

SUS management in interstate health regions: assessment of the government's capacity

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Abstract *This study displays an assessment of SUS management in a Brazilian interstate health region. An evaluative study was conducted with levels of regional analysis and data production, combining interviews with key informants and documentary analysis. Sources and data were compared and linked to analytical categories of the Government Triangle, showing a cutout of the outcomes and the government's capacity assessment. There is a low capacity for government in interstate health regions when managers and co-management spaces are unable to influence regional political decisions, limiting themselves to normative and ratifying government strategies. Disparities in the management capacity among the border states prevent the sustainability of coordinating state decision-making goals, exposing that management strategies are not enough to institutionalize interstate regionalization. There is a predominance of low SUS governance capacity in interstate health regions, and its political pattern becomes an unclear project restricted to the ideological level. The broad documentary appreciation with the use of powerful theoretical referential are methodological contributions of this research for the political analysis of SUS management in spaces that were the least examined, such as interstate borders.*

Key words *Unified Health System, Regional Health Planning, Health Policy,*

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Introduction

Brazil has 440 health regions established¹ and distributed in a federative organization with shared power between the Union, states and municipalities². This contributes to a complex architecture of government of the Unified Health System (SUS) on interstate borders, which aggregate, in addition to this triple composition, at least two states.

Despite the Interstate Health Regions (RIS) being complex spaces, they did not assume centrality in the SUS regionalization policy, given the lack of normative instruments for their regulation at the national level³ and methods to facilitate the interstate management of the health system⁴.

The proposals for the regionalization of health systems are not recent. However, in Brazil, this discussion was delayed in relation to other countries in Western Europe and Latin America⁵. Regionalization has been adopted as a form of organization of the SUS since the 1980s, but only in the 2000s it reached prominence in government decisions and norms⁶, without, however, formulating specific guidelines for the construction of projects aimed at the interstate management of the system. and also to other areas and regions, in unique contexts, such as border areas and metropolitan regions.

For more than a decade, the focus of decentralization in municipalities marginalized state entities in the SUS management process, and attempts to rescue the state role were not successful^{5,7}, at first, making the participation of the State Health Departments (SES) in the management of interstate health regions more fragile.

Despite the publication of several regulations to organize SUS government strategies in health regions, in Brazil, unlike countries such as Italy⁸, Japan⁹ and England¹⁰, there is still a low capacity for regional planning¹¹, for establishing agreements and intergovernmental cooperation¹², decision-making power over political aspects¹³⁻¹⁵ and institutionality of regional deliberative⁷, mainly in the North and Northeast regions¹³. Not even the most recent propositions of Public Action Organizational Contracts (COAP) were successful in expanding the capacity of intergovernmental agreements in the SUS⁷. This scenario has greater implications for RIS, which lack interstate deliberative spaces and present several concomitant regional decision-making structures, under unique dynamics and profiles.

Thus, the coexistence of autonomy and interdependence of power between federative entities,

without a regional health authority to coordinate this relationship, weakens the ability to govern health regions¹⁶, a challenge that is more significant at interstate borders, where intergovernmental articulation is crucial to ensure SUS management capacity.

Political, service offer, fiscal and administrative inequalities of federative entities are limiting factors for governing health regions¹⁵, deepening in interstate territories, whose territorial design comprises a greater diversity of municipal and state entities. Added to this are the inequities of financial transfers¹⁷, which in border territories between countries or states do not include the migration of users of the system¹⁸.

In the literature, studies on regional management of the SUS are centered on intrastate territories, and only a few elucidated political issues of system management at interstate borders. The only ones identified refer to the analysis of the implementation of regionalized management¹⁹ and the conformation of an Interstate Health Network²⁰. There is also the superficiality of national studies on regionalization, whose approaches are more “exploratory” and less evaluative²¹.

In this study, we sought to analyze the government capacity of municipal and state managers to govern an Interstate Health Region. This article presents an excerpt of the results of a doctoral thesis that took as its object of study the political design and the dynamics of power in an interstate health region in the Brazilian Northeast. It is intended to contribute to the political analysis of the ability to govern health systems across interstate borders, based on a study supported by a broad documentary appreciation and a network of key informants, linked to different spaces of power. It starts from the analysis of the pioneering experience of the Interstate Health Network in Brazil, whose political design included the creation of the Interstate Health Co-Management Commission (CRIE) and the Interstate Regulation Center for Beds (CRIL).

