DOI: 10.1590/1413-81232017224.26552016

ARTICLE

Thoughts on the development of active regional public health systems

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Abstract *Decentralization and regionalization are strategic themes for reforms in the health system. This paper analyzes the complex process of health regionalization being developed in Brazil. This paper identifies that the normative framework from the Brazilian National Health System, SUS has made advances with respect to its institutionalization and overcoming the initial centrality involved in municipalization. This has strengthened the development of regionalization and the intergovernmental agreement on health but the evidence points to the need to promote a revision. Based on document analysis, literature review and the views given by the authors involved in management in SUS as well as generating radically different views, the challenges for the construction of a regionalization that is active, is debated. We also discuss: its relations with planning and the dimensioning of service networks, the production of active care networks and shared management spaces, the inter-federative agreements and regional regulations, the capacity to coordinate regional systems and financing and the impact of the political dimension and electoral cycles. Regionalization (and SUS itself) is an open book, therefore ways and possibilities on how to maintain an active form of regionalization can be recommended.*

Key words *Regionalization, Decentralization, Health management, Brazilian National Health System, Primary Health Care*

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Introduction

The institutional and legal framework that SUS finds itself in, is an expression of the anxiety for reform in the Brazilian health system with regionalization being on the agenda based on the idea of political and administrative decentralization.

The politics of decentralization, the widening of care and the integration of health services constitute significant characteristics of the recent reforms that are underway in industrialized countries[1]. On one side are those seeking reforms who are apparently against decentralization, whilst on the other side there are those that believe in integration. They are, in practice, phenomena that is interdependent which comes together to induce dynamics that ensure the development and continuity of the public health system[2].

Many factors have contributed to the major fragmentation of the health organizations such as a tendency of impermeability of the professional frontiers (helped by the expansion of knowledge and techniques) and financing modalities that generate various sub-systems. Recent initiatives aimed at strengthening the integration of health services have shown differences in concepts in relation to the mechanisms adopted for its operationalization and its sought-after objectives[3].

Integration can be examined in three different ways: the redefining of organizational structures which may take the form of vertical integration (hierarchical networks), horizontal services of the same size being inter-sectoral or inside of a context of political decentralization of responsibilities between different spheres of government (municipality and the state). There is also the restructuring of the work processes aimed at the integration of care and services in networks and the potential for coherent governance practices with a clear definition of responsibilities and as a consequence, the strengthening of autonomy. Decentralization has, as a result, led to the multiplication of the areas of decisions and measures in a system. It also means a reduction in control in the central sphere over the other areas and it appears to be positively associated with the notion of autonomy. Integration aims at reducing the fragmentation of the system and guaranteeing unity in actions with a positive appearance associated with control and negativity in relation to autonomy. In the logical plan, a tension between the two concepts seems to be present[4].

In the final throes of the military dictatorship, a strong movement opposed the policy of centralization and argued for decentralization and the empowerment of the sub-national entities for the re-democratization of the country[5]. This was also a part of the agenda for sanitary reform as well as the fight for the right to health and the diminution of inequalities[6].

The SUS constitution in 1988 set out the implementation of a decentralized system with the integration of the three spheres of government. The aim was to guarantee measures and health services and a hierarchical and regionalized network of health services. Since then, decentralization and regionalization have been strategic themes in the management of SUS.

During the last two decades, there has been major centrality in municipalization of health care, induced by the operational standards of the 90s in detriment to regionalization. This has put municipalities in the position of leading out in the health care system resulting in: wider access to health care, effective social controls and care qualifications. This is an intense process that is tense, imperfect, constructed by measures and by people that have disputes in health projects whose outputs eventually become part of the principles of SUS as its reference. However, it comes with the distinct ideas on how relations between federal organizations and organizations of services in regional heath, should produce productive working relationships. It is this complex process of the regionalization of health care and the challenges with reference to its implementation, that we decided to analyze.

