

Discoordination promoting institutional racism: considerations on Indigenous access to health policy

Descoordenação a serviço do racismo institucional: considerações sobre o acesso de indígenas à política de saúde

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Abstract

The Brazilian policy for indigenous health has its efficacy conditioned by the promotion of intergovernmental coordination between the Special Secretariat for Indigenous Health (SESAI), municipal, and regional health services. This coordination should be done both in the policy formulation and in its implementation—which should occur between medium and street-level bureaucrats. Based on the literature that discusses federalism and intergovernmental coordination mechanisms, this article investigates the mechanisms and difficulties of cooperation in the frontline of health services offered to Indigenous peoples. A total of six semi-structured interviews were carried out with professionals of the SESAI in the Mato Grosso do Sul DSEI. It was identified that the difficulties are related mainly to institutional racism, the overload of the Brazilian National Health System (SUS), the unaccountability of municipal services, and the weak communication between SESAI and hospitals. The cooperation mechanisms are personal relations, situated agency of SESAI professionals, and a monetary incentive. In conclusion, there is a need for more intergovernmental collaboration mechanisms that consider these difficulties in integrating the implementation of these services.

Keywords: Health Indigenous Service; Systemic Racism; Street-Level Bureaucracy; Federalism.

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Resumo

A política de saúde indígena necessita de coordenação intergovernamental entre Secretaria Especial de Saúde Indígena (Sesai) e serviços municipais e estaduais de saúde para sua eficácia. Tal coordenação deve ser feita tanto em nível de formulação como na sua implementação - que deve ocorrer entre burocratas de médio escalão e de nível de rua. Baseado na literatura que discute o federalismo e mecanismos de coordenação intergovernamental, este artigo investiga os mecanismos e as dificuldades de cooperação na ponta dos serviços de saúde aos povos indígenas. Foram feitas entrevistas semiestruturadas com seis profissionais atuantes na Sesai do DSEI Mato Grosso do Sul. Identificou-se que as dificuldades dizem respeito principalmente ao racismo institucional, à estrutura sobrecarregada do SUS, à desresponsabilização por parte dos municípios e à má comunicação entre Sesai e hospitais. Já os mecanismos de cooperação identificados foram relações pessoais, agência situada de profissionais da Sesai e a existência de incentivo financeiro. Conclui-se que são necessários mais mecanismos de colaboração intergovernamental que considerem todas essas dificuldades de integração na implementação do serviço.

Palavras-chave: Serviços de Saúde Indígena; Racismo Institucional; Burocracia de Nível de Rua; Federalismo.

Introduction

In Brazil, the Indigenous peoples have a specific agency responsible for their care: the Special Secretariat for Indigenous Health (SESAI). Nevertheless, they still face several difficulties in accessing health. The literature in the area indicates how the lack of resources and professional qualification represent a historical problem of quality health care for the Indigenous population in Brazil (CIMI, 2013; Garnelo, 2004). The SESAI, linked to the Ministry of Health, is responsible for primary care, whereas care in medium and high complexity services requires integration with the municipal and state secretariats, which offer these services. Despite this, there are indications of a lack of coordination, which can accentuate the access barriers of these populations and potentiate the processes of institutional racism within the policies aimed at them.

The National Policy on Indigenous Health (Brasil, 2002) defines the need for intergovernmental and intersectoral articulation for its proper implementation. This article seeks to investigate aspects of coordination at the frontline between institutions with attributions related to Indigenous health and how the lack of coordination can exacerbate institutional racism. To this end, a series of interviews with Indigenous health professionals from Mato Grosso do Sul are carried out, to deepen the knowledge of how cooperation occurs in the implementation of the service.

The first section presents the structure of SESAI and discusses the relevance of coordination mechanisms in the Brazilian context, in which the universalization of health occurred concomitantly with the municipalization of this service. Then, the methodology of the study is indicated, and the results are analyzed, examining the challenges and mechanisms of cooperation reported by the interviewees. Finally, the final considerations address some possible ways to increase cooperation between the institutions responsible for Indigenous health in Brazil.

