Programa de Pós-Graduação
Desenvolvimento Regional
mestrado e doutorado

DOI: 10.17058/redes.v29i1.18303

Regionalization of health and the Government Triangle: reflections from the perspective of municipal health managers

Priscila Farfan Barroso
Universidade Estadual do Sudoeste da Bahia – Vitoria da Conquista – BA – Brazil
ORCID: 0000-0002-4815-4792

André Luis Alves de Quevedo
Universidade Federal do Rio Grande do Sul – Porto Alegre – RS – Brazil
ORCID: 0000-0001-9314-7578

Arthur Chioro
Universidade Federal de São Paulo – São Paulo – SP – Brazil
ORCID: 0000-0001-7184-2342

Cristian Fabiano Guimarães
Universidade Federal de São Paulo – São Paulo – SP – Brazil
ORCID: 0000-0003-3101-634X

Abstract
This article analyzes the perception of municipal health managers about the process of regionalization of health in the state of Rio Grande do Sul. It has a qualitative nature, using semi-structured interviews with eight municipal health managers, chosen deliberately. In the theoretical approach, the concept of Government Triangle was used combined with the categories of thematic analysis. In the government project of health regionalization, the means and objectives identified were the Pact for Health, financing, solidarity, access, health consortia, models of supply and contracting of health actions and services. In the capacity of government in the Health Care Networks and the instances of agreement, the ways of conducting, maneuvering, and overcoming that emerged from the analysis were the Regional Intermanagers Commission, the decentralization of health services and intersectorality. In terms of management and health governance, the interviewees identified the manager as having no time and/or not prioritizing the planning and management processes, managers as political figures and without preparation, technical staff without specific training, gaps in care and the permanence of professionals. The results of this study point to clues on possible ways forward in the field of health management and regionalization.
Keywords: Regional Health Planning. Health Management. Health Governance. Health Manager. Health Services.

CC BY

Regionalização da saúde e o Triângulo de Governo: reflexões a partir da perspectiva dos gestores municipais de saúde

Resumo

Este artigo analisa a percepção de gestores municipais de saúde sobre o processo de regionalização da saúde no Estado do Rio Grande do Sul. Tem natureza qualitativa, empregando entrevistas semiestruturadas com oito gestores municipais de saúde, escolhidos intencionalmente. Na abordagem teórica utilizou-se o conceito de Triângulo de Governo, cotejando com as categorias da análise temática. No projeto de governo sobre a regionalização da saúde, os meios e objetivos identificados foram o Pacto pela Saúde, financiamento, solidariedade, acesso, consórcios de saúde, modelos de oferta e contratualização das ações e serviços de saúde. Na capacidade de governo nas Redes de Atenção à Saúde e as instâncias de pactuação, as formas de conduzir, manobrar e superar que emergiram da análise foram a Comissão Intergestores Regional, a descentralização dos serviços de saúde e a intersetorialidade. Quanto à governabilidade e a governança, os entrevistados identificaram o gestor não ter tempo e/ou não priorizar os processos de planejamento e gestão, gestores como figuras políticas e sem preparação, o corpo técnico sem formação específica, os vazios assistenciais e a fixação de profissionais. Os resultados do presente estudo apontam pistas sobre caminhos possíveis a serem trilhados na temática da gestão e da regionalização da saúde.

Palavras–chave: Regionalização da Saúde. Gestão em Saúde. Governança em Saúde. Gestor de Saúde. Serviços de Saúde.

Regionalización de la salud y el Triángulo del Gobierno: reflexiones desde la perspectiva de los gerentes municipales de salud

Resumen

Este artículo analiza la percepción de los gestores municipales de salud sobre el proceso de regionalización de la salud en el Estado de Rio Grande do Sul. Tiene carácter cualitativo, empleando entrevistas semiestructuradas con ocho gestores municipales de salud, elegidos intencionalmente. En el abordaje teórico se utilizó el concepto de Triángulo de Gobierno, comparándolo con las categorías de análisis temático. En el proyecto de gobierno de regionalización de la salud, los medios y objetivos identificados fueron el Pacto por la Salud, el financiamiento, la solidaridad, el acceso, los consorcios de salud, los modelos de oferta y contractualización de acciones y servicios de salud. En la capacidad de gobierno en las Redes de Atención a la Salud y las instancias de concertación, las formas de conducción, maniobra y superación que surgieron del análisis fueron la Comisión Regional Intergestores, la descentralización de los servicios de salud y la intersectorialidad. En cuanto a la gobernanza y la gobernabilidad, los entrevistados identificaron al gestor sin tiempo y/o no priorizando los procesos de planificación y gestión, los gestores como figuras políticas y sin preparación, los técnicos sin formación específica, las lagunas de atención y la fijación de profesionales. Los resultados de este estudio apuntan pistas sobre posibles caminos a seguir en el tema de la gestión y regionalización en salud.

Palabras clave: Regionalización. Gestión en Salud. Gobernanza. Gestor de Salud. Servicios de Salud.