Methods

In the first part of this paper, constructive elements of the historical process were used in relation to the implementation of SUS. This was the clear path towards regionalization of health care in Brazil. Secondly, going beyond the historical narrative, and permitting an analysis of cycles of policies or the balance of advances, we looked to obtain context, texts and tensions that make it possible to identify and analyze the challenging principles that exist due to regionalization and SUS.

The analysis reflects the process of accumulation and critical observation done by subjects that are clear and who reject, a priori, any scientific pretense of neutrality assuming an engaged character of its triple nature with SUS. They are like actors in the situation of government (managers in distinct spheres of government since

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1989). Workers in the area of public health and researchers have the intention of producing radical thoughts and they are committed to SUS[7]. It is understood that from an epistemological stance, it is possible to have a policy with the object of producing knowledge through the government by people who are able to re-invent it based on their ability to understand and put into operation their will, possibilities, limits, desires and opportunities[8]. This is a policy that is centrally defined but can only be carried out in tandem with other people and in other institutional spaces. It is inevitable that it will be "heard" and re-drafted in the ambit of the region in a peculiar way and implemented through discussions being had at all levels amongst managers covering each reality. These interactions take place with those representing civil society who, within the process, switch to assume new intentions and conformities[9].

For this paper, decrees, official public notices, documents and publications from the Ministry of Health (MS) were reviewed. Documents were also reviewed from representative institutions from the municipal and state health secretaries. We also looked at sites, thesis, books and scientific articles related to the theme.

It is understood that regionalization (and SUS) being an open issue, provides some paths and possibilities on how to maintain a type of regionalization that is active and brings the contribution of Ball[10] who is interested in the analysis of cycles of policies.

Constitutive Elements: decentralization and regionalization in SUS

Brazil is a federative system that is made up of three spheres of government which are autonomous (the Union, 26 states and the Federal District, and 5,570 municipalities). This is the case for countries characterized by heterogeneity and for the respect that they have for democratic values in situations that accentuate differences in policies, economics, culture, religion or social areas. They are complex in terms of the implementation of social policies on a national scale, especially when there is marked inequality and social exclusion.

Brazilian federalism which is still "in construction", has been marked by periods of authoritarian centralism and recent re-democratization. It is characterized by the level of responsibilities placed on the municipalities in the implementation of public policies and the diversity of people that it has (in terms of numbers, social and economic development, institutional capacity and the collection of taxes). This implies the possibility of different responses.

The decentralization in health care acquired incipient contours in the 80s. The Integrated Actions in Heath include the state and municipal secretaries as relevant participants in the provision of health services that started to receive financial resources for the provision of assistance in obtaining agreements with the Instituto Nacional de Assistência Médica da Previdência Social (National Institute of Medical Assistance of Social Security-INAMPS). This strategy was deepened with the Decentralized Brazilian National Health Service (SUDS) that came into existence between 1987 and 1988. It had important implications for SUS in transferring to the states, services and federal workers in addition to the execution of agreements with the municipalities which were financed with resources from the Union[11]. Decentralization restricted to the assistant functions as functions of public health, continued being centralized in the MS. Management functions as the control of spending on the system and the production of services, stayed in the regional offices of INAMPS and were not transferred to the states[12].

The Laws 8080 and 8142 as well as the Basic Operational Standards (NOB) public notices in the 90s (NOB 01/91, 01/92, 01/93 and 01/96) and the Organization Standard for Assistance to Health-NOAS (2001 and 2002) had the fundamental role of consolidating the guidelines for decentralization and regionalization on regulating aspects of the division of responsibilities. This was done amongst managers and there was a transference criteria of federal resources for the states and municipalities[13]. The widening of access to the services, the creation of agreements, the incorporation of new people and the strengthening of the social controls are the results of decentralized management in SUS[14].

NOB 91, brought in through INAMPS, kept the previous spirit of centralization of the moment and reserved for the municipalities and states the role of being mere providers. This introduced the logic of payment based on the table from INAMPS for the transference of resources without proposing any regional arrangements.

