DOI: 10.1590/1413-81232017224.03742017

Political Obstacles to Regionalization of the SUS: perceptions of Municipal Health Secretaries with seat in the Bipartite Interagency Commissions

Marcelo Rasga Moreira [1]
José Mendes Ribeiro [1]
Assis Mafort Ouverney [1]

Abstract *This paper aims to identify and analyze the political obstacles to the implementation of Organizational Contract of Public Action (COAP) based on the perceptions of municipal health secretaries of Bipartite Interagency Commissions (CIB). For this purpose, we interviewed 195 secretaries (92% of the total) from October 2015 to August 2016. Based on the approach of policy analysis, the main hurdles identified were, in short, a traditional obstacle (lack of resources), one that has been gaining strength in recent years (judicialization of politics) and another, perhaps unheard of: the party-political system and the State Executive Branch are the great absentees in the coalitions in support of SUS regionalization policies. We can conclude that such obstacles indicate an extremely negative setting for the implementation of the COAP and other SUS regionalization policies. Thus, it is incumbent upon those involved to reflect, negotiate and build consensus on improving the health of the population and overcome such obstacles if, of course, they embrace the authors' concept that regionalization is fundamental for the SUS.*

Key words *Regionalization, Political obstacles, Policy analysis, Implementation of the COAP*

[1] Escola Nacional de Saúde Pública, Fiocruz. R. Leopoldo Bulhões 1480, Manguinhos. 21041-210 Rio de Janeiro RJ Brasil. rasga@ensp.fiocruz.br

Introduction

The political-administrative decentralization of the health system was one of the main flagships of the Movement for Health Reform. Built, among other aspects, on the critique of centralization in the sector, then conducted by INAMPS (National Institute of Medical Care of Social Security), the proposal was victorious in the Constitutional Assembly of 1986-1988, becoming one of the fundamental principles of the Unified Health System.

The principle of decentralization was also incorporated into the other social policies legislated by the Federal Constitution of 1988, especially education and social assistance, which, in articulation with health, lay the foundations of a state of social protection. On the contrary, the economic policies that are ultimately responsible for the resources that would build and sustain a welfare state have maintained heavy centralization characteristics, drawing an intricate political economy that, as a rule, has subjected the resources of social policies to the economic-financial guidelines of governments.

Concomitantly, the number of municipalities in the country has increased significantly: from 1990 to 2016, they grew by 24.0% (from 4,491 to 5,570), which in political terms represents the entry in the country's federative game of more than 1,000 subnational entities with broad political autonomy.

As the institutional norms for the creation of these municipalities were not based on the capacity to generate income and employment nor to provide compatible health and education services, this increase contributed to most of the Brazilian municipalities becoming extremely dependent on the Federal government, whether financial transfers or of its policy-making and policy-inducing capacity.

To health decentralization, the historical concomitance of a setting of social policies dependent on economic policies, the increased number of municipalities and their economic, political and managerial dependence on the federal government are the explanation of contradictions that still have not been overcome today, making it an unfinished process that is difficult to sustain.

This is the context where regionalization of the SUS emerges as a vital strategy for the decentralization process. Articulate neighboring municipalities in search of the construction of a health network that can attend to all of its populations, distributing costs and investments and creating common goals and targets have become health system's needs.

Important political-normative strategies have been established since law 8080/90, with a greater or lesser degree of agreement, in order to boost and/or implement regionalization (NOBs, NOAS, and Health Pact). Despite advances in certain aspects and regions, these regulations were insufficient to overcome the hurdles to regionalization and decentralization.

In 2011, the Federal Government presented, through Decree 7508, a new policy through which municipalities and states are encouraged to enter into the Organizing Contract for Public Action (COAP), which, by regulating on an agreement basis the relationships between health services of the municipalities of the 438 Brazilian health regions, aims to consolidate the process of regionalization and decentralization of the SUS.

Since then, the Ministry of Health has been working to build a consensus on the COAP throughout the country. A vigorous political movement has been developed and advances have been achieved, but, in fact, only two states (Mato Grosso do Sul and Ceará) have signed the Contract, pointing out that there are important obstacles to overcome.

These obstacles are articulated around the most important realms of the SUS, especially regarding the supply/provision of professionals, services and equipment, legal and normative adaptation (both in judicialization and in health responsibility) and political and economic issues involved.

If, on the one hand, part of these obstacles is more visible, on the other, an important part remains partially or totally veiled, whether in its enunciation or in its causes and motives.

This paper aims to contribute to the identification and understanding of these hurdles, selecting those referring to political issues (in particular, linked to sector financing and judicialization) and, as a theoretical contribution, the policy analysis reference.

The analysis of policies and their contributions to regionalization studies

Regionalization of the public health system reflects the political issues associated with territorial decentralization or municipalization itself. The political coalitions that sustain this debate and generate solutions in terms of normatization have a lot of identity and decentralization is addressed here to cover the different formats of transfer of political status to subnational entities.

