Regionalization of health in Brazil: an analytical perspective

Regionalização da saúde no Brasil: uma perspectiva de análise

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Abstract

This article aims to contribute to the debate on the SUS regionalization policy and the establishment of health regions in Brazil. Understanding them require to recognize the dichotomy between public health and individual health - which marks the history of Brazilian public health - and identify the different rationalities that lead this process. Such rationalities allow not only to consider the legacy of municipalization in the current regionalization process, as well as to establish links between the two fields of fundamental knowledge to the debate, epidemiology and geography. Clinical epidemiology, privileging individual health, gives basis to a healthcare model that prioritizes the optimization of resources. The recognition of health in its broader concept, in the social epidemiology, bases an attention model aimed at social determinants. With geography, functional regions can be formulated, based on Christaller's theory, or *lablachianas* regions which recognize the social loco / regional structure, allowing intervention in determining or conditioning the way of illness and death of populations.
Keywords: Regionalization in Health; Health Regions; Municipalization in Health; Brazilian National Health System.

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Resumo

Este artigo visa a contribuir com o debate sobre a política de regionalização do SUS e a constituição das regiões de saúde no Brasil. Compreendê-las pressupõe reconhecer a dicotomia entre saúde coletiva e saúde individual – que marca a história da saúde pública brasileira – e identificar as diferentes racionalidades que conduzem esse processo. Tais racionalidades permitem não apenas considerar o legado da municipalização no atual processo de regionalização, como também estabelecer nexos entre dois campos do conhecimento fundamentais para o debate, a epidemiologia e a geografia. A epidemiologia clínica, ao privilegiar a saúde individual, fundamenta um modelo assistencial que prioriza a otimização de recursos. O reconhecimento da saúde no seu conceito ampliado, na epidemiologia social, fundamenta um modelo de atenção voltado para os determinantes sociais. Com a geografia, podem-se formular regiões funcionais, baseadas na teoria de Christaller, ou regiões *lablachianas*, que reconhecem a estrutura social loco/regional, possibilitando a intervenção nos determinantes ou condicionantes da maneira de adoecer e morrer das populações.

Palavras-chave: Regionalização na Saúde; Regiões de Saúde; Municipalização na Saúde; Sistema Único de Saúde.

A bit of health history in Brazil

The Brazilian public health history is marked by the dichotomy between public health and individual health (Luz, 1978; Braga, Paula, 1986). This dichotomy allows highlighting different rationalities in the construction of health policies, sometimes favoring the rational use of available resources, whose main objective is to organize the supply of health actions and services, sometimes a view to the transformation of people's living conditions through interventions that go beyond the supply and access to actions and health services. These rationalities appear sometimes in a complementary form, sometimes concurrent, with a predominance that may or may not be altered over time. Seize them, in public health, requires an understanding of the historical moment and the identification of the actors leading the process of building such a policy.

In Brazil, as it had already occurred in the industrialized countries, public health fulfilled a key role in the social modernization process. In addition to restraining epidemics, it was also for the health actions to ensure the productivity of labor and the social order (Luz, 1978; Braga, Paula, 1986; Carvalheiro; Marques; Mota, 2013). Thus, the Brazilian health policy is being formulated in line with the logic of the capitalist structure within the country.

Consistent with the country's modernization process, Braga and Paula (1986) point out the "restricted" character of health policy, which took place without the induction of popular transforming movements, but in the social accommodation to new forms of production (Luz, 1978; Braga, Paula, 1986). Public health actions organized in the period led to specific and fragmented health interventions - socially, geographically and sectorally - not setting in a national integration project.

In addition to the social and spatial fragmentation, it is noteworthy that a large set of actions concerning the population's health has been formulated and implemented in different government bodies, sometimes under the influence of international organizations. The Special Public Health Service (SESP), founded in 1942, was created from an agreement between the governments of the United States

and Brazil. Institutes of Retirement and Pensions (IAP), linked to the labor unions, suffered great influence by specific interests of professional categories. Also, different ministries exercised "complementary or matching" public health actions as pointed by Singer, Campos and Oliveira (1978).