Method

This is an evaluative study whose methodological strategy was to carry out a single case study with an intensive approach and one level of analysis, adopting as theoretical-conceptual elements the theory of action of Calos Matus, in particular, the Triangle of Government and the Theory of Social Production²². In this article, we present an excerpt of the study whose focus is “government

capacity”, understood as the “management and direction capacity, accumulated in the person, in the team or in an organization or a set of techniques, methods, skills and abilities, necessary to conduct theoretical, methodological and technical processes of government”²².

Study scenario

The study was carried out in the Northeast region of Brazil, with a political design composed of 53 municipalities, two states and the Union. It refers to the interstate border between the Northern Bahia macro-region and the São Francisco Valley, in Pernambuco, with 28 municipalities in Bahia and 25 in Pernambuco. Each macro-region had three health regions with a Regional Inter-management Commission (CIR) in place, and the headquarters of the Region were the municipalities of Juazeiro-BA and Petrolina-PE²³. The regional population was approximately two million inhabitants²⁴, spread over an area of 127,887.91 km². The region in question hosted the first experiences: interstate regionalization of the SUS (started in 2008), with the involvement of the federal entity; interstate regulation of beds, managed by two states; and the institution of a CRIE, with a tripartite management proposal.

In Pernambuco, each health region had a Regional Health Management (GERES), related to the state coordination of the municipalities. In Bahia, there was only a similar structure for the three health regions, simultaneously, called the North Regional Health Center (NRS)²². At the interstate level, there was a CRIE, instituted since 2010 as a deliberative space, composed of municipal, state, federal and Federal University representatives. There was also CRIL, created in 2011, financed and managed by the states.

Data production and analysis

The production of the empirical basis of analysis, between October 2017 and August 2018, combined document analysis, interviews with key informants and researchers’ field diaries. Documents with a time frame from 2008 to 2018 were used, considering the first discussions for the construction of the regional design and the completion of the fieldwork, respectively. A total of 499 documents were analyzed, namely: service coverage reports, reports from RIS work groups, CRIL, institutional letters, state resolutions, federal ordinances, implementation project for the Region, subproject and base documents of the

QualiSUS-Regional network and dossier, technical notes from the National Council of Health Secretaries, minutes from the CIR and CRIE, national, state and municipal management plans and reports and the states’ Regionalization Master Plan (PDR).

Actors who occupied a strategic position in the process of formulation or implementation of the Region or belonged to spaces of articulation, decision and management of actions and health services in the region or those identified as influential in the dynamics of regional power were included. The interviews were recorded on a digital recorder and fully transcribed. We interviewed 35 key informants, linked to the scope of municipal, state, regional and interstate management, the Federal University, indirect administration organizations, the Federal Public Ministry, influential economic groups and the physicians’ union in the region. The saturation criterion was adopted to close the research field.

Documentary information was gathered from the national to the municipal level, and its systematization used the support matrices-synthesis of documentary information, whose material was compiled in a single file, entitled “documentary appreciation”, to facilitate its processing. The data were processed in the QRS NVivo11 program, through which the data sources were triangulated, in addition to coding the empirical basis by analytical categories of the Government Triangle, namely: the project, governance and government capacity²². Then, the empirical data were based on an analytical data plan (Chart 1), which guided the construction of the results.

The dynamics of the CIR and CRIE were analyzed from the minutes of the meeting and interviews. Concerning the CIRs, an in-depth analysis was carried out in the host regions of the border (Juazeiro-BA and Petrolina-PE) as they concentrate most of the interstate reference services. The decisions of the SES between 2008 and 2018 were also analyzed, through the resolutions and minutes of the Bipartite Intermanagement Commissions (CIB). In the political design of the Region, it was expected that the states would act as the main articulators of the municipalities on the interstate border and that the decisions between the SES would be articulated to build an agenda that would allow overcoming obstacles for the interstate management of the SUS.

The study was approved by the Research Ethics Committee (CEP) of the Federal University of Bahia (CAAE 74178617.4.0000.5030). Respondents signed the Free and Informed Consent

Chart 1. Clipping of the analytical plan of the study with the analytical categories, definition, operationalization and detailing.