SESAI and the importance of intergovernmental cooperation

For years, Indigenous health has been conceived and implemented in a tutelary manner (Cardoso; Santos; Coimbra Júnior, 2007). The concept of Indigenous health as a collective construction, in which these peoples are the protagonists of decisions (CIMI, 2013), was structured only after the Federal Constitution of 1988 (Brasil, 1988). In 1990, Law No. 8080 (Brasil, 1990)—also called the Organic Health Law—established the structure of the Unified Health System (SUS) and indicated its political-administrative decentralization, with a regionalized and hierarchical network of services with an emphasis on the decentralization of services to the municipalities. This decentralization went hand in hand with the universalization of access to health for the Brazilian population, but it brought paradoxes to Indigenous health policies given its national character.

In 1999, Law No. 9,836/99 (Brasil, 1999) was approved—also called the Arouca Law, which established the creation of the Indigenous Health Care Subsystem (SASI-SUS), supposedly based on the Special Indigenous Health Districts (DSEI). The DSEI were created with Ordinance No. 852/1999, according to the territorial jurisdiction, the ethnic groups, Indigenous Health Centers, and other territorial and population characteristics. Each DSEI is responsible for organizing health services in a given Indigenous territory in a hierarchical logic. This law and the ordinance inaugurated a new phase for Indigenous health, overcoming the dispute between institutions and establishing attributions at each level of government. Primary care for Indigenous peoples was assigned to SASI-SUS, which should be articulated with the other medium and high complexity services of the SUS in a hierarchical and integrated manner. The SESAI was created by Decree No. 7,336 (Brasil, 2010), and was assigned the coordination of the implementation of Indigenous health policy based on democratic and participatory management, in addition to promoting articulation between government sectors with attributions under the indigenous health policy.

Currently, the Indigenous health policy continues to be coordinated by SESAI and structured within SUS, demanding a high level of articulation between different agencies for its effectiveness. Primary care is the responsibility of SESAI, which has facilities such as the base centers in the villages and the Indigenous Health Centers (CASAI) in the cities, in which multidisciplinary teams work. They also have Indigenous health agents (AIS), who have more direct contact with patients and carry out home visits. Secondary and tertiary level care, on the other hand, are the attributions of the local, municipal, and state SUS networks, following the territorialized and hierarchical logic of this system according to the complexity of the case of each situation.

The lack of research observing intragovernmental coordination in the field of Indigenous health is noteworthy. The bibliographic survey by Maia et al. (2019) on Indigenous populations' access to medium and high complexity services found only 19 relevant publications, including manuals and articles. Among the 11 publications indicated by the authors as the most relevant, seven are from the Ministry of Health and only four are from independent researchers. In view of this gap, investigations and academic reflections on which mechanisms of intergovernmental cooperation are present in the articulation of these services and, mainly, which are lacking are urgently needed.

Intergovernmental coordination and mechanisms to encourage cooperation are central to a federalist country such as Brazil, in which the three federative entities—the Union, the states, and the municipalities—have complementary or concurrent competences in the implementation of public policies. To understand the need for intergovernmental cooperation mechanisms for Indigenous health care, reflecting on Brazilian federalism and its implications for public policies in this country is necessary.

A federalist country is based on a double objective, as defined by Burgess (1993): unity and diversity. Unity refers to the recognition of the interdependence between different federative units and the benefits of a union; diversity, on the other hand, is linked to the mutual independence and autonomy of the entities. The challenge of a system

like ours is to ensure interdependence between the parties, maintaining their autonomy, without falling into a centralization of public policies. To balance these two factors, having mechanisms to coordinate the actions of the different entities, which allows for the nationalization of policies without taking away the autonomy of the parties, is important.

