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Regional governance: strategies and disputes in health region management

Governança regional: estratégias e disputas para gestão em saúde

ABSTRACT

OBJECTIVE: To analyze the regional governance of the health systemin relation to management strategies and disputes.

METHODOLOGICAL PROCEDURES: A qualitative study with health managers from 19 municipalities in the health region of Bahia, Northeastern Brazil. Data were drawn from 17 semi-structured interviews of state, regional, and municipal health policymakers and managers; a focus group; observations of the regional interagency committee; and documents in 2012. The political-institutional and the organizational components were analyzed in the light of dialectical hermeneutics.

RESULTS: The regional interagency committee is the chief regional governance strategy/component and functions as a strategic tool for strengthening governance. It brings together a diversity of members responsible for decision making in the healthcare territories, who need to negotiate the allocation of funding and the distribution of facilities for common use in the region. The high turnover of health secretaries, their lack of autonomy from the local executive decisions, inadequate technical training to exercise their function, and the influence of party politics on decision making stand as obstacles to the regional interagency committee's permeability to social demands. Funding is insufficient to enable the fulfillment of the officially integrated agreed-upon program or to boost public supply by the system, requiring that public managers procure services from the private market at values higher than the national health service price schedule (Brazilian Unified Health System Table). The study determined that "facilitators" under contract to health departments accelerated access to specialized (diagnostic, therapeutic and/or surgical) services in other municipalities by direct payment to physicians for procedure costs already covered by the Brazilian Unified Health System.

CONCLUSIONS: The characteristics identified a regionalized system with a conflictive pattern of governance and intermediate institutionalism. The regional interagency committee's managerial routine needs to incorporate more democratic devices for connecting with educational institutions, devices that are more permeable to social demands relating to regional policy making.

DESCRIPTORS: Health Services Administration. Regional Health Planning. Health Care Rationing. Health Services Coverage. Consumer Participation. Health Management. Health Manager. Unified Health System.

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RESUMO

OBJETIVO: Analisar o sistema de governança regional em saúde quanto a estratégias e disputas de gestão.

PROCEDIMENTOS METODOLÓGICOS: Pesquisa qualitativa com gestores de saúde de 19 municípios que integram a região de saúde no estado da Bahia. Foram realizadas 17 entrevistas semiestruturadas com gestores/gerentes (estadual, regional e municipal), grupo focal, observações na Comissão Intergestores Regional e documentos institucionais, em 2012. Foram analisados os componentes político-institucional e organizacional e interpretados pela hermenêutica-dialética.

RESULTADOS: A comissão intergestores regional foi a principal estratégia da governança regional, sendo ferramenta fundamental para fortalecimento da governança por reunir diferentes sujeitos responsáveis pela tomada de decisão nos territórios sanitários e pela negociação da alocação de recursos e distribuição dos estabelecimentos de uso comum na região. A rotatividade de secretários de saúde, baixa autonomia nas decisões executivas, a qualificação técnica insuficiente para exercício da função e o atravessamento das políticas partidárias na tomada de decisão são fatores que obstruem a comissão intergestores regional às demandas sociais. Recursos financeiros insuficientes não viabilizam o cumprimento da programação pactuada integrada nem o aumento da oferta pública na rede e impunham ao gestor a compra de serviços no mercado privado por valores acima da Tabela do Sistema Único de Saúde. Foram relatados atravessadores contratados para agilizar o acesso aos serviços especializados (diagnóstico, terapêutico e/ou cirúrgico) em outros municípios mediante pagamento direto a médicos por procedimentos já custeados pelo Sistema Único de Saúde.

CONCLUSÕES: A rede regionalizada de saúde apresenta padrão de governança conflitante e com institucionalidade intermediária. A comissão intergestores regional necessita incorporar, à rotina de gestão, dispositivos mais democráticos que logrem articulação com instituições de ensino, permeáveis às demandas sociais, para definição das políticas regionais.

DESCRITORES: Administração de Serviços de Saúde. Regionalização. Alocação de Recursos para a Atenção à Saúde. Cobertura de Serviços de Saúde. Participação Comunitária. Gestão em Saúde. Gestor de Saúde. Sistema Único de Saúde.