In that disintegrated command process and heterogeneous social and territorial results, the national health policy was organized from two sub-sectors: the public health, mainly based on sanitary-campaigner model, and the health care, based on the welfare- private model (Carvalheiro; Marques; Mota, 2013). Despite the coexistence between them over time, it is clear that the latter, in view of the social welfare security, expands itself from the 1950s, along with the change of the Brazilian industrialization pattern, and shall constitute an effective application for the work process.

The care model that has been developed in this context has the individual as object of intervention, strongly based on Flexnerian model training and specialized medical attention (Pessoto, 2010). It is noteworthy that, even in the context of expansion of such Flexnerian paradigm, it is possible to identify several initiatives in different countries in this period, advocating the preventative theories, conforming "a movement of articulation of interdisciplinary approaches in the medical and health field when dealing with the health-disease process "(Carvalheiro; Marques; Mota, 2013, p. 10). In Latin America, this movement is expressed in the so-called "developmental sanitarism", of the Economic Commission for Latin America and the Caribbean (ECLAC), which strengthens the preventative speech in Brazil (Carvalheiro; Marques; Mota, 2013).

Despite the strengthening prevention discourse in this period, the consolidated model is that of the social security medicine which, being strongly based on medical care and the use of technology, generates the expansion of public spending and stimulates the structuring of an advanced capitalist organization industry (Braga, Paula, 1986), without, however, producing the improvement of the population's health condition (Singer; Campos; Oliveira, 1978).

Despite the existing contradiction between the

increase in public spending resulting from the newly structured medical industry pressure, and the worsening of the population's health status, the health care reform, carried out in 1968 with the *"Plano de Coordenação das Atividades de Proteção e Recuperação da Saúde"* ("Coordination Plan for Health Protection and Recovery Activities"), deepens the model based on social security medicine and exposes, for the first time, that dichotomy between collective and individual health (Singer; Campos; Oliveira, 1978; Luz, 1978).

Even as acknowledging the existence of regional initiatives for development actions more strongly in the preventive model, such as those made by Walter Leser in the São Paulo State Health Secretariat and Social Assistance (Carvalheiro; Marques; Mota, 2013), what I observed is the strengthening of the welfare-privatized model, with the reorganization of the Ministry of Welfare and Social Assistance (MPAS) and the creation of the National Institute of Medical Assistance and Social Welfare (Inamps).

In addition to all critical factors in the National Health Policy of that period, the 1980s begins marked by the global crisis generated by the new logic of capital movement requiring the accumulation of productive capital-oriented dynamics to value through fictitious capital and which is evident especially from the late 1970s (Chesnay apud Mendes, 2012). Although being not object hereof, it is noteworthy that such a change obstructs the public funding of social policies by compromising the State's ability to appropriate the surplus generated in the production and drain public resources via public debt (Mendes, 2012). The Brazilian economic scenario of that period ended up in a decade of hyperinflation as a result of such non-consolidation of endogenous productive forces capable of opposing the expropriation imposed by the growing national financial capitalism, and especially international (Tavares, 2012).

It is in this context of wage squeeze, unemployment, growing social inequalities and transition from military rule to the New Republic, marking the first half of the 1980s, where the basis of the Brazilian National Health System (SUS) are gestated. Social mobilization is amplified as the old political

base regime weaken and the health movement[1] gains strength in the criticism of the health care system then in force. In the discussion of the construction of health policy, the different dimensions of social life - food, housing, education, income, employment, access to land, and access to health services emerge. Health begins to be considered as a result of the form of social production and not only as a state of absence of disease. Thus, social issues and democratic construction of political space open for the public health development.

The formulation of various plans and programs that sought the rational use of available resources generated the need to strengthen the role of states and municipalities in order to enable the use of idle public resources and the expansion of service to the entire population, regardless of the social security bond. At the same time the strengthening of the state's role happened as a leader of the Brazilian National Health System, the struggle between the different actors working in the sphere of public health and private medicine was structuring a "form of smooth and efficient interaction" between the public and the private sector (Escorel, 2008).

