

Regional management and singular production of Urgent and Emergency Care Network

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Abstract *This study aims to understand the movements of the Urgency and Emergency Care Network production in two health regions. It is characterized as a qualitative multiple case study and was developed through open interviews with managers of the Brazilian Health System, SUS (Sistema Único de Saúde), in two Brazilian states. The empirical material was organized and discussed through identified categories adopting the analytical scheme of the fields of organizational interventions which were: the multiplicity of movements in the production of the RUE, the power of the hospitals; and, the weakness of government regulation. Despite the different times and contexts in these states, both processes emphasized organizational aspects and financing, with low inputs in the production of different modes of health care production. Regional governance is, therefore, produced in the complex relations between national policy and local action. The RUE as a public policy induced nationally by the Ministry of Health becomes a singular production in the field of regional management.*

Key words *Health Care Network, Emergency, Regionalization, Health management, Micropolitics*

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Introduction

The main organizational reference of the Brazilian Health System (SUS) since 2010 has been the Health Care Networks (RAS)¹. The model, advocated by the Pan American Health Organization², has been used in countries in demographic and epidemiological transition where chronic conditions and diseases predominate³, presenting itself as an alternative to the fragmentation of health systems⁴. The legal regulations that instituted the RAS propose a polyarchic model consisting of different points of care and the links that communicate them to obtain better epidemiological and comprehensive health care results¹.

In this context, the Urgent and Emergency Care Network (RUE) was proposed to articulate and integrate health equipment, expanding and qualifying the access of users in urgencies and emergencies in an agile and timely manner, having as components: health promotion, prevention, and surveillance; primary care; Mobile Emergency Care Service (SAMU); stabilization room; National Health Force; Emergency Care Unit (UPA); hospital and home care⁵.

The conformation of networks presupposes regionalized planning through the articulation between states and municipalities⁶. While regionalization has guaranteed more access and quality, the mere existence of regional management spaces does not guarantee a live and powerful process⁷. Padilha *et al.*⁸ (2018) observed the insufficiency of political instruments and coordination arrangements developed to implement the RUE in the metropolitan region of São Paulo. Even so, advances have been achieved, difficulties need to be overcome, and improvements are needed to engender new management arrangements and care practices⁹.

This study is based on the assumption that public policies are redefined in the field of practices. From an epistemological point of view, it is possible to take a public policy as an object of knowledge production, in particular, what happens from its 'entry' into the organizational field, constituted by actors who reinvent it based on their intentions, interests, possibilities, limits, desires, and opportunities¹⁰. The micropolitical performance of managers and other actors in the regional space is understood in this study as the staging described by Ball¹¹: the conversion of the written word into actions takes place as a play. We have the text, but it only comes to life when someone represents it in an interpretation process invested with local and personal values. This study

aims to understand the production movements of the Urgent and Emergency Care Network in two health regions.

Methodology

The research has a qualitative character, is characterized as a multiple case study and developed through the collection of testimonies with key informants identified among SUS managers in the health region of Campinas (RSC), in the state of São Paulo, and in the health region of Planalto (RSP), in the state of Rio Grande do Sul. The multiple case study method involves more than a single case. It can provide a more robust study by using multiple sources of evidence, being influential in substantiated research in the relationship between depth, the type of experience lived, and their understanding. Its emphasis is not on the potential for generalization but on its understanding, which strongly connects with intentionality and expansion of experience¹².

In this study, "health regions" result from the inter-managers pact regulated in the Brazilian legal regulations that conceptualize them as continuous geographic spaces constituted by groupings of neighboring municipalities. They are delimited by cultural, economic, and social identities and by communication and infrastructure networks of shared transport, to integrate the organization, planning, and execution of health actions and services⁶. The choice of the two regions was for convenience due to the facilitation of access to the field. Also, the differences by location, population size, socioeconomic characteristics, installed capacity of health services, and the agreement of the RUE carried out in different times and scenarios confer the potential to make the diversity and multiplicity visible in the cases studied. Although the study is not comparative, the two regions have different characteristics, as shown in Chart 1.

Open interviews collected testimonies from regional directors of state secretariats and health managers from municipalities of different sizes about the process of planning, agreement, and implementation of the RUE (Chart 2). The inclusion criterion for the interviewees was their participation in the process of formulating and agreeing on the Regional Action Plan – PAR. The material was recorded and transcribed, encrypting the interviewees' identification to guarantee confidentiality and anonymity.