INTRODUCTION

There are wide disparities among Brazilian municipalities because of geographic, demographic, political, technical-administrative, socioeconomic, and financial conditions, as well as the complexity of the population's needs and demands. These disparities present problems that can only be challenged by moving beyond municipal borders, as "the scope of comprehensiveness depends upon the articulation of municipal care systems in regional networks"[8] (p. 287). In fact, these disparities expose the need for inter-municipal connections that open up space for "the profusion of new forms of relationship between State and society, placing the bedrocks of the power structure, the organization and management of existing political institutions, within the framework of public discussion"[5] (p. 11), conferring a new governance model that combines decentralization with the need for solidary integration.

In Brazil, delays in regionalizing the *Sistema* Único *de Saúde* (SUS – Unified Health System) pacified the local health systems' capacity for problem solving, amplifying municipalities' disputes over resources instead of creating an interdependent and cooperative network. Thus, the absence of regional planning in strategies to

decentralize the SUS intensified the inequalities of these sub-national units. It also weakened and damaged the role of state power; since 1990, thousands of local, isolated systems have sprung up without the managerial capacity to facilitate comprehensiveness and with no mechanisms or expertise to form inter-municipal networks.[24]

Regionalization is an attribute of national health systems that are organized to increase access and reduce inequalities, strengthen the principles of universality and equality.[13] In this sense, regionalization should facilitate the use of technology for care in an opportune time and place, anywhere in the territory. It should also be guided by a systemic rationality, which cooperatively contemplates disparities present in the distribution of different services and resources necessary for comprehensiveness and inter-sectoral coordination.[20]

Studies have shown the difficulties in combining a "regional government," given inadequacies in funding, fragile work management policies, constraints on the provision of services, and extended waiting times.[a] The private sector's interference in the SUS throughout the entire process of regionalization,[b] and the conflictive and disputatious relationships among municipalities, in the absence of any regional discussion",[11] emphasize the strategic role that state management plays in inducing regionalization[c] and establishing regional bodies.[a] Therefore, in contrast to an objective image that models gains from regionalization, its implementation has been complex and incremental, alternating between advances and retreats.

Rule 7,508,[d] of June 28, 2011, directs the establishment of regionalized networks and defines health regions as privileged spaces for the integration of health services. It considers the Regional Master Plan as its starting point, but makes the necessary adaptations that respond appropriately to territorial dynamics, encouraging cooperative interagency action. It also defines the role of regional interagency committees as bodies that connect municipal administrators. These administrators should propose the distribution of health services and workers in a coordinated and solidary manner to ensure broad access to health actions at different care levels, enabling equality and comprehensiveness through care management. In this sense, regional interagency committees are innovative, as they are co-management bodies in a regional space. They establish a permanent and continuous channel for negotiation and decision making between the municipalities and the state, filling a "void" in regional governance.[24]

Regional governance is one of the components of a regionalized network[16] and is recognized as a process of participation and negotiation among several subjects with different degrees of autonomy. It represents a diverse group of interests (public and private) in a stable institutional framework that encourages cooperative relationships among governments, agents, organizations, and citizens to establish links and networks between subjects and institutions.[25]

The importance of a regional interagency committee and its strategic role in the regionalization process makes it possible to identify specific types of governance.[25] Governance depends on institutional design and dialogue with a society's organized groups to define, monitor, and implement public policies.[3]

Thus, governance must involve the modes of exercising authority and the processes of integrating social interests in the government's agenda.[6] It can be used as an analytical tool to research and transform the processes of policy formulation and health system management. The analytic use of governance allows it to "describe and explain the interactions of actors, processes, and rules of the game, and thus gain a better understanding of behavior and decision making in society"[10] (p. 36).

From the perspective of an integrated system, the management of a regionalized network is vital to the core of a social policy such as the SUS. Health problems demand a coordinated, interdependent, and cooperative system with "multiple dimensions of integration between different sub-systems relating the clinic and governance to collective representations and values"[9] (p. 336).

The objective of this study is to analyze the regional governance system for health in terms of management strategies and disputes.

