023.

SEDUR - Urban Development Secretariat; SEPLAN - Planning Secretariat; SESAB - Bahia State Helath Secretariat.

Source: Observatório Baiano de Regionalização. Accessed march 21 2021. Available at: http://consorcios.saude.ba.gov.br/. Portal of Bipartite – BA. Accessed may/2021. Available at: http://www5.saude.ba.gov.br/portalcib/index.php?option=com_content&view=article&id=445&Itemid=188. SPlanning Secretariat. Territorial Planning Board (Bahia). Bahia State Territorial policy. Implementation History, 2003. Accessed august/2023. Available at: https://www.seplan.ba.gov.br/wp-contant/uploads/Texto-DPT-Politica-Territorial_-V-2.0-2022.pdf.

provision of specialized services, among others. Studies showed that vertical health consortiums were a relatively new phenomenon in the Brazilian scenario[19,27].

Despite the continuation of the Labor Party mandate in the state government, a new governor took office, and there were changes in the composition of the Bahia Legislative Assembly. This scenario, in 2015, resulted in alteration of the composition of the administrative teams of the various state secretariats, including SESAB. In addition to personnel replacements, they occurred concurrently with modifications to the political agenda and proposals/initiatives. Such changes involved key changes in the government agencies, in the administrative and legislative sphere, affecting power disputes and indicating situations in which policy alternatives, previously considered inappropriate or unviable, became valued[28].

The political decision of the state executive, namely the governor and health secretary, the strong resoluteness of SESAB in CIB and in the articulations with mayors, associated with change in administration, led to a political environment that would facilitate the establishment of the PHC. There was a notable convergence of elements to build a political, administrative and legislative context favorable to the development of appropriate action[17].

Specificities of the composition of public health and regional polyclinic consortiums in Bahia

As stated above, Bahia's PHC were inspired by Ceará State's experience. Although the Bahian government adopted the Ceará model as a guideline for the creation of PHC, records pointed out that the territorial composition had distinct contours. In Ceará, there was convergence among the health regions and the coverage area of PHC and polyclinics. In the Bahian experience, the territorial distribution of the PHC and polyclinic coverage did not follow the cartography of the 28 health regions in the RMP. Thus, the territory covered by polyclinic services in Bahia presented groupings of municipalities of different health regions, some of which were divided to compose different consortiums (Chart 3).

Reports found in the 2016 and 2018 minutes pointed out the influence of consortium formats on the composition of the health regions. Both representatives of SESAB and COSEMS reported that, during the movement to create consortiums and polyclinics, there were cases of municipalities that left one health region to join another. In different minutes, there were records of administrators presenting the need to revise the Bahia Health Map, as well as the RMP. Thus, evidence showed that the composition of some health regions may have changed as a consequence of the process of creating and establishing consortiums and polyclinics.

During the first stage of consultation of the Observatório Baiano de Regionalizaçãção (BRO) in 2020, regulations and minutes showed a total of 19 PHC established, covering 26 health regions. In a new consultation in 2021, there were four more (CISCD, Unida Chapada, CBTS and CONPIS), including two new health regions (Porto Seguro and Seabra), as well as encompassing the municipalities of three health regions that were already in other consortiums (Itaberaba, Salvador and Serrinha).

In 2022, it was observed that the number of PHC remained the same, although their compositions had changed. The Alto Sertão consortium included a municipality (Botuporã). From the CISVITA, three municipalities (Aratu, Guajeru and Malhada de Pedras) left and migrated to CISB. This also applied to seven more consortium members (Boquira, Érico Cardoso, Ibipitanga, Livramento de Nossa Senhora, Macaúbas, Paramirim and Rio do Pires). In Reconvale, there was withdrawal of the towns, Muritiba and Conceição da Feira. These municipalities entered the Sertão Portal consortium, from which Irará had exited.

COISAN joined the Tucano municipality, which had left CONPIS. The town of Maraú became a member of the CISCAU consortium, and the Ubaitaba municipality, which had previously participated in CIRCJ. In turn, CISBARC comprised three municipalities (Bom Jesus da Lapa, Sítio do Mato and Serra do Ramalho) and had lost three (Serra Dourada, Tabocas do Brejo Velho and Correntina).