In the case of Indigenous health policies, this means having guidelines and a central coordination, but also having elements in planning and implementation that meet local specificities. This is what is sought with the national guidelines, the national coordination of SESAI and local implementation managed by the DSEI. However, the articulation with other services at the local level faces difficulties (Garnelo, 2004), possibly due to the absence of clear attributions and incentives to municipal and state services for the qualified care of the Indigenous population. In a federalist system, a public policy that does not have effective coordination mechanisms has risks for its proper execution. The absence of mechanisms that define the structure of cooperation can imply a competitive game between entities, leading to problems such as what Peterson (1995) calls “race to the bottom,” which is a problem of collective action when the tendency is for all states (or municipalities) to offer fewer social policies.

The risk is accentuated in areas where different entities have shared competences. This sharing creates a difficulty in the processes of accountability of governments for the execution of the policy, since it is not evident to citizens from which part of the government they need to demand the effective execution of such policy; thus, this articulation is extremely important for the compatibility of the traits of autonomy and interdependence of each government. According to Abrucio (2005), coordination between subnational states and the federal government consists of the ways in which different entities integrate, share, and decide collectively.

One of the main coordination strategies used in Brazil is the elaboration of public policy systems, such as the National Health System (SUS). This was the first Brazilian social policy system, which was founded with the Federal Constitution of 1988.

The universalization of health services accessibility was based on the cooperation of the municipal, state, and central spheres, proposing that primary care services should be offered by all municipalities, while those of medium or high complexity should be offered in a regionalized manner, in which state entities would have greater competence. However, many municipalities did not have—and still do not have—financial resources or technical capacity for formulating and implementing social policies (Menicucci; Marques, 2016). Franzese and Abrucio (2013) state that several social policies, in the post-1988 Constitution, had their success conditioned to the elaboration of incentive mechanisms and coordination at the national level. Resources or other support linked to the implementation of predetermined policies represent incentives for cooperation.

These mechanisms and the better definition of which actions are the competence of which spheres provided a greater degree of cooperation and homogenization of SUS policies throughout the country (Franzese; Abrucio, 2013). The SUS articulates the actions and services offered by federal, state, and municipal public agencies based on a hierarchical and regionalized structure and on guidelines for universal access, equity, and comprehensiveness of care (Cardoso; Santos; Coimbra Júnior, 2007).

In the light of the regionalized and hierarchical structure of the SUS, its mechanisms of cooperation and intergovernmental incentive, it is necessary to look at the specificities of Indigenous health policy. The SUS is highly marked by the decentralization and municipalization of the provision of services; however, indigenist practices have always been marked by the role of the federal government in the conduction and execution of public policies. In 2004, therefore, after the implementation of the Special Indigenous Health Districts (DSEIs), but before the creation of SESAI, Garnelo (2004) analyzed this contradiction in the *modus operandi* of the SUS and the Indigenous health policy. The author indicated that one of the challenges for these policies is the implementation at the local level by a national body, a scenario made more complex by the fact that the health policy for the rest of the population is marked

by municipalization. Thus, Indigenous health managers had to develop two types of strategies (Garnelo, 2004): the first was to implement the policy at the local level by outsourcing; the second was cooperation with municipal and state health services, but this integration was not well regulated.

The National Policy on Indigenous Health indicates the need for “a broad articulation at the intra- and intersectoral level, with the executing body of this policy being responsible for promoting and facilitating this process” (Brasil, 2002; free translation). Intra-sectoral articulation should involve SUS managers at the national, state, and municipal levels in “a planning agreed upon in the Indigenous Health Districts that safeguards the principle of ultimate responsibility at the federal level and an effective Social Control exercised by Indigenous communities” (Brasil, 2002; free translation). The articulation between the different levels of government is essential for the proper execution of the Indigenous health policy. The executing body of the policy, at the time the National Health Foundation (FUNASA),¹ today SESAI, is responsible for conducting and facilitating this process of articulation; however, as Garnelo (2004) indicates, the interrelations between the municipal and state bodies of the SUS and the Indigenous health subsystem have not been clearly established. For example, the place where to refer patients or health problems that the DSEI did not have the institutional or technical capacity to attend to and solve was not well determined. Access to medium and high complexity health services is among the main barriers to access to health for Indigenous peoples. Not only do they find it difficult to enter the system, but once inside, their cultural specificities are generally disregarded and the presence of cultural interpreters is rare, as identified by Maia et al. (2019).