METHODOLOGICAL PROCEDURES

This is a case study in the health region of Vitória da Conquista, BA, including 19 municipalities that comprise the *Comissão Intergestores Regional* (CIR – Regional Interagency Committee). The case study was adopted to explore the organizations' dynamics, the inter-relationships between programs' implementation

[a] Lopes CMN. Regionalização em saúde: o caso de uma microrregião no Ceará (1998-2002 e 2007-2009) [tese de doutorado]. Salvador: Instituto de Saúde Coletiva da UFBA; 2010.
[b] Coelho APS. O público e o privado na regionalização da saúde: processo decisório e condução da política no Estado do Espírito Santo [dissertação de mestrado]. Rio de Janeiro: Escola Nacional de Saúde Pública; 2011.
[c] Pereira AMM. Dilemas federativos e regionalização da saúde: o papel do gestor estadual do SUS em Minas Gerais [dissertação de mestrado]. Rio de Janeiro: Escola Nacional de Saúde Pública; 2009.
[d] Presidência da República, Casa Civil, Subchefia para Assuntos Jurídicos. Decreto nº 7.508, de 28 de junho de 2011. Regulamenta a Lei nº 8.080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde - SUS, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências [cited 2014 Jul 8]. Available from: http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2011/decreto/D7508.htm

and results, and how and why things happen.[23] The results emerged from the analyses and intersections of narratives produced in 17 semi-structured interviews[18] with administrators/managers at the state (three subjects), regional (three subjects), and municipal (11 subjects) levels, as well as a focus group with institutional supporters from the State Secretary of Health. Analyses of records from "nonparticipant" observation[7] and the CIR meetings conducted between 2011 and 2012 were included. The respondents occupied a strategic position in the Health secretariats (Municipal and State) or in the regional board of health. They were chosen through an observation of their performance (active and frequent) in the CIR meetings and through recommendations from key informants who selected the administrators/managers that had accumulated experience in their respective positions and/or had great representation/influence among their peers. All interviews and observations were conducted by one of the authors of this study. Part of an "analysis matrix for care management in a regionalized health system" was used[e] at the political, institutional, and organizational levels, starting from their sub-dimensions and respective indicators to craft the scripts for interview and observation (Table 1).

The political-institutional level is responsible for the legal framework, and thus the subjects' proposals/intentions and actions to implement regionalized networks. The organizational level includes an operational dimension, which occurs at the interfaces between various institutions and organizations in the health regions, undergoing interventions and interactions by different subjects – which comprise and imprint a logic for management and production in the network.

To analyze the results, the data was collected[2,18] from a general reading of the transcribed material, and a first organization of the different data was included in the interviews, focus group, and observations. Next, the material was classified as per Assis[2] and Minayo;[18] in this stage, the transcripts were thoroughly read, and the passages with relevant structures and central ideas (nuclei of meaning) were selected, grouped, and classified as per the sub-dimensions of the "analysis matrix" that defined the investigation's boundaries. The arguments from the interviews and focus group were challenged, followed by a comparison between the different discourses, in a dialectical confrontation of the subjects' ideas and positions that established relationships for regional management. For the final data analysis,[2,18] the assorted data that had been collected was woven together, supplemented by the minutes from the CIR meetings, and convergences and divergences were identified, linking them with a theoretical framework of dialectical hermeneutics,[17,18] to produce a comprehensive and critical analysis (Figure).

From a methodological viewpoint, the hermeneutic approach seeks to clarify the context of different subjects and the proposals that they produce, since it claims to have a level of rationality and responsibility in different languages that serve as a communication vehicle. In fact, dialectical thinking creates instruments to critique and understand the contradictions in language; it values the dynamic processes of contradictions, within which the opposition between evaluator and evaluated is itself established as the foundation of social practices.[19] From this perspective, dialectical hermeneutics are productive for supporting qualitative assessments of understanding communication. While hermeneutics emphasizes the significance of what is consensual in mediation, agreement, and unity of meaning, dialectics is oriented toward difference, contrast, dissent, disruption of meaning, and criticism.[17,18]

Four empirical categories emerged from the analyses, and they comprise the results and discussion: a) CIR's organization: the subjects' dynamic in the construction of local and regional policies, b) implications of the SUS' financing and the health region's subordination to the logic of private interests, c) immediacy in debates and regional planning, and d) micropowers: the paradox between regional bodies and local interests.

The research was approved by the Research Ethics Committee of the *Escola Nacional de Saúde Pública Sérgio Arouca* of the *Fundação Oswaldo Cruz* (ENSP/FIOCRUZ) on October 4, 2011, Opinion 207/11.