Thus, the pursuit of rational use of existing resources responded to social demands at the same time still providing a capital appreciation of space in the healthcare industry. Carvalheiro, Marques and Mota (2013) claim that the changes in the health sector are marked by two political proposals, one linked to democratic movements and the other conservative, proposing the setting of the private model:

The 1988 constitutional reform incorporated concepts, principles and guidelines in the industry that have become a mixture of the two proposals: Health Reform and the neoliberal project (Carvalheiro; Marques; Mota, 2013, p. 14).

Within this process, slowly and unevenly, the accountability of the government gains strength as a driver of health actions, from proposals based on epidemiological, regionalization and hierarchy

of public and private services, of the appreciation of the basic activities, the reference and counter guarantee and decentralization of the planning and management process (Escorel, 2008).

These guidelines were built in the light of the dichotomy between collective and individual health, which signals to continue, defined by the rational use of existing resources and expanded health concept.

Regionalization as a legacy of municipalization

The ideology of the new proposal for the national health sector, reflected in the doctrinal principles of universality, comprehensiveness, equity and social participation, has the decentralization policy as the foundation necessary to overcome the social, territorial and command fragmentation which was current then. However, the term decentralization within the SUS, carries within it many meanings, which can be interpreted also from different rationalities. These, in turn, can provide elements for understanding the process of regionalization of health policy that has been effecting through the different regulatory mechanisms and instruments of SUS.

As pointed out by Luz (2000), proposals for decentralization and citizen participation, in general and health in particular, began to be made from the second half of the 1950s. The III National Health Conference, held in 1963, already proposes the decentralization of health services and the promotion of upward planning techniques in the health sector (Escorel; Teixeira, 2008). This process, interrupted by the military coup, was taken initially based on the same actors (bureaucracy and professionals from the health and welfare area) and on the same grounds (sanitary and developmental), deepening the idea of social participation over time (light , 2000).

In fact, decentralization in the context of health reform, is understood as a democratization strategy

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and incorporation of new actors. It is strongly linked to the municipal movement which took power from the country's democratization process and the Constituent Assembly of 1987. The municipalities have been nominated to federal entities roster from the Federal Constitution of 1988 and a period of tension between the central government and sub nationals begins in the controversy for functions and resources in public administration, which meant advances and setbacks.

The fact is that decentralization was not just an ideal of democratizing movements, but also part of the recommendations of international organizations, in order to improve the allocation of resources and creating accountability systems (Oliveira, 2007). This aspect is also recognized in the health field:

The ideals of democratization and reducing the size of government, although they are based on different political and ideological bases, generated a certain consensus on decentralization and favored the development of this process within the SUS, albeit with different contours of the Sanitary Reform original design (Levcovitz et al, 2001 apud Noronha;. Lima; Machado, 2008 454 p.).

In Brazil, decentralization showed high rates of municipal adhesion in the health sector (Arretche, 2011). Even without the intention to exhaust the debate about the advances and retreats of the decentralization process in municipal's molds towards the health sector, one can list some problems revealed over the past 25 years of SUS implementation: the inequality of political, administrative, technical, financial and health needs identified in the Brazilian municipalities become an extremely intricate process; competition among federal agencies, in many cases, did not allow the real municipal autonomy nor the management of the existing equipment in their territorial limits or in the available financial resources; the lack of participatory culture of the society which has not transformed the municipal health councils in legitimate drivers of local health policy; the legacy of welfare medicine, whose actors continued to influence logic of the system organization.