The absence of cooperation mechanisms is a symptom of institutional racism to which Indigenous peoples are subjected in accessing the public services offered. Kalckmann et al. (2007) reflect on institutional racism in health services, focusing on the racism to which the Black population is

subjected. According to the authors, institutional racism happens when people who share a culture, color, or ethnic origin do not receive adequate institutional service. Institutional racism is broader than interpersonal and explicit racism. It manifests itself in policies, practices, and institutional norms that generate unequal treatment. When commenting on institutional racism against the Black population in health services, Kalckmann et al. (2007) state that it is marked by the difficulty of access, the low quality of health care, the absence of the racial issue in the training of professionals, etc. In the research of these authors, the dismissal of Black patients' complaints and the denial of care are notable. The researchers' conclusion points to the need to consider the presence or absence of institutional racism as an indicator of quality in the health services provided to the population.

The Indigenous population is also subjected to processes of institutional racism in various public policies, which is strongly marked in the health system. Benites et al. (2023) point out some manifestations of this racism in the care of Indigenous people in Mato Grosso do Sul, such as medical negligence, shortage of doctors in primary healthcare units and lack of inclusion of cultural specificities, traditional practices, and care in the Guarani language. Likewise, the lack of coordination can be another manifestation of institutional racism against these peoples. The lack of adequacy of the SUS structure to serve Indigenous peoples and the lack of incentives to make this adaptation effective generates worse treatment for this portion of the Brazilian population.

The health crisis generated by the COVID-19 pandemic has highlighted institutional racism and barriers to Indigenous peoples' access to health services. The plan to combat COVID-19 in Brazil, prepared by the Association of Indigenous Peoples of Brazil (APIB, 2020), indicated the racism present in the underreporting of these cases when they were attended by the SUS, in addition to pointing to the need for an articulation between SESAI systems, other instances of the Ministry of Health,

1 FUNASA was responsible for carrying out actions to prevent and promote the health of Indigenous peoples until 2010 (CIMI, 2013).

and the municipal and state health departments. Coordination between the different health services for Indigenous populations is essential.

Methodology

In view of the importance of coordination for Indigenous health policy, a series of interviews were conducted with SESAI professionals of the Mato Grosso do Sul DSEI. The interviews aimed to elucidate aspects of the coordination and articulation between SESAI and other SUS services, highlighting difficulties and possibilities of this process. To diagnose the reality of intergovernmental relations and cooperation at the level of local managers and Indigenous health professionals, interviews were conducted with these actors.² The interviewed actors worked in different SESAI base centers, but they were all from the Mato Grosso do Sul DSEI. This state is marked by having a large Indigenous population, mainly of the Guarani, Kaiowá, and Terena ethnic groups. The Indigenous reservations of this state have a high population density, since these peoples were expelled from their traditional territories throughout the twentieth century and confined to small Indigenous reservations demarcated by the Indigenous Peoples Protection Service (SPI). The land conflict between large landowners and the Guarani and Kaiowá struggle for the demarcation of their territories is intense (Morais, 2017).

The scenario of Mato Grosso do Sul certainly interferes with the implementation of all public policies aimed at local Indigenous populations. The literature on middle-level and street-level bureaucracy points to their importance for the success of policies, and to how the action of these professionals is guided by their values and social positions (Cavalcante; Lotta, 2015; Lipsky 2019; Pires and Lotta, 2019). In the case of Indigenous health, intragovernmental cooperation depends on the work of mid-level and street-level bureaucrats, those who are in the health departments, hospitals, SESAI equipment, and transport services, such as

Urgency Mobile Attention Service (SAMU) and the Fire Department. The investigation was therefore carried out in an adverse context for cooperation at the frontline.