1 Introduction

Health regionalization is a strategy for organizing the supply of actions and services in the Brazilian Unified Health System (SUS). The first effort of the Executive Branch to translate the text of the Constituent Assembly was the decentralization of health management for municipalities, in order to offer health care closer to citizens

(Reis *et al*., 2017). From the 1990s until 2006, the reorganization of the territory focused on decentralization for municipalities as a new way of organizing health care. The first steps towards a new form of regional composition were established in the 2001 Health Care Operational Standard and, more consistently, in Ordinance No. 399/2006 of the Ministry of Health, which established the Pact for Health.

However, considering the demographic distribution of Brazil's over 5,000 municipalities, most of which have small populations (Lui *et al*., 2020), the pact for health has not proved sufficient to tackle issues related to access and financing at the different levels of health care (primary, secondary, and tertiary health care) that make up the Health Care Networks (*Redes de Atenção à Saúde* – RAS).

As a result, in 2011, with Decree No. 7.508, the concept of health region—considering a group of municipalities in the same territory—gained institutional status in the Brazilian public health system, effectively reorienting the organization of regionalization (Santos, 2017). Then, in 2018, Resolution No. 37 of the Tripartite Interagency Committee established another level of health regionalization in the SUS: health macro-regions—groupings of health regions in a state. The new form of reconfiguration sought to help strengthen the organization of the RAS, especially in terms of access to high-complexity services.

In this process of decentralization and regionalization, municipal health managers had to think about the organization of the health system beyond the municipal territory. It was, therefore, up to them to form agreements with other municipal managers with a view to regionalizing health in order to organize the citizen's access to different levels of health care and strengthen the health regionalization processes.

However, this is not a straightforward process; it involves disputes over financial, technological, and human resources, as well as the definition of reference health services. With this in mind, this study **aims** to understand the perception of municipal health managers on the process of health regionalization in the state of Rio Grande do Sul, in order to better understand how the idea of health regionalization was consolidated in this state.

The theoretical approach used was the concept of the government triangle, in its three interrelated variables: government project, government capacity, and governability (Matus, 2005; Aleluia *et al*., 2022). According to the author, the government project can be understood as the means and objectives that commit a change to the expected situation. Governing capacity, on the other hand, expresses the ability to lead, maneuver and overcome the difficulties of the proposed change. Lastly, governability is determined by the degree of acceptance or rejection of the project and the ability of social actors to back up their motivations (Matus, 2005). From this perspective, planning is understood as technopolitical and as the very act of governing.

2 Methodology

This is a qualitative study that used semi-structured interviews with eight municipal health managers chosen intentionally for their trajectory in the implementation of the SUS in Rio Grande do Sul. One representative was interviewed per health macro-Region (Midwest, Metropolitan, Missionary, North, Ridge, South,

CC BY

and Valley), along with the representative of the Council of Municipal Health Secretariats of Rio Grande do Sul (COSEMS/RS), totaling eight interviewees. This study is part of the research "*Análise dos processos de regionalização, gestão e planejamento para a implementação das Redes de Atenção à Saúde no Rio Grande do Sul*," which was approved by the Ethics Committee of the Faculdade Meridional de Porto Alegre (IMED)/Porto Alegre and the Health Research Ethics Committee of the School of Public Health of Rio Grande do Sul, under CAAE number 39496820.6.0000.5319.

The interviews, scheduled by phone, were carried out according to the availability of each interviewee. Data collection took place from August to October 2021, virtually, using the Cisco Webex platform, with each interview lasting 52 minutes on average. The strategy of digital interviews was chosen due to the COVID-19 pandemic, which was affecting the country at the time of data collection. When approached to take part in the study, none of the interviewees refused. Before data collection, participants were explained the purpose, methodology, data collection method, risks, and benefits of the research. Subsequently, each interviewee signed an informed consent form, respecting the ethical precepts of research involving human beings, in accordance with the resolutions of the National Health Council. In order to maintain the interviewees' anonymity, they were identified by health macro-Region and COSEMS/RS representation.

The interviews were recorded with the consent of the participants and then transcribed and analyzed using NVivo software. This software, specific to qualitative research, allows the identification of nuclei of meaning that favor qualitative analysis. The information obtained during the interviews was subjected to content analysis, which is defined as a set of communication analysis techniques that seek to obtain, by describing the content of recorded messages, indicators that make it possible to infer knowledge regarding the conditions of production and reception of these messages (Bardin, 2011).

For the content analysis, the thematic analysis technique was applied. This method seeks to discover the nuclei of meaning that make up a communication, using patterns or themes that are expressed or repeated and that have meaning for the desired analytical objective. Thus, thematic analysis proposes the study of the motivations, values, inclinations, attitudes, and beliefs of the interviewees (Bardin, 2011).