Nonetheless, the progresses made in order to carry out the decentralization of health policy are admittedly responsible for the population's access to services, especially of primary care, and

the considerable improvements in national health indicators. According to Paim et al. (2011), the system decentralization has enabled improved access to primary care, with emphasis on the Family Health Strategy, resulting in positive effects on universal vaccination coverage and prenatal care, reduction of post-neonatal infant mortality and the unnecessary hospitalizations. Vasconcelo and Pasche (2006) also emphasize the role of community workers and the earnings proportioned by the appropriateness of actions of local population as well as the training of large numbers of municipal activity qualified professionals to manage that SUS' instruments.

Even considering the difficulties in the accurate measurement of improvements resulting from actions and health services of decentralized management, it is certain that this process represented advances in the formulation of public health policies when it added a large number of different actors distributed throughout the national territory, and part of them connected to the municipal level.

Despite the advancements made by the decentralization of health policy, there is no consensus among different authors on the suitability of this process for the continued implementation of a universal health care system. To meet the principles of fairness and integrity, the Brazilian National Health System must be organized in regionalized networks aimed at ensuring the efficiency and scale required in the provision of some goods and services (Andrade, 2002; Kuschnir; Chorny, 2010). However, the fragmentation of the health care system that could be overcome by regionalization is widely recognized (Silva; Mendes, 2004; Wagner, 2006; Dourado; Elias, 2011). From this perspective, mainly based on more rational use of resources, the health regionalization theme has taken on greater importance in the policy debate on the improvement of SUS.

Regionalization in SUS and its foundations

The dichotomy between individual and collective health, problematic at the beginning hereof, is also reflected in the design and implementation of the principle of regionalization in health. Understand-

ing this process requires efforts to establish links between two fields of knowledge, epidemiology and geography.

Whether observe the perspective of the organization of health services or from the perspective of understanding and organization of social space that epidemiology tried to operate within the health field, the theoretical and conceptual elements of geography were mobilized to make sense to the forms of order which the Brazilian National Health System should take according to their protagonists. From the theory plan for effective practice in public bodies, the concept of regionalization or the implementation of processes suffer contamination of theoretical perspectives which inform the field of Geography.

This process of regionalization should be divided into two moments or movements. There is the process of regionalization of such services, which is trying to organize the service as a way to make them more efficient and effective, that is, able to achieve the goals of SUS on universality, comprehensiveness and equity in higher quality and lower financial cost. There is yet another implicit process of regionalization, or rather, creation of health regions from epidemiological characteristics of a given population living in certain space and time. In fact, both have different inspirations, in the case of organization of movement of services, the inspiration is what one might call "*ibegeana inspiration*" (Guimarães, 2005, p.1021). This is the Brazilian state planning tradition after the war of 1945. Specifically, the planning of services from the territorial division into functional or polarized regions, as proposed in 1972 (Bezzi, 2004).

In the case of health, regionalization, one of the SUS organizing principles, enters the agenda only in the late 90th and early 2000s as a central concern of managers. And, as proposed by NOAS 2001 and 2002, presupposes the formation of functional health regions, that is, it clearly has the inspiration of the Christaller Theory of Cities Centers.

The regionalization process should include an integrated logic planning, including the notions of territoriality, in identifying priorities for action and conformation of functional health systems, not necessarily restricted to municipal, while respecting its limits as an indivisible unit, so to ensure public access to all actions and services required to solve their health problems, optimizing the available resources. (*Brasil*, 2002, p. 9)

The functional regionalization adjectives bring us to the theoretical matrix of neo-positivism in geography. According to Haesbaert (2005):

the region is the one that is linked to functionalism, seeing the space as a flow system where each part or subsystem performs a specific set of functions. Functional regions appear, also inspired by the Christaller Theory of Cities Centers, where an urban polarizing center extends its influence on a regional space, assuming the areas of overlap with other functional regions. (P. 12)

For Bezzi (2004):

Christaller works with quite elaborate concepts, as centrality, complementary region and hierarchy, which form the foundation of his Theory of Cities Centers [...] a localization theory for services and urban institutions ... (p. 158).