In March 2023, few modifications were identified in PHC compositions. The Monte Santo municipality left CONPIS to move to the consortium in the Senhor do Bonfim region. There was a return of some municipalities to the consortiums in which they had previously been members, such as Muritiba to Reconvale, and Correntina to CISBARC.

In October 2022, municipalities of the 28 health regions in Bahia were covered by PHC, totaling 407 of the 417. In March 2023, according to BRO data, this number increased to 408.

Possible consequences of the PHC compositions and the territorial scope of polyclinics for the negotiation process among the municipalities are noteworthy. In 2017, there was a sign of difficulties in conducting and implementing the agreement process among municipalities of different health regions, which were described by a technical area representative of the state administration as "*problematic procedures*". The divergence among the territorial aspects of the PHC and the health regions resulted in difficulties in the Integrated Agreement Programing process (IAPP), an instrument that deals with the reference and counter-reference for outpatient and hospital services with greater technological concentration, which culminates in allocation of resources of medium and high complexity (MAHC), passed on by the Ministry of Health to the Municipal Health Funds of the municipalities executing services not available in others.

Regarding the position of CIB members on this process, consensus was noted among administrators about the need for cooperation among municipalities of different sizes. Thus, the PHC were viewed as a strategy to unite these municipalities, aiming to reduce the lack of integration among services, improve resource distribution among municipalities, and increase access to services, resoluteness and strengthening of the regional health network. Experience in the southern region demonstrated that the consortiums had made it possible to economize in the acqui-

Chart 3. Public Health Consortiums established in Bahia between 2015 and 2022.

Consortiums	PHC data	Polyclinic data	Health regions	Municipalities in consortiums
Alto Sertão	2017	2017	Guanambi and Brumado	23 municipalities **Guanambi:** Caculé, Caetité, Candiba, Carinhanha, Feira da Mata, Guanambi, Ibiassucê, Igaporã, Iuiú, Jacaraci, Lagoa Real, Licínio de Almeida, Malhada, Matina, Mortugaba, Palmas de Monte Alto, Pindaí, Riacho De Santana, Rio do Antônio, Sebastião Laranjeiras, Tanque Novo, Urandi **Brumado:** Botuporã.
Consaúde	2017	2017	Teixeira de Freitas	13 municipalities **Teixeira de Freitas**: Alcobaça, Caravelas, Ibirapuã, Itamaraju, Itanhém, Jucuruçu, Lajedão, Medeiros Neto, Mucuri, Nova Viçosa, Prado, Teixeira de Freitas, Vereda.
CISRJ	2017	2017	Jequié and Itabuna	27 municipalities **Jequié:** Aiquara, Apuarema, Barra do Rocha, Boa Nova, Brejões, Cravolândia, Dário Meira, Ibirataia, Ipiaú, Irajuba, Iramaia, Itagi, Itagibá, Itamari, Itaquara, Itiruçu, Jaguaquara, Jequié, Jitaúna, Lafaiete Coutinho, Lajedo do Tabocal, Manoel Vitorino, Maracás, Nova Itarana, Planaltino, Santa Inês. **Itabuna:** Ubatã.
CRSIrecê	2017	2017	Irecê, Ibotirama, Itaberaba, Jacobina and Seabra	24 municipalities **Irecê:** América Dourada, Barra do Mendes, Barro Alto, Cafarnaum, Canarana, Central, Gentio do Ouro, Ibipeba, Ibititá, Irecê, Itaguaçu da Bahia, João Dourado, Jussara, Lapão, Mulungu do Morro, Presidente Dutra, São Gabriel, Uibaí. **Ibotirama:** Barra e Buritirama. **Itaberaba:** Bonito. **Jacobina:** Morro do Chapéu, Tapiramutá. **Seabra:**Souto Soares,
COISAN	2017	2021	Ribeira do Pombal and Serrinha	16 municipalities **Ribeira do Pombal:** Adustina, Antas, Banzaê, Cícero Dantas, Cipó, Coronel João Sá, Fátima, Heliópolis, Nova Soure, Novo Triunfo, Olindina, Paripiranga, Ribeira do Amparo, Ribeira do Pombal, Sítio do Quinto. **Serrinha**: Tucano.
Reconvale	2018	2018	Santo Antônio de Jesus and Cruz das Almas	28 municipalities **Santo Antônio de Jesus:** Amargosa, Aratuípe, Castro Alves, Conceição do Almeida, Dom Macedo Costa, Elísio Medrado, Itatim, Jaguaripe, Jiquiriçá, Laje, Milagres, Muniz Ferreira, Mutuípe, Nazaré, Presidente Tancredo Neves, Salinas da Margarida, Santa Teresinha, Santo Antônio de Jesus, São Felipe, São Miguel Das Matas, Ubaíra, Varzedo **Cruz das Almas:** Cabaceiras do Paraguaçu, Cachoeira, Cruz das Almas, Governador Mangabeira, Maragogipe, Muritiba.
Baixo Sul	2018	2018	Valença and Salvador	13 municipalities **Valença:** Cairu, Camamu, Gandu, Igrapiúna, Ituberá, Nilo Peçanha, Nova Ibiá, Piraí do Norte, Teolândia, Taperoá, Valença, Wenceslau Guimarães. **Salvador:** Itaparica.