The categories used for analysis emerged from the central themes of the research (regionalization, regional planning, Health Care Networks, governance, and instances of agreement) together with the theoretical approach of the concept of Government Triangle (Matus, 2005). The description of this qualitative study was based on the Consolidated Criteria for Reporting Qualitative Research (COREQ), translated and validated for Brazilian Portuguese (Souza *et al*., 2021).

3 Results and discussion

Of the eight interviewees, four were women and four were men. The professions declared by the participants were: nurse, veterinarian, information technology, biologist, hospital manager, dental surgeon, and administrator. The length of time the interviewees had worked in the SUS ranged from 12 to 21 years,

CC BY

and three of them had already held the position of president of COSEMS/RS. In this sense, it has been pointed out that managers from the health sector favor the continuity of qualified management and facilitate municipal participation in regional planning (Medeiros *et al*., 2017).

3.1 The government project for health regionalization and regional planning

As the municipal health manager points out, changes in the regionalization of health are procedural, requiring the participation and protagonism of managers: "The processes of regionalization happen day by day. They seem to come all of a sudden. Actually, it does not work that way" (Interviewee from the North Health Macro-region).

In this vein, there are reflections on the reorganization of regionalization in the SUS, in other words, the sometimes very rapid transition from municipalities to health regions and then to health macro-regions is questioned without municipal health managers properly assimilating the importance of these different territorial sections. However, it can be said that regionalization processes are learned and built procedurally in everyday practice.

In turn, decentralization has brought greater responsibilities to municipalities in the management of health services and actions, in addition to expanding autonomy so that these federal entities can define where and how public funding will be applied. However, this autonomy is not guaranteed only by the process of health regionalization, requiring constant negotiation between entities, continuous funding, and other management tools for bottom-up and participatory planning (Silva *et al*., 2020). From this perspective, health financing as an inducer of regionalization processes is also an issue to be considered in the context studied.

> When the question of the Pact [for Health] came up, the studies, the first concern was: how much funding is going to be available? Will there be more funding? How is this going to happen? There was the whole situation of taking on more responsibilities (Interviewee from the North Health Macro-region).

> Managers were afraid to sign the Pact [for Health]. Why? Why were we afraid to sign the Pact? Because governments made promises and did not fulfill them. What can I say? They promised resources that did not come. You were accredited for some programs and there was no transfer (Interviewee from the Midwest Health Macro-region).

The process of health regionalization, more than a "living" territory, are the "locus" of planning, decision-making and agreements between SUS managers, which are then expressed as political arenas for construction (and sometimes disputes) around the composition of Health Care Networks, especially in aspects related to their financing.

In this segment, the interviewees expressed the view that regionalization, with the inducement of funding, helps to organize management processes and the provision of health actions and services. That is, adequate funding not only helps to define unilateral responsibilities, but also contributes to inter-managerial agreements being made in a solidary and shared manner, with the ultimate aim of making the SUS

CC BY

effective in the territory. The need for effective funding was also identified by municipal health managers in a study carried out in the state of Rio Grande do Sul (Arcari *et al*., 2020).

It should be noted that the process of negotiation and consensus-building in the Regional Inter-Managerial Commission (CIR) is carried out by way of a struggle over the financing of the SUS. This struggle unfolds in different spaces of dialogue that municipal health managers inhabit in order to align and articulate political issues, strengthening decision-making that can favor their municipalities and regions (Biscarde *et al*., 2019).

Thus, "The structuring of health care networks requires the establishment of a financing and investment policy to meet the care needs of the regions" (Martinelli *et al*., 2022, p. 10; our translation), as well as concrete intervention at the level of inter-managerial political negotiations. Composing this space of political disputes seems to be a challenge for advancing regionalization processes and the creation of Health Care Networks in the regional territory.

While the regionalization of health organizes the RAS, it also defines which services in the health region or health macro-region will receive financial contributions. This leads to disputes over contracting processes, especially for medium and high-complexity references.

From this perspective, according to municipal health managers, in order to build Health Care Networks, it is necessary to establish relationships of solidarity and co-responsibility—overcoming the logic of competition. Along these lines, collective pacts and agreements must be respected above individual interests, avoiding the fragmentation of the RAS. "We do not have competitiveness. We are all complementary [...] We have a harmonious relationship, a well-established relationship of competencies" (Interviewee from the Missionary Health Macro-region).

It should be noted that, although municipal health managers find it difficult to recognize themselves as sharing a common identity as a health macro-region, solidarity permeates the pacts of these managers in the organization of regionalization (Carvalho *et al*., 2017).

The municipal health manager of the Metropolitan Health Macro-region emphasized that the RAS must be prepared to serve SUS users regardless of the service they access and that this is one of the great challenges of health regionalization. At this juncture, well-established referral and counter-referral strategies, electronic medical records, flows, and regulation in the networks are essential to make health regionalization a reality.

The issue is that it is necessary to deconstruct the common belief among municipal managers that the public resources intended to finance health policies and actions, as well as the organization of the care network, are exclusively for the residents of their territory. It is still a challenge to build a more structural vision of the SUS and its public character, not restricted to a specific territory or population, but for all Brazilians, given the principle of universality.