The optimization of resources is a necessary logic to the system, including not to autarchy the region itself (and not the city) because some procedures are rare and expensive and it is not reasonable that they exist in any municipality, module and even region. Especially because, according to Corrêa (2001, p. 102-103), to study the urban networks in Brazil from the Christaller's theory, relations between cities and city networks are worked out in different directions, including relations between cities of non-contiguous regions, a fact that derives from the complexity of the territorial division of labor that occurs from mid-twentieth century. Also according to the author, one should take into account that the Brazilian urban network does not fit into a single spatial pattern for having created cities at different times and for different reasons and agents (Corrêa, 2001, p. 96-7). However, this is a complicating factor in the structuring of a regionalized network of SUS, especially when facing, as a theoretical refer-

ence, regional studies of other national states with historically older cities networks with lower speed in the creation of new cities as occurred in Brazil in the past 30 years.

Add to this fact that Brazil has a colonial past that contributed to the formation of such network cities of dendritic type. In this way, the primate city is located on the coast and between that city, which concentrates most of the large-scale services, and the excessive number of small centers, there is "an absence of intermediate centers located interstitially" (Correa, 2001: p. 44). Clearly, we can not imagine this colonial heritage implemented in its pure model for the twenty-first century, however, it is necessary to study the stay model when we think both Brazil as a whole, as for how to structure the SUS.

In the context of the **capital internationalization**[2], with the expansion and deepening of the international division of labor and the exponential increase in circulation, the choice of sites is strategic and result of conflicts and complementarities between the different forms it takes capital (industrial, commercial and financial). They become the form and content of the regions by the intensification of the appreciation of space (Santos, 1996). The subspaces are increasingly capillary, due to the combination of different vectors of verticality and horizontality. For this reason, there is a gain in thickness of each unit space, considering that the time of each place is a result of the global social tension with time at a synchronous set (given the simultaneity of events from different locations), and the same time, diachronic (because it is a long-term historical process), according to Silva (1991).

When we refer to the capillarity of such regions, we draw attention to their borders, since the health regions established by SUS have delineated boundaries for legal and administrative units of the Brazilian federal republic, which separates one unit from the other (Guimarães, 2006). Traditionally, we established a synonymic chain between these two ideas (limit and border) because the territorial delimitation of Brazil was marked by a series of international treaties that sought to establish the

legal and administrative boundaries of Portuguese domain in South America, leading us to confuse the second by the first. But Brazil's territorial formation is also the result of enlargement of these institutional boundaries by expanding borders, which is still an ongoing process, as taught by Machado (2006). Only considering this historical dimension, we can conclude that the border idea reveals a much more permeable reality, a contact zone between neighboring units, Santos (1996, p. 228) called vectors of horizontality. The capillarity is also the result of determination and decision-making processes more distant of the next space, forming vertical vectors with power to transform different places networked. This produces a synchrony between places with profound implications for population mobility, the flow of information and spatial patterns of morbidity and mortality (Guimarães, 2006).

The 1988 Constitution and other infra-rules, when speaking about regionalization in SUS, have as a logical perspective that it is endogenous to services and has as parameter the flow of patients to the system internally. Regionalization is meaningful only when thought with the hierarchy. However, the direction of that regionalization / hierarchy should have two-way, the so-called reference and counter referrals adrdressing. This process is distinct from the process of decentralization which interfered in the scope of population, having as unit to conduct the sick person alone, and therefore shall engender in concrete workers operating the flow within the system and their managers, a system logic that when the patient is cured in a hierarchically superior technological level, it is given as output element, which does not return to the lower technological levels of care. With very few exceptions the system works with the counter-reference, which leads to certain autonomy of elements of such system, especially those with greater aggregate technological density.

However, other logic also reported and also informs the discussions and proposals for construction of health regions in the history of the formulation and implementation of the SUS. Their practices origins date back to the districting process

occurred in the late 1980s and early 1990s. This was a comprehensive experience and which sought to systematize the work of health workers who worked in the health services in many parts of the country, coming against with the so-called proposal of the Local Health Systems (SILOS) of the Pan American Health Organization (PAHO).