Ciência & Saúde Coletiva, 22(4):1097-1108, 2017

The term "regionalization" is polysemic, reflecting different notions that range from strategies of devolution of duties to markets to administrative decentralization and deconcentration of powers to smaller groups. In this paper, regionalization, decentralization and municipalization will be addressed as parts of the same agenda and typical of similar political coalitions.

In this context, the sectoral literature shares beliefs about the virtues in reducing regional and social inequalities, which is noted when researching the political orientations of leaders, as was done in this paper.

Therefore, regionalization responds to a government policy. As such, its study is a frequent subject of humanities and involves different schools and methodological strategies, of which one of the most traditional and important is the "policy analysis", with a multidisciplinary character and geared not only to the understanding of the decision-making process in the public sector, but to propose solutions for government policies.

As Geva-May and Pal[1] show, the development of policy analysis has generated, in several countries, an activity that, advancing in the academic-political frontiers, has been established in a field different from that of evaluative studies not oriented to recommendations of governmental actions.

While policies can be studied by different methods and schools, "policy analysis" is more appropriate due to the focus on the search for explanations and the production of recommendations, in a process that articulates information obtained by raising perceptions and opinions of officers, experts, leaders and entrepreneurs; documents and regulations; administrative data; and inquiries of various kinds.

An important study on the model of the policy analysis, its multidisciplinary character and its scientificity, is the one conducted by Majone[2]. The study contains opinions and perceptions of sector leaders and experts that are of particular relevance, which reinforces the option of considering it here as a theoretical-methodological reference.

Another pillar of the field of policy analysis is the recognition that decision-making occurs in complex environments where stakeholders have a limited rationality, that is, they do not have full capacity to establish their own interests or even to understand others'. Thus, perceptions, notions of values and benefits, while robust, are adjusted throughout the decision-making process and according to institutional environments.

Even in such contexts, some patterns can be identified. Lindblom[3], in an incrementalist approach, highlighted the ability of agents to capture information to guide viable and marginally different political choices amid a consensual core.

In decision-making arenas more restricted to legislatures and governments, the influential model developed and updated by Kingdom[4] highlights decision-making flows involving entrepreneurs, windows of opportunity, public opinion, and actions of politicians and officials, who, in special circumstances, can generate a virtuous cycle of innovations and political changes.

The adequacy of the "policy analysis" methods for the Brazilian context – of still embryonic democratic institutions – is evident to authors of this paper and can be identified, in its own origins, as a science for democracy and destined to influence governments[5].

This tradition strengthened by Wildawsky[6] guides the analyses developed here from the opinions and perceptions of health secretaries who occupy privileged decision-making spaces in the implementation of the Brazilian public health policy. This adaptation is reinforced by recent studies of Vaitsman et al.[7], which highlight the Brazilian context of attempted redemocratization.

This set of references support this paper in analyzing the obstacles to the implementation of a recent regionalization policy, the Organizing Contract of Public Action - COAP, emphasizing the perceptions of decision-makers. In order to understand the extent of "policy analysis", the reflections and results presented here should be linked to the results observed in recent research on the implementation of the COAP from a partnership between ENSP/FIOCRUZ and DAI/SGEP/MS[8].

The next step of this paper is to identify how sectorial literature addresses the SUS regionalization process, dialoguing with authors who studied the issue in order to highlight how they approached their deadlocks and obstacles. Articulating these findings to the "policy analysis" approach discussed above, the theoretical-practical framework that guides the presentation and discussion of hurdles that arise from the perceptions of the municipal secretaries interviewed is constructed.

Studies that seek to understand the evolutionary pathway of intergovernmental relationships and the political-institutional dynamics of SUS decentralization provide specific insights about the obstacles that hinder regionalization

of health actions and services, seeking to understand them from three groups of explanatory factors (i) macroeconomic transformations of a political, economic and institutional nature external to the health sector; (ii) internal political dynamics and sectorial correlation of forces; and (iii) decentralization rules and financial incentives defined by the Ministry of Health.

The first set of studies stands out through emphasis on the expressive influences of national agendas on the sectoral regime of federative relationships, identifying and explaining significantly opposing trends when comparing the orientation of changes that have taken place in the last three decades along the decentralization-centralization axis.

These trends can be summarized as follows: on the one hand, the agenda of the transition period for democracy, driven by the return of direct elections, the fiscal strengthening of subnational entities and the innovations of the Federal Constitution of 1988, which emphasized the strengthening of local governments; on the other, the transformations promoted by neoliberal reforms of the 1990s, with monetary stabilization measures, state administrative reform, renegotiation of state debts, privatization of banks and state enterprises, Unbundling of Federal Government's Revenues – DRU, among others, who have created a recentralizing impulse[9-14].

These divergent agendas resulted in insufficient and precarious decentralization that did not enable the establishment of consistent financial and administrative bases, leading states and municipalities to have little capacity to hire professionals and managers, to compete for resources (fiscal war), implement access hurdle strategies against users and refuse, in many cases, to assume responsibility. This context produced little incentive for cooperation and articulation among municipalities in health regions, hampering SUS regionalization.