it continues

Chart 3. Public Health Consortiums established in Bahia between 2015 and 2022.

Consortiums	PHC data	Polyclinic data	Health regions	Municipalities in consortiums
Portal do Sertão	2018	2018	Feira de Santana and Serrinha	29 municipalities **Feira de Santana:** Amélia Rodrigues, Anguera, Antônio Cardoso, Baixa Grande, Candeal, Capela do Alto Alegre, Conceição do Jacuípe, Conceição da Feira, Coração de Maria, Feira de Santana, Gavião, Ichu, Ipecaetá, Ipirá, Irará, Nova Fátima, Pé de Serra, Pintadas, Rafael Jambeiro, Riachão do Jacuípe, Santa Bárbara, Santanópolis, Santo Estêvão, São Gonçalo dos Campos, Serra Preta, Tanquinho, Teodoro Sampaio, Terra Nova; **Serrinha:** Água Fria.
Metro Recôncavo Norte	2019	2019	Camaçari and Salvador	6 municipalities **Camaçari:** Camaçari, Conde, Dias D'ávila, Mata de São João, Simões Filho. **Salvador:** Lauro de Freitas.
CISVITA	2019	2019	Vitória da Conquista and Itapetinga	28 municipalities **Vitória da Conquista:** Anagé, Barra do Choça, Belo Campo, Bom Jesus da Serra, Caetanos, Cândido Sales, Caraíbas, Condeúba, Cordeiros, Encruzilhada, Maetinga, Mirante, Piripá, Planalto, Poções, Presidente Jânio Quadros, Ribeirão do Largo, Tremedal, Vitória da Conquista; **Itapetinga:** Caatiba, Ibicuí, Iguaí, Itambé, Itapetinga, Itarantim, Macarani, Maiquinique, Nova Canaã.
CONSAN	2019	2019	Jacobina	17 municipalities **Jacobina:** Caém, Caldeirão Grande, Capim Grosso, Jacobina, Mairi, Miguel Calmon, Mirangaba, Ourolândia, Piritiba, Quixabeira, São José do Jacuípe, Saúde, Serrolândia, Umburanas, Várzea da Roça, Várzea do Poço, Várzea Nova.
CPISRJ	2019	2019	Juazeiro	10 municipalities **Juazeiro:** Campo Alegre De Lourdes, Canudos, Casa Nova, Curaçá, Juazeiro, Pilão Arcado, Remanso, Sento Sé, Sobradinho, Uauá.
CISRP	2019	2019	Paulo Afonso	9 municipalities **Paulo Afonso:** Abaré, Chorrochó, Glória, Jeremoabo, Macururé, Paulo Afonso, Pedro Alexandre, Rodelas, Santa Brígida.
CISCAU	2019	2019	Itabuna, Ilhéus and Itapetinga	31 municipalities **Itabuna:** Almadina, Aurelino Leal, Barro Preto, Buerarema, Camacan, Coaraci, Floresta Azul, Gongogi, Ibicaraí, Ibirapitanga, Itabuna, Itaju do Colônia, Itajuípe, Itapé, Itapitanga, Jussari, Maraú, Ubaitaba, Pau Brasil, Santa Cruz da Vitória, São José da Vitória; **Ilhéus:** Arataca, Canavieiras, Ilhéus, Itacaré, Mascote, Potiraguá, Santa Luzia, Una; **Itapetinga:** Firmino Alves, Itororó.

it continues

sition of health inputs, as the cost was shared among several members[8].