ANALYSIS OF THE RESULTS AND DISCUSSION

CIR's organization: the subjects' dynamic in the construction of local and regional policies

The CIR is not an equitable organization. It comprises two representatives from the *Secretaria Estadual de Saúde* (SES – State Secretary of Health) and all 19 municipal Health secretaries within the health region. It was a deliberative institutional space, with a local and regional governance status capable of interfering in regional health policies through its agents. However, there was no social participation. In the CIR, there was local power reproduction (of a clientelistic tradition), which was connected, through financial inducement rather than collective needs, to other local interests of a partisan political order. It did not redefine new health scenarios, but rather created a healthcare network without a solidary identity, even though the municipalities were interdependent. Some political and organizational characteristics of the health region's municipalities are in Table 2.

[e] Santos AM. Gestão do cuidado na microrregião de saúde de Vitória da Conquista (Bahia): desafios para constituição de rede regionalizada com cuidados coordenados pela Atenção Primária à Saúde [tese de doutorado]. Rio de Janeiro: Escola Nacional de Saúde Pública; 2013.

Table 1. Matrix to analyze governance in a regionalized health system. Vitória da Conquista, BA, Northeastern Brasil, 2012.

Components of regional governance	Political-institutional level	Organizational level
Sub-dimensions	Criteria/Indicators	Criteria/Indicators
Mechanisms of regional governance	Government strategies to strengthen regional governance and improve healthcare networks in the health region	Operation and regularities of the Regional Interagency Committee meetings
		Content of the debate in the Regional Interagency Committee to strengthen the regionalized network
		Advisory mechanism of the 20th Regional Health Directorate to strengthen the regionalized network
	Institutional strategies to strengthen regional governance in the health region	Municipalities that signed the Management Commitment Terms and assumed Sole Command
		Existence and operation of the Inter-municipal Consortium of Health
		Existence of an agreement between federal agencies through the Public Health Action Organizational Contract
	Institutional strategy to develop and implement the Regional Action Plan for the health region	Existence, implementation, and monitoring of the Regional Action Plan for the health region
		Method of implementing the Integrated Agreed-upon Program for the supply of vacancies and existence/type of actions that contribute to reduce gaps in care
Regional funding	State strategies for funding and encouraging regionalization	Existence and type of regional investment (origin, types, and purposes)
		Existence and type of solidary allocations of financial resources aimed at offsetting inequalities in the region
Public-private relationships	Private providers' mode of participation in the regionalization process and regional plans	Existence and use of contracting and monitoring of agreed-upon targets with private providers in the health region
		Private sector's influence on the process of regionalization and regional plans

Although there were regular CIR meetings in the Vitória da Conquista region, BA, Northeastern Brazil, analysis revealed that the subjects' dynamics in formulating and steering the agendas implied tentative strides toward strengthening the regional network of health services; roundtable discussions were reduced, causing the committee to be underutilized. The CIR remained a bureaucratic enclave, with agendas set by national/state policy, leaving insufficient space for dialogue on the causes of specific problems in the region; these characteristics are similar to those observed in the health region of Baixada Santista, SP, Southeastern Brazil.[11] The plenary sessions were marred by delays and absences of the incumbent members, inattention and, very often, the administrators' lack of interest in discussing regional issues. In fact, they restricted their participation and collaboration to the agendas that were of interest to their own municipality, relegating regionalization, contradictorily, to the background.

The Health secretaries' professional training interfered with their understanding of relevant subjects discussed in the plenary sessions, leading many administrators to omit their opinion entirely. In fact, they ceded ground to those secretaries with some training in the area and/or with a long history in the position (even without specific training), who had accumulated knowledge from experience. In the CIR, the debates were shortened to fit into the small window of time (resulting from delays) set aside for the meetings. Recurrently, the administrators were absent during the agendas related to presenting new health policies; they were frequently dispersed, returning to the plenary sessions only for the approval and ratification of projects, focused more on the administrative rites than on the perspective of regional planning or assessment. Similarly, inadequate training for health management in a health macro-region in Minas Gerais,[12] Southeastern Brazil, led to inadequacies in both the technical competence for the position held and the management capacity of local leaders.

