

Capacity of government in Municipal Health Departments

Capacidade de governo em Secretarias Municipais de Saúde

Celmário Castro Brandão¹, Magda Duarte dos Anjos Scherer^{1,2}

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ABSTRACT From the decentralization of Unified Health System (SUS) management, there is a need to discuss the capacity of government, or management, at the municipal level, to implement this policy. This study aims to analyze the capacity of government of Municipal Health Departments in municipalities of Bahia, based on the experience of managers. An online questionnaire, subdivided into 03 dimensions, was applied to 15 managers representing municipal departments of small size (size I) and large size (size II) in the 09 macro regions of health of the state. A punctuation matrix was used, which allowed the quantification and classification of municipalities in each of the dimensions and their capacity to govern. It was obtained that 12 of the municipalities presented moderate, and 03 presented low capacity of government. The dimension related to the organizational design of the Secretariats was the one in which the municipalities presented better performance, followed by work systems in these organizations and professional trajectory of managers. Still, municipalities of size I and those located in more developed regions obtained better overall results. To qualify the managements, it is considered essential to invest in training initiatives and institutional support, prioritizing small size municipalities and located in regions of greater socio-economic vulnerability.

KEYWORDS Public health. Health management. Health planning.

RESUMO *A partir da descentralização da gestão Sistema Único de Saúde (SUS), surge a necessidade de se discutir a capacidade de governo, ou de gestão, no âmbito municipal, para a implementação dessa política. Este estudo objetiva analisar a capacidade de governo de Secretarias Municipais de Saúde em municípios baianos, tendo por base a experiência dos gestores. Foi aplicado questionário on-line, subdividido em 03 dimensões, a 15 gestores representantes de Secretarias de municípios de pequeno (porte I) e grande porte (porte II), nas 09 macrorregiões de saúde do estado. Foi utilizada uma matriz de pontuação, que permitiu a quantificação e a classificação dos municípios em cada uma das dimensões e quanto à sua capacidade de governo. Obteve-se que 12 dos municípios apresentaram capacidade moderada, e 03 apresentaram baixa capacidade de governo. A dimensão relacionada ao desenho organizativo das Secretarias foi aquela em que os municípios apresentaram melhor desempenho, seguida por sistemas de trabalho nessas organizações e trajetória profissional dos gestores. Ainda, municípios de porte I e os situados em regiões mais desenvolvidas obtiveram melhores resultados globais. Para a qualificação das gestões, considera-se essencial o investimento em iniciativas de formação e de apoio institucional, priorizando municípios de pequeno porte e situados em regiões de maior vulnerabilidade socioeconômica.*

PALAVRAS-CHAVE *Saúde pública. Gestão em saúde. Planejamento em saúde.*

¹Universidade de Brasília (UNB), Departamento de Saúde Coletiva, Programa de Pós-Graduação em Saúde Coletiva - Brasília (DF), Brasil. celmariocb@gmail.com

²Conservatoire National des Arts et Métiers (CNAM), Centre de Recherche sur le Travail et le Développement (CRDT) - Paris, França.



Introduction

From the most significant victories of the Brazilian health reform movement, with the inclusion, in the Constitutional text, of health as a right of all and duty of the State, and the consequent creation of the Unified Health System (SUS), obstacles of different natures have been presented to the implementation of this policy, and much of this debate has been occurring around a false dichotomy between financing and system management.

The financial injection of SUS is a recurrent theme of studies, with its underfunding heavily demarcated in the literature of the field of collective health¹⁻⁵. At the beginning of the 1990s^{2,4}, there was an intense movement of decentralization of management from the publication of the Basic Operational Norms, containing guidelines, such as federative orientation with division of competencies, the nature of the instruments and requirements for adherence to the decentralization strategy, regional coordination mechanisms and the model of financial transfers between government levels⁶.

The regulations contained in these documents, reinforced by the hierarchical and upward planning guidelines, presented in Presidential Decree n° 7.508, of June 28, 2011, entailed the assumption of new responsibilities by other spheres of government, requiring the states and, above all, the municipalities that from then on to take charge of the management of most of the health services. To this end, there is a need for greater qualification of local actors to manage a system with the challenging proposal of universality and completeness, considering, above all, the great regional disparities of a country with the size of Brazil, with its socioeconomic inequalities.

There is, then, the debate on the government capacity, or management, understood as the set of techniques, methods, skills, abilities and experiences accumulated by

an actor, his/her government team and the organization that he/she runs, to conduct the public machine, given the governability provided by the state structure, to the propositional content of the government project⁷⁻⁹, so that it promotes comprehensive health care for Brazilian citizens.