After the interviews, narratives elaborated by the researchers who sought to describe the histo-

ry of the RUE agreement in the studied regions were discussed and reviewed in research group meetings. For Brockmeier and Harré¹⁴, the narrative has the sense of organizing experiences and assigning meanings that are of a singular order and, at the same time, cultural and social. Thus, extensive reading of the empirical material enabled us to highlight the micropolitical relationships placed in the implementation of 'grand politics' from the understanding that micropolitics is the process of producing subjectivities from power relations, decisive to think about the management, production of care, and training in the health area¹⁵.

The analysis of the material was carried out by identifying the narratives of categories and organizing the results, adopting the analytical scheme of the fields of organizational interventions proposed by Lins and Cecílio¹⁶, in research seminars of the group that developed the inves-

tigation. The research had an inducing character, i.e., concepts were researched, and new references were added from the empirical material, considering the theoretical pluralism proposed by Ball¹¹.

Interviewees signed an Informed Consent Form, and the Ethics Committee of the Federal University of São Paulo – UNIFESP approved the project through Opinion No. 2,447,067. The National Council for Scientific and Technological Development – CNPq and Southern College – IMED funded the research.

Results

The following analysis categories were highlighted: the multiplicity of movements in the production of the RUE, the power of hospitals, and the weakness of government regulation. Some of these categories even have potential as analyzers,

Chart 1. Characterization of the research field.

Health region	Campinas Metropolitan Region – SP	Planalto Health Region – RS
Population	3,231,033 inhabitants	414,138 inhabitants
Number of municipalities	20	28
Area	3,792 Km ²	7,814 Km ²
Headquarter city	Campinas	Passo Fundo
Demographic density	852.06 inhabitants/Km ²	52.88 inhabitants/Km ²
GDP per capita/year	R\$ 48,332.79	R\$ 31,915.00

Source: IBGE, 2010¹³.

Chart 2. Managers interviewed by region, role, and professional category. Campinas Health Region – SP. Planalto Health Region – RS. 2018-2019.

Region	Interviewee	Role	Professional category
Campinas Health Region – SP	GEC1	Regional state manager	Occupational therapist
	GEC2	Regional state manager	Speech therapist
	GEC3	Regional state manager	Psychologist
	GEC4	Regional state manager	Dental surgeon
	GMC1	Municipal health manager	Doctor
	GMC2	Municipal health manager	Social worker
	GMC3	Municipal health manager	Occupational therapist
Planalto Health Region – RS	GEP1	Regional state manager	Nurse
	GEP2	Regional state manager	Social worker
	GMP1	Municipal health manager	Nurse
	GMP2	Municipal health manager	Psychologist
	GMP3	Municipal health manager	Pharmacist
	GMP4	Municipal health manager	Nurse
	GMP5	Municipal health manager	History teacher
GMP6	Municipal health manager	Nurse	
GMP7	Municipal health manager	Administration agent	

Source: Authors.

considered essential devices for the researcher's displacement¹⁷.

The multiplicity of movements in rue production

The RUE planning and agreement processes in the two regions took place at different times and dynamics. In RSC, it occurred soon after the publication of the ordinances that regulate the policy, between 2011 and 2012, in a joint action between the state and municipalities, with a solid federal financial induction:

It was a very rich process, with the participation of municipalities, providers, [...] the Ministry of Health was very present. We called the managers and agreed, then called the services (GEC3).

There was a guarantee of resources [...] everyone said, I expand, I do, there is money [...] the RUE funding was significant (GEC1).

A deficiency in the regional state agency for process coordination appears in the managers' speeches, having been overcome by the performance of technical teams from some municipalities and services:

The difficulty starts with the regional teams. We articulated to bring in experts on the subjects, specialists [...] they were local actors from the universities and specialized services in the municipalities [...] it is very bad for you to have to coordinate the implementation of a policy and not have human resources (GEC1).

However, in the RSP, there was a markedly notarial process, carried out late, only in 2018. Also, in search of funding, planning was carried out centrally by the regional team of the State Secretariat of Health. Municipal managers were absent from the process and were called to ratify the PAR only at the end:

Not having been discussed with the main actors, such as primary care teams and municipal managers, who could add a lot to the plan. The elaboration of the PAR was bureaucratic and centralized in the Regional Health Coordination (GMP1).