Analytical categories	Definition	Operationalization	Detailing
Government project	Set of ideas, proposals, objectives or forecast of actions of the actor(s) that govern(s).	Ideas, proposals, objectives and actions thought and/or elaborated by the actor(s) that govern for the political design and dynamics of the RIS.	Previous situation that stimulated the first proposals of conformation of the regional design; characteristics of decision-making processes for the formulation of regional political design; objectives and axes of regional design; ideas and proposals for organizing health services; ideas and proposals for inter-federal articulation and regional management; correspondence between the proposals idealized for the region and the proposals of the federative entities, from the perspective of the actor(s) that govern the Region.
Governability	Degree of control of the actor(s) that govern(s) the relevant and decisive variables for their government project.	Main political aspects (degree of autonomy and type of political support received by the actor(s) that govern(s) the regional space) that represented obstacles or facilities for the realization of the ideas, proposals and objectives idealized for the RIS.	Critical points that made it impossible to comply with the proposals for the organization of services and management of the RIS; achieved and unachieved proposals in relation to the RIS project; actions and proposals for less and greater governance; correspondence between the actions thought and the goals devised by the federations for the region; facts that represented alliance or opposition to the proposals of the actor(s); correspondence between interstate decisions and statewide decisions.
Governing	Leadership capacity, skills, methods, techniques or expertise of a social actor (individual, group of individuals or an organization), to lead, direct, maneuver and overcome difficulties to achieve a given project.	Strategies and driving capacity of the actor(s) to implement the regional design and circumvent the critical points of implementation of the idealized proposals for RIS.	Institutionality of regional and interstate inter-management commissions to operationalize the political design of the interstate region and circumvent its implementation obstacles; management capacity of the State Health Departments for the integration of planning, agreement, management and regulation of access in the RIS; ability to articulate decisions between states for the implementation of health actions and services in the interstate territory.

Source: Authors, 2019.

Term (FICT), under consent to participate in the study.

Results

The results of this study were organized into two subsections, based on the presented clipping of the analytical category “government capacity”.

The first addresses the institutionality of regional and interstate co-management spaces, analyzing to what extent they had the management capacity to operationalize an interstate health policy and circumvent its implementation obstacles; the second presents an analysis of the management capacity of the SES and the results on the analysis of the strategies of the states in the articulation of interstate decisions in health.

The institutionality of inter-management commissions and interstate health policy

In the political design of the Region, at the intrastate level, it was expected that the CIR would act in the agreement of actions and services between municipal managers and, at the interstate level, the CRIE would act in the articulation of interstate agreements. However, this design had low institutionality, due to the fact that the commissions were restricted to debates at the local level, to bureaucratic and informative aspects, with a predominance of guidelines on enabling municipal services and reports at the state level.

The analysis of the agendas revealed a frequent influence of the state representations in the Inter-managers Commissions, which had little participation of the municipal managers from the definition to the discussion of the agendas. Managers found it difficult to maintain their attendance at CIR and CRIE meetings, including representatives of the regional headquarters, confirmed by the frequent lack of quorum, constituting an impasse for building deliberative capacity in support of the interstate regionalization of the SUS (Chart 2).

In the CIRs, the proposal for interstate regionalization of the SUS was not sustainable in the debate agenda, in both health regions, evidenced by the recurrent suppression of agendas on the RIS in the analyzed minutes and by the prioritization of demands related to the municipalities. The commissions did not develop strategies to expand the capacity for inter-federative articulation, resulting in inertia of tripartite decision-making agendas for the implementation of an interstate health policy (Chart 2).

CIR municipal managers had little ability to influence the definition of meeting agendas, often induced by state representations. The analysis of the minutes showed a low decision-making capacity and sustainability of previously defined agendas, with frequent divergence between agendas and deliberations, in addition to a predominantly homologating and informative dynamic.

The deliberations of the Inter-management Committees distanced themselves from the proposal of interstate regionalization of the SUS, noting, in the analyzed guidelines, in addition to the focus centered on the municipal scope, an inertia of these spaces between 2015 and 2017, where there was no debate on aspects related to the political design of the interstate health region formulated since 2008.

Asymmetries of power between municipal managers were observed. State representatives

and managers of the host municipalities, and actors with greater leadership and argumentative capacity, influenced decisions, because they had privileged information from the central state level or because they concentrated greater power over financial resources and hosted reference services in the RIS.

The inequalities in the political capacity of the municipal managers in the commissions collaborated so that representations of the host municipalities printed, in an arbitrary way, decisions with an impact on the Region. In the minutes, decisions of the municipal managers of the headquarters of the Region were evidenced, that culminated in the disqualification of specialized services of orthopedics and traumatology (regional critical point), disrupting the flow of users agreed with other municipalities. This evidenced that little progress was made in the construction of strategies to fulfill interstate agreements.