In order to contribute to the reflections on the capacity of government, Carlos Matus^{7,10-13}, from his experience with several Latin American governments, proposed the articulation of three mutually conditioned and interdependent variables in the so-called Government Triangle. In this model, in addition to the governance and government project vertices, government capacity is presented with the following composition: expertise of the managers – a set of qualities, knowledge and skills acquired throughout school positions, professionals, etc. or more fields of social life, that is, the ‘professional trajectory’¹⁴; work systems of an organization – which relate to the ‘top management systems’ of that organization and the Situational Strategic Planning (PES); and design of the organization – which refers to the autonomy and support that this organization has in front of the other entities of the administration¹¹.

Despite the importance of studies on government capacity, it seems opportune to deepen this debate, in view of, especially, the high turnover of the actors included in the management spaces¹⁵. In view of the above, this study aims to analyze the capacity of government of Municipal Health Departments (MHD) in municipalities from Bahia, based on the experience of managers.

Methods

Based on the Governance Triangle of Matus^{7,10-13}, centrally, at the apex of government capacity, a descriptive, cross-sectional, qualitative-quantitative study was carried out, with municipal health secretaries of the state

of Bahia, during the period from August 26, 2016 to October 31, 2017.

Bahia has a total of 417 municipalities, subdivided according to the state Regionalization Master Plan for health¹⁶, in 09 macro-regions of health. According to the Brazilian Institute of Geography and Statistics, the total population of the state, in 2017, reaches 15.344.447 inhabitants, and its territorial extension reaches 564.732.642 km². The Municipal Human Development Index (HDI-M) reaches an average of 0.660, placing the state in the 22nd place in the ranking of the United Nations Development Program (UNDP-2010).

Fifteen municipal health secretaries participated as key informants. The study sample was made for convenience, considering the managers who were willing to collaborate with the research. However, it was recommended to include two municipalities in each of the nine macroregions

of health of the state, being a municipality of large size, or size I, preferably, the largest municipality in the macro-region, and a municipality with a population that is smaller and more approximate of 20.000 inhabitants, considered of small size, or size II. Necessarily, these managers were ahead of the respective MHD between the months of December 2016 and January 2017.

Among the participants, 08 secretaries were from size I municipalities, and 07 municipalities of size II, reaching, at least, 01 municipality of each macroregion of health of the state. In order to identify the participating municipalities, a specific nomenclature was adopted, which considered the size of the municipality, followed by a letter corresponding to the respective health macro-region, and in cases where there was more than one municipality of the same size and the same macro-region, an apostrophe (') was inserted (*chart 1*).

Chart 1. Identification of participating municipalities

SIZE	MACROREGION	LETTER ASSOCIATED TO MACROREGION	ADOPTED NOMENCLATURE
I	Extreme South	A	IA
II	Extreme South	A	IIA
II	South	B	IIB
II	South	B'	IIB'
I	Centre-North	C	IC
II	Centre-North	C	IIC
I	East	D	ID
II	East	D	IID
II	East	D'	IID'
I	West	E	IE
II	West	E	IIE
I	Centre-East	F	IF
I	Southwest	G	IG
I	Northeast	H	IH
I	North	I	II

Source: Own elaboration.

An online questionnaire was sent to the participants (*chart 2*), developed through the FormSUS tool (version 3.0, developed by the Department of Informatics of the SUS of the Ministry of Health – Datasus). Access to the contacts of the managers was possible through the data available on the portal of the National Council of Municipal Health Departments (Conasems), in addition to being requested access to the contact database of managers of the Department of Primary Care of the Ministry of Health.

The questionnaire was elaborated considering the discussion of Matus^{7,10-13} on governance capacity, added to methodological and discursive components of the works of Lotufo¹⁷ and Vilasbôas¹⁸. As a product of this formulation, an instrument was obtained made up of three dimensions of governance: 1 – Professional trajectory of the secretaries; 2 – Work systems of the Secretariats; and 3 – Organizational design of these institutions.