A second set of studies on intergovernmental relations in the SUS emphasizes the extent of the power agreement that gave MRS political power to promote significant transformations in the institutional design of the Brazilian health system[15-19].

In this logic, the deeper reforms that led to the SUS, seeking to improve it, is directly related to the MRS' ability to rearticulate the broad and multi-party political and social movement that included academics, students, managers, opposition party members, health care professionals, part of the federal bureaucracy and service providers, among others, around defense of national agendas.

While this multi-party basis has been articulated in defense of the minimum assumptions for the implementation of decentralization over the three decades, its ability to drive agendas such as sector financing, relations with the sectoral private sector and regionalization is limited. This has been related to the characteristics of the SUS implementation process that, among other things, directed the attention of the sector's stakeholders to the internal agenda; reduced ties with civil society stakeholders (parties, social movements, class associations, etc.); generated disputes over scarce resources in the areas of social security (health, welfare and social assistance); involved the judicialization of politics; and federal conflicts between MS, CONASS and CONASEMS.

Finally, a third set of studies assigns to the microinstitutional federative regulation, expressed in legal provisions and financial incentives defined by the Ministry of Health and its organizational units, the direction assumed by the intergovernmental relations in the SUS. Its authors, in general, emphasize the impact of internal induction strategies on the health sector on the changes that have occurred in the arrangement of relations between the Union, states and municipalities[20-24].

These studies assign to the scope of distribution of responsibilities and attributions registered in temporary regulations, edited by the Ministry of Health (most of the time with the validation of CONASS and CONASEMS), in the form of operational or similar norms, the configuration assumed by the regiment of intergovernmental relationships in the SUS at each moment of the decentralization process.

In this perspective, the difficult progress of regionalization of the SUS can be explained from the scope of rules contained in each of the normative frameworks of decentralization, which could have induced the concentration of power, responsibilities and resources in the municipal sphere, or even preserved and maintained more centralizing federal legacies favoring the federal level. Authors also emphasize the weakening role of the state level in the governance and coordination of health care networks.

Common to these three branches of the literature on intergovernmental relationships in the SUS is the realization that regionalization is a multidetermined process in which political, economic, and institutional factors interfere in the direction and consolidation of strategies, and this broader focus, which is worked on in this paper.

Ciência & Saúde Coletiva, 22(4):1097-1108, 2017

As the aforementioned authors did not focus on the COAP, the challenge is to identify in their visions what can be worked on in the analysis of a new policy that will be worked on as belonging to the lineage of those who tried to boost regionalization of the SUS, subject to, logically, their specificities, in particular that of proposing a contract as an official expression of the agreement.

The COAP draws on the interdependence and agreed sharing of resources and expertise from the federal spheres. It intends to establish a new federative governance of a contractual nature, whose objective is to materialize the commitment among the federative spheres regarding the integration of health actions and services of a certain region, with a view to establishing a federative coordination strategy based on the clear definition of responsibilities of each entity and goals to be achieved.

Despite being established by a Presidential Decree and having had a significant prominence in the national SUS agenda in the initial years of the first term of President Dilma Rousseff, its implementation has been difficult and has progressed little ever since, which suggests that significant obstacles have been imposed. Therefore, the knowledge of these hurdles is extremely relevant for the design of future regionalization agendas, and the municipal health secretaries, especially those with a seat in the CIBs, are strategic informants to obtain qualified information about the possible impacts of the various aspects pointed out in the sectoral literature discussed above. Their position as central decision agents brings them closer to the internal and external political system to the health sector, to the extent that their responsibilities as managers make them knowledgeable of the daily economic and administrative aspects of the implementation of policies and programs at the local SUS level. We then turn to the methodological aspects of the research that gathered their perceptions and, then, to their discussion thereof.

Methodological aspects

The objective of analyzing the political, managerial and financial hindrances to the implementation of the COAP stems from a highly relevant guiding question for public policy. It is the low capacity that the SUS in regionalizing health care toward reducing the great regional inequalities pointed out by the very specialized literature previously discussed and objectively defined in a recent study[25]. Thus, analyzing the perceptions of decision-makers in the main collegiate bodies of the SUS is methodologically quite advantageous to achieve the general objective of the study.

In order to identify the political-economic obstacles to the implementation of the COAP, we decided to work with the perceptions of the Municipal Health Secretaries with seat in the Bipartite Interagency Committees (CIBs). This option is justified because these Secretaries are key stakeholders in the process of implementing the COAP, since they combine representativeness, political activism and decision-making power.

The perceptions were gathered through semi-structured interviews carried out within the framework of the aforementioned research on the national implementation of COAP[8], coordinated by the authors of the paper. For the interview, the Research Team developed an instrument containing 38 questions, of which 6 were open, 24 were closed and 8 were mixed.

The 26 Bipartite Interagency Committees scattered throughout the country have 212 seats for the Municipal Health Secretaries. In this paper, 195 (92%) secretaries were interviewed in the period October 2015-August 2016. The loss of 8% was of a random nature; it was not caused by refusal and can be dismissed, giving this survey a census character.