The low autonomy of health administrators compared to the municipal executive power also represented a barrier to strengthen collective decisions. When added to the asymmetries of technical and political power, deliberations were yoked to the partisan political criteria above the technical such as, for example, the geographical distribution of health facilities and the contracting of medically specialized services/procedures. On this issue, Lotufo & Miranda,[15] considering the results of research with 36 administrators from 12 states, argue that:

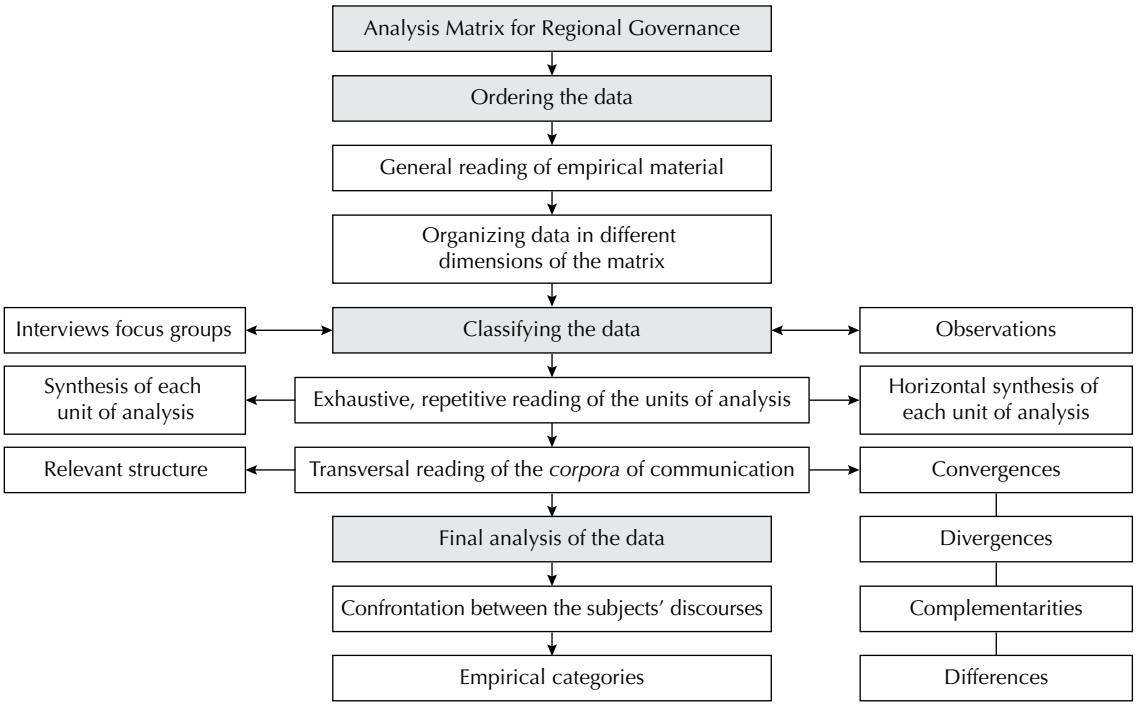
> "The prerogatives of power and institutional autonomy of these health administrators, as well as their political capital, come from an indirect delegation and a contractual (informal) relationship of trust with those public administrators who hold the formal political authority of an elective office. Therefore, their agency is sanctioned by those who delegated the prerogatives of decision-making power to them and delimit their margins of political autonomy" (p. 1146).

A study with Health secretaries from 20 cities in the state of Sao Paulo[4] found a limited ability to formulate, implement, and evaluate municipal health policies, equally linked to the predominance of untrained administrators, with no experience in public management and no understanding of what the SUS is. The power play in the CIR's dynamic is uncertain; if, on the one hand, it feeds the idea of regional strengthening, on the other hand, local hegemonic forces have commandeered it to conserve the status quo.

Implications of the SUS' financing and the health region's subordination to the logic of private interests

In the health region studied, a shortfall in public vacancies and long waiting times for access to specialized services in the SUS have pressured users to seek alternatives through direct disbursement, private health insurance, or through privileges from network professionals and/or political patronage, bypassing formal regulations for access. The administrators participating in the research attributed these issues, also observed in other studies,[4,22] to the SUS being underfinanced. Insufficient financial resources prevented the SUS from complying with the Agreed-upon Program, or increasing its own public provision of services in the network. Paradoxically, it forced public administrators to purchase services on the healthcare market for values above those on the SUS' Unified Table, since the prices charged by private providers were also freely inflated by public demand.

A critical point in the region's network of services was the action of intermediaries, who were contracted by Health secretaries to expedite access to specialized services – diagnostic, therapeutic, and/or surgical support services – in other municipalities through direct payment (fees and bonuses) to physicians for procedures that were already covered by the SUS, issues that were repeated in another study.[4] To expedite the surgical procedure in the region, physicians were contacted by Health secretaries or users and agreed on parallel criteria to perform this type of surgery in the SUS network, through "irregular payment". They thus bypassed access regulations, not always supported by clinical priority criteria, contributing to an obstruction of vacancies, generating care iniquities and encouraging sponsorship, and the private use of public space. This



Source: Adapted from Assis & Jorge2 (2010), p.155.