Actors linked to private health services had high influence over political decisions in the Region, using argumentative methods and alliances with political groups to co-opt strategic actors in the decision-making of the Inter-management Committees (Chart 2). These actors concentrated administrative power on specialized or highly complex services, not offered by their own network, having a wide network of political and economic alliances.

In the discussions recorded in the minutes of the CIR, it became evident that the space of the Inter-management Commissions became an arena of disputes between private providers, whose main mechanism of influence was participation in ordinary meetings, mediated by representatives of greater political power in the collegiate. There was a clear objective to obtain the consent of managers to hire specialized regional services with low supply in their own network, such as ophthalmology for glaucoma screening, cataract surgeries or ophthalmological emergencies.

Although instituted since 2012, the CRIE has not been able to implement tripartite articulation mechanisms to broaden discussions on the interstate regionalization of the SUS, evident by the discontinuity of debates on interstate health policy, with the absence of the federal entity and the rare participation of the states. The minutes and interviews analyzed revealed that not even the quarterly regularity of ordinary meetings, established by the Internal Regulations, was fulfilled, confirming that the commission became a rhetorical space, with a recurring lack of quorum and stagnation of activities between 2015 and 2017 (Chart 2).

Chart 2. Interstate Health Region, Brazil, 2019.

Evidence	Excerpts
Absence of strategies by the Inter-management Commissions for inter-federative articulation and implementation of an interstate health policy	“Then, in this discussion of the network, they thought about interstate integrated planning, an integrated budget, but it seems that it did not work. It didn’t manage to plan an interstate PPI; an interstate budget” (Interstate Regulation Manager).
Institutional dynamics centered on the municipal at the expense of the interstate	“However, in my perception, we are still very much in the perception of the local focus. The municipality would have to see the implementation of that service from a network perspective or from a regionalization perspective. We have difficulties with the management because it does not want to open up to the regionalized service, even having the profile” (Regional Health Manager I).
Low institutionality of the CIRs fostered by the lack of support from the states	“Several meetings were scheduled and canceled, but the fact is that they did not take place and there was this evasion by the states. Bahia, in particular, evaded decisions a lot, in the sense of knowing that there were some obstacles that he would need to advance in some services” (Regional Health Manager).
Asymmetries of power between representations in the CIRs	“Petrolina has a much greater political force. Petrolina has, from the A family, a mayor, who is a mayor and a state deputy, he left his charge of deputy to be mayor of the city. There is a federal deputy who is now a minister and there is a senator, only from Petrolina. There are two more federal deputies. So, this whole federal issue, of course, makes it easier for the municipality” (Representative of Economic Group I).
Low institutionality and stagnation of CRIE activities	“I think the managers lost, as I told you, they discredited the collegiate. Because as there is no resource, there is no new resource, credibility was lost and managers had no interest in meeting, the network was collapsing and services that were implemented at the time there in 2011 were closing” (Municipal Health Secretary V).

Source: Authors, 2019.

The findings of this study on the low institutionality of the Inter-management Commissions confirm that these spaces have become emptied, and that even constituting the political design of the Region, they did not assume, in their management strategies, the interstate regionalization of the SUS as centrality.

Management capacity among the State Health Departments

The proposal of political design of the RIS included state entities as participants in interstate management. State managers were part of regional and interstate Intermanagement Commissions, in addition to participating in the management of CRIL. However, this study showed inequalities in government capacity among the SES, which had direct repercussions on the interstate management of the SUS (Chart 3).

State disparities (territorial extent, number of municipalities, population and health regions) proved to be decisive in the government’s ability

of the SES to coordinate the SUS regionalization policy on the studied border. Different territorial delimitations between the analyzed PDRs made it possible to highlight extensive macro-regional designs, requiring different state capacities to act in the health regions that are more peripheral to the headquarters of the Region.

The State Health Plans (PES) analyzed revealed that the SES built guidelines with a shallow alignment in relation to the territory studied, confirming a tangency of planning practices to operate the interstate management of the SUS. In Bahia, this distance was greater than in Pernambuco, especially after the establishment of a new management team in 2016, identifying a clear rupture of purposes for the health sector, compared to those defined by the team that was responsible for the process of formulating the Region design.