All respondents agreed to use their statements in scientific papers, attesting to their acceptance by signing an Informed Consent Form.

Focusing on an analysis of the perceptions of key political players, this paper builds on a typical approach to policy analysis, which seeks to articulate social research from a primary source, theoretical reference of political science and production of evidence to guide decision-making.

This is the context in which reflections presented here assume aspects of recommendations aimed at debating and improving the SUS regionalization policy. Hence, we must first show the theoretical references on analysis and regionalization of policies that will structure the data analysis.

Perceptions of the Municipal Health Secretaries with seat in CIBs on the possible implementation of the COAP in 2015-2016

In order to contextualize the discussion around political and economic obstacles of the implementation of the COAP, Table 1 shows selected characteristics of the secretaries interviewed, outlining a brief profile of the research subjects.

Table 1. Selected characteristics of the Municipal Health Secretaries interviewed with seats in the CIBs and the Municipalities in which they work. Absolute and relative frequencies. (N = 195).

Gender	108 (55.4%) men; 87 (44.6%) women;
Age group	64 (32.8%) 41 to 50 years; 62 (31.8%) 31 to 40 years; 50 (25.6%) 51 to 60 years; 6 (3.1%) over 60 years; 1 (0.5%) did not answer.
Education	124 (63.5%) Postgraduates; 50 (25.6%) Higher; 19 (9.7%) Secondary; 2 (1.0%) did not answer.
Experience in this position	107 (54.9%) held the position of Secretary before; 88 (45.1%) did not hold the position of Secretary before;
Party affiliation	118 (60.0%) affiliated to a political party 75 (38.5%) not affiliated to a political party 2 (1.5%) did not answer.
Regional location of the municipality	N (66/33.8%); NE (53/27.2%); MW (26/13.3%); SE (30/15.4%); and S (20/10.3%)
Municipality population size	0-5 thousand (12/6.2%); 5-10 thousand (30/15.4%); 10-20 thousand (27.13.8%); 20-50 thousand (47/24.1%); 50-100 thousand (27/13.8%); 100-500 thousand (34/17.4%); and +500 thousand (18/9.2%)
% of CIB Meetings in which he/she has participated since assuming the position of Secretary	147 (75.4%) from 80 to 100%; 23 (11.8%) from 60 to 80%; 9 (4.6%) from 40 to 60%; 7 (3.6%) from 20 to 40%; 6 (3.1%) from 0 to 20%; 2 (1.0%) did not answer; and 1 (0.5%) there was no meeting.
Municipality signed the COAP	YES (12/6.2%) NO (183/93.8%)

Source: Own elaboration of authors from data of study "Analysis of the Implementation of the Organizational Contract of Public Action – COAP"[1].

We note, at first, that approximately 94% of respondents were secretaries of municipalities that did not sign the COAP (of which 17 capitals), indicating the powerful obstacles faced by the implementation of this policy and giving greater interest to answers of respondents, who are the leading figures of this process.

Although the participation of women and first-time secretaries cannot be considered low, a profile of the respondents that takes into account the most frequent variables in Table 1 indicates a predominance of men, aged between 30 and 50 years, with postgraduate degrees, affiliated to political parties and who have already held the position of municipal health secretary, whether in the current or in another municipality, and who have a high attendance at CIB meetings.

The comparison of this profile with that of Fleury and Mafort[26] for the year 2006, from a larger set of municipal secretaries, shows that, among the leaders with a seat in the CIBs, a pattern characterized by a greater presence of men (55.4% vs. 49.2%, pointed by Fleury and Mafort), older (28.7% versus 21.7% over 50 years of age), with more education (89.1% versus 67.3% have at least the higher education) and with more previous experience (54.9% versus 23.6% had previously held the position). The levels of partisan membership of the secretaries observed in both surveys are almost the same (60% versus 60.4%).

Taking into account the very high percentage of respondents who are secretaries of municipalities that had not yet implemented the COAP, the answers to the first statement in Table 2 are extremely important to point out the disbelief in signing the contract until the end of 2016, since 67.3% showed a "low" or "very low" level of agreement with such a statement.

Ciência & Saúde Coletiva, 22(4):1097-1108, 2017

Table 2. Perceptions of Municipal Health Secretaries with seats in CIBs interviewed about the COAP implementation process. 2015. (n = 195).