NOB 93 had as its objective the discipline of decentralization and management of measures and health services, defining forms of management for the states and municipalities with the emphasis on municipalization. Regionalization was understood as an articulation and a form of

municipal mobilization creating associations or establishing corporate relations. The Tripartite Inter-managers Commission (CIT) and Bipartite (CIB) are institutionalized giving centralism to the National Council of Health Secretaries (Conass) and the National Council for Municipal Secretaries of Health (Conasems) that switch to having a strategic role with the MS in the conducting of agreement processes.

NOB 96 had a strong and explicit municipal component. This was a consolidation of the full exercise and the centralism of the municipalities in the management of the system. The rest was left to the state and federal powers for their corresponding role. With respective competencies or a lack of support from the municipality functions, it fell to the states to measure the relations between municipalities.

The NOAS 2001 assumed in its title the centralism of regionalization: *Regionalization of the assistance in health care, going deeper into decentralization with equity in access*. The emphasis was placed on integrated regional planning with the institution from a Directors Plan of Regionalization as an instrument to managing the process of regionalization of assistance in each state. The key concepts were limited, such as the health region to be defined by the state and there was a mandatory minimum base for the provision of assistance. In 2002 another official notice was published which advised on the reorganization of the health systems through regionalization with the view to strengthening the role of the negotiator in the states and to ensure the full and complete provision of assistance.

For some analysts, the NOAS goes against municipalization having independent characteristics induced by the NOB 96[15]. Others, with different opinions, state in its defense that this process can be explained through the reluctance of the states in assuming the coordination of the regional health systems and in decentralizing assistant functions. This means conceding on the management of federal resources and the direct relations with the public and private service providers.

In 2005 all the states and municipalities were accredited, which was a formal process that did not result in any substantial changes. However, there was a push towards the construction of a federative model in health with successive attempts to define the role of each sphere in management and the creation of a structure and specific institutional mechanisms that would build relationships between SUS managers, such as the inter-management commissions[16]. At the beginning of the 2000s, the need for advances in regionalization was unquestionable. The idea was to surpass the strengthening of the isolated municipal systems and the creation of a regionally agreed space with more power.

Within this context the, the Health Agreement (2006) spotlighted regionalization as an essential strategy for the consolidation of SUS, with there being a shared responsibility between the three spheres of government *to coordinate the configuration process of the design of the primary care network having inter-municipal relations with the participation of the municipalities in the region*[17]. This strategy was motivated by the need to extend decentralization through new spatial formats and planning instruments, taking into account the fragmentation of SUS and that 72% of the municipalities have less than 20 thousand inhabitants. This is reflected in access, resoluteness, management capacity and financing. In addition to this, the strategies and existing regional integration instruments had a low form of institutionalism or were restricted to structured collaborative arrangements in “thematic networks” (oncology, cardiology, etc.).

The agreement introduced integration strategies and articulations seeking to overcome the fragmentation in the policies and Brazilian programs. It advocated for a regional space as a privileged area for the construction of agreed responsibilities. The concept of a regional space was realigned being understood as not being under the exclusive jurisdiction of any of the government spheres[18]. Regionalization assumed the status of the principle process for the re-defining of the model of decentralization in SUS.

With the Primary Health Care network (RAS), in 2010, the MS sought to revive the constitutional basis of the organization of SUS as a regionalized network for generating health care outcomes based on inter-municipal and inter-state articulations and between the three spheres of government and through a redesigning of the system and a strengthening of governance. The organizational guidelines that guided the constitution of the RAS were centered on the following: territorialism, changes in the primary health model, having primary health care as the main guiding force for the provision of care, inter-sector elements, integrated strategic planning, structured regional regulatory marks that provides stability and unity in the decision making process, having the Regional Management Group (CGR) as co-management and financing

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in conjunction with inter-governmental bodies. They were also centered on: combining health need criteria with institutional stimulus for the continuance of primary care, the sharing of responsibilities and performance in the compliance with the objectives and fixed goals, a unification of the investment decision making processes, a materialization of the Director´s Investment Plan and participation and social control.