The asymmetry in negotiations between states and municipalities was evidenced in both regions by the different relationships between states and municipalities with different degrees of cooperation or subordination. Added to this are the mobilization capacity and action ways of university hospitals, philanthropic and private service providers.

Among the challenges of the regional management of the RUE, the interviewees express the effect of contingencies on regional governance,

such as the discontinuity of administrations and the high turnover of management staff, weakening agreements.

We feel the difficulty of the municipalities when it changes. Everything changes, and I can't do it anymore [...] we go forward, then there is a setback, and we have to reconfigure the network. Moreover, it's not just at the municipal level, but also at the state and federal level (GMC3).

Interviewees also report the non-internalization of the RUE for services and workers who operate it daily:

At RUE, I can't say if there was this conversation within the municipal services with doctors, nurses... we don't know if the person who participated made the conversation inside (GEC1).

Users are "blamed" for going to hospital emergency rooms to the detriment of primary care, even though there is recognition of the motivations for these movements:

I think the population lacks much awareness of what an urgency and emergency are. People end up looking for situations that are not urgent (GMP5).

Culturally, the population looks for the emergency room; it is the place where they find solutions. In primary care, sometimes he gets an appointment, sometimes he doesn't, needing to schedule an appointment (GEP1).

Some advances were noticed in RSC, such as the implementation of home care, risk classification, and lines of care:

I think a great achievement was the use of risk classification protocols in Emergency Departments. With the expansion of the UPAs, this classification culture was introduced into the municipalities and services [...] the Home Care service was very good. Most of the municipalities started the service, and that's what saved the network: these people are not occupying a hospital bed, and we are still overcrowded (GEC3);

AMI and stroke, we advanced by working on prevention, promotion, the opportune time, thrombolytic [...] along these lines, we advance (GMC3).

Due to the notary and recent character in RSP, the study points to a fragmented and poorly articulated process, which expresses the network fragility in the territory.

The power of hospitals

Hospitals' real and symbolic power remains untouched, whether due to their directors' leading role in the process or the centrality they acquired in planning the RUE, or their role in the network design. In RSP, perceptions were evi-

denced that the RUE would be the hospital itself as if it were synonymous with emergency hospital care and actions in primary care were not part of the network:

RUE is closely linked to the hospital. While we do this in the units, but it's not much... we prefer to work more on the preventive part. So it turns out that this whole issue is left to the hospital, that's why the municipality chose to invest in the hospital (GMP9).

In addition to the understanding that the emergency care coordinates care and the 'preventive' function of primary care, there are also reports in RSC that the insertion of primary care in the RUE was not addressed:

Another thing we didn't do was the role of primary care in the network. We even discussed risk classification, but then they say: the UBS is the gateway, it needs to be by vulnerability [...] It became out of place (GEC3).

The implementation and operation of SAMU in both regions face many difficulties. In RSC, the absence of state participation in funding emerges, making it unfeasible.

Another issue in the plan, which was much discussed and did not happen, is the SAMU. [...] and it has everything, project, studies, accounts, spreadsheets [...] we proposed the state to provide a part of the financing [...] then came the answer: that would be the regulation and helicopter [...] who asked for a helicopter? [...] and the subject cooled off (GMC2).

In the RSP, although implemented, the SAMU, whose regulation is centralized in Porto Alegre, competes with the actions of firefighters, without articulation actions from them:

In that period when you keep calling (the SAMU), they give you information, the other citizen who sees what's happening and calls the firefighter. When you finished your SAMU service, the firefighter already arrived (GMP9).

The weakness of governmental regulation

In RSP, reports indicate that regulation is fundamentally professional¹⁸ and carried out directly between service providers, predominantly private:

Our doctor makes contact with the doctor who will refer him to the emergency. We even have a WhatsApp group, just for our doctors and the emergency room doctors. So, the case is already more or less discussed before sending it (GMP 9).

In RSC, difficulties are expressed with state regulation, centralized in the Center for Regulation of Offers of Health Services (CROSS):

[...] enters through the ER, goes to Santa Casa, and CROSS doesn't provide a vacancy. You open a file, and it doesn't have a vacancy, then the file is closed! You put it on the other day, it closes. What am I going to do with the patient? Discharge him too? (GM2).

There are also manifestations of a game of pressure and weaknesses of managers in the process, who are often submissive to the services' interests:

Many municipal managers are in the hands of providers. The state too. The discussion is always tough. [...] The manager who had a good understanding of his policy could have a good discussion with his provider and joined the network. Others who did not have a good understanding, or had political restrictions, then we were not able to advance that much (GEC4).