Chart 2. Data collection questionnaire with values assigned to each type of answer

QUESTIONS - DIMENSION 01	VALUES*
1) Time ahead of this Municipal Health Secretariat (MHD) (in months):	> 24 = 1.00; 12 - 24 = 0.50; < 12 = 0.25
2) Bachelor Degree: () Yes () No () N.A.	Yes = 0.50; No = 0
2.1) Area of the course:	Health = 0.50; Administration = 0.25; Other area = 0
3) Post-graduation (specialization): () Yes () No () N.A.	Yes = 0.50; No = 0
3.1) Area of the course:	Public Health = 0.50; Administration = 0.25; Other area = 0
4) Post-graduation (stricto sensu): () Master's degree () Doctorate () N.A.	Yes = 0,50; No = 0
4.1) Area of the course:	Public Health = 0.50; Administration = 0.25; Other area = 0
5) The knowledge and skills acquired at the academy positively influenced the current role of secretary of health**: () 1 () 2 () 3 () 4 () 5 () N.A.	4 and 5 = 1.00; 3 = 0.50; 1 and 2 = 0
6) In the last year, did some type of work-oriented training (permanent education):	Yes = 0.50; No = 0
6.1) Which area (s):	Public Health or administration = 0.30; Others = 0
6.2) Weekly working hours: () Up to 2 hours () Up to 4 hours () Up to 6 hours () Up to 8 hours () More than 8 hours () N.A.	More than 8 hours = 0.20; Up to 8 hours = 0.10
7) Have you served as secretary of health before: () Yes () No	Yes = 1.00; No = 0
7.1) In which sphere (s):	State and municipal = 0.50; Municipal = 0.25; State = 0.15
7.2) Time (months):	> 24 = 0.50; 12 - 24 = 0.25; < 12 = 0.15
8) Have you already worked in other areas (outside health) of public management before:	Yes = 0.50; No = 0
8.1) In which sphere of government:	At 03 spheres = 0.50; 02 spheres = 0.25; 01 sphere = 0.10
9) Have you hold elective position (councilor), deputy, mayor etc.:	Yes = 1.00; No = 0
9.1) Which position(s):	Federal position = 0.50; State = 0.25; Municipal = 0.15
9.2) Time (months):	> 48 = 0.50; 24 - 48 = 0.25; < 24 = 0.15
10) The knowledge and skills acquired in other spaces of management positively influenced the current function of secretary of health**:	4 and 5 = 1.00; 3 = 0.50; 1 and 2 = 0
11) Participated/participates in social movements:	Yes = 0.50; No = 0
11.1) Function:	Leader = 0.30; Member = 0
11.2) Time (months):	> 24 = 0.20; 12 - 24 = 0.10; < 12 = 0.05

Chart 2. (cont.)

12) Participated/participates in political parties:	Yes = 0,50; No = 0
12.1) Function:	Leader = 0.30; Member = 0
12.2) Time (months):	> 24 = 0.20; 12 - 24 = 0.10; < 12 = 0.05
13) Knowledge and skills acquired through involvement with social movements and/or political parties have positively influenced the current function of the health secretary**:	4 and 5 = 1.00; 3 = 0.50; 1 and 2 = 0
QUESTIONS - DIMENSION 02	VALUES*
14) His/her agenda is mostly occupied with the actions of the secretariat's planning and adjustments made on his/her own initiative **:	4 and 5 = 1.00; 3 = 0.50; 1 and 2 = 0
15) His/her agenda is mostly spent with calendars crossed or established by initiative of agents external to the MHD**:	1 and 2 = 1.00; 3 = 0.50; 4 and 5 = 0
16) There is a Crisis Management Plan (epidemics, catastrophes, etc.) that guides MHD**:	4 and 5 = 1.00; 3 = 0.50; 1 and 2 = 0
17) Action planning is carried out, for the implementation of the government project**:	4 and 5 = 1.00; 3 = 0.50; 1 and 2 = 0
17.1) Participate in planning: () Secretary () Management team () Workers	The 03 bodies listed = 0.25; 02 bodies = 0.15; 01 of the bodies listed = 0
17.2) Others. Which ones:	Social control = 0.25; Executive, legislative or judiciary = 0.15
17.3) Regularity of the meetings to review the Plan:	Quarterly = 0.25; Biannual = 0.15; Annual = 0.05
17.4) MHD planning is systematized into documents (policies, projects, etc.) that are easily accessible and understood by all staff members:	Yes, by all = 0.25; Yes, partially = 0.10; No = 0
18) The management team monitors the execution of each planned action**:	4 and 5 = 0.25; 3 = 0.15; 1 and 2 = 0
18.1) Monitoring results in a return to the management body, for review of planned actions**:	4 and 5 = 0.25; 3 = 0.15; 1 and 2 = 0
18.2) The monitoring considers the commitments assumed by each sector or subject**:	4 and 5 = 0.25; 3 = 0.15; 1 and 2 = 0
18.3) Responsible are awarded or penalized according to the achievement of objectives**:	4 and 5 = 0.25; 3 = 0.15; 1 and 2 = 0
19) The individual and collective commitments of the plan are agreed between all workers**:	4 and 5 = 0.50; 3 = 0.25; 1 and 2 = 0
19.1) There is support to assist these workers in achieving their goals**:	4 and 5 = 0.50; 3 = 0.25; 1 and 2 = 0
20) Management promotes interaction between managers**:	4 and 5 = 0.50; 3 = 0.25; 1 and 2 = 0
20.1) How: () Ordinary Collegiums () Random meetings () Meetings as needed () Workshops of education/training/permanent education () N.A.	All items listed = 0.50; 03 of the items listed = 0.40; 02 of the items listed = 0.30; 01 of the items listed = 0.20
21) In the governance project of the MHD, resources are designed for each objective**:	4 and 5 = 1.00; 3 = 0.50; 1 and 2 = 0
QUESTIONS - DIMENSION 03	VALUES*
22) The management of the MHD has political support from other entities/institutions:	Yes = 0.50; No = 0
22.1) Which entities: () Mayor () Municipal Health Council (MHC) () Private sector () Government of the State () Councilor's Chamber () Workers of the MHD () Local media () N.A.	7 or more entities = 0.50; 05 or 06 entities = 0.40; 03 or 04 = 0.30; 02 = 0.20; 01 = 0.10; No entity = 0
23) MHD seeks political support for the development of its actions **:	4 and 5 = 0.50; 3 = 0.25; 1 and 2 = 0
23.1) How: () Open discussions with the population () Agreement with the MHC () Discussion of the project with the municipal legislative () Discussion of the project with the chief of the executive () N.A.	4 or more of the listed actions = 0.50; 02 or 03 actions = 0.30; 01 action = 0.10
24) The management of the MHD has autonomy before the municipal management (city hall)** :	4 and 5 = 1.00; 3 = 0.50; 1 and 2 = 0
25) The secretary has autonomy in the management of health financial resources**:	4 and 5 = 1.00; 3 = 0.50; 1 and 2 = 0
25.1) There is a specific bidding committee for the MHD:	Yes = 0.50; No = 0