The Federal Decree 7.508\11 aims to legally empower the inter-federative articulation process. This puts the RAS as an important element in the organization of the services in the health region and it guarantees its integral nature in addition to ratifying the concept of the health region introduced by the Agreement. It brought in the Organizational Contract for Public Action (COAP) which is an agreement signed between the federative entities to organize and integrate the actions and health services in the regionalized and hierarchical network: with the definition of responsibilities, indicators and health service`s goals, performance evaluation criteria, financial resources that will be available being a form of control and enforcement. It is a legal instrument that emphasizes consensus and commitment agreed by the managers in each region including the allocation of resources for the three spheres of government that would increase administrative security on connecting the signatory entities to compliance with their defined responsibilities in a formal document.

In spite of this, the agreement to the provisions in the Decree under the ambit of the CIT, the implementation of the networks (Cegonha, Emergency Care, Psycho-social Care, care given to the Disabled and Primary Health Care to People with Chronic Diseases), the financial incentive institution covering the costs of the States for implementation and the strengthening of the CIR and the planning of SUS, were done in a disarticulated way in that this process arrived at the states and municipalities in disarray. It reproduced the traditional fragmentation in the organization of the services and financing[19].

In June 2016, only 24 of the 438 health regions in existence had signed COAP agreements (20 in the state of Ceará and four in Mato Grosso do Sul). Amongst the problems with the signing of the CAOP, the following can be highlight: hypertrophy of the role of the COAP to the detriment of the regional planning process, the complexity of the instrument, insufficient financing, dispersion and inadequacy in the implementation of the regional systems, planning that was not associated with its financing, low participation of the health professionals in planning and difficulties in the change of the work processes and little impact in attending users[20].

The recent normative framework of SUS sought to institutionalize regionalization and to strengthen the inter-governmental agreement, but the evidence shows that this process needs re-thinking. More than 90% of the Health Regions did not sign the COAP, which is an indication of the non-reaching of the intended results. An audit carried by the TCU showed that the health regions did not show the great characteristics in integration in the organization and the provision of measures and health services. It determined that *the link of financial transferences to fractionated installments in the form of various incentives* [...] *can bring about a series of negative effects for the regionalization process* [...][21].

Problems and challenges to the regionalization of health care

SUS is considered one of the most important sectors for reform on the world stage in the last few years. The widening of access and the advancement of others in bring about positive health care outcomes, is undeniably needed. The distance, however, between the idea and practice is starkly evident. Amongst the challenges for SUS to be effectively implemented, the need for advancement in regionalization can be highlighted.

The Decree 7.508/11 gave the health regions legal status that was being constructed through agreements. Currently there are 438 health regions all of them have their CIR. It is worth analyzing, however, how regionalization has been helping to guarantee greater access and quality. The simple existence of the health regions and the regional spaces for management, does not guarantee an active process and the potency of regionalization. Without the intention of ending them, the search here is to identify and analyze the challenging principles for an effective regionalization of health care that is central for the consolidation of SUS.

Regionalization, planning and the dimensioning of the network of services

We did not rely on the regional planning processes that serve as instruments for defining and providing order to SUS. The network of services is insufficient and disorganized. Its expansion occurs, invariably, through decisions taken by

an isolated entity that subsequently shows, in a non-articulate way, their demands through the covered costs of resources directed towards the federal government. This is to do with "errant expansion" that does not consider planning and regional pacts necessary for the sustainability of the system. The communication to the CIR occurs in an officially registered way. The planning task for regional systems in the medium and long term is indispensable, creating a state plan with a regional base that points to the need for new services, a widening of services, restorations and even the closure of services that became anarchic and unsustainable. This is a tendency that was observed in various countries. There was a production in sustainable regional planning with the intention of the financing of resources and investment (that is not taken as just a reference in historical series) which became essential and which involved the participation of: governors and mayors from the legislature, managers, services, teams and users all articulating in an integrated way in relation to resources from the three spheres of government.