Statement / Question of the Research	Level of agreement (%)						
	Very High	High	Fair	Low	Very Low	Did not reply	Does not know
1) "By the end of 2016, most health regions in your state will have signed the COAP"	3.6	6.7	20.0	23.1	44.6	1.5	0.5
2) "The state government has no interest in implementing the COAP in your State"	13.3	12.3	28.7	20.5	22.6	1.5	1.0
3) "The federal government has no interest in implementing the COAP in the country"	5.6	14.9	27.7	27.2	23.6	0.5	0.5
4) "The municipal governments have no interest in implementing the COAP in your Health Regions"	5.1	10.8	34.9	29.7	18.5	0.5	0.5
5) "The COAP will only be implemented in the country if the Federal Government applies new resources linked to its signature"	47.2	35.9	7.2	5.1	4.1	0.5	0.5
6) "The COAP will only be implemented in the State if the State Government apply new resources linked to its signature"	42.6	42.1	10.3	3.1	2.1	0.0	0.0
7) "Municipalities will be the biggest beneficiaries of COAP's signature in their Health Regions"	21.0	37.9	23.0	11.8	6.2	0.0	0.0
8) "Signing the COAP only concerns small municipalities"	2.6	7.7	45.0	35.9	30.3	0.0	0.5
9) "The COAP is a cumbersome process and without any advantages since it is not associated with new federal transfers"	14.4	18.5	23.6	23.1	20.5	0.0	0.0
10) "The COAP is a cumbersome process and without any advantages since it is not associated with new state transfers"	13.3	17.4	23.6	22.6	22.6	0.5	0.0

Source: Own elaboration of authors from data of study "Analysis of the Implementation of the Organizational Contract of Public Action – COAP"[1].

This first point already indicates that the COAP implementation process faces powerful obstacles. This paper also aims to identify, in the perception of these important stakeholders of the process the main economic and political obstacles. Table 2 provides important clues to such identification by pointing out that (i) state governments have an interest in implementation; (ii) municipalities will be the major beneficiaries of the COAP signature; but (iii) implementation will be very difficult if the federal and state governments apply no new resources.

The economic issue, most notably the investment of new resources by the Federal Government and the States, begins to assume, in the perception of the respondents, the position of main obstacle to the implementation of the COAP, which is endorsed by Table 3, in which "Lack of financial resources of the Federal Government" is predominant, "lack of financial resources of the State" is the third most frequent and the "lack of financial resources of the municipality" comes fourth. The three obstacles total 54.9%. It is also possible to add to these, those that indicated "lack of managers' interest in allocating existing financial resources to increase network efficiency" to arrive at 58.0%.

It is important to note that, in the question that originated in Table 3, we showed respondents a list of 12 illustrated situations and asked them to sort them in terms of importance, that is, ranking them from the most important to the

Table 3. Perceptions of the Municipal Health Secretaries with seats in CIBs interviewed about obstacles to implementing COAP. 2015. (n = 195).

Obstacle for the implementation of the COAP	N	%
Lack of resources of the federal government	67	34.4
Fear of lawsuits in the judiciary and / or the Public Prosecutor's Office activity	25	12.8
Lack of financial resources of the State	23	11.8
Lack of financial resources of the Municipalities	17	8.7
Lack of political interest of the Governor	13	6.7
Difficulties of municipalities in sharing health actions and services in the regions	8	4.1
Insufficient number of state public services in the territory	6	3.1
Lack of managers' interest in allocating existing financial resources to increase network efficiency	6	3.1
Insufficient number of private services in the health regions	5	2.6
Lack of political interest of mayors	5	2.6
Lack of interest of the Ministry of Health	4	2.1
Lack of physicians to compose teams in health regions	4	2.1
Don't know/Did not answer	12	6.2
OVERALL TOTAL	195	100.0

Source: Own elaboration of authors from data of study "Analysis of the Implementation of the Organizational Contract of Public Action – COAP"[1].

least important. Thus, Table 3 focuses on the real and proportional frequencies of the situations that were indicated as the most important by the respondents.

Table 3 shows that the second most quoted obstacle is "fear of lawsuits in the judiciary and/or the Public Prosecutor's Office activity", which is greater than the "lack of resources of the State" and supplanting the sum of those related to insufficient service network and doctors. This points to the worrisome burden of health judicialization in SUS management.

The "lack of political interest" of the Executive Branch certainly is a strong obstacle to the implementation of any public policy, even more in the federal context of the SUS, without hierarchies. However, in relation to the other situations, fewer respondents considered it as the most important, as shown in Table 3.

Table 4 further analyzes the issues of "political interest" by systematizing respondents' perceptions of the stance of the main leaders and institutions of their State in relation to the implementation of COAP.

The most important finding on this Table 4 is that respondents do not know the stance of most leaderships and institutions of their State, and the most familiar positions are those of the health sector itself. The high proportion of "don't know" regarding governors, political parties and government leadership in the legislature is impressive.

Table 5 explores these data by illustrating that the respondents' perception of the interest in the implementation of the COAP on the part of political parties that are part of the state management, the municipal chambers and the leadership of the health regions is "non-existent" or "low" in more than 60% of the cases.

These results allow a better analysis of those verified in Table 3, overcoming a possible impression that the "lack of political interest" is not such a big obstacle to the implementation of the COAP, because when we note that important Health Secretaries do not know the stance of political leaderships and institutions, it is clear that such public policy has little or no relevance beyond the spheres of health.

Ciência & Saúde Coletiva, 22(4):1097-1108, 2017

Table 4. Perceptions of the Municipal Health Secretaries with seats in CIBs interviewed on the stance of the main political leaders and institutions of their State in relation to the implementation of COAP. 2015. (n = 195).