Chart 2. (cont.)

25.2) The manager of the Municipal Health Fund is an indication of the secretary:	Yes = 0.50; No = 0
26) The secretary has autonomy in the selection and appointment of technicians for the positions**:	4 and 5 = 1.00; 3 = 0.50; 1 and 2 = 0
27) The current organizational chart of the MHD is known by all management workers:	Yes, by all = 0.50; Yes, partially = 0.25; No = 0
27.1) There are conflicts/misunderstandings regarding function within the management team	No = 0.50; Yes = 0
28) How many technicians currently make up the MHD management team: () 1 - 3 () 4 - 6 () 7 or more	07 or more = 0.50; 04 to 06 = 0.30; 01 to 03 = 0.20
28.1) How do you evaluate the qualification of this management team:	Excellent or Good = 0.50; Regular = 0.30; Bad or terrible = 0
29) Workers feel engaged and motivated with the MHD governance project **:	4 and 5 = 1.00; 3 = 0.50; 1 and 2 = 0

Source: Own elaboration.

*Values assigned to each type of possible response in the questionnaire.

**The answers will correspond to: 1 - totally disagree; 2 - partially disagree; 3 - neither disagree nor agree; 4 - partially agree; 5 - totally agree.

N.A. = Not Applicable.

Associated with the questionnaire a scoring matrix was developed assigning specific values related to each type of possible response to be issued by the participant, and, from these values, a standardization (from 0 to 100) was made to reach the value of each dimension, being: dimension 1 = 52.63 points; dimension 2 = 31.58 points; and dimension 3 = 15.79 points.

From the sum of the municipalities' scores in each dimension, the final score was obtained, which indicated the government capacity in each MHD. This score, whose maximum value was 100 points, allowed the measurement, better visualization and comparability between the different levels of government capacity of the MHD. The different weights and values of the dimensions are based on the writings of Matus¹³, where the author states that for the construction and analysis of government capacity, the weight of the relevant variables may vary according to the objective (project) and technical and political capacities of the ruler. Thus, the dimension related to the professional trajectory of the secretaries was highlighted with greater value in the scoring matrix, since, besides having a greater number of questions, this component exerts a strong influence, being able to impose a ceiling

of quality to all the other constituents of the government capacity in an organization¹³.

In order to analyze the performance of the municipalities in each dimension alone, the results were considered, increasingly, as close as possible to the maximum possible value in each one of them. Likewise, with the objective of enabling a better visualization of the government capacity of each MHD, from the final scores, the following categorization was made: final score >75 = high government capacity; final score > 50 and >75 = intermediate or moderate government capacity; and final score >50 = low government capacity. The study was approved by the Research Ethics Committee of the University of Brasília (opinion 1.910.491).