What was underway, in the ambit of the MS, was the construction of a General Programming of Measures and Health Services tool that, based on the need parameters, would dedicate itself to supporting the people in each region in the identification of needs, priorities and the programming of the care networks and prospecting for costing and investment plans. It is a provision that would only have the potential, however, inside of a wide process of prioritization of regional planning based on the global planning of SUS in the short, medium and long term through defining the role of each service in the care regional network. This is the production of a regional space as a protagonist of this planning process and it is more than an assumption in needing to be a bet on management for all the principle stakeholders being involved.

Regionalization and the production of active care networks

The construction of active care networks that connect the various existing services in the territories produces a meeting of workers and users with the power to elaborate and execute singular therapeutic projects. It is one of the central objectives and one of the major challenges for regional construction. It has the requirement of going beyond the structure of the physical network and access rules and its use considers the dynamism of the micro-policies of the care[22] networks that challenge the management spaces in SUS and ask for a singularly regionalized look. For this, the debate on health needs must be central on the agenda of the management spaces that are regionally shared.

It is necessary to agree and to implement a process of effective support to the territories similar to that which was being done with the re-ordering of the support strategy of the MS. This created reflection spaces on the care process and permanent dialogue between the services that make the construction of therapeutic projects possible in a live way, amongst the various network points. It is not possible to have advancements without involving health workers and social movements which demands interlocution that goes beyond the management teams and the formal spaces of social control. The legitimacy of the system will be directly proportional to the capacity of being able to work together and to create permanent spaces for dialogue with the creativity and autonomy of those who are involved. It is necessary to re-encourage workers and social stakeholders for the SUS project.

The production of shared regional management spaces and the singular management processes

In order for the regional spaces to be able to deal with the challenges taking into account its attributes, it is necessary to have active output. The three federal entities present themselves as being autonomous but with different powers in daily life. The Brazilian inter-federative design being unique and with notable development, did not come accompanied by a decentralized process for the power for the regions. There were no tax reforms that effectively decentralized the financial resources for the sub-national entities that are compatible with the magnitude of the transferences of the attributes. In addition to this, the operationalization of SUS demands the carrying out of responsibilities that are concurrent and the need for a high level of dialogue between the three entities.

The regional representation of the state and a part of the municipal managers for health are still hesitant in recognizing and prioritizing the CIR with the production space of regionalization. Few participated in or administered bureaucratically the demands that make up the agenda in discussion treating the majority of the agreed processes in an official and fragmented way.

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The different abilities of the managers ought to be considered amongst the various municipalities and the regional representations of the states as well as the fragility of the process for the training of the stakeholders. Thus, it has become essential to invest in the widening of the tool box for the management teams, considering the specifics of each territory that permits the construction of a singular management project for each one of the 438 regions. What is being dealt is maybe, one of the most ambitious and necessary challenges for SUS when one observes the predominance of small municipalities that can only ensure full access to the citizens in the perspective of regionalization.

On the other side, but still under the perspective of singularization of the regional management process is the special challenge that imposes itself in the situation of the "citizen-state" (Sao Paulo, Rio de Janeiro, Salvador and Brasília). There will be success and the consolidation of SUS without establishing singular management processes with intra-municipalities when applicable and adequate arrangements to meet necessities.

The production of more regional management powers depends on the investment in relational micro-policies in the perspective of the meetings that happen in each territory. It is necessary to delve into the micro-political field of the relational powers to understand how one constructs and re-designs the strategies and to have influence in the power of institutional arrangements. This is a scenario where the stakeholders produce through actions with the evidence that it is a relational field (and not in the normative expectation) that the real CIR produces. The functioning of the CIR has demonstrated itself as being vital for the process of co-management and the consolidation of SUS[23,24].

These actions permit the constitution of a permanent political arena for disputes concerning projects, where there are the constructions of a new hegemony[25] in relation to power that confronts itself in the policy formation process and it imposes itself as power. The CIR can construct itself while there are effective spaces where managers make feasible *acting in processes, be they through the formulation of projects as intentional construction fields for the subjects or decisions on the direction of policies*[26].