Stakeholders	Very contrary	Contrary	Indifferent	Favorable	Very favorable	Don't know	Did not answer
Governor	0.5%	9.2%	13.8%	20.5%	7.2%	48.7%	0.0%
State Health Secretary	1.5%	8.2%	12.3%	37.4%	11.8%	27.7%	1.0%
Government Leader	0.5%	1.5%	19.5%	7.2%	0.5%	70.8%	0.0%
Opposition Leader	0.0%	2.1%	20.0%	7.2%	0.0%	70.8%	0.0%
Secretary of Finance	0.5%	7.2%	11.8%	4.1%	0.5%	74.9%	1.0%
President of COSEMS	0.0%	8.2%	5.1%	48.7%	26.2%	11.8%	0.0%
SMS major cities	1.0%	11.3%	7.7%	40.5%	11.3%	28.2%	0.0%
SMS small cities	1.0%	9.2%	15.9%	36.9%	17.4%	19.5%	0.0%
Workers	0.0%	2.1%	32.3%	24.1%	3.6%	37.9%	0.0%
Public hospitals' directors	0.0%	4.6%	25.1%	21.5%	4.6%	43.1%	1.0%
Private hospitals" directors	0.5%	8.7%	24.1%	9.2%	2.1%	55.4%	0.0%
Judges	0.0%	0.0%	13.3%	22.1%	8.2%	56.4%	0.0%
Public Prosecutor's Office	0.0%	0.0%	9.7%	30.8%	12.8%	46.7%	0.0%
Parties	0.0%	0.5%	24.6%	7.2%	0.0%	67.7%	0.0%
Laboratories	0.0%	6.2%	22.1%	12.8%	0.5%	58.5%	0.0%
Imaging centers	0.0%	5.6%	20.5%	14.4%	0.5%	59.0%	0.0%
Unions	0.0%	3.1%	22.1%	18.5%	0.5%	55.4%	0.5%
Associations of residents / popular leaderships	0.0%	1.5%	17.9%	17.9%	1.5%	61.0%	0.0%
Regional Council of Medicine	0.0%	5.6%	20.5%	11.8%	1.5%	60.5%	0.0%
MPs / councilors	0.5%	2.1%	21.0%	13.3%	0.0%	63.1%	0.0%
Churches	0.0%	0.0%	21.5%	8.7%	0.5%	68.7%	0.5%
Media	0.0%	0.5%	24.1%	12.3%	0.5%	62.1%	0.5%
Inter-municipal consortia	0.0%	4.6%	10.3%	31.3%	4.1%	45.1%	4.6%
State Health Councils	0.0%	2.1%	9.2%	45.1%	8.7%	34.4%	0.5%
Municipal Health Councils	0.0%	3.6%	12.3%	53.3%	8.7%	22.1%	0.0%
Health plans and Insurers	3.1%	8.7%	17.9%	2.6%	0.0%	67.7%	0.0%
Court of Accounts	0.0%	0.5%	8.7%	29.2%	8.7%	52.8%	0.0%
Pharmaceutical and Equipment Industry	1.0%	5.1%	19.0%	8.2%	0.5%	66.2%	0.0%

Source: Own elaboration of authors from data of study "Analysis of the Implementation of the Organizational Contract of Public Action – COAP"[1].

Final considerations

Persistent regional inequalities are widely reported in the literature analyzed here and, in addition to their persistence, there are signs of aggravation, as recently highlighted[27]. Thus, such regional asymmetries represent an obvious obstacle to regionalization by increasing the cooperation effort among unequal. As has been shown, the social status of individuals and their place of residence is an important factor for access to health services in the country[28].

Other obstacles to regionalization stem from important factors associated with weaknesses in regional development policies that many attribute to the impact of macroeconomic policy

Table 5. Perceptions of Municipal Health Secretaries with seats in CIBs interviewed on the interest of parties and key political leaders of their State in relation to COAP. 2015. (n = 195).

Parties and Political Leaderships	Non-existent	Low	Fair	High	Don't know / Did not answer
Governor's political party	3.0%	22.6%	24.1%	5.1%	9.3%
Other State government base's parties	39.5%	25.1%	25.1%	1.0%	9.3%
City council	43.6%	27.7%	18.5%	2.1%	8.2%
Parties leadership of health regions	33.3%	26.7%	28.7%	3.1%	8.2%

Source: Own elaboration of authors from data of study "Analysis of the Implementation of the Organizational Contract of Public Action – COAP"[1].

agendas aimed at reducing the role of the state in the economy[29,30]. As we have seen, what is observed is that it shrinks the capacity of Brazilian federalism to produce cooperative effects on the health system[25].

Besides aligning in this direction, results of this study shed light on the knowledge of motivating factors of political action by important decision makers in the system. In short, as already seen, the political and party coalition around advocacy of SUS foundations has weakened and is nowadays more fragile than in the context of the 1980s, which resulted in the creation of SUS.

The first obstacle to be analyzed concerns "transaction costs", which, as previously mentioned, tend to be high in contractual processes involving entities with political autonomy, in case of national implementation of the COAP.