Municipal health managers equally mentioned the need for organization by health micro-region. Notably, this concept comes from the initial health regionalization regulations of the 1990s and 2000s, especially the Basic Operational Norms (*Normas Operacionais Básicas* – NOBs) and the Operational Health Care

CC BY

Standard (*Normas Operacionais da Assistência à Saúde* – NOAS), which proposed dividing states into health micro-regions, setting up a territorial basis for regionalized planning, offered by care modules (Preuss, 2018). Thus, the question remains as to whether this form of organization helps to build agreements in the territory, so that municipalities that are closer to each other join forces to sign agreements with the aim of making Health Care Networks effective.

The interviewee from the Vales Health Macro-region brought up the issue of the participation of municipal managers in other forums, such as the Regional Health Councils, which were abolished in the state of Rio Grande do Sul in 2010. "We had the Regional Health Council, which was another body that was very strong before, which discussed a lot, worked together a lot" (Interviewee from the Valley Health Macro-region).

In one way or another, these councils, which are made up of equal numbers of managers, workers, and civil society, also contribute to the establishment of agreements that favor the regionalization of the SUS. It seems that the Regional Health Councils, active in Rio Grande do Sul in the 1990s and early 2000s, together with the municipalities, form the genealogical basis of regionalization in the state.

Health consortia also appear as part of the government project in the scenario studied, disputing the arrangements for regionalization and health agreements.

> It is important for you to know that the consortium is an aberration. Because the consortium was created to meet demands that the state does not fulfill [...] for a long time, the Regional Health Coordinating Bodies looked down on the consortium because they thought it was a competition with the state. Not us, we did not think so. It was an outlet" (Interviewee from the Midwest Health Macro-region).

> We understand—and this is already a discussion at the regional level that we have been having for a long time—that the consortium is not characterized as a service network because it does not have all the care that the user needs right from the start. What do we have? We have a specific consultation today, we have a specific exam. [...] It is not complete. It does not provide all the care the user needs. Which is one of the points of the care networks: they have to be comprehensive (Interviewee from the Vale Health Macro-region).

Health consortia play a supporting role in the Health Care Networks, since they offer health actions and services on a one-off basis, without effectively integrating them into the logic of the RAS, especially in terms of continuity of care and integration of the system, thus breaking with the principle of integrality of the SUS. However, health consortia should be seen as short- or medium-term alternatives for organizing the health system, defined by regional agreements. Thus, they should be provisional and integrated into the RAS, ultimately aiming to meet the constitutional requirements of the Unified Health System.

In addition, the controversy regarding the potential and the challenges of municipal health managers using health consortia to expand access to health care, it is important to understand that this is already a strategy used and that it has an impact as a governance mechanism in the regionalization of the SUS (Andrade *et al.*, 2022; Flexa; Barbastefano, 2020). Managers therefore need to understand and agree on how these devices will be used for the benefit of the SUS and the population.

CC BY

The interviewees also discussed the conception of the models for the provision and contracting of health actions and services, whether these should be public or in partnership with private entities, and how the ideology of the party in charge of health management can impact the government project.

3.2 Government capacity in Health Care Networks and instances of agreement

As part of the health regionalization process, progress was made from the Regional Management Board (known as COGERE in the state of Rio Grande do Sul) to the Regional Inter-Managerial Commission (*Comissão Intergestores Regional* – CIR). Thus, the field of correlation of forces evolved to create a powerful forum for articulating the demands of each health region. This was done so that the regional demands would have greater strength to be approved in other deliberative spaces of the SUS, such as the Bipartite Interagency Commission (*Comissão Intergestores Bipartite* – CIB) and the Ministry of Health itself.

> COGERE came to teach us how to work as a team, in a [health] region. And the CIR came to give us the legal backing for this. Like this: "no, you have power, you can decide at the regional level." If it is not decided in the region, it will not follow this, it will not go to the other instances (Interviewee from the Valley Health Macro-region).
>
> The CIR is very resolutive. It leaves it up to the region to discuss small demands. Because we sometimes saw discussions that could have been resolved within the CIR coming to a CIB, for example, because of differences between neighboring municipalities. So, I think that little by little and over time, especially in recent years, the state has empowered the Regional Health Coordinating Bodies a great deal, demanding from the legal representatives that demands of this kind no longer take on unnecessary proportions" (Interviewee from the Metropolitan Health Macro-region).

The CIRs develop coordination and cooperation mechanisms for the regionalization of the SUS, favoring autonomy and negotiation capacity between federative entities (Silva *et al*., 2020). In this sense, it is important for all the managers of a health region to participate in the CIR, so as to plan actions to respond to health demands, share common problems to seek regional solutions and exchange experiences on health management, with the aim of boosting regionalization (Medeiros *et al*., 2017).