Results

The population average among participating municipalities of size I was 168.432 inhabitants, and the average of the HDI-M equal to 0.665, index classified by the PNUD as medium, being higher than the state average (HDI-M = 0.660). Among municipalities of size II, the population average of each municipality was 16.860 inhabitants, and the average

HDI-M, 0.595, classified (PNUD) as low and lower than the state average. Among the participating managers, 08 (municipalities with size I = 05, municipalities with size II = 3) were male, and 07 (size I = 03; size II = 04) female. The average age of the secretaries was 39 years (size I = 40, size II = 37), the maximum age being 53, and the minimum equal to 31 years of age. The mean time ahead of the MHD was 26 months (size I = 26, size II = 26), the maximum time equal to 73 (size II) and the minimum equal to 01 month (size I).

As for the performance of the municipalities in each of the dimensions, it was observed that,

with regard to the professional trajectory of the managers (dimension 1), municipalities of size I obtained the 03 best results, besides 06 of the 07 best, while among the 08 worst results, 06 were from municipalities of size II (*table 1*). This good performance of municipalities of size I was also present when the different sizes in the same region were observed, except in the Western region. Among the municipalities located in different regions, those in the Extreme South (size I), East (size I), North, South (size II), and Centre-East had more expressive results.

Table 1. Performance by dimension and classification of government capacity of the municipalities

MUNICIPALITIES	PERFORMANCE BY DIMENSION			FINAL SCORE (Top mark = 100)	GOVERNMENT CAPACITY
	DIMENSION 1 (Top mark = 52.63)	DIMENSION 2 (Top mark = 31.58)	DIMENSION 3 (Top mark = 15.79)		
IA	37,72	21,05	10,18	68,95	Moderate
IC	25,44	26,84	11,49	63,77	Moderate
ID	31,58	14,04	15,26	60,88	Moderate
IE	11,40	25,44	12,72	49,56	Low
IF	28,42	28,25	15,79	72,46	Moderate
IG	18,42	25,61	15,09	59,12	Moderate
IH	24,74	24,39	14,04	63,16	Moderate
II	30,88	20,53	10,09	61,58	Moderate
IIA	23,51	30,00	13,33	66,84	Moderate
IIB	28,60	21,75	11,84	62,19	Moderate
IIB'	19,47	24,91	14,12	58,51	Moderate
IIC	22,46	25,79	14,21	62,46	Moderate
IID	18,60	26,14	11,93	56,67	Moderate
IID'	11,40	18,60	4,56	34,56	Low
IIE	15,26	11,75	7,46	34,47	Low

Source: Own elaboration.

In the dimension related to the work systems of the Secretariats (dimension 2), it was noticed that there was a certain heterogeneity in the classification, with a municipality of size II occupying the first place,

followed by 02 municipalities of size I and 02 municipalities of size II, consecutively. This heterogeneous result was also repeated when comparing municipalities of different sizes in the same region, with emphasis on

the municipality IIA, which obtained the best result among all the participants. Among the different regions, the municipalities of the Extreme South (size II), Centre-East, Centre-North (size I), East (size II) and Centre-North (size II) regions were the ones that obtained the best results.

Regarding the dimension that deals with the organizational design of the Secretariats (dimension 3), the municipalities of size I presented more satisfactory performances, obtaining the 03 best scores. The same happened when comparing municipalities of the same region, with emphasis on the ID municipality, which more distanced itself from the other municipalities of its region. Among the different regions, there was a variation among the best results, with a municipality in the Centre-East region occupying the first place, followed by municipalities in the East, Southwest, Centre-North and South regions.

According to the classification criteria, from the scores, the government capacity observed in this study was moderate in 12 and low in 03 municipalities, thus, none of the participants had a high government capacity (*table 1*). The ranking order was: 1^o = IF (Centre-East), 2nd = IA (Extreme South), 3rd = IIA (Extreme South), 4th = IC (Centre-North), 5th = IH (Northeast), 6th = IIC (South), 7^o = IIB (South), 8^o = II (North), 9^o = ID (East), 10^o = IG (Southwest), 11^o = IIB' = IE (West), 14^o = IID'(East) and 15^o = IIE (West).

Discussion

Professional trajectory and expertise of managers

The professional trajectory is related to the sequence of social occupations over time, involving formal learning environments and valuing individual subjectivity in decision making. It is carried by technical, political, institutional, social and perceptual references,

enhanced by the expertise of the subject about the topic in question and with possible interventions, reflecting in his/her choices for the formulation and the capacity to implement government projects^{19,20}.