Identified as facilitating aspects of this process were the resolute support of the State Government to promote an administrative model and organization of services favoring SUS regionalization. In this sense, the allocation of state resources to enable the creation of polyclinics and establishment of consortiums was highly valued by the administrators.

Chart 3. Public Health Consortiums established in Bahia between 2015 and 2022.

Consortiums	PHC data	Polyclinic data	Health regions	Municipalities in consortiums
Senhor do Bonfim	2019	2019	Senhor do Bonfim and Serrinha	13 municipalities **Senhor do Bonfim:** Andorinha, Antônio Gonçalves, Campo Formoso, Filadélfia, Itiúba, Jaguarari, Pindobaçu, Ponto Novo, Senhor do Bonfim; **Serrinha:** Cansanção, Nordestina, Monte Santo, Queimadas.
CBTS Baía de Todos os Santos	2019	2023	Salvador	6 municipalities **Salvador:** Candeias, Madre de Deus, Santo Amaro, Saubara, São Francisco do Conde, São Sebastião do Passé.
CLINAB	2020	2020	Alagoinhas and Camaçari	19 municipalities **Alagoinhas:** Acajutiba, Alagoinhas, Aporá, Araçás, Aramari, Cardeal da Silva, Catu, Crisópolis, Entre Rios, Esplanada, Inhambupe, Itanagra, Itapicuru, Jandaíra, Ouriçangas, Pedrão, Rio Real, Sátiro Dias. **Camaçari:** Pojuca.
CONSOB	2020	2020	Barreiras, Ibotirama and Santa Maria da Vitória	22 municipalities **Barreiras:** Angical, Baianópolis, Barreiras, Brejolândia, Catolândia, Cotegipe, Cristópolis, Formosa do Rio Preto, Luís Eduardo Magalhães, Mansidão, Riachão das Neves, Santa Rita de Cássia, São Desidério, Tabocas do Brejo Velho, Wanderley; **Ibotirama:** Brotas de Macaúbas, Ibotirama, Morpará, Muquém de São Francisco, Oliveira dos Brejinhos, Paratinga; **Santa Maria da Vitória:** Serra Dourada.
CONPIS	2021	2021	Serrinha	13 municipalities **Serrinha:** Araci, Barrocas, Biritinga, Conceição do Coité, Euclides da Cunha, Lamarão, Quijingue, Retirolândia, Santaluz, São Domingos, Serrinha, Teofilândia, Valente.
CISB	2021	2021	Brumado	20 municipalities **Brumado:** Aracatu, Barra da Estiva, Brumado, Caturama, Boquira, Contendas do Sincorá, Dom Basílio, Guajeru, Ibicoara, Ituaçu, Jussiape, Livramento de Nossa Senhora, Malhada de Pedras, Paramirim, Macaúbas, Rio de Contas, Tanhaçu, Érico Cardoso, Ibipitanga, Rio do Pires.
Chapada Unida	2021	2021	Itaberaba and Seabra	23 municipalities **Itaberaba**: Andaraí, Boa Vista Do Tupim, Iaçu, Ibiquera, Itaberaba, Itaeté, Lajedinho, Macajuba, Marcionílio Souza, Nova Redenção, Ruy Barbosa, Utinga, Wagner; **Seabra**: Abaíra, Boninal, Ibitiara, Iraquara, Lençóis, Mucugê, Novo Horizonte, Palmeiras, Piatã, Seabra.
CISCID	2021	2021	Porto Seguro	7 municipalities **Porto Seguro:** Belmonte, Eunápolis, Guaratinga, Itabela, Itagimirim, Itapebi, Santa Cruz Cabrália.
CISBARC	2022	2022	Santa Maria da Vitória	11 municipalities **Santa Maria da Vitória:** Bom Jesus da Lapa, Canápolis, Correntina, Cocos, Coribe, Jaborandi, Santa Maria da Vitória, Santana, São Félix do Coribe, Serra Do Ramalho, Sítio do Mato.