This proposal, which sought to counteract the dictates of the World Bank structural adjustment of state spending, started recommending the health planning based on actions which restrict not only to the specific sector of health services, but to consider the social health conditions. The SILOS are formulated as an organizing strategy of health services that would enable responding to the health needs (Pessoto, 2001). Regarding the SILOS, Pessoto (2001) writes:

> In this new form of organization of services, it would be possible to integrate all scattered services and actions that, as a rule, overlapped each other by duplicating interventions and raising the overall costs of the health sector. The emphasis in planning and development of human resources, their management side, would be a way to enable and enhance inter-sector collaboration in the territory bounded by SILOS, increasing up the efficiency and effectiveness of interventions (Pessoto, 2001, p. 65).

The construction of health districts or SILOS contains a number of workshops, one of which was the territorial, which consisted in the recognition of the territory surrounding the health services by the technicians of the same services. Research of geographic borders, transport services, trade, housing in risk areas, other public facilities and services were made. A survey on records, the user place of residence were also done to check the area of "influence" of such service. All of these procedures and their derived information were condensed in the information workshops, which would support the negotiation with other services in the coverage area delimitation and, by the end, the health district that included several health facilities.

These attempts at organization of services, as thought by health workers working in the units,

mainly in large urban centers, have suffered indirect influence of La Blache. The author, in Brazil, reported that these attempts were taken by Milton Santos, mainly in the discussion about the region or health district, identifying the place with the region. Although its most grounded formulation is that of 1996, it was already present before, even in embryonic form in the book *Metamorfoses do espaço habitado*, of 1988.

Let's see how the relationship between place and region is thought, by Santos in 1996:

> Both the region and the place are subspaces subject to the same general laws of evolution, where the time goes into an experiential condition of possibility and the existing geographical entity enters as an opportunity condition. [...] The distinction between place and region becomes less relevant than before [...]. In fact, the region can be considered as a place, provided that unity and continuity of the historical event occurs. And every place - see the example of the great cities - may also be regions (Santos, 1996, p. 132)

First, what draws attention to this approach of Milton Santos is the impossibility of thinking the region or place without time. The articulation of these two human dimensions, from a geographical point of view, requires a time empirical idea, since the geographer analysis space is an empirical space. Thus, there remains a methodological consistency of association of space and time under one point of view (Santos, 1985, p. 57).

In turn, the link between space and time is the technical object (a health equipment, for example), that holds itself to the memory of a set in a given place and time. Thus, "the techniques are a set of instrumental and social media, with which man realizes his life, produces and at the same time, creates space," according to Santos (1996, p. 25). As this author:

> the relationship that we should try between the space and the technical phenomenon, is widely of all events, including techniques of the action itself [...] and as the technical object defines both the actors and space (Santos, 1996, p. 31).

The technique is not the adaptation of the subject to the environment, but otherwise, the adaptation of the environment to humans, since they are the only people with projects and able to run them (Ortega, Gasset, 1963). Thus, the medium itself does not exist; it exists only through someone or something. It is a relational space, inseparable from the intersubjective experiences, and advancing together with them. From this point of view, all the relationships that occur between humans and the environment are technical, deriving the objects and actions which are configured in each place.

When a technical object is installed in a particular place, the standards set in distant places are needed, whether in technical procedures to be adopted with the equipment, as well as in labor relations involving their use (Santos, 1996, p. 182). This is why the standard is one of the cornerstones of the systemic order. There are organizational procedures (such as the regionalization of health by SUS managers) and technical objects installed in different places (health services with different levels of complexity, for example) which regulate the territory and therefore people's lives.

These characteristics of production of social space already would bring us many theoretical challenges to understand the place of the space in the regionalization process. The work done in each place is increasingly fragmented and is part of integrated circuits to the same system, that only works for the regulation of activities and organizational unification of the commands. The technological innovations on transport and telecommunications allow these articulations (Silveira, 2008). In turn, the control power is increasingly centralized in upper and distant instances, verifying an asymmetry in the relationship between social actors, located and articulated in several scalar levels. On a broader level, whether the nation-state or even the world system, there is a place of command, which is the scale of the forces that define the rules. In the local or regional level, there has been the place of realization of such phenomenon (Santos, 1996, p. 121).