Considering that the guarantee of the right to health of Brazilian citizens passes, among other factors, through the need of action of professionals and managers with knowledge and practices that make it possible to qualify their performance in SUS^{4,21}, in the present study, through less expressive results among all the others, this dimension proved to be the most challenging for the improvement of the capacity of health management in the municipalities.

These results corroborate the findings of several studies that point out limitations in the expertise of the managers²²⁻²⁵. Cecílio and cols.¹, investigating the professional trajectory of managers of municipalities in the state of São Paulo, identified that there is a large number of these actors with no training or experience in public management, being thus scarce the understanding of SUS as public policy and of its role as manager before it.

Demonstrating the importance of the variable professional qualification/training for local health management capacity, Vilasbôas and Paim²⁶ showed that the expertise of the municipal manager was one of the greatest virtues for the development of SUS in a municipality in the Northeast of Brazil, whose management performance showed great advances in the process of decentralization. Likewise, Santos and Giovanella¹⁵, studying governance in a health region of the state of Bahia, identified that the poor training of managers interfered negatively in the understanding and contribution in the debates in spaces on topics relevant to health management in their municipalities.

A total of 07 managers reported having previously served as secretary of health, and the governance capacity of their respective municipalities was considered intermediate/moderate. This previous exercise was not reported in

municipalities that presented results of lower governance capacity, suggesting that previous management experience may cooperate for greater government capacity.

A national survey, carried out in 2006 by Fleury and Ouverney⁴, found that 76.2% of the secretaries had not previously held this position. There is a great loss for the management of institutions and for the continuity of policies, which have to undergo a managerial slowdown or rupture²⁴, as well as jeopardizing the accumulation of knowledge and institutional learning¹⁵, especially, in each municipal electoral process, given the high rotativity or turnover²⁷ in this function.

In general, the training of managers for SUS has been a challenge for the improvement of the system. The limitation of the managerial capacity of the actors involved in these management processes raises the debate about the current model of university graduation in the Country, about the degree of specialization and technical nature of managers, as well as the demand for effective permanent education policies aimed at this public, which are capable of contemplating an integration between education and work in management^{28,29}.

The working systems in the MHD

This dimension dialogues with macro-practices of work, that determine the systems of high direction, decisive for the institutional capacity of government, with strong relation with the ways to use the time, to analyze options, to calculate, to decide, to evaluate, to monitor, to direct and to manage, and that centrally involve situational strategic planning¹¹, with clear guidelines for budgeting and negotiation with workers and the management team.

The performance of municipalities in this dimension can be considered satisfactory due to the large number of results close to their maximum value. Ratifying the importance of structured work systems, Sampaio and cols.⁹ identified that the absence of these components was central to the low capacity of

government in the State Health Department (SHD) investigated.

In observing this central question in the dimension, it is noticed that 14 managers informed to carry out planning for the implementation of the respective government projects. In addition, according to them, the planning characteristics pointed out, especially by the municipalities with better final scores, protected methodological familiarity with the situational strategic planning. This fact strengthens the hypothesis that, in municipalities with greater government capacity, managers not only dominate, to some extent, planning techniques, but also implement, monitor and evaluate the plan¹¹. Thus, planning is considered a fundamental tool in the organization of a management, since it contributes to the capacity to implement health policies at the municipal level²⁶.

Contrary to this path, Cecílio and cols.¹ identified that most of the municipalities studied did not even have a municipal health plan, did not know how to produce a plan or did not use a health plan as an instrument of value for management in the setting of priorities for evaluation and accountability of its activities. This way, in spite of the high number of positive responses regarding planning practice in the present study, in order to ascertain the effectiveness of this planning or if it has been done merely to meet legal requirements, an in-depth study would be appropriate, *in loco*, as done by Vilasbôas and Paim²⁶, when they identified that the non-institutionalization of structured planning practices, as well as the incipience of the work systems in the researched MHD converged to weaken the leadership capacity of the management team.

It is important to emphasize that in this second dimension the 'iron triangle', by Matus¹¹, is also involved, which defines the existence/nonexistence and quality of all the other seven remaining systems of strategic direction and management (top management systems) studied here. Almost all of the municipalities with the highest government

capacity have positively noted the issues in the iron triangle, identifying that the secretaries have autonomy over the management of their agenda, that individual and collective commitments are agreed with all workers and that the responsible for actions are awarded or penalized according to the achievement of their objectives.

Weaknesses in planning practices related to deficiencies in the components of the iron triangle, even though this planning is documented in the PES model, were identified by Lotufo¹⁷, analyzing the capacity of government of an SHD. The author verified that the Secretariat operated in an environment of low responsibility, since the planning was very formal, considered dispensable and, therefore, superfluous for most managers, not having, in the organization, an effective system of collection and accountability.