Thus, despite the different moments and contexts, in both regions, it is evident that there was an emphasis on the organizational aspects and financing of the RUE, influenced by the multiple movements of the actors involved, with low investment in the production of different modes of care and living health networks.

Discussion

Based on the premise that managers, when choosing strategies for conducting organizational change, are influenced by different ways of interpreting reality, Lins and Cecílio¹⁶ formulated an analytical scheme. It is called 'Fields of Organizational Interventions without Health,' whose framework

was built from the concept of socio-analysis institution and categorized organizational interventions into universalist, particular, and singular, depending on the theoretical assumptions that support them and the developed actions' nature¹⁶.

For Lorau¹⁹, the moment of universality has as its content the systems of norms, the values that guide socialization, ideology, in short, the instituted. At the moment of particularity, its content comes down to material and social determinations that deny universality; it is the instituting moment. At the moment of singularity, the concept of the institution has as its content the organizational, legal, or anonymous forms necessary to achieve a particular purpose, institutionalization.

In the Brazilian context of a federative organization, the implementation of networks in the SUS brings unique challenges. Thus, the solid

national induction of health policies by the MS, such as the RUE, cannot be characterized as a universalist organizational intervention, as it depends on the inter-federative interaction between managers⁶ and local actions in the municipalities.

In this study, micropolitics is observed operating in regional spaces, evidenced by disputes, movements, and interests of managers and actors present or who influenced the planning scenario of the RUE. For Deleuze and Guattari²⁰, micropolitics operates in detail, through flows of intensities, which can be extended to the whole of the social body but have an unpredictable character. Especially in the health area, studies explaining micropolitics through the action of workers with relative autonomy concerning management determinations are common^{15,21,22}, through the relationship between health professionals and users in the production of health care²³⁻²⁶, or by the actions of users in the production of care maps¹⁸ and their therapeutic itineraries²⁷.

This research seeks to observe and analyze the micropolitical action in the management space, inter-federative relationship, and regional governance. Based on these assumptions, the discussion of the results will be made through the questions: 'regional management as a field of interests and disputes' and 'the locoregional re-configuration of national politics.'

Regional management as a field of interest and disputes

In the cases under study, the asymmetric power relations for negotiating the RUE, the heterogeneity between municipalities, the role of hospital service providers, and the state secretariats were present, having a strong influence on the production of PAR.

The Regional Inter-Management Commission (CIR) is defined as an instance of agreement between federative entities to define the rules of shared management of the SUS, its organization, and operation in health care networks⁶. Integration between the three spheres of SUS management is essential for the RUE to be implemented⁹. Co-management takes place by constructing collective spaces and the constitution of subjects with capacity for analysis and intervention, considering that in front of each power nucleus, there are counterpowers with which one has to relate in struggle and negotiation schemes²⁸. Thus, the CIR is understood not as an idealized space but as a field where conflicts, disputes, and forces become central. As defined by Bourdieu²⁹,

fields are spaces of practice created or driven by actors with positions defined by greater or lesser power, legitimacy, postures, behaviors, values, and knowledge.

Both in RSC's CIR and RSP's CIR, although in different times and contexts, actions by actors mobilizing their powers in the field of the RUE agreement were observed. In RSP, there are reports of a centralized notary process, coordinated by the State Secretariat team, with a subordinate role for municipal managers and with influence from hospital services. In RSC, despite a participatory process, there is recognition of the limitations of the state regional agency team, the expressive performance of MS members, the power of the technical teams in some municipalities, the fragility of some managers vis-à-vis service providers, and the active participation of representatives of teaching hospitals.

There was a solid federal induction to implement the RUE, through the expansion of financing, with the release of immediate resources, and to fund new services⁹. Although at different times and different moments due to local contexts, the search for funding emerges as the leading interest for the agreement of the RUE in the two health regions.

Some participants' knowledge and technical expertise from municipalities, state agencies, and university services contributed to expanding their powers in the negotiations. According to Testa³⁰, technical power in health can generate, access, and deal with information with different characteristics, including medical, sanitary, administrative, or theoretical frameworks. In a study on the regional governance of the RUE, Padilha *et al.*⁸ observed the technical power present in the relationships between professionals, between units of the same service, between services, between management structures and health care, between spheres of government, and between all these and the users.