For the political process, this indicates that the entity that has an interest in the implementation of the policy must be able to establish a chain of incentives that can convince and induce other entities involved in the contractualization. In practical terms, it is incumbent upon the federal government, through the Ministry of Health, to set such incentives in order to mobilize states and municipalities to implement the COAP.

Precisely because it is a contract, this chain of incentives needs to address the demands of those with whom we want to contractualize. This is when intense political, financial and economic hurdles to the COAP implementation process emerge.

According to the perceptions of the Municipal Health Secretaries interviewed, the key element of this chain of incentives involves financial resources, especially the so-called "new resources", that is, an increase in the health budget, not originally provided for.

If this increase was not planned in the Dilma Rousseff government, which launched the COAP, it seems unlikely to occur in the coming years, especially because of the proposed amendment to constitution 55/2016, approved by the national congress on December 13, 2016, which sets a ceiling for the growth of public spending for a period of 10 to 20 years.

Considering public spending as one of the main economic problems of the country, the current government indicates that the limit of resources for social policies should be the current expenditure, with a minimum expectation of positive variation, which, by the way, is supplanted by cut-off expectations. Thus, the Brasilia-centralized economic policy does not support social policy decentralization initiatives, subjugating the interests of municipalities and states, already heavily indebted and demanding the federal government changes in the profiles of their debts and increasing gaps in the Fiscal Responsibility Law.

Currently, the perception of the municipal health secretaries interviewed about the need to increase financial resources to encourage the implementation of the COAP points to a very unsurmountable obstacle.

If these perceptions actually represent reality, the economic hindrance represented by the impracticability of new resources will probably be the one whose potential to make the COAP more unfeasible is more noticeable. In general terms, this impediment is not a novelty in the SUS, and movements for increased health resources are well known.

Ciência & Saúde Coletiva, 22(4):1097-1108, 2017

What appears to be a powerful new obstacle is what, according to respondents' answers, indicates that the political-partisan system and the State Executive Branch are the major absentees in the coalitions in support of SUS regionalization policies.

This is an unusual situation in the health sector. Since the Movement for Health Reform and the establishment of the SUS, health policy has been of extreme interest to political coalitions. It is possible to affirm that the SUS had, throughout its history, cross-party and social leaderships' support, often manifesting itself in the pressure and/or the occupation of positions in the municipal and state executive branches that ensured their support in several critical moments.

This absence is not a matter of value judgment here. There is no data to go far beyond the finding of the issue. This situation points to an agenda of future research that is concerned with understanding motivations, identifying whether this occurs in other aspects of the health policy and how it can be overcome.

In conclusion, there is another type of obstacle, which translates into the judicialization of health, more specifically in the relations between the Judiciary and Public Prosecutor's Office, on the one hand, and municipal and state health managers. Judicialization has gained prominence in the sectoral debate, and this paper does not intend to discuss its specificities. What we want to point out here is that such relations seem to create a negative environment, which, for most respondents, can make it impossible to implement the COAP (a contract).

In addition to this more immediate aspect, such an obstacle can also be seen as an indicator that policy has been seen and addressed by certain national legal institutions as an "evil in itself", an environment in which, a priori, there are veiled interests, and that virtue, in order to be produced, must be enforced under penalty of punishment involving even imprisonment. Historically, attitudes such as these generate a violent social environment, of vindictive inclinations and blame; the removal of qualified professionals from the most important public positions; and the consequent shrinking of institutional and political innovations.

The articulated obstacles shown here indicate an extremely negative setting for the implementation of the COAP and other policies that seek the regionalization of the SUS. Before this situation, it is incumbent upon those involved to reflect, negotiate, build consensus on improving the health of the population and overcome such hurdles if, of course, they embrace authors' conception that regionalization is fundamental for the SUS.

Collaborations

The authors worked together on the design and the outline of the paper; MR Moreira was responsible for writing, analyzing, and interpreting data; JM Ribeiro and AM Ouverney were responsible for the critical review of the text.

Acknowledgements

We wish to thank the Department of Interfederative Articulation (DAI) – at the time of Research at the SGEP/MS, and currently at the Executive Secretariat, Ministry of Health – its Directors and Coordinators for their assistance since 2013, especially Isabel Senra, for her support and dedication.

We also wish to thank the team of field investigators who participated in the "Evaluation of the National Implementation of COAP" for their dedication and quality work, without which it would not have been possible to carry out the interviews whose answers were analyzed here.