During the month of July 2020, interviews were conducted with six SESAI professionals who can be considered mid-level or street-level bureaucrats: a doctor, two nurses, an Indigenous health agent, a nursing technician, and a base center coordinator, who are distributed among four base centers. The interviews were semi-structured, and the questions focused on the moments in which it is necessary to articulate with other SUS services outside the scope of SESAI and on its difficulties. The interviewees were also asked about the heterogeneity of the level of cooperation with the different municipalities that aggregate it, since this heterogeneity can give indications of how cooperative relations are currently built in this service. The interviews were recorded, and the audios were transcribed.

Note that the interviews were conducted at the height of the COVID-19 pandemic, which demanded a high level of articulation from health services. Sometimes, the interviewee answered with reference to the intergovernmental relations that were carried out to face the pandemic, even though they were always asked about what relations were like before this crisis. We start from the perspective of grounded theory (Charmaz, 2006) and abductive epistemology (Simpson, 2018). Qualitative studies carried out from the perspective of grounded theory construct theoretical propositions based on field data (Charmaz, 2006).

Abductive epistemology is characterized by the continuous process of formulating possible explanations for observed events (Simpson, 2018), hypotheses are built from the data and then tested by deductive logic. In practice, the procedures performed were the transcription of all interviews, their cross-sectional analysis, and the creation of analytical categories present in the interviewees' reports, which we will discuss in the next section.

² The interviews were conducted via Zoom, phone calls, or WhatsApp audios. The means of communication was chosen according to the interviewee's possibility.

Results and discussion: how does cooperation take place at the frontline?

The professionals' reports revealed the presence of several barriers to the implementation of integration in the Indigenous health policy.

In addition to the barriers, they also pointed out how cooperation takes place when it happens and what mechanisms are effective in increasing cooperation. We have developed two areas of analysis: integration difficulties and cooperation mechanisms. Table 1 shows the analytical categories within each domain.

Table 1 – Domains and categories of analysis of the interviews

Domain	Category	Interviews in which the category was addressed
Integration difficulties	Institutional racism	A, B, C, D, E, F
	Overloaded structure	A, C, F
	Non-accountability of the municipality	A, B, E
	Communication between SESAI and hospitals	C
Cooperation mechanisms	Personal relationships	A
	SESAI professional's situated agency	A, B, E
	Financial incentive	B, C, E

Source: elaborated by the authors

The *integration difficulties* of SESAI with other SUS institutions were addressed by all the interviewees and appear in several daily situations, such as the absence of care in the villages, the delay in consultations and exams, and the process of getting vacancies in hospitals.

Racism and discrimination were pointed out by the statements of all the interviewees, and it is revealed as one of the difficulties in cooperation. The statements were identified as revealing the presence of *institutional racism* whenever they pointed to obstacles to quality care marked by barriers to the entire community. The first aspect of this racism is the very disregard of Indigenous people as citizens with the right to health services in the network. They also point out the difference in care for Indigenous people and city dwellers and that many Indigenous people report having poor care and suffering discrimination. One of the professionals reported that in some cases Indigenous people are only seen at the end of the day in an emergency room, whereas non-Indigenous people are called before to be treated:

[there's one] *patient who went for an appointment and came back without care because there was no*

one to guide him within the environment where he was. All this because of the difficulty of not knowing how to speak and also no one asked the Indigenous person what they were doing there or offered help. Here [in the emergency room of the local hospital] there were patients who said they arrived very early but were seen last because they attended to the non-Indigenous people first! [Interviewee F]

One of the professionals reported the resistance of Indigenous patients to go to other SUS services that are outside SESAI. Another professional said that Indigenous patients sometimes feel ashamed to be treated in these services. These cases are also associated with institutional racism, which is exacerbated by the lack of intercultural elements in these hospitals. The lack of Indigenous or Guarani-speaking professionals in hospitals and other health facilities acts as a barrier to Indigenous patients, who do not understand many of the procedures they undergo. The absence of these intercultural elements in hospitals in cities with large Indigenous contingents is also generated by a lack of coordination of Indigenous health.