The hospitals' real and symbolic capital also gave them centrality in the process. The participation of university hospital managers in RSC and the strength of private service providers in RSP led to their hegemony in the RUE. For Foucault³¹, power is linked not only to law but the truth, which is produced by the power that demands it and needs it to operate. This truth declared in the interviewees' speeches about the centrality of hospitals reproduces the idea that the hospital is synonymous with the RUE, making other services in the network invisible. In a study that analyzes the insertion in the RUE of a

large hospital in the Central-West region of Brazil, Soares et al.³² conclude that it happens slowly and depends on the articulation of several other services and instances of the SUS. For Jorge et al.⁹ (2014), the hospital, historically working in isolation and disconnected from other points of care, is based on curative care dissociated from any articulation with the RAS. Also, there is the incessant search of patients for care and who see them as lifelines for all health problems, guaranteeing its legitimacy and endowing it with even greater power. For Beltrammi and Reis³³, hospitals are the cause and consequence of the fragmentation of universal health systems. They need to belong to the region as a whole, have it as the object of permanent reflection, regardless of the administrative nature or the federative entity to which they are subordinate. Otherwise, they risk being self-referenced, with a restricted look to the user's path within themselves and not in the regionalized network⁸.

For the articulation of regional networks, the operation of the CIRs is vital, as their performance allows the constitution of a permanent political arena for the dispute of projects, where the construction of new power relations that imposes itself as power can take place⁷. For Furtado³⁴, the current spaces of regional management are essential but not sufficient to guarantee shared and qualified management in the regions, as macrostructures are produced all the time in the space of micropolitics. Diving into the micropolitical field of power relations is required to understand how strategies are constructed and redesigned and influence the power of institutional arrangements, showing that it is in this relational field, and not in the normative one, that the actual CIR is produced⁷.

The locoregional reconfiguration of national policy

The processes of implementing national health policies in Brazil are complex. For Viana et al.³⁵, the political cycles to organize SUS comprise two periods in which decentralization to subnational entities prevailed. The municipal sphere played a leading role in the first (1988 to 2000) and the regionalization and construction of RAS in the second (2000 onwards). In this context, there are immense challenges, such as the heterogeneity between regions and the plurality of their territorial arrangements, to guarantee a universal, comprehensive, equitable system with quality and social legitimacy⁷.

While the constitution of inter-federative management instances at the federal, state, municipal, and regional levels has given voice to states and municipalities, it has not yet replaced the inducing and regulatory activities of the Ministry of Health. The maintenance of a centralized practice and the use of instruments of political and financial induction submit other entities to the system's rules, not always with policies agreed upon and sustained in the different realities of the country³⁶. The transfer of resources pre-defined by the federal government may suggest a reduction in autonomy and limitation of locoregional solutions³⁷. For Reis et al.⁷, the production of comprehensive care in regional networks requires facing the inheritance of vertical programs and the logic of specific standardized incentives for a country of continental and heterogeneous dimensions.

The federal inducing action does not nullify the autonomy of states and municipalities for the development of local policies, nor the acceptance or not to the offers of the MS. Also, centrally defined policies, which can only be carried out in conjunction with other actors and other institutional spaces, tend to be redesigned at the regional level peculiarly. They are implemented with different levels of dialogue by managers in each reality, interacting with other social actors and assuming new intentions and conformations¹⁰. The simple financial induction of policies such as the RUE is not enough for the immediate implementation of its model, objectives, and guidelines, nor the recommended devices and arrangements.

In the RUE, which is already operationalized in daily life regardless of the pact or tutelage of regional governance, the mere reproduction of the policy formulated at the federal level seems to be very far from being achieved. The investigation makes visible the multiplicity of factors that operate in the micro-political construction of the RUE in each space beyond the intended induction of a national policy. Thus, it is not possible to think of this process as a universalist intervention. The organization is seen as a system that tends to homeostasis by determining a rational/legal axis¹⁶.

The non-adherence to the model defined by the national policy does not necessarily mean the disqualification of the RUE, as the singular processes of construction of policies in the territories can produce more powerful arrangements that are coherent with the needs. On the other hand, we cannot understand the RUE as a particular-

ist intervention either. The field of particularist interventions is defined by the action/freedom of subjects to redefine the structure of the organization¹⁶. Even though planned, agreed upon, and executed in the locoregional space by actors with formal autonomy and crossed by many disputes, the RUE is a policy that comes from a solid central induction. Thus, practices already instituted and operating in regional and municipal management spaces and the services themselves are observed to tend to be maintained or transformed through possible instituting actions triggered by local actors. The implementation of a new public policy presupposes transformations. In a study analyzing the implementation of the British health system, Klein³⁸ described it as a model of “exhortation and hope,” where the central government exhorted and hoped that measures would be taken at the local level. Health policies implemented in Brazil seem to be based on this model.