It was still possible to verify that the majority of the municipalities whose secretaries were longer ahead of the MHD received better results in this dimension. Again, it can be seen that the political and administrative discontinuity of the management, the great turnover and the lack of preparation of the municipal managers, with reduced potential of formulation, implementation and monitoring of the local government projects, impair an effective association of monitoring and evaluation actions which are subsidiary or intrinsic to planning and management and support the formulation of policies, the decision-making process and training of the subjects involved³⁰. All this scenario presents itself as an obstacle to the development of government and governance capacity of a management, compromising its performance^{1,31,32}.

Autonomy and organizational design

For Matus¹³, the organization quality of the government apparatus is an aspect of the institutional capacity of government and also contributes to governance. The approach taken in the present study on organizational design

was based on technical requirements, such as the organizational project and work micro-practices (macro-project and micro-project level, for Matus, respectively), as well as the intrinsic political elements of management, mainly related to the form how this organization is conceived or seeks its conception in the public machinery.

These last elements are based on what Vilasbôas¹⁸ calls the 'technical-political calculation for the construction of viability', in a study in which the author identified that the governance capacity of a leading team, in what concerns to the domain about the accomplishment of strategic actions (the various forms of negotiation), seems to have contributed to strengthening its capacity to implement the government project of the MHD.

In this dimension 3 the results were even more expressive than in dimension 2, since a larger number of municipalities obtained a score close to the maximum value of the dimension. This fact demonstrates that MHD have presented an organizational design favorable to the development of its government capacity.

Municipalities with greater government capacity presented positive results regarding the autonomy of their financial management, including independence in the nomination of manager to the municipal health fund, in addition to having a specific commission of bids for MHD. In other works, the absence of these attributes has posed an important barrier to the government capacity of the Secretariats^{23,26,33,34}.

The capacity for mobilization of support has also shown an important initiative among the MHD with a better performance in this dimension, since a large part reported having a good accession of the workers to the project, political support from other entities and institutions (city hall, city council, municipal health council etc.). These components, combined with the clear distribution of functions among the management team (coherence with the organization chart), are elements of the

government capacity, founders of governability and, therefore, crucial for the implementation of the government project in municipal management²⁶.

In general, for the good performance of a management, it is fundamental that there is capacity and autonomy decision and administrative by the local manager. The absence of these principles leads to the need for efforts by secretaries and teams, compromising their agendas with conviction, cooperation raising and co-option of other actors relevant to the health project, if these managers have the legitimacy and technical and political ability to do so^{18,33}.

Government capacity and relation with size and regional location

In this study, the inclusion of municipalities with different population sizes and located in different regions of the state allowed a look at the different regional contexts in which each one is inserted, as well as on the challenges and potentialities related to their demography.

The results of the final scores show superior government capacity in large municipalities and little expressive results in small size municipalities. This same outcome can also be observed when analyzing each dimension in isolation and corroborates the findings of Fonseca and cols.³⁵.

The poor performances obtained by small size cities in dimension 1 (professional trajectory) may be associated with their distancing from large university training centers, which usually retain the best professional staffs, in addition to concentrating most of the educational offerings. Furthermore, the low salaries practiced in the small municipalities end up making them less inviting for the better qualified managers, leading them, as soon as they acquire a certain experience, to migrate and stay in the big cities⁴. Fleury and Ouverney⁴ identified that, in the larger municipalities (50 to 200 thousand inhabitants), the frequency of secretaries with experience in health

management was higher, a result consistent with that identified in the present study.

In addition to the deficit in undergraduate education, as in the work of Castro and cols.³⁶, there was still a low practice of permanent education in small municipalities, where professional trajectories with little preparation for management were most strongly identified. It is clear that, even recognizing the gaps in their training, education for work and at work has not been a constant in the daily routine of these managers.

The socioeconomic factor can also be identified as one of the major responsible for the greater government capacity among large municipalities (they have average of HDI-M, Gross Domestic Product – GDP per capita and collection of Tax on Circulation of Goods and Transportation and Communication Services – Higher ICMS). Looking, this way, at the dimension 3, it is perceived a power related to the development of greater local autonomy and, consequently, government capacity³⁷, since, due to the volume of revenues, there are better conditions for sustaining a project of its own strong financial induction by federal policies, emphasizing local priorities and technical decisions.

Moreover, government capacity and the resulting model of health services organization reproduce the inequalities between the macroregions and between the municipalities of the state of Bahia, also determined by their degree of social and economic development³⁴. This is evidenced when, among the 05 municipalities with the highest final scores, 04 of them are located in regions of high socioeconomic development in the state. Antagonistically, the worst results were identified in municipalities located in medium to low development regions.