Another case of institutional racism reported is the lack of care within the village when there is an emergency and the patient, his family, or the professionals of the base center themselves require municipal transport services (such as SAMU and the Fire Department). In the words of one of the interviewees: “[in this village] *when we call, they don’t come. SESAI says that it has to be SAMU and the Fire Department, but they complicate things among them*” [Interviewee D].

Another professional also suggested the researcher read a report in a local newspaper, which cites a lawsuit by the Federal Public Prosecutor’s Office (MPF) that was accepted by the federal court of Dourados, making three former coordinators of SAMU, a member of the Fire Department, and a medical regulation technician of SAMU defendants for omission of help in a village of Dourados, in 2019, and the resulting death of an Indigenous patient.³ In this case, both agencies were called to help the patient in the village, but claimed not to have the competence to enter the Indigenous reserve. The MPF’s investigation uncovered a protocol of non-attendance in the villages within the scope of the local SAMU, which would not be legally valid. This is an evident problem of coordination between the institutions that, linked to the local conflicting situation, generates a serious problem in the care of the Indigenous people of the region. It is, therefore, a manifestation of the institutional racism present in the health service.

The *lack of responsibility of the municipality* for Indigenous health is also pointed out as one of the great difficulties of cooperation by one of the interviewees; two others also cite this problem, but report that the situation has improved a lot in the last ten years. When commenting on this topic, the interviewees always state that the Indigenous person is a citizen, the money that goes to the municipality also considers the Indigenous population and, therefore, they should be co-responsible for the Indigenous health services. Another evidence of the lack of coordination is the difficulty pointed out by one of the interviewees in

the communication between the SESAI teams and the hospitals. In this case, the problem is that the patient goes to the hospital without a SESAI companion and, when he returns to the SESAI service, the exams or any reference contact from the hospital are not forwarded. Both the *lack of accountability of the municipality* and the communication difficulties *between the SESAI teams and the hospitals* are manifestations of institutional racism since they generate unequal treatment to the detriment of Indigenous people.

Three other professionals reported that the difficulty is in accessing secondary and tertiary care, mainly due to the *overloaded structure* of the municipal and state SUS networks. When exams and consultations with specialists are necessary, the person in charge of the base center inserts the Indigenous patient in the list of the Regulation System (SisReg), which is a list of demands for SUS services, and then it depends on the network’s time of service. This difficulty is more linked to a general problem of the SUS than to the coordination of Indigenous health, although it has greater effects for these peoples, due to their specificities and conditions of vulnerability.

We also identified some *cooperation mechanisms* reported in the interviews. Although all of them report problems at the present time, three professionals with many years of experience at SESAI indicated an improvement in the coordination of services in the last decade, with the municipality starting to support SESAI for various services, such as transportation and medicines, which were previously denied. Another aspect that one professional indicated was the incorporation of Indigenous cultural specificities in the service. When they report the improvement in recent years, three aspects are evident in the interviewees’ statements: the first, present in the speech of one of the professionals, is the integration motivated by *personal relationships*; the second factor is that, most of the time, the initiative to increase cooperation comes from SESAI, a category that we call a *situated agency*; finally, the professionals point

3 <https://www.progresso.com.br/cidades/servidores-do-samu-e-bombeiros-viram-reus-acusados-de-racismo-na/374543/>.

out the importance of *financial incentives* and the inclusion of Indigenous people in the SUS budget for an improvement in cooperation.

Integration by *personal relationships* was mentioned by one of the interviewees. Throughout the interview, several times the interviewee pointed out the importance of old personal relationships or speaking nicely to achieve cooperation. In the words of the professional:

We have way greater access at the hospital in [municipality A], because the people who are inside are connected to us, they are friends from college, they have worked here. Integration happens more between people, it becomes a conversation between the team here and the team there, it goes much more through collegiality and understanding the other than through administrative processes. [Interviewee A]

The question pointed out by Interviewee A can be interpreted in the light of the analysis of mid-level bureaucrats from a relational perspective. This perspective looks at these actors through their multiple relationships and, in this case, the relationship observed is intragovernmental, and its good consolidation makes all the difference for the effectiveness of the policy. According to Lotta and Cavalcante (2015), this bureaucracy develops different methods of articulation and negotiation to consolidate relations with several important agencies for politics; however, the ability to establish these articulations depends not only on a personal capacity, but also on the priority of their policies in a comprehensive view of the government and on their empowerment in the face of other agencies. In the case of Indigenous health policy, we see a heterogeneity in its degree of prioritization in each municipal government. Governments that do not have guidelines to promote this articulation hinder collaboration at the frontline. In the case of Interviewee A, the professional bases her relationships on her social capital, with personal relationships built throughout her career and personal life.