In Pernambuco, regional agreements showed little participatory characteristics when compared to those in Bahia, which managed to institute this process in a computerized way for the

Chart 3. Evidence on the management capacity of the State Health Departments in the Interstate Health Region, Brazil, 2019.

Evidence	Excerpts
State inequality of interfederative pact strategies	“The PPI was a little more complicated, because the PPI of the State of Pernambuco is, let's say, frozen since 2005 [...] for us there is no discussion. It is not dynamic in Pernambuco. The PPI in Bahia, on the other hand, is more dynamic. There's a system, they can... Even with a budget, let's say, static, they can somehow talk [...]” (Interstate Regulation Manager I).
Absence of strategies by the state secretariats to institute revisions of inter-federative agreements	“There was no reason why, to this day, the PPI of the state of Pernambuco we do not discuss. Now it was placed for people who needed to be taken back. The following is done: the municipalities only replicate the amounts they have received since 2005” (Interstate Regulation Manager II).
	“Because then, what you have to program, is the same resource. It didn't advance, you discuss programming with the same resource you have. The State of Bahia is now reviewing the PPI since 2012. There in the manual, the first thing it says is saying this, that there is no new resource [...]” (Municipal Regulation Manager).
Asymmetrical capacity for regional management among the	<p>“Pernambuco, I really like the way they work, because they are regionalists. All of Pernambuco is regionalist. Unlike Bahia, which is municipalist. The refusal goes to the municipality and the municipality manages with this amount. Not the State, the State of Pernambuco does not release the high complexity resource” (Interstate Regulation Manager II).</p> <p>“In the management of Pernambuco, GERES works effectively with the municipalities to monitor, manage, identify difficulties and solve them. Management is efficient. On the Bahia side, we have a Regional Health Center. There is one person for three health micro-regions and who has no political power. He alone will do nothing; You don't have the ability to know the entire health region, right? So, this is a very important differential” (Interstate Bed Regulation Manager II).</p>
Recentralization of regional management strategies in Bahia	“The Regional Health Centers were so emptied that today they are just relays of processes, from here at the secretariat. The central level decides. They are work makers. They are task workers” (Regional Health Base Manager II).
State management strategies influenced by technical action and party-political action	“You go to a meeting with Pernambuco and Bahia. Pernambuco shows population statistics, population by beds, services, a whole picture of actions. It has a numerical and situational observation of each place, he has by municipality, by microregion; he demonstrates a knowledge if not of needs, but at least of what is being done. We realize that if they have Bahia, they don't, but I believe they don't, because if they did, they would show a demonstration of knowledge and knowledge. It is as if Bahia had a very political and technically ineffective role. It (Bahia) is very political, but little technical” (Hospital Director II).
Different state strategies for hiring personnel responsible for the management of health regions	“In Pernambuco, the position is technical, despite being a commissioned position, it is open to competition. It is a commissioned position, but there are some selection processes. It has an open call for everyone, there are prerequisites with four stages, one of which was the elaboration of an action plan for a health region, focusing on the main indicators - first stage and eliminatory. Then there was a curriculum analysis and an interview” (Regional Health Manager I).
Limited management capacity to regulate beds on the interstate border	“CRIL has no difficulty in the regulation process. The problem is the shortage of vacancies, as we have no guarantee that the Juazeiro Regional Office will perform the trauma-orthopedic surgeries that were contracted. We have no way of expanding SOTE's surgeries; resume surgeries at the hospital in S. do Bonfim; regular patient for the CHESF hospital in Paulo Afonso, etc. If there is no service, there is no way to regulate it” (Interstate Regulation Manager II).
Absence of strategies to implement a system to regulate interstate access	“So what happens? We have a system that is national, which is SISREG, so everyone was trained, everyone uses it. However, let's say, we need to regulate a nebulization, which we don't do here yet. So, when the HU, which is a high-complexity reference, asks us, we include both in Bahia and Pernambuco, in the state centrals, which are other systems. So, in Bahia we use SUREN and in Pernambuco we use SISREG for ICU beds, but for urgency and emergency cases it is by email. So we use several systems and they don't talk to each other, there's no interaction per unit. So, this is also a hindrance to the regulation process here” (Municipal Regulation Manager).

Source: Interviews and documents analyzed. Authors, 2019.

entire state. The interviews revealed that the institutional times for preparing PDRs and reviewing the States' Agreed and Integrated Programs (PPI) occurred at different times, contributing to the low capacity of articulating these instruments between border entities. Even at the intrastate level, PPIs became management rhetoric, as both states failed to establish review mechanisms, contributing to their stagnation in Pernambuco and Bahia, since 2005 and 2010, respectively (Chart 3).