The idea of the implementation of health districts following the model of local health systems (SILOS), as proposed by PAHO, approaches the *lablachiana* / Miltonic region design concept: the

district delimitation, especially in metropolitan areas, comprised a recognition movement of such "covering area" and performance of services and the system which should stick to the physical and natural aspects of the "environment", to the people facilities or circulation difficulties , social and economic characteristics of that resident population. The work process coined as *territorialization*, in fact, follows the logic of recognition of the space from the perspective of building a distinctive health region to the other and, therefore, allowing for specific and singular intervention policies, in addition to the general policies of the municipality, state or union.

Obviously that here protrudes discussion in terms of constructive logic, not necessarily as classical definition of a *lablachiana* region, in which the problem of a minimum scale is inserted aiming to a distinctive area between portions of the physical space or landscape.

In fact, this district apportionment logic, which we understand here as a variant logic of such *lablachiana* regionalization, due to be updated in the modern industrial capitalism and urban prominence time, updates a little recurring theme in construction of such region by the French theorist. As stated by Lencioni (2003):

> Affirming the unity of the physical and human aspects through the regional study, Vidal de La Blache incorporates to the Geography that concept of the way of life, which is defined as the result of physical, historical and social influences, present in man's relationship with the environment . (Lencioni, 2003, p. 103)

Also according to the author, although not central to her theory, the concept became current from the 90s of the XIXth century, but it was more employed in the study of primitive societies, which led to emphasize "the ecological bias, underlining how man takes advantage of the environment" (Lencioni, 2003, p. 104). However, the update in time becomes more relevant the second aspect of the concept of way of life, "one who considers the relationships that men interlace together. This latter aspect has been relatively neglected "(Lencioni, 2003, p. 103).

The central idea is, from this synthesis of inter-

relationships - proper of the creation of such geographical region - to create the health region with the practical perspective of what is called health surveillance today, that is, the understanding of disease and death processes of the related populations to certain systems or health subsystems, and it would be responsibility of those services or (sub) systems any intervention in determining or conditioning the way of illness and death of these populations.

We are facing a real problem of organizing health regions. Two ways of thinking (planning of services or epidemiology) or focus on the object (the services and the internal flow of patients, and the extramural movement of health workers trying to recognize the surroundings and the coverage area under their responsibility) enabling the creation of two distinct regions with different logics. This is a challenge that geography imposes on the health sector. Especially since, as noted by Corrêa (2001), "in Brazil there is no a long-rooted regional stability, because the creation, undo and redo the regions are extremely quickly processed " (p. 193).

Anyway, what matters is not the length of the regional spaces, but not lose sight of their role in territorial planning and the historical sense. One way to discuss this would be through the use and appropriation of territory by numerous social agents (Monken; Barcelos, 2007; Monken et al., 2008).

As these problems involve defined political actors, which are mainly public and state agents, there are problems of "internal geopolitics" order and are not restricted to Brazil (Costa, 2008, p. 322). The problem of decentralization and regionalization, according to the author, is an issue, as few, clearly interdisciplinary. And its essence is the distribution of political power in the "context of territorial-national formations" (Costa, 2008, p. 323). But this distribution takes on different configurations according to the country that is observed. In the United State of America, studies on federalism focus on the possibility of loss of autonomy of local authorities, while in France the bottom line of such problem remains in the breach of the centralism of the State at the expense of the departments and communes (Costa, 2008, p. 322-323). In Brazil, the problem is the dialectic of the relationship between the three spheres.

No one questions the need for decentralization and devolution of the power lying on the Union, what is sought is to balance the forces between the spheres, without what has been achieved at the municipal level is lost in the name of economic rationality and political market, the optimal cost of services, how the economists intend and the state governments.