A central element is a perception that there was not necessarily the formation of integrated networks, but a more significant investment in the hospital component and emergency care services to the detriment of other points of care, always guided by the search for more funding in a brutally unfinanced system³³. The SAMU, conceived as an element of network articulation, presents itself as a critical node in the two studied regions. Primary care, with the attribute of horizontality of care, was separated and neglected in both regions.

Another issue that highlights the instituted operating in the RUE is regulation, especially the weakness of government regulation. Cecilio *et al.*¹⁸ identify different regulatory regimes - governmental, professional, clientelistic, and lay - indicating that this is a field in permanent dispute, a social production. In the cases under study, a government regulation centralized by the state is observed in RSC. In RSP, regulation is even more incipient, centered on services, markedly professional, and carried out informally through applications. For Jorge *et al.*⁹, there is a lack of political decision to regulate in most managers, and the operation of networks without regulation has been the rule.

An important observation in implementing the RUE in the regions, which express the relationship between universal, particular, and singular, was the little emphasis given to the proposed changes in health care practices. For Reis *et al.*⁷, the construction of living care networks, which connect the various services existing in the terri-

ories, is one of the central objectives of regional governance. The agreement made ‘from above’ was not internalized for the services, managers, and workers who operate the ‘de facto’ policy daily. This perception is supported by studies that identify that implementing the set of components of the RUE was not accompanied by modifying the care model towards comprehensive, resolute, qualified, and user-centered care^{8,9,32}. Such occurrence would require bringing together and encourage the protagonism of worker³², reinvent the internal arrangements in the production of care⁸, and evaluate the implementation of the predicted qualification devices⁹.

Thus, the RUE becomes a singular production when it enters the organizational field of regional management, being crossed by the micropolitical action of actors that shape it according to the relationship of interests and powers they operate. For institutionalists, at the singular moment, society works because universal norms, admitted as such, are not directly incarnated in individuals but go through the mediation of singular social forms, adapted modes of organization¹⁹. In the cases under study, a complex relationship can be seen between the policy in action – the process – and the official policy – the model – producing a singular policy in the context of practices.

For Lorau¹⁹, the action of particular subjects concerning the universal is triggered mediated and organized by the singular dimension. According to Lins and Cecilio¹⁶, in singular organizational interventions, the organization’s official project embodies the institution’s discourse to which it is linked. It represents the tremendous normalizing axis, ‘cross-cut’ by several other projects disputed by protagonist groups skilled in handling resources for its autonomy.

Deleuze and Guattari²⁰ use the concept of segmentarity to explain this relationship. For the authors, every society and individual is crossed by two segmentarities: a molar and a molecular one. They are distinguished but inseparable, always presupposing the other. Every policy is both macro and micropolitics. There is, then, a hard segmentarity (molar) and a flexible segmentarity (molecular), which mix and coexist. For Merhy *et al.*²⁵, understanding how these lines are intertwined all the time and mutually constituting, in movements of escape and construction of change and processes of resistance and confirmation of the instituted, helps to understand the daily life of the SUS.

An important question then emerges: the singular production, in the relationship between

the formulated policy and the policy in action, is not necessarily good or bad¹⁹. What can be an innovative action or a necessary adaptation to the local reality in the RUE policy can also be an act of resistance and maintenance of the instituted against proposals and objectives formulated at the federal level. However, a health policy that could enable transformations to build a more inclusive system committed to the defense of life can, however, strengthen powers, institutions, and processes that do not necessarily contribute to the common interest. Thus, the study findings regarding micropolitical action, disputes, powers, and singularities in the field of inter-federative regional management should be considered by the formulators and conductors of health policies. It is essential to build singular management projects⁷ for each region, considering each territory's specificities.

Final considerations

Health policies induced nationally by the MS become singular productions in health regions, municipalities, and health services. The planning, agreement, and implementation process

of the RUE in the two studied health regions can be understood as organizational interventions in the field of singularity since they were produced or reproduced in a different way from what was predicted in the formulated policy. Public policies aimed at organizing the health system into networks are reprocessed in particularity and singularity fields, acquiring other unplanned designs.