From the Thematic Networks to the Primary Health Care Networks

The obtaining of full health care outcomes in the regional networks requires facing the inheritance of programs and vertical projects and the logic of official government notices in addition to specific incentives that are standardized for a country that has a continental dimension and heterogeneity. The regional management guided by the primary health care and by the full health care for users (in the network) and not through the logic of the procedures offered or services and the "specific networks", ought to overcome the imposition of an agenda based on the logic of the providers of services.

Being as important as having an agreement is to produce the "internalization" of the network with the workers and the services that makes it up, with a permanent educational process without there being restrictions to the official dimensions used only to qualify services and the capturing of resources.

It is necessary to advance in overcoming the bottleneck represented by SUS´s specialized primary health care and to re-agree provisions that guide the access to medical appointments, exams and therapies from the integral care modules facing the excesses of medicalization. This is one way of guided care through the health needs and the possibility of full and interdisciplinary care constructed together with the users and which produces more autonomy and life.

The fragility of the inter-federative agreements

The agreements have been established as bureaucratic instruments with little responsibility for the managers and little permeability of social control. Many times, this was to comply with formal requirements and to capture resources without the resulting consequences of non-observance. Nor the instances of internal and external control of the public administration and the social control of SUS ended up using these instruments. The idea was that the COAP would produce a new regime of responsibilities and competencies but this has not materialized. The legal proposal that has been in the Brazilian National Congress since 2003 that would institute the Law on Sanitary Responsibility, has given rise to questions concerning how to produce a greater degree of responsibility and solidarity in the face of decisions and agreements between managers.

The management of SUS cannot transform the force of standards and bureaucracy. It is necessary to simplify life as well as to facilitate the organization, the assumption of commitments and the guarantee of complete health care.

Regional Regulation

The production of active networks in each region ought to come accompanied by regional regulation based on shared management between the municipalities and the state. The management of a regulated space can be done either by the state or the municipality, as long as the management is subjected to decisions of a regional coordinating authority. New arrangements are necessary, for example, for shared management of a single line for complex surgeries and the sharing of care protocols that make the municipalities responsible for primary health care and the exercise of qualified regulatory facts. The distinct dimensions of the regulation (relating to clinics, services and systems) should be understood in search for an equilibrium between the stakeholders and the existing processes. We will not have the RAS without the subordination of all of the service providers (state under direct administration or OSS, university students, municipalities, agreement and contracts) to the regionally shared management processes without harming the single management with the dynamic regulatory process with monitoring and evaluation.

The use of SUS by users with private health care insurance should be regulated and considered in the planning of regional needs as well as the standard of care cover that is offered. The following should also be taken into account: the sharing of the providers of services (including those for public hospitals to the development of laws) the adoption of measures for the prioritization of access for beneficiaries of private health care plans that cover medium to highly complex cases at the detriment of SUS users, as they are directly a part of the health care network and its sustainability.

The strengthening of capabilities for the coordination of the regional health care system

The sum of the municipal health systems in the ambit of the geographical region does not produce a regional system that effectively constructs itself in the articulation of processes between the stakeholders and the social subjects that are involved in the different spheres of government. The strengthening of the capabilities of regional coordination by the state managers is decisive for regionalization. This is one of the most important lacunas between the macro-functions attributed to the state managers which depends on the success of regionalization and SUS[27].

It is also necessary to continually train and strengthen the abilities of the COSEMS management covering its acts in the regions and the technical support that can be given to the municipal managers as well as giving potential for the ability of interlocution with other social stakeholders such as CONASEMS, the State Council for Health, the Legislature, the social movements etc.

The political dimension of the regional space and the care at every electoral cycle

The political and electoral conjuncture that occurs every two years imposes a challenge to produce administrative renovation that comes from the popular will with continuing solutions in the direction of public policy. The renewing of management teams is a common practice in Brazilian public administration which weakens regional agreements. In relation to COSEMS and the states spheres, it falls to them to draft strategies to tackle this transitions that is the fruit of the dynamic democratic process which is decisive for regionalization. Providing continuity in public health policies for every change that is a result of elections, is essential for consolidating SUS as the State policy.