On the other hand, it is questionable whether the CIR is, in fact, a space formally created and used to endorse decisions that have already been discussed, aligned, and even agreed upon in other instances (Teston *et al*., 2019). However, it seems that the use of this space for agreement will depend on the situational context and the uses that managers will constitute in these forums. Nevertheless, the CIR seems to be the privileged and legitimate space to discuss the shape and different arrangements for the RAS.

The regionalization processes also lead to the construction of autonomy, on the part of managers, to administer agreements at the regional level and the reality of their municipalities. From this perspective, changing the concept of access in the regionalization of health requires imaginative efforts to organize the RAS, as can be

CC BY

seen in the following excerpt: "A small municipality with 20,000 inhabitants, you want to bring a reference of 750,000 people into the municipality [...] "No, I think regionalization is for everyone" (Interviewee from the South Health Macro-region).

It is observed that the organization of the RAS should not be limited to large municipalities but should distribute care referrals throughout the region (Medeiros; Gerhardt, 2015), in order to facilitate access and avoid the concentration/centralization of health services. In turn, the contradictions in the implementation of the RAS organization agreement process were also pointed out by the managers interviewed.

> What we often see is some municipalities qualifying certain services, using a health region or surrounding municipalities to get qualified, and in fact this service is not provided for everyone, but only for their own population (Interviewee from the Valley Health Macro-region).

> It is not acceptable for each manager to think only of themselves, of their municipality, because the resources and qualifications are not for their municipality, they are for the health region [...] Many managers misappropriate this (Interviewee from the Metropolitan Health Macro-region).

The managers also discussed the fact that, even though there may seem to be (and sometimes there is) a long time between discussing and agreeing on medium- and high-complexity health services and actions, in the logic of the RAS, for the user it is very important, as it means decentralizing services and bringing in referrals to provide citizens with more adequate and timely access.

Notably, CIR meetings are important spaces for discussions and deliberations, as specific local issues and situations are debated (Nogueira *et al.*, 2021). These meetings usually have a set frequency and take place in person, with the participation of health managers from the municipalities in each health region. But with the COVID-19 pandemic, many of these meetings started to take place virtually.

In this sense, the interviewees pointed out that the way in which the agreement meetings are organized can also influence decision-making, because while some interviewees stated that online meetings facilitate the management process, others felt that this modality did not have the same dynamics and contribution as in-person meetings.

> Before, it took a lot of effort to get everyone together. The cost was very complicated, very high in terms of daily fees, commuting, and fuel. Today, since we can do it online, it has become very easy (Interviewee from the South Health Macro-region).

> In-person meetings are different. They have a different essence. They have a different kind of warmth. They are entirely different, I must say. I think online meetings are colder. They often do not allow for exchanges [...] So we see this in the territory. Often it is that hug that cannot be given, but it is that little nudge that keeps us there. We see so much complicity, so much that can be constructed there. I think that forms our network. The power of our network is there, in fact, when one municipality sees itself in the reality of another and tries to join in to help build up their health care systems (Interviewee from the Ridge Health Macro-region).

CC BY

According to the interviewees, the in-person meetings made the exchange between managers explicit, making it easier to understand the territorial complexities of organizing health management and regionalization. But on the other hand, virtual meetings can be more objective, allow greater participation by managers and involve lower financial costs.

The manager of the Missionary Health Macro-region discussed the fact that care in Health Care Networks does not only involve issues related to health, but also social assistance, education and other areas of the government and civil society, which means that integration is needed in order to create care networks. "But the integration of the care system has created safety nets. It's not always financial, it's sometimes the ability to understand your territory" (Interviewee from the Missionary Health Macro-region).

Thus, there seems to be a degree of openness for the CIR, at certain times and depending on the issues debated, to integrate intersectoral actors into the discussion and decision-making process of municipal and regional health managers, with a view to shaping the RAS.

Along these lines, intersectorality has historically been understood as a strategy for care and the composition of Health Care Networks, especially in the area of Mental Health and Primary Health Care (Tãno; Matsukura, 2019). These powerful experiences can help us think about RAS arrangements beyond the technological and structural dimension, moving towards a relational perspective that effectively offers users the right to health, in an integrated manner and respecting the provisions of the constitution.

3.3 Governability and governance: acceptances and rejections

The changes in the processes of health regionalization bring various challenges, especially in the reorganization of care and management practices. These challenges involve the need to understand the advances in health policy and daily work. This can be seen in the statements of the managers interviewed.

> Because when a new regulation comes along, a situation, "is it more for us?". No, it is more benefits for our community. It is our job. I always say: "It's a good thing we are in demand, otherwise we would not need to be working." So, we still see a lot of difficulty, a lot of resistance (Interviewee from the North Health Macro-region).

Notably, having proper management teams in the municipalities, with permanence and secure employment ties, training for health planning and regionalization, are essential aspects that contribute to strengthening Health Care Networks. Likewise, the time dedicated by municipal managers to participating in the agreement scenarios also appears to be a necessity for achieving governability in the scenario studied.