Figure. Development of a dialectical hermeneutics analysis.

Table 2. Characteristics of the municipalities and health administrators. Vitória da Conquista, BA, Northeastern Brazil, 2012.

Municipality	Population (inhab.)[a]	Health management	Health secretary's training	Year they assumed their position[d]	Mayor's party[b] (2009-2012)	Mayor's party[b] (2013-2016)
Anagé	25.516	State	Law	2009	PTB	PT
Barra do Choça	34.788	Municipal	Administration	2009	PP	PP
Belo Campo	16.021	Municipal	Nursing	2010	DEM	PSD
Bom Jesus da Serra	10.113	State	Pedagogy[c]	2008	PMDB	PSD
Caetanos	13.639	State	Administration	2006	PSB	PSDB
Cândido Sales	27.918	State	Administration[c]	2011	PMDB	PSB
Caraíbas	10.222	State	High school	2007	PTB	PDT
Condeúba	16.898	State	Geography	2008	PMDB	PT
Cordeiros	8.168	State	Nursing	2009	PT	PSD
Encruzilhada	23.766	State	Law[c]	2010	PTB	PT
Maetinga	7.038	Municipal	Biology	2007	DEM	PT
Mirante	10.507	State	Administration	2009	PMDB	PMDB
Piripá	12.783	State	Nursing	2005	PDT	PP
Planalto	24.481	State	Nursing	2006	PP	PT
Poções	44.701	State	Engineering	2009	PTB	PC do B
Pres. Jânio Quadros	13.652	Municipal	Pharmacology	2009	PMDB	PT
Ribeirão do Largo	8.602	State	Middle Level	2011	PT	PMDB
Tremedal	17.029	State	Administration[c]	2009	PSC	PT
Vitória da Conquista	306.866	Municipal	Nursing	2010	PT	PT

[a] Source: IBGE – 2010 Census.
[b] Source: Superior Electoral Court, 2012.
[c] In progress.
[d] Held the position in December, 2011.

issue also appeared as a common behavior of mayors and councilors, who coerced the Health secretaries in establishing processes parallel to the regional regulation, through paying physicians to expedite certain procedures. They sought to consolidate certain privileges for political supporters, which ended up exacerbating inequalities in access to and use of public resources.

These conditions result in asymmetries of power (i.e., political, economic, and symbolic) among government, administrators, health professionals, and users, which are a part of social relationships in territories with populations that are socioeconomically weakened and lack effective universal social policies – although formally defined – in an explicit restriction of citizenship.[21]

Immediacy in debates and regional planning

Regional strategies to strengthen the network itself were tentative, focused on charging money to expand the specialized and hospital offerings in the region's most important municipality, without coordinated actions to strengthen and resolve Primary Health Care and/or appropriately use the instruments for clinical management in each municipality. Furthermore, the municipal administrators were not able to properly regulate the private health sector. No mechanisms to curb the arbitrariness of private providers, who are free to increase the amounts collected from the SUS and directly charged to the users, were observed in the CIR. Other studies[1,b,f] also show that private providers organize themselves and seek to fill the gaps in SUS care, occupying more strategic and profitable niches, and exerting considerable attractiveness for new demands and a strong political, technical, and symbolic influence on public systems.

The administrators centered the debate in the CIR around the allocation of resources, particularly in regards to the failure to provide part of the services that the municipalities had already agreed they would perform, the difficulty of hiring and retaining physicians for different services, and the unavailability of beds in important hospitals. Although they recognized that their offerings were insufficient, they did not address a regional plan that would challenge these limitations.

[f] Lima LL. Gestão da política de saúde no município: a questão da autonomia [dissertação de mestrado]. Porto Alegre: Instituto de Filosofia e Ciências Humanas da UFRGS; 2005.

Furthermore, there was no permanent technical staff (technical board), internal to the CIR, to analyze and propose strategies for strengthening the regional network and overcoming common problems, or broach these proposals at the plenary sessions.