In the Eastern region, there was an exception to the observed patterns of good performance among municipalities of size I and developed regions, in which the municipalities presented extremely low final scores. In the size I municipality, this is probably associated

with the high number of unanswered questions in the questionnaire. As for the municipalities of size II, although this region is the most developed in the state, there is a relationship with the exorbitant intra-regional socioeconomic inequalities.

Despite the high HDI-M of the municipalities of the Western macroregion, the deficient professional trajectory contributed greatly to its low final scores. This region has still very restricted offers of training, with recent creation of public university courses in the health area and few local offers of permanent education.

In either case, the training of managers for the SUS and the development of their management capacity have been a general challenge for the improvement of the system, especially in the most remote areas, of extreme socioeconomic contexts and where access to information and training is even more scarce. For Mota³⁸, if the organizational structure is highly dependent on the environment and this varies in time and space, its management should also be equally variable and result from a constant adaptation to the different contexts.

When comparing the municipalities of the same macroregion, the ratings for the final scores were predominantly close, which indicates similar characteristics among them regarding the governance capacity. However, municipalities of size I also presented a discrete highlight, confirming the trend observed in the general classification. In this way, it can be considered that the population size of the municipality, highly related to its economic capacity, may also be associated with its greater governance capacity^{34,37}.

Final considerations

The present study has evidenced the ability of health management from intermediate to low in the Bahia municipalities studied. In dimension 1 (professional trajectory of managers) it is where the greatest difficulties were

encountered in achieving results that would contribute to the increase of government capacity, followed by dimensions 2 (work systems of the Secretariats) and 3 (organizational design of institutions).

The variation in results showed, as well, a greater accumulation of government capacity among the municipalities with larger population sizes and located in the most developed macroregions of the state. This behavior can be generalized by analyzing each dimension separately.

It can be said that the choice of the theoretical framework of Carlos Matus^{7,10-13} to base the present work was appropriate, since it made possible a methodological orientation, besides the deepening of the reflections about a theoretical-practical model of public management and its implications. However, it is necessary to use new references and methodologies, especially the use of tools that go beyond the experience of the secretaries, with the purpose of better describing and analyzing the capacity of government in the MHD, adding new elements to this debate.

The weaknesses identified in managerial expertise suggest that the choice of health secretaries by the heads of the Executive has probably been given, largely, consideration to the personal or political relationship to the detriment of the required technical profile. This tends to be repeated in the composition of the assessment of the MHD and, in addition to jeopardizing the implementation of the government projects, still promotes a great rotation of the management, presented here as a potentiator of low government capacity. It is neither possible nor needed, in democracies, to make demands with respect to the training of actors chosen by popular vote to perform political functions¹², however, in the case of non-elective positions, it is imperative that technical criteria of individual capacity for their occupation can be prioritized.

Matus proposes¹¹, and here it is ratified, the need for the creation of Government Schools, which effectively promote the training of

managers in a different way from the current model of university formation, departmentalized, super-specialized and centered on proceduralism. This training has pulled away the actors from the logic of health management in the municipalities, which involves a series of social determinants, nowadays often mistakenly left out of situational analyzes, which makes it impossible for the State to intervene on the basis of the health problems of the population.

In addition, it is fundamental that the states, Federal Government and other institutions involved in the development and representation of MHD, such as the Councils of Municipal Health Departments (Cosems), commit themselves to ensuring the qualification of the administrations and with the institutional support, approaching the secretaries and other managers in the municipalities. These actions should prioritize small size municipalities and located in underprivileged regions from the socioeconomic point of view, contributing to the minimization of communication and organizational barriers between formulators and executors of public health policies.

It is important to highlight that, once there is a bankruptcy in the municipal management sphere, which is directly responsible for the execution of a large part of the services,

especially Primary Care, which is responsible for ordering the entire health services network, there may be involvement of a whole production chain and management of health care of citizens, end-of-system activity. While the capacity of the municipalities to govern does not follow the complex management dynamics of the SUS, taking into account their technical and political components, the efforts undertaken during the 30 years of existence of this policy may be at risk.

It can be stated, as well, that the improvement of management capacity is vital for strengthening the correlation of forces in favor of a universal, integral, totally public and quality system, that positively impacts the lives of Brazilian citizens before the neoliberal agenda that has gained space within the SUS in recent years.

Collaborators

Brandão CC (0000-0001-8201-1130)* and Scherer MDA (0000-0002-1465-7949)* contributed to the conception, planning, analysis and interpretation of data; critical review of the content; and approval of the final version of the manuscript. ■

*Orcid (Open Researcher and Contributor ID).

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