It is not a simple problem, as pointed out by Castro (1997), "the expansion of the Brazilian State in the 70's resulted in the expansion of its institutional network and also the difficulty of articulating it efficiently." The expansion occurred in all administrative, federal, state and local scales. This fact should be seen in their difficulties from two points of view: the "territorial dimension of state action," which makes it difficult to coordinate the actions of governments for "assumption of influence areas"; and own areas of influence of each territorial level. These two views suppose the "definition of powers and limits of territorial scales" of each sphere of government. However, the regional level would be "more of a resource management level than a proper decision." (Castro, 1997, p. 39). This is a central issue that the public health seeks to address through the Pact for Management, a component of the Pact for Health (besides the Covenant for Life and the Pact in Defense of SUS), signed by federal, state and local governments as of 2006 (*Brasil*, 2006), and that engendered a collectively solving problems at the regional level, which is configured as a real improvement over the Health Assistance Operating Standards of 2001 and 2002. How territorial solidarities are being established is a good field for Brazilian Political Geography studies. It is an ongoing process.

It is worth remembering that the complexity of this process leads to several proposals for regionalization between different countries and between different economic sectors in the same country. The "water crisis", present in some regions in Brazil requires the political definition of provisional regional management bodies of various hues: among the states in the Southeast with the Federal Government; between the Metropolitan Region with the Government of São Paulo. The most remembered example of the contradiction between a caring rationality and other commercial in health was the

trivialization of generous WHO policy proposal to deploy the Primary Health Care (PHC) as a strategy for achieving Health for All (SPT/ 2000). At first the goal would be global, for everyone. The primary indicator of success, number of countries that politically adhered to the proposal showed that the target would be hardly achieved. New shares of public health were set up, emphasizing the public / private partnership (or mixed) and the regionalization as new ways of seeing the APS. Measuring success (relative) of such SPT proposal was transferred to the district level, and this had a working definition: "district is the administrative level with some form of local government that assumes responsibilities delegated by the central government; it is considered the point of intersection between top / down management planning and the bottom-up community participation "(WHO, 1993).

The Decree 7.508 / 2011, which regulates the Law 8.080 / 1990, gives emphasis to the implementation of the Health Care Regional Networks (RRAS) as a strategy to sort the different levels of care - primary, secondary and tertiary - overlapping health regions regulated by the Pact for Management , whose perspective was to strengthen the power and the relationship between the federal entities in defined territories from the loco / regional social dynamics and their health needs. Numerous mechanisms and tools were created for implementation of this regionalization, such as the Public Action Organizational Contract (COAP), the Regional Management Committee (CGR), the Health Care Networks Managing Committees (CGRedes), the conducting Groups, Support Matrix, etc. These recent initiatives in policy formulation, which together deal with care networks and social dynamics of the places for recognition of health needs, show the different rationales given by the public health and individual health. It is necessary to invest the form of interaction between these rationales, their complementarities, overlaps and especially subjections.

Final considerations

Despite the importance of the contribution that different rationalities which lead this process may have, it is necessary to emphasize the subordination of the individual health to the collective health, for the establishment of a policy that seeks health in its broader concept. In other words, the social transformation is the policy object and the care model rationality that legitimately seeks the effective and efficient use of resources, which should be guided by the doctrinal principles of universality, comprehensiveness, equity and social participation.

As regionalization is an ongoing process, we must ask which rationality shall prevail? Shall it be a statement of doctrinal and organizational principles of SUS, which point to the construction of a state of social welfare in which health is considered as a human constitutional right? Or favoring health rationality as merchandise, maintaining the dichotomy between public health and individual health?

Epidemiology and geography are two fields of knowledge for identifying different rationalities in the formulation and implementation of public policies. They also allow the public health dialogue with other sectoral policies to promote integrated planning in the territory.

One can not think the regionalization policy without establishing the links between living conditions and health. In other words, one can not think of health in its broader concept, without considering the social determinants of health-disease process.

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