Financing and regionalization

What has become both chronic and serious is the under-financing of the sector for advancements in the base regional system. The approval of the constitutional amendment nº. 86/14 did not resolve the financial problem in health care. The National Congress showed reluctance in scrutinizing PEC 1/16 that directs more resources to health care based on the demands of the social movement (Saúde + 10). The commitment of the municipal budget with health being very much beyond the mandatory minimum (15%), is pernicious for the balancing of management in the cities. There is a continuation in the poor participation of States in the provision of finances and state resources have not been agreed with the municipal managers. Recent incentives are being brought in aimed at freezing public spending for two decades which will greater affect the

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effectiveness of SUS. Without the prospect of new resources, planning and regional programming becomes impossible.

It is necessary to return, with vigor, to mobilizations and the fight for permanent financing that is both sufficient and can sustain SUS. It is also necessary to democratize the planning and execution of the resources that the state and municipal government allocate in the area of health care. It is fundamental to continue the defragmentation of the transference of resources to the states and municipalities and to finance the integral care modules and the regional base which was the proposal of the program More Specialties.

Regionalization and an agenda that goes beyond assistance

To advance in the perspective of integralism and the regional agreements as well as being committed to the agendas that involve changes in the assistance model, there needs to be: the promotion of health, vigilance, the qualification of pharmaceutical assistance, permanent education and training, amongst others.

The needs that have been identified based on the demographic, epidemiological and nutritional profiles ought to be at the center of any changes. Tackling violence or epidemics, for example, demands shared regional coordination. Going beyond national and state priorities having an ascendant flow needs to be established that is based on local and regional needs. A possible synthesis must be constructed through the capacity for negotiating with those that are involved in this area.

Conclusion

SUS is still facing immense challenges to ensure a universal system that offers a complete and fair health service based on quality and social legitimacy. Amongst these one can highlight the heterogeneity of each region in the country as well as the plurality of the territorial arrangements that challenge our managerial abilities.

However, it is necessary to consider the historical path and the context in which regionalization is being implemented. The elements that have been presented here point to a process of decentralization and powerful regionalization resulting in disputes that have been solidified but are replete with limits and possibilities.

Regionalization assumes a central character in the conformation of SUS in that it produces new institutionalized aspects and arrangements amongst the stakeholders who are a part of the management of the regional and municipal system. This makes for the possibility of opportunities to construct a different model for formulating and implementing health care policies.

Amongst the main challenges for SUS, the need to plan and effectively implement regionalization can be highlighted involving the redefining of responsibilities amongst the federal entities. This also includes the promotion of municipally integrated systems based on health regions and guided by the needs of the population and not by what the service offers. It is therefore necessary to tackle fragmentation given that a region is much more than the sum of its municipalities and what it can produce. It requires the articulated force of many stakeholders to obtain a regionalization that is active. This is a fundamental role to be coordinated by the state governments. This is also necessary to face the problem of access to health care, changing the logic of financing and overcoming payment problems through procedures covering integral care modules that are regionally based and that are under public regulation.

Regionalization is a minefield for relational forces and powers. It is an area where there are disputes and it is the constant subject of sanitary policies. We have to put it under perspective and critically analyze it[28].

Active regionalization requires strong investment from the managers so that the regional space can become an active space and have the power of shared management. Without this there would be a reduction in the formal space instituted by the standards and with power to conduct implementation in SUS with quality in each region thus having the ability to produce more life in the system for all Brazilians.

Collaborations

AAC Reis worked on the concept, scoping, methodology, drafting and the production of the final version of this paper. APM Sóter and LAC Furtado worked on the concept, scoping, drafting and the critical review of this paper. SSS Pereira worked on the concept, scoping, critical revision and the published version of this paper.

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Article submitted 22/05/2016
Approved 04/08/2016
Final version submitted 23/09/2016