Another aspect revealed by the interviews is that the SESAI professional is almost always the

actor who promotes the articulation while the other professionals have a passive and, sometimes, resistant performance. This can be observed in the following statements:

But it was something we from SESAI sought, they were not the ones who came after us. [Interviewee B]

[...] We need to call, we need to fight, we need to say that the Indigenous person is a citizen and need to be taken care of. [Interviewee E]

In these reports, it is observed that the articulation occurs by the action of the SESAI professional, an action that can be analytically understood by the concept of situated agency. The notion of situated agency looks at professionals as agents who act reflecting personal values and beliefs, while their agency is conditioned by the historical and institutional context (Souza; Gomes, 2015). Even in the face of the limits of adverse organizational and political contexts, these bureaucrats assert themselves as negotiators and promote articulation with other bodies for the implementation of the policy in question.

In the light of this notion of situated agency, we observed from the interviews that the work of SESAI professionals in articulation with municipal or state SUS services is essential to obtain a minimum of cooperation and positive results for Indigenous health in medium and high complexity services. The absence of a strong superior actor who demands greater collaboration hinders the articulation process, and professionals from health institutions external to SESAI apparently do not have many incentives to promote collaboration. In general, the search for closer relations comes from SESAI's professionals. Only one interviewee pointed out that after consolidating a relationship with the local hospital, its professionals also began to be proactive in cooperation with SESAI. In this case, the positive result of a cooperative relationship generates reciprocity within the relationship.

Another aspect that encourages cooperation in Indigenous health policy are *financial incentives*. This is observed both when the interviewees indicated that the money that goes to the municipality includes

Indigenous people, and when they mentioned the importance of the Incentive for Specialized Care for Indigenous Peoples (IAE-PI) for the improvement of medium and high complexity care in local hospitals.

It has improved a lot because the funds are also for the Indigenous people. What is invested here also has to be invested in the village. [Interviewee B]

*The Indigenous person is a citizen, so within the SUS the amount of capital comes to all citizens, and [our municipality] receives it for the Indigenous people as well, today we are 18,500 [Indigenous people] according to SIASI.*⁴[Interviewee E]

When reflecting on the importance of showing that the municipality also receives money for the Indigenous population, we observe a logic of thought, which is: the resources provided to the municipality also account for the Indigenous population, therefore, the money must be spent on them. While this statement may have an aspect of justice, no legal mechanisms ensure that the money that arrives to the Indigenous population is spent on them. The absence of such mechanisms can be interpreted as yet another expression of institutional racism.

Brazil has public policies with adhesion financing mechanisms, which links the use to the execution of a certain policy. This type of mechanism, the IAE-PI, was mentioned by one of the interviewees as being of great relevance for the improvement of relations in recent years. After it was cited, in the interviews that followed, the professionals were also asked about this mechanism. Everyone who addressed this incentive has a positive view of it, which would have facilitated the adaptation of hospitals to Indigenous people (hiring professionals who speak the Indigenous language, creating specific spaces, etc.).

The IAE-PI was formulated to qualify the medium and high complexity health services of the SUS aimed at the Indigenous population.⁵ Health facilities at the outpatient and hospital level that serve Indigenous

patients and that meet certain prerequisites can obtain it. Among the prerequisites is the preparation of a Plan of Goals and Actions (PMA), which must be presented and approved by the DSEI coordination and include at least two objectives among those listed by law. The objectives listed include aspects of coordination with DSEI professionals, promotion of intercultural aspects in patient care, enabling the right to an interpreter, among others.