References

1. Geva-May I, Pal LA. Good fences make good neighbours: policy evaluation and policy analysis – exploring the differences. *Evaluation* 1998; 5(3):259-277.
2. Majone G. *Evidence, argument, and persuasion in the policy process*. New Haven: Yale University Press; 1989.
3. Lindblom CE. The science of muddling through, *Public Administration Review* 1959; 19(2):79-88.
4. Kingdon JW. *Agendas, alternatives and public policies*. 2nd ed. Boston: Longman; 2011.
5. Lasswell H. The policy orientation. In: Lerner D, Laswell H, editors. *The Policy Sciences*. Stanford: Stanford University Press; 1951. p. 3-15.
6. Wildawsky A. *Speaking truth to power – the art and craft of policy analysis*. London: Macmillan; 1979.
7. Vaitsman J, Ribeiro JM, Lobato L, editors. *Policy Analysis in Brazil: the state of art*. Bristol: Policy Press; 2013.
8. Ribeiro JM, Moreira MR, Ouverney AM. *Análise da Implementação Nacional do COAP* [relatório final de pesquisa]. Rio de Janeiro, Brasília: Fiocruz; 2016.
9. Arretche M. A Política da Política de Saúde no Brasil. In: Lima NT, Gerschman S, Edler FC, Soarez JM, organizadores. *Saúde e Democracia: Histórias e Perspectivas do SUS.* Rio de Janeiro: Editora Fiocruz; 2005.
10. Silva SF. *Municipalização da Saúde e Poder Local: Sujeitos, Atores e Políticas.* São Paulo: Hucitec; 2001.
11. Noronha JC, Tavarez L. A política de saúde no Brasil nos anos 90. *Cien Saude Colet* 2001; 6(2):445-450.
12. Luchese P. Descentralização do financiamento e gestão da assistência à saúde no Brasil: a implementação do Sistema Único de Saúde — retrospectiva 1990/1995. *Planejamento e Políticas Públicas* 1996; 14:75-158.
13. Dain S. Os impasses do financiamento fiscal do SUS. *Trab. educ. saúde* 2008; 6(3):623-632.
14. Viana A, Machado CV. Proteção social em saúde: um balanço dos 20 anos do SUS. *Physis* 2008; 18(4):645-684.
15. Falleti T. Infiltrando o Estado: A Evolução da Reforma da Saúde No Brasil, 1964 – 1988. *Estudos de Sociologia* 2010; 15(29):345-368.
16. Fleury S. Reforma sanitária brasileira: dilemas entre o instituinte e o instituído. *Cien Saude Colet* 2009; 14(3):743-752.
17. Paim JS. Eqüidade e reforma em sistemas de serviços de saúde: o caso do SUS. *Saude soc.* 2006; 15(2):34-46.
18. Faleiros VD, Senna JD, Vasconcellos LF, Silveira GR. *A Construção do SUS: Histórias da Reforma Sanitária e do Processo Participativo.* Brasília: Ministério da Saúde; 2006.
19. Ribeiro JM. Conselhos de saúde, comissões intergestores e grupos de interesses no Sistema Único de Saúde (SUS). *Cad Saude Publica* 1997; 13(1):81-92.
20. Levicovitz E, Lima LD, Machado CV. A Política de Saúde nos Anos 1990: relações intergovernamentais e o papel das normas operacionais básicas. *Cien Saude Colet* 2001; 6(2):269-291.
21. Santos L, Andrade OM. *O Espaço da Gestão Inovadora e dos Consensos Interfederativos: aspectos jurídicos, administrativos e financeiros.* Campinas: Instituto de Direito Sanitário; 2007.
22. Scatena JHG, Tanaka OY. Os instrumentos normalizadores (NOB) no processo de descentralização da saúde. *Saude soc.* 2001; 10(2):47-74.
23. Carvalho G. A inconstitucional administração pós-constitucional do SUS através de normas operacionais. *Cien Saude Colet* 2001; 6(2):435-444.
24. Mafort A. A construção da municipalização da saúde: estratégias normativas. In: Fleury S, organizador. *Democracia e inovação na gestão local da saúde*. Rio de Janeiro: Cebes/Fiocruz: 2014.
25. Ribeiro JM, Moreira MR. A crise do federalismo cooperativo nas políticas de saúde no Brasil. *Saúde em debate* 2016; 40(n. especial):14-24.
26. Fleury S, Ouverney AM, Zani FB, Möller RC, Kronemberger TS. *Democracia e inovação na gestão local de saúde*. Rio de Janeiro: Cebes/Editora Fiocruz; 2014.
27. Piola SF, França JRM, Nunes A. Os efeitos da Emenda Constitucional 29 na alocação regional dos gastos públicos no Sistema Único de Saúde no Brasil. *Cien Saude Colet* 2016; 21(2):411-421.
28. Travassos C, Oliveira EXG, Viacava F. Desigualdades geográficas e sociais no acesso aos serviços de saúde no Brasil: 1998 e 2003. *Cien Saude Colet* 2006; 11(4):975-986.
29. Gadelha CAG, Machado CV, Lima LD, Baptista TWF. Saúde e territorialização na perspectiva do desenvolvimento. *Cien Saude Colet* 2011; 16(6):3003-3016.
30. Viana ALD, Lima LD, Ferreira MP. Condicionantes estruturais da regionalização na saúde: tipologia dos Colegiados de Gestão Regional. *Cien Saude Colet* 2010; 15(5):2317-2326.

Article submitted 06/06/2016
Approved 04/08/2016
Final version submitted 13/02/2017