Considering the micropolitical action of actors inherent to the regional management scenario using their knowledge, powers, and actions was central in making the RUE construction process visible in each region. Despite the macro-determinations of national policy, the regional governance field and the micro-political relationships of the actors involved produce singular processes. Therefore, regional governance is produced in the complex relationships between national politics and local action, understood not as dichotomous or deterministic but as immanent. The construction process of the RUE in the two health regions, based on a normalizing axis, was noted to be cross cut by different powers and projects in dispute between the local actors, producing in each territory the possible synthesis between a national policy and the locoregional realities.

Collaborations

LFN Tofani: elaboration and supervision of the project, collection and analysis of data, elaboration, writing and final revision of the article. A Chioro: elaboration and supervision of the project, data analysis, elaboration and final revision of the article. LAC Furtado: design and supervision of the project, data analysis, preparation and critical review of the article. R Andreazza: design of the project, data analysis, preparation and critical review of the article. CF Guimarães: design and supervision of the project, data analysis, preparation and critical review of the article. A Rebequi: design of the project, collection and analysis of data, preparation and critical review of the article. J Harada: data analysis, preparation and review of the article. AL Pereira: data analysis, preparation and review of the article.

References

1. Brasil. Ministério da Saúde (MS). Portaria nº 4.279, de 30 de dezembro de 2010. Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde (SUS). *Diário Oficial da União* 2010; 30 dez.
2. Organización Panamericana de La Salud (OPAS). *Redes integradas de servicios de salud: conceptos, opciones de política e hoja de ruta para sua implementación em las Américas*. Washington: OPAS; 2010.
3. Mendes EV. As Redes de Atenção à Saúde. *Cien Saude Colet* 2010; 15(5):2297-2305.
4. Organização Panamericana de Saúde (OPAS), Organização Mundial de Saúde (OMS). *A atenção à saúde coordenada pela APS: construindo as redes de atenção no SUS*. Brasília: OPAS/OMS; 2010.
5. Brasil. Ministério da Saúde (MS). Portaria nº 1.600, de 7 de julho de 2011. Reformula a Política Nacional de Atenção às Urgências e institui a Rede de Atenção às Urgências no Sistema Único de Saúde. *Diário Oficial da União* 2011; 7 jul.
6. Brasil. Presidência da República. Decreto nº 7508/2011, de 28 de julho de 2011. Regulamenta a Lei nº 8.080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências. *Diário Oficial da União* 2011; 28 jul.
7. Reis AAC, Sóter APM, Furtado LAC, Pereira SSS. Reflexões para a construção de uma regionalização viva. *Cien Saude Colet* 2017; 22(4):1045-1054.
8. Padilha ARS, Amaral MA, Oliveira DC, Campos GWS. Fragilidade na governança regional durante implementação da Rede de Urgência e Emergência em Região Metropolitana. *Saúde em Debate* 2018; 42(118):579-593.
9. Jorge AO, Coutinho AAP, Cavalcanti APS, Fagundes AMS, Pequeno CC, Carmo M, Abrahão PTM. Entendendo os desafios para a implementação da Rede de Atenção às Urgências e Emergências no Brasil: uma análise crítica. *Divulgação em Saúde para Debate* 2014; 52:125-145.
10. Reis AAC, Cecílio LCO. A política de reestruturação dos hospitais de ensino: notas preliminares sobre os seus impactos na micropolítica da organização hospitalar. *Saúde em Debate* 2009; 33(81):88-97.
11. Mainardes J, Marcondes MI. Entrevista com Stephen J. Ball: um diálogo sobre justiça social, pesquisa e política educacional. *Educação & Sociedade* 2009; 30(106):303-318.
12. Stake RE. Case Studies. In: Denzin NK, Lincoln YS, editors. *Handbook of qualitative research*. Thousand Oaks: Sage Publications; 2000. p. 435-454.
13. Brasil. Instituto Brasileiro de Geografia e Estatística (IBGE). Estimativas da população residente com data de 1 de janeiro de 2019. 2000. [acessado 2020 Ago 22]. Disponível em: www.ibge.gov.br
14. Brockmeier J, Harré R. Narrativa: problemas e promessas de um paradigma alternativo. *Psicol Reflex Crít* 2003; 16(3):525-535.