As demonstrated by Franzese and Abrucio (2013), the effective implementation of some policies, such as the operationalization of the SUS itself at the municipal level, was conditioned by processes of governmental induction, intergovernmental cooperation, and resource redistribution. Incentives were created for adherence to certain policies, linked to resources for the execution of certain actions, such as the Decentralized Management Index (IGD) within the scope of the Unified Social Assistance System (Grin; Abrucio, 2018). From the statements of the interviewees, the IAE-PI was shown as a powerful mechanism for improving Indigenous health services in hospitals and clinics in the region, promoting an articulation with SESAI from the planning of the policy, since it is necessary to prepare the PMA. As pointed out by Interviewee E, the obligation to revert the money to the Indigenous population, that is, the linkage of the resource, induces a qualification of the service to this population.

Other mechanisms to encourage Indigenous health for municipal and state services that also serve these populations could be formulated, since the IAE-PI only considers health institutions such as hospitals and outpatient clinics. Services such as hospital transportation, which many professionals point out as one of the obstacles, could be a point of attention of federative policies of articulation between SESAI and municipal and state health departments. Indicators of the quality of care provided to the Indigenous population in these services could also be formulated and considered in the transfer of resources, as the IGD promotes in relation to social assistance policies.

4 Indigenous Health Care Information System.

5 <https://www.gov.br/saude/pt-br/assuntos/noticias/2022/setembro/gestores-podem-solicitar-incentivo-para-atencao-especializada-a-saude-dos-povos-indigenas>

Final considerations

This article analyzed the collaboration of different government institutions in the implementation of Indigenous health policy. The current structure of this policy requires the articulation between SESAI and municipal and state secretariats, since primary care is the responsibility of SESAI and medium and high complexity care is provided by municipal and state services, in a regionalized and hierarchical manner. Despite this, the literature points out that the undefined cooperation mechanisms can lead to a game of ping-pong, in which the responsibility of implementing policies are thrown back and forth between governments. To understand the level of cooperation in Indigenous health policy, interviews were conducted with middle and low-level bureaucrats from SESAI in Mato Grosso do Sul.

The analysis of the interviews identified several difficulties in the articulation of SESAI with the other local health services, which revolve around the denial of care within the villages, the lack of a sense of co-responsibility of local managers, poor communication between professionals and institutions and the overload of SUS services. Such elements are manifestations of institutional racism, generating worse treatment of Indigenous peoples than of the rest of the local population. The difficulties in integrating SESAI with other health services increase the precariousness of health care for Indigenous peoples, a precariousness already recognized due to structural problems, such as lack of resources and professionals in the field of Indigenous health. As Kalckmann et al. (2007) suggest, constructing quality indicators that integrate the presence or absence of institutional racism in their configuration can be an alternative to improve these services.

Although the Indigenous health care situation remains quite fragile, some of the professionals reported that SESAI's relations with local institutions have improved in the last 10 years. Three aspects mark this improvement: the importance of mobilizing personal relationships for articulation; the predominance of SESAI professionals as actors who promote articulation; the importance of financial incentives, especially when linked to

the qualification of health care for the Indigenous population, as is the case of the IAE-PI. This incentive was pointed out by the interviewees as positive in the articulation between hospitals and other local health facilities with SESAI professionals. Reports showed that the equipment that receives the IAE-PI presents a qualification of the service to the Indigenous people, integrating cultural aspects in the service.

These notes are congruent with the literature in the area, which, on the one hand, points out the importance of frontline bureaucrats in articulating the implementation of a policy and, on the other hand, the need to establish the attributions of each entity and promote incentives for the proper execution of municipal governments for the implementation of public policies. The formulation of Indigenous public policies needs to consider the challenges of local implementation, especially in contexts conducive to institutional racism. Good intergovernmental coordination is a prerequisite for ensuring the right to health for Indigenous peoples.

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Authors' contribution

Gabriela Thomazinho was responsible for the literature review, methodological elaboration, data collection and analysis, and writing of the article.

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