> What do we notice now? In the CIR meetings, this issue of obligation, commitment, the participation of managers, which I think is extremely important. Because this is a time for discussion [...] It is an important space for discussion. I think there's still a lack of greater appreciation on the part of managers, prioritization on the part of managers, mayors too, with the issue of CIR meetings. Because in these CIR meetings we are deciding on

CC BY

> regionalization effectively [...] Having more experience in the municipality, I can see that the more time I dedicate to planning, the less demand there is on my doorstep (Interviewee from the North Health Macro-region).

In a study carried out with 2,313 managers, from 2017 to 2018, as part of the National Survey of Municipal Health Secretaries, the importance of training the teams that work in health management was identified, as well as the need to provide workers, aiming to produce greater institutionality in health regionalization processes (Ouverney *et al*., 2019).

The involvement of municipal managers in the health planning process is central to organizing and structuring the SUS, in other words, it is a strategy aimed at overcoming the difficulties of health management. In the meantime, regionalization and decentralization have become means of facilitating decision-making and governance, with the aim of establishing dialogue, negotiations, and agreements between managers at different levels of government, making the planning process a lively and dynamic movement that can respond to the population's health needs.

From this perspective, planning must be a priority on the agenda of public managers and not merely a normative act, which often fails to reflect the government's priorities and the health needs of the territory. In turn, the retention of professionals in remote parts of the Health Care Network and care gaps were also mentioned as challenges for the regionalization process.

> The countryside pays more, it has to pay more to keep its professionals, otherwise it will never be able to keep its services open, maintain care referrals or sometimes even meet or fulfill the targets that are demanded (Interviewee from the South Health Macro-region).

> So, it is important to encourage health resources to be allocated on a regional, decentralized basis, so that we can make it possible for certain health regions not to have so many care gaps that the population migrates from one region to another (COSEMS/RS Representative interviewee).

The challenges of health regionalization in terms of care gaps, the concentration of services in metropolitan regions, the establishment of professionals, health regulation, and the "scattering of small hospitals, with low resolubility and occupancy" were also identified in a study carried out in the state of Bahia (Almeida *et al*., 2016, p. 330).

On the other hand, according to the interviewees, the regionalization of health as a strategy to overcome the fragmentation of the system is also crossed by political and sometimes partisan issues, which can facilitate or hinder the process.

> If you want to be a reference for a region, you are going to have to receive a lot of resources. Then everything depends on the deputies, everything depends on the Ministry of Health, everything depends on pressure on the Ministry of Health, everything depends on pressure on the Governor to accept your city as an important [health] macro-region. So, everything is politics. [...] Even if it is approved by the CIB, sometimes you need political regulation to get resources. [...] Many mayors see the health secretariat as a gateway to votes [...] We still see many secretaries who are just

CC BY

> politicians and not technicians. This greatly hinders the issue of planning and organization (Interviewee from the Midwest Health Macro-region).

The processes of agreeing on the regionalization of health are pendular, that is, they involve the technical and political movements of health managers in the different instances of agreement, such as the Regional Interagency Commission, the Bipartite Interagency Commission, and the Tripartite Interagency Commission. This shows that the impasses surrounding the regionalization process permeate economic interests, political clashes, competitiveness between federal entities and governance (Silveira Filho *et al.*, 2016).

In this sense, the vision of municipal health managers must be considered since they play a crucial role in the process of regionalizing the SUS. And they are the ones who will effectively operationalize federal and state health regulations, based on local and regional specificities.

4 Final considerations

The municipal health managers interviewed have extensive experience in the SUS and in the process of regionalizing health. The interviews show the ability of these actors to move away from the reality of their municipalities towards a consistent reflection on regional agreements and instances of agreement in the territory of Rio Grande do Sul. By making this move, they contributed to the reflection on the process of health regionalization and regional planning in Rio Grande do Sul, providing important elements for thinking about these issues in other scenarios.

In the government's project, regarding the regionalization of health and regional planning, the means and objectives identified were financing, solidarity, access, health consortia, supply models, and the contracting of health actions and services. In terms of government capacity in Health Care Networks and the instances of agreement, the ways of leading, maneuvering, and overcoming that emerged from the analysis were the Regional Interagency Commission, the deconcentration/decentralization of health services, intersectorality and the participation of social control.

In terms of government capacity in Health Care Networks and the instances of agreement, the ways of leading, maneuvering, and overcoming that emerged from the analysis were the Regional Interagency Commission, the deconcentration/decentralization of health services, intersectoriality and the participation of social control. It should be noted that, depending on the perspective adopted, acceptance factors can become project rejection factors and vice versa.

Furthermore, the interpretative effort based on the Matusian Theory of the Government Triangle does not summarize the processes of health regionalization in the scenario studied, given the complex web of interwoven relationships. However, it can offer us clues as to possible paths to be followed in the area of health management and regionalization.