However, the CIR presented itself as a space for dialogue between administrators with different visions and projects, especially when the national/state legal norms required a regional discussion. The processes to approve new local and regional programs and policies required the administrators to present their projects in the plenary session for consideration by the CIR members. Even with the prerogative of municipal autonomy, the CIR continued, via negotiation and consensus, to limit the inter-municipal relationships to define the sites to expand and improve the regional network's offering, particularly with respect to defining the urgency and emergency networks (regional SAMU) and the maternal and child network (Stork Network).

In this direction, each municipality's special projects (Family Health Strategy, Support Center for Family Health, Oral Health Teams, Academy of Health, School Health Program, among others) were also presented in the meetings, requiring the CIR approval as a condition for receiving state and federal resources. Consequently, even though it was a bureaucratic and, to some extent, ritualistic space to get investments, the CIR functioned as a space for exchanging project designs and, potentially, played an educational role among its members, coinciding with the findings of other studies.[1,11]

The CIR's positive characteristics have been accelerated by the SES through the recommendations of technicians experienced in organizing networks with effective members, which contributed to qualifying the debates and conducting the plenary sessions. Furthermore, the State Board of Primary Care, through institutional supporters, and the Regional Directorate of Health have contributed to resolving contentious issues, such as the technical definition for allocating resources and/or establishing health in the region, and aggregating municipalities around projects that require extensive membership, as with the Program for Improving the Access and Quality of Primary Care. The municipalities themselves sent professionals to attend meetings, where they technically supported the secretaries and qualified the debate for decision making.

Micropowers: the paradox between regional bodies and local interests

The CIR's internal inconsistencies strain the private interests of local political power at the municipal level and the regional needs of a more solidary nature. The findings of Lanni et al[11] indicate that one of the challenges for SUS administrators is to "articulate the SUS' ongoing process of decentralization and regionalization in different local and regional policy scenarios, from the perspective of disrupting local patronage and autarchic actions among the levels of government" (p. 927). Through this prism, governance in the region of Vitória da Conquista expresses these ambiguities, as partisan political interferences compromise the construction of an integrated network of services and private providers exert strong pressure on the supply and densification of services. Furthermore, social participation, whether institutional through municipal health councils or through advocacy, does not critically vocalize the problems of regionalization. This correlation of forces runs through the regional board as well, since the Health secretaries are the interlocutors and representatives of these local and regional forces and weaknesses.

FINAL CONSIDERATIONS

The regional debate is permeated with urgent issues: insufficient provision of services; an increase in salaries and procedures, particularly that of physicians; overcrowding in hospitals; a large unhelpful Family Health Strategy, among others. Thus, the central points, such as planning a regionalized provision of services, defining a care model, and reorganizing the health work process to produce care, either do not appear or remain marginal.

Under the protection of the Health Pact, regionalization assumes a network of interdependent health services with mutual responsibility among the subnational entities, but without implying subordination among them.[15] This perspective, which presumes municipal autonomy and regional coordination aligned with the plurality of subjects involved in regional management, should assume the design of public governance in the health services network.

The region studied also presents preliminary characteristics for a regional governance. From the viewpoint of institutionalism, the CIR's existence – with regular operation and required processes for raising funds and investments in the region linked to the board's consensus – is a powerful mechanism for asserting relationships of co-responsibility. The institutional learning that results from the dynamic of participating in the CIR strengthens interagency management and presents itself as an important component for constructing a regionalized network. In contrast, the exercise of governance is limited to the premises of the CIR, which is only instituted by Health secretaries. However, the other subjects that form the regionalized network establish hierarchical and/or informal interfaces in the decision-making process, seeking to defend their interests before the State or influence its decisions about sectorial policies that affect them, within a panorama of scarce financial resources.

In summary, the characteristics found in the region demonstrate a regionalized network with a conflictive

pattern of governance and an intermediary institutionalism. In a conflictive-type governance, the relationship between the actors is conflicted and the technical-political context has low coordination, while the presence of intermediary institutionalism presents a process wherein regional maturity and integration between the actors have not been consolidated or are incipient, but there are indications in this direction.[14,25] In the CIR, this has been explained by the absence of permanent technical groups, lack of regional instruments for planning and investment, the Health secretaries' high turnover rate – notably every municipal election period – which affects the accumulation of knowledge and institutional learning. In addition, Health secretaries have low autonomy in comparison with the municipal executive (few are Municipal Health Fund administrators), and agendas are driven by ministerial/state demands to the detriment of planning and debating local and regional issues.

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