In an analysis of the CRIL reports, it became clear that the state management capacity of the region's reference hospital services was unequal and directly proportional to the number of units under the direct management of the SES. In Pernambuco, the State Health Department (SESPE) had greater regulatory power over hospital providers, while in Bahia, where most of them were under indirect administration, there was less sustainability of regulatory actions and service resolution, evidenced by the higher number of users from Bahia who crossed the Pernambuco border in search of high-complexity hospital care, without the intermediation of interstate regulation of beds.

The interviewees were unanimous about the regional management practices in Bahia having more municipalist characteristics, while the Pernambuco management had a more regionalist performance (Chart 3). In view of this, the interstate management of the SUS in the region has advanced little, due to the asymmetrical capacity of regional coordination of the municipalities. In Bahia, for example, political decisions resulted in the extinction of the Regional Health Directorates (DIRES) in two of the three health regions belonging to the Region, since 2014, causing, according to interviewees, the displacement of personnel from management jobs for hospital units and significantly reducing SESAB's capacity to govern in the regional articulation of municipalities.

While SESPE maintained its GERES in each health region belonging to the interstate border, SESAB centralized its state management in just one NRS to advise the entire North health macro-region, with 28 municipalities, thus characterizing a recentralization movement with a regressive effect on the capacity of state government, exemplified by several interviewees as an unequal presence of states in regional management.

The centralization of SESAB's regional management in NRS resulted in limitations to define priorities and build regional plans in the North of Bahia, contributing so that only the region,

headquarters of the nucleus, maintained financial and administrative autonomy in relation to the others that had the DIRES extinct. This emptying of regional management contributed to the regions being subordinated to the headquarters in the nucleus, and the decision to exclude the DIRES produced an important emptying in the capacity of regional government of SESAB, as well as concentrated decisions in representatives with political indication, subordinated to the central level of SES. This situation, according to interviewees, distanced the state entity from the municipalities, helping to reinforce a fragmented interfederative logic and predominant local interests.

The informants were unanimous in considering that the administration carried by the state of Bahia had more party-political characteristics in relation to the Pernambuco administration. An example of this was evident in the occupation of the coordinator position of the NRS, via political appointment, which made the government capacity of the Nuclei vulnerable to central decisions by SESAB. In Pernambuco, according to the 2012-2015 Annual Management Reports, despite being a commissioned position, there was a record of public selection to hire regional health managers and public health workers, responsible for regional planning and management. In the interviews, all Pernambuco regional managers confirmed that they were the result of this process of free competition.

In the document analysis, a greater involvement of SESPE was identified for the implementation of instruments for regional management of the SUS, such as the COAP. Some ordinances and resolutions analyzed established executive groups for regionalization and conducting groups for the General Programming of Health Actions and Services, in all health regions. Documentation was identified proving the holding of debates aimed at COAP, in partnership with municipal health departments and the State Council of Municipal Health Secretaries, however, without contemplating the interstate regionalization of SUS. In Bahia, these institutional initiatives were not identified in the documents.

There were isolated attempts among municipalities and states to organize their health systems, but not all of them were successful and took on the interstate regionalization of the SUS with breath. One of them included qualifications for the implementation of prevention and health promotion programs in Primary Health Care, but they did not occur at the same speed among

the 53 municipalities in the Region, being, therefore, insufficient to reduce avoidable hospitalizations, as recorded in the reports of Working Group for the Implementation of the Interstate Health Network.

In specialized care, there were initiatives to implement new services in both states. Pernambuco stood out for the creation of Specialized Care Units (UPAE) and Bahia for the creation of inter-municipal consortia to implement regional specialty polyclinics. All consortia in the North of Bahia were signed in the second half of 2018, but no service had been implemented. In addition, the state decontracted private services, with the purpose of transferring them to the Regional Hospital of Juazeiro, but without success, due to several structural problems of the hospital, such as equipment and personnel.

One of the main critical points of government capacity in the Region was the services to support diagnosis and therapy, which were not expanded in their own network and were concentrated in private and philanthropic providers. The minutes of the CIR proved that managers did not have effective mechanisms to regulate the provision of contracted services, selectively offered at the highest remunerated values in the SUS Table and not by regional needs. Attempts to organize specialized care in the North of Bahia failed in the health regions of Paulo Afonso-BA and Senhor do Bonfim-BA, generating inequalities in the management of specialized care at the interstate border.