The limitations of this study include the methodological design of the qualitative research, which allowed us to build some clues to understand the issues arising from the interviewees' statements but did not contribute to the establishment of inferences and extrapolations. However, these reflections can help delve deeper into aspects of the regionalization of health from the perspective of

CC BY

municipal health managers, aiming to explain the challenges of strengthening management processes in the SUS.

From this perspective, it seems that health planning and regionalization have a challenging agenda for strengthening the SUS, with goals such as: tackling the underfunding of the public system; overcoming health inequalities; eradicating infectious and parasitic diseases as far as possible; tackling the epidemiological transition; adequately training health professionals and managers to work in the SUS; strengthening management and decision-making processes; and providing users with adequate access to health actions and services—challenges that have the potential to become analytical objects to be explored in future studies.

In conclusion, for health planning to be feasible and executable, political support, adequate funding and social participation in the defense and implementation of the SUS are necessary. As much as health planning and regionalization contribute to organizing the public health system, these strategies alone will not account for all the necessary changes. Another kind of governance—a broader, more participatory process involving different players, transcending governance—needs to be put into effect. This will give health planning and regionalization a better chance of being implemented and fulfilling their essential potential in Brazil's public health system.

REFERENCES

ALELUIA, Ítalo Ricardo Santos; MEDINA, Maria Guadalupe; VILASBÔAS, Ana Luíza Queiroz; VIANA, Ana Luiza D'Ávila. Gestão do SUS em regiões interestaduais de saúde: análise da capacidade de governo. **Ciência & Saúde Coletiva**, Rio de Janeiro, v. 27, n. 5, p. 1883-1894, 2022. DOI: https://doi.org/10.1590/1413-81232022275.10392021

ALMEIDA, Patty Fidelis de; SANTOS, Adriano Maia dos; SANTOS, Valdomiro da Paixão; SILVEIRA FILHO, Roberto Moreira. Integração assistencial em região de saúde: paradoxo entre necessidades regionais e interesses locais. **Saúde e Sociedade**, São Paulo, v. 25, n. 2, p. 320-335, 2016. DOI: https://doi.org/10.1590/S0104-12902016153295

ANDRADE, Silvia Karla Vieira; MENDONÇA, Fernanda de Freitas; ENDLICH, Angela Maria; GONZALEZ, Alberto Durán. Consórcio Público de Saúde no processo de regionalização: análise sob o enfoque da ação coletiva. **Physis:** Revista de Saúde Coletiva, Rio de Janeiro, v. 32, n. 1, p. e320107, 2022. DOI: https://doi.org/10.1590/S0103-73312022320107

ARCARI, Janete Madalena; BARROS, André Phylippe Dantas; ROSA, Roger dos Santos; MARCHI, Renato De; MARTINS, Aline Blaya. Perfil do gestor e práticas de gestão municipal no Sistema Único de Saúde (SUS) de acordo com porte populacional nos municípios do estado do Rio Grande do Sul. **Ciência & Saúde Coletiva**, Rio de Janeiro, v. 25, n. 2, p. 407-420, 2020. DOI: https://doi.org/10.1590/1413-81232020252.13092018

BARDIN, Laurence. **Análise de conteúdo**. 70ª Edição. Lisboa: Edições, 2011.

BISCARDE, Daniela Gomes dos Santos; VILASBÔAS, Ana Luiza Queiroz; TRAD, Leny Alves Bonfim. Consenso e pactuação regional entre gestores do SUS no nordeste do Brasil. **Ciência & Saúde Coletiva**, Rio de Janeiro, v. 24, n. 12, p. 4519-4527, 2019. DOI: https://doi.org/10.1590/1413-812320182412.25922019

CARVALHO, Andre Luis Bonifácio de; JESUS, Washington Luiz Abreu de; SENRA, Isabel Maria Vilas Boas. Regionalização no SUS: processo de implementação, desafios e perspectivas na visão crítica de gestores do sistema. **Ciência & Saúde Coletiva**, Rio de Janeiro, v. 22, n. 4, p. 1155-1164, 2017. DOI: https://doi.org/10.1590/1413-81232017224.30252016

FLEXA, Raquel Gonçalves Coimbra; BARBASTEFANO, Rafael Garcia. Consórcios públicos de saúde: uma revisão da literatura. **Ciência & Saúde Coletiva**, Rio de Janeiro, v. 25, n. 1, p. 325-338, 2020. DOI: https://doi.org/10.1590/1413-81232020251.24262019

LUI, Lizandro; SCHABBACH, Letícia Maria; DALLA NORA, Carlise Rigon. Regionalização da saúde e cooperação federativa no Brasil: o papel dos consórcios intermunicipais. **Ciência & Saúde Coletiva**, Rio de Janeiro, v. 25, n. 12, p. 5065-5074, 2020. DOI: https://doi.org/10.1590/1413-812320202512.03752019

MARTINELLI, Lúcia Martinelli *et al*. Regionalização e Rede de Atenção à Saúde em Mato Grosso. **Saúde e Sociedade**, São Paulo, v. 31, n. 4, p. e210195pt, 2022. DOI: https://doi.org/10.1590/S0104-12902022210195pt

MATUS, Carlos. **Triângulo de Governo**. Caracas: Strategia Consultores LTDA, 2005.