Source: Bahian Regionalization Observatory. Accessed: 2023 August 28. Available at: https://consorcios.saude.ba.gov.br/

For the first time the State Government had indicated new funding for the municipalities in order to make consortiums viable, and thus was injecting 40% of the costs of the structures of medium com-

plexity that municipalities had committed to assume and share via consortiums – Minutes of 2017.

Experiences in different realities in Brazil point to the importance of state participation as one of the reasons for expanding PHC. Evidence from Pernambuco State demonstrated that state administration participated in the articulation with the municipalities and in the financing of regional actions, these being fundamental for the establishment, legitimacy and sustainability of the consortiums[29]. In Mato Grosso State, this participation ensured financial viability[11]. The Paraná State administration acted in the promotion of intermunicipal cooperation, encouraging and articulating with municipalities to better adhere to consortiums[30]. A study of Ceará revealed the protagonism of the state, because of its legitimacy in the formal spaces of negotiation and decision at the regional level, impacting the ascension of the PHC[24]. Research in Bahia also pointed out that capital expenditure on construction, equipment, patient transport and permanent co-finance on the part of the state administrator were factors that encouraged adherence to vertical consortiums[19].

The format of shared financing and assumption of technical and financial responsibility by the state government to fund the polyclinics was fundamental in the Bahian scenario. However, one can notice that one of the points that hindered the above was the municipal administrators' concern to guarantee their part of the resources, in view of the underfunding of the SUS and municipal budget restrictions.

Final considerations

Historically, the process of regionalization in Bahia has been marked by administrative deconcentration and political conflicts, without the necessary decentralization of power for regional territories and administrative structures. The adoption of PHC has become an alternative to strengthen regionalization through cooperation among unequal federal entities, aiming to provide services and develop joint actions that take into account collective interests and public benefits, thus consolidating the process of political decentralization.

Discussions about the PHC based on the CIB involved the need to strengthen regional territories, effectively contributing to the regionalization of the SUS. Despite the existing weaknesses, the importance of establishing regional polyclinics is emphasized, as a PHC strategy in Bahia will expand access to specialized care through consultations, diagnostic and therapeutic support procedures at the regional level.

This study presents limits since documental analysis does not allow deepening of the nuances of the political aspects inherent to SUS regional administration, which permeated the decision-making for the establishment of regional PHC and polyclinics in Bahia. There is a need for other studies to further analyze this process, based on the conception of actors, agreements and a decision-making process involving different municipalities and regions of the state. A strong point is the strategic role of states in the inducement and coordination of SUS regionalization, as well as specificities related to the territorial scenario and state capacities. Although inspired by the case of Ceará, there are peculiarities in the PHC and polyclinic formats in Bahia, which diverge from the composition of the health regions delimited by the RMP. Such aspects need to be investigated to discover the motivation for these formats, and the consequences for regional planning and administration, for the user access flow, organization and care integration of the regional health service network. Moreover, it is necessary to conduct analyses about the relationships among the PHC, the process of public participation and social control in the SUS and the Regional Administrative Commissions that, a priori, would be decision-making instances conducting the SUS regional administrative process.

Collaborations

DGS Biscarde worked in all the production stages, from conception to final edition; JVP Santos dealt with the data collection and analysis; VO Santos handled data collection, review/revision and final edition; AM Santos and NMBL Prado were engaged in the conception, review/revision and final edition; PF Almeida and APCM Pereira were likewise involved in the review/revision and final edition.

Funding

Fundação de Amparo à Pesquisa do Estado da Bahia (FAPESB) – TO – SUS0030/2018.

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Article submitted 10/05/2023
Approved 09/09/2023
Final version submitted 11/09/2023

Chief editors: Maria Cecília de Souza Minayo, Romeu Gomes, Antônio Augusto Moura da Silva