15. Feuerwerker LCM. *Micropolítica e saúde: produção do cuidado, gestão e formação*. Porto Alegre: Rede Unida; 2014.
16. Lins AM, Cecílio LCO. Campos de Intervenções Organizacionais: a contribuição das ciências humanas para uma leitura crítica das propostas de gestão das organizações de saúde. *Interface (Botucatu)* 2007; 11(23):503-514.
17. Guizardi FL, Lopes MR, Cunha MLS. Contribuições do movimento institucionalista para o estudo de políticas públicas de saúde. In: Mattos RA, Baptista TW, organizadores. *Caminhos para análise das políticas de saúde*. Porto Alegre: Rede Unida; 2015. p. 319-346.
18. Cecílio LCO, Carapineiro G, Andrezza R, Souza ALM, Andrade MGG, Santiago SM et al. O agir leigo e o cuidado em saúde: a produção de mapas de cuidado. *Cad Saude Publica* 2014; 30(7):1502-1514.
19. Lorau R. *A análise institucional*. Petrópolis: Vozes; 1996.
20. Deleuze G, Guattari F. *Mil platôs: capitalismo e esquizofrenia* (v. 3). Rio de Janeiro: Editora 34; 1996.
21. Barros LS, Cecílio LCO. Entre a “grande política” e os autogovernos dos Agentes Comunitários de Saúde: desafios da micropolítica da atenção básica. *Saúde Debate* 2019; 43(6):4-9.
22. Merhy EE, Feuerwerker LMC, Santos MLM, Bertussi DC, Baduy RS. Rede Básica, campo de forças e micropolítica: implicações para a gestão e cuidado em saúde. *Saúde Debate* 2019; 43(6) 70-83.
23. Feuerwerker LCM, Bertussi DC, Merhy EE, organizadores. *Avaliação compartilhada do cuidado em saúde: surpreendendo o instituído nas redes – Livro 2*. Rio de Janeiro: Hexis; 2016.
24. Mendes PPS, Moebus RLN. A produção do cuidado como micropolítica. *Diversitates Int J* 2016; 8(1):38-53.
25. Merhy EE, Baduy RS, Seixas CT, Almeida DES, Slomp Júnior H, organizadores. *Avaliação compartilhada do cuidado em saúde: surpreendendo o instituído nas redes – Livro 1*. Rio de Janeiro: Hexis; 2016.
26. Melo SM, Cecílio LCO, Andrezza R. Nem sempre sim, nem sempre não: os encontros entre trabalhadores e usuários em uma unidade de saúde. *Saúde Debate* 2017; 41(112):195-207.
27. Hadad ACAC, Jorge AO. Continuidade do cuidado em rede e os movimentos de redes vivas nas trajetórias do usuário-guia. *Saúde Debate* 2018; 42(4):198-210.
28. Campos GWS. *Um método para análise e co-gestão de coletivos*. São Paulo: Hucitec; 2007.
29. Bourdieu P. *Razões práticas: sobre a teoria da ação*. Campinas: Papiro; 1996.
30. Testa M. *Pensar em saúde*. Porto Alegre: Artes Médicas; 1992.
31. Foucault M. *Micropolítica do poder*. Rio de Janeiro: Graal; 1999.
32. Soares EP, Scherer MDA, O’Dwyer G. Inserção de um hospital de grande porte na Rede de Urgências e Emergências da região Centro-Oeste. *Saúde Debate* 2015; 39(106):616-626.
33. Beltrammi DGM, Reis AAC. A fragmentação dos sistemas universais de saúde e os hospitais como seus agentes e produtos. *Saúde Debate* 2020; 43(5):94-103.
34. Furtado LAC. *O desafio da construção do comum nas máquinas de governo: o estado em disputa* [tese]. Rio de Janeiro: Universidade Federal do Rio de Janeiro; 2016.
35. Viana ALA, Bousquat A, Melo GA, Negri Filho A, Medina MG. Regionalização e redes de saúde. *Cien Saude Colet* 2018; 23(6):1791-1798.
36. Baptista TWF. Análise das portarias ministeriais da saúde e reflexões sobre a condução nacional da política de saúde. *Cad Saude Pública* 2007; 23(3):615-626.
37. Moreira LMC, Ferré F, Andrade EIG. Financiamento, descentralização e regionalização: transferências federais e as redes de atenção em Minas Gerais, Brasil. *Cien Saude Colet* 2017; 22(4):1245-1256.
38. Klein R. Britain’s National Health Service Revisited. *N Engl J Med* 2004; 350(9):937-942.

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