MEDEIROS, Cássia Regina Gotler *et al*. Planejamento regional integrado: a governança em região de pequenos municípios. **Saúde e Sociedade**, São Paulo, v. 26, n. 1, p. 129-140, 2017. DOI: https://doi.org/10.1590/S0104-12902017162817

MEDEIROS, Cássia Regina Gotler; GERHARDT, Tatiana Engel. Avaliação da Rede de Atenção à Saúde de pequenos municípios na ótica das equipes gestoras. **Saúde em Debate**, Rio de Janeiro, v. 39, n. spe, p. 160-170, 2015. DOI: https://doi.org/10.5935/0103-1104.2015S005201

NOGUEIRA, Maria Sônia Lima; OLIVEIRA, Lucia Conde de; COSTA, Liduína Farias Almeida da. Comissão Intergestores Regional como mecanismo de governança da política de saúde no Ceará. **Saúde em Debate**, Rio de Janeiro, v. 45, n. 129, p. 263-274, 2021. DOI: https://doi.org/10.1590/0103-1104202112901

OUVERNEY, Assis Luiz Mafort; CARVALHO, Andre Luis Bonifácio de; MACHADO, Nádia Maria da Silva; MOREIRA, Marcelo Rasga; RIBEIRO, José Mendes. Gestores municipais do Sistema Único de Saúde: perfil e perspectivas para o Ciclo de Gestão

2017-2020. **Saúde em Debate**, Rio de Janeiro, v. 43, n. spe 7, p. 75-91, 2019. DOI: https://doi.org/10.1590/0103-11042019S706

PREUSS, Lislei Teresinha. A gestão do Sistema Único de Saúde no Brasil e as regiões de fronteira em pauta. **Revista Katálysis**, Santa Catarina, v. 21, n. 2, p. 324-335, 2018. DOI: https://doi.org/10.1590/1982-02592018v21n2p324

REIS, Ademar Arthur Chioro dos; SÓTER, Ana Paula Menezes; FURTADO, Lumena Almeida Castro; PEREIRA, Silvana Souza da Silva Reflexões para a construção de uma regionalização viva. **Ciência & Saúde Coletiva**, Rio de Janeiro, v. 22, n. 4, p. 1045-1054, 2017. DOI: https://doi.org/10.1590/1413-81232017224.26552016

SANTOS, Lenir. Região de saúde e suas redes de atenção: modelo organizativo-sistêmico do SUS. **Ciência & Saúde Coletiva**, Rio de Janeiro, v. 22, n. 4, p. 1281-1289, 2017. DOI: https://doi.org/10.1590/1413-81232017224.26392016

SILVA, Renan Carlos Freitas da; SANTOS, Erlene Roberta Ribeiro dos; MARTELLI, Petrônio José de Lima; SOBRINHO, José Eudes Lorena; SOUTO, Camila da Costa Lima. A governança e o planejamento na perspectiva regional de saúde. **Physis**: Revista de Saúde Coletiva, Rio de Janeiro, v. 30, n. 3, p. e30033, 2020. DOI: https://doi.org/10.1590/S0103-73312020300331

SILVEIRA FILHO, Roberto Moreira; SANTOS, Adriano Maia dos; CARVALHO, Jamille Amorim; ALMEIDA, Patty Fidelis de. Ações da Comissão Intergestores Regional para gestão compartilhada de serviços especializados no Sistema Único de Saúde. **Physis**: Revista de Saúde Coletiva, Rio de Janeiro, v. 26, n. 3, p. 853-878, 2016. DOI: https://doi.org/10.1590/S0103-73312016000300008

SOUZA, Virginia Ramos dos Santos; MARZIALE, Maria Helena Palucci; SILVA, Gilberto Tadeu Reis; NASCIMENTO, Paula Lima Tradução e validação para a língua portuguesa e avaliação do guia COREQ. **Acta Paulista de Enfermagem**, São Paulo, v. 34, p. eAPE02631, 2021. DOI: https://doi.org/10.37689/acta-ape/2021AO02631

TÃNO, Bruna Lidia; MATSUKURA, Thelma Simões. Intersetorialidade e cuidado em saúde mental: experiências dos CAPSij da Região Sudeste do Brasil. **Physis**: Revista de Saúde Coletiva, Rio de Janeiro, v. 29, n. 1, p. e290108, 2019. DOI: https://doi.org/10.1590/S0103-73312019290108

TESTON, Luci Maria; MENDES, Áquilas; CARNUT, Leonardo; LOUVISON, Marília Cristina Prado. Desafios políticos e operacionais na percepção de gestores sobre a regionalização em saúde no Acre. **Saúde em Debate**, Rio de Janeiro, v. 43, n. 121, p. 314-328, 2019. DOI: https://doi.org/10.1590/0103-1104201912102

CC BY