The analysis of regional urgency and emergency plans confirmed that government decisions made little progress towards expanding services, limiting themselves to debates on the interstate regulation flows of access to hospitals in the Region, without institutional consensus between CRIL managers and managers of services, making it impracticable due to the non-expansion of physical, technological and personnel structures in regional hospitals.

Although the implementation of the CRIL has been one of the main strategies for interstate regulation of the SUS, there was little capacity to manage this space on the beds of the Region, being justified, in the minutes and reports, by the imposition of arbitrary decisions of the demanding municipal managers or managers of performing services that frequently broke with the defined flow of regulation, due to the lack of beds to meet the demand in some health regions and the lack of an integrated system of regulation between the states (Chart 3).

Logistical support systems, since the political idealization of the Region, were a critical point of management, recorded in several analyzed minutes. Despite attempts at improvements, such as the decentralization of the creation of the National Health Card for services and actions to expand health transport in some municipalities, it was observed that these attempts occurred in a heterogeneous way, disconnected from an interstate regionalization policy of health.

These findings allowed us to support that expanding the SUS government capacity in interstate territories is a tripartite challenge, and the inequalities in the management capacity of SES contribute to creating obstacles to the implementation of interstate health policies, since RIS are territories of great uncertainty, political-institutional and because they demand a high capacity to integrate the decision-making agendas of the states.

The SES were unable to produce integrated decisions, thus orienting their management processes towards an intrastate regionalization policy. A good part of the decisions identified in the minutes of the CIB pointed to methods of government supported by a strongly decentralizing bias, characterized by the predominance of guidelines on enabling health services aimed at municipal entities.

Characteristics of state decisions revealed that there was no correspondence between the decision-making agenda of the SES and the SUS interstate regionalization policy. There was no evidence of state strategies for articulating their management teams, confirming that the dynamics of decisions remained fragmented.

Finally, inequalities in the speed of decisions between the SES for the implementation of services in the health regions belonging to the interstate border limited the equitable supply and distribution of these services in the health system structure. Decisions regarding regional urgency and emergency plans and the provision of specialized and highly complex hospital services (a critical point in the Region) advanced more in Pernambuco when compared to Bahia, contributing to a low capacity for interstate regulation of access.

Discussion

The Matusian theory²⁴ highlights three important and interdependent elements in the governing process: the project, governability and

the capacity to govern. The latter relates to the expertise of the actor(s) to carry out a project. Such expertise would reflect the domain of the actor(s) over the theoretical, methodological and technical processes of management, based on experience, knowledge and leadership. The present study identified that managers were unable to develop sufficient methodological, technical and political processes to implement an interstate health policy.

In addition, governing is the ability to produce results, related to a given project, and to overcome inertia, adversities and contradictions that can escape the control of the social actors who conceived this project²⁴. In interstate territories, the ability to produce effective results still remains at the level of intentions when it comes to operationalizing SUS regionalization projects.

According to Matus²², building government capacity requires expanding personal and institutional capacity to overcome obstacles in the implementation of a given project. In this sense, in SUS interstate regionalization projects, the construction of this capacity still remains in the rhetoric, when analyzing the management strategies of the Interagency Committees of the Region, resembling situations present in intrastate regions of the Brazilian Northeast^{25,26}, where mechanisms were not established to expand political power and influence decisions among the various actors in the health system.

The low institutionality of the Intermanagement Commissions in the region studied confirms the difficulty in building the capacity to manage the interstate SUS, similar to situations identified in other health regions in the North and Northeast of Brazil, even if intrastate^{19,26}, where practices of regional management were also predominantly formalistic and bureaucratic²⁷, under the recurrent influence of state representations on the agendas and asymmetries of power between managers^{11,28}, in addition to the commissions becoming the stage for disputes between private sector actors^{26,27}.

Governing corresponds to a game that is doubly determined: on the one hand, by the ability to influence those who govern and, on the other hand, by the conditions of viability vis-à-vis other actors that make up this game²⁴. On interstate borders, SUS regionalization projects have low government capacity when regional and interstate management spaces do not have sufficient political and decision-making power over the region and when state entities do not build strategies to articulate strategic actors such

as municipal and regional managers, and federal agencies in the implementation of an interstate health policy.

The tangency of the interstate regionalization of the SUS in the regional and state decisions analyzed ratifies not only the limited capacity of subnational entities to produce sufficient responses for the implementation of an interstate health policy, but also the need to implement interstate Intermanagement Commissions under representation and tripartite support, especially from the federal entity, in view of the complexity of articulating two or more states, since even in less complex regional designs, such as intrastate ones, low SUS management capacity has been evidenced^{11,28}.

Government capacity can also be conceptualized as the “capacity for action on a project”, that is, the ability to overcome difficulties between proposals and their scope²⁴. In this study, great challenges were evidenced to govern the SUS at the interstate level, highlighting those related to the organization of strategies for the integration of government projects and decision-making agendas between border states, which in the researched scenario becomes a situation very critical for requiring the active participation of states in the constructive mediation of regional health policy^{11,25}.

Contrary to instituting strategies to expand the capacity of regional management, the extinction of DIRES in Bahia clearly illustrated the weakening of SESAB's institutional role in coordinating the municipalities in the Region. Although the purpose of the DIRES was to channel political-institutional communication between municipalities and state management²⁷, their interruption confirmed both a depletion of regional management capacity and a trend of absent state participation in the SUS regionalization policy^{1,25,26} and the difficulty of providing sustainability to regional administrative structures^{11,26}, aspects already pointed out in other studies.

The findings of this study on the political-party influence on the regional management of the SUS in Bahia expose the predominance of political indications for representations and coordination of regional administrative structures, which compromises the construction of feasibility of projects for the interstate regionalization of the health system, in reason for the permanence of power asymmetries between its idealizers and opponents. According to some articles, it is a tradition in Bahia and, at the same time, a politi-

cal strategy to influence decision-making at the central state level over the government of health regions^{26,27}.

The inequalities in the management capacity of the SES make the government capacity of the SUS critical across interstate borders, because they produce fragmented decisions and limit the implementation of strategies to overcome the adversities of planning and coordinating an interstate health policy. Not even in intrastate health regions, studies have shown sufficient institutional capacity in the SES to manage the regionalization policy^{19,25,26,29}. According to some articles, this is explained by historical and political-institutional aspects of the regionalization of each state, ranging from political alignment between federations to resistance to the regionalization process^{20,26}.

Furthermore, the regional political dynamics tend to atrophy the decision-making power of managers in political-economic disputes with actors outside the SUS management spaces. This confirms the theoretical propositions of Matus²², as he reflects that the process of governing involves a diversity of disputed projects and reflects the interest (not always convergent) of various social actors, which in complex scenarios, such as the interstate management of the SUS, it involves betting on a project of mutable, imprecise and uncertain relationships.

The present study made it possible, through one of the variables of the Government Triangle of Matus²⁴, to understand the limits and conditions of SUS management capacity to operationalize the interstate regionalization of the system. The low government capacity, evidenced in this study, reduces the policy of regionalization in interstate territories to the ideological level and informal agreements.

Personal, political and financial disputes suppressed government methods, techniques and skills, which tends to limit municipal autonomy and contribute to dependence on the state and federal entity, producing an emptying of deliberative spaces and subjecting managers to co-optation by the government. economic and political power. The directionality of state decisions diverged from regional needs and little was articulated in favor of interstate agreements, which weakened the capacity for integrated regional planning.

In short, the RIS are challenging spaces for the management of the SUS, with several possibilities for investigation, including political determinants of user flows across borders, in addition to the analysis of experiences in the formulation and implementation of Interstate Health Networks. There is also an urgent need for other political analyzes in these territories that seek to understand the power of actors from the university, the judiciary and indirect administration organizations over the actions and services produced in the interstate sphere.

Collaborations

ÍRS Aleluia collaborated in the design of the project, analysis and interpretation of data; in the writing of the article and its critical review of the intellectual content; in the review and final approval of the version to be published and in the guarantee of its integrity and accuracy. MG Medina collaborated in the design of the project, analysis and interpretation of data; in the writing of the article and its critical review of the intellectual content; in the review and final approval of the version to be published and in the guarantee of its integrity and accuracy. ALQ Vilasbóas collaborated in the analysis and interpretation of data; in the writing of the article and its critical review of the intellectual content; in the review and final approval of the version to be published and in the guarantee of its integrity and accuracy. ALD Viana collaborated in the writing of the article and its critical review of the intellectual content; in the review and final approval of the version to be published and in the guarantee of its integrity and accuracy.

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