Care integration in a health region: a paradox between regional needs and local interests[1]

Integração assistencial em região de saúde: paradoxo entre necessidades regionais e interesses locais

Patty Fidelis de Almeida
Universidade Federal Fluminense. Departamento de Planejamento em Saúde. Niterói, RJ, Brazil.
E-mail: pattyfidelis@id.uff.br

Adriano Maia dos Santos
Universidade Federal da Bahia. Instituto Multidisciplinar em Saúde. Vitória da Conquista, BA, Brazil.
E-mail: maiaufba@ufba.br

Valdomiro da Paixão Santos
Universidade Federal do Recôncavo da Bahia. Centro de Ciências da Saúde. Santo Antônio de Jesus, BA, Brazil.
E-mail: valdopsantos@gmail.com

Roberto Moreira Silveira Filho
Universidade Federal da Bahia. Instituto Multidisciplinar em Saúde. Vitória da Conquista, BA, Brazil.
E-mail: roberto.ibce@bol.com.br

Abstract

This study aims to identify and analyze the development of regional strategies for care integration in the context of health regions, with special focus on the role of Primary Health Care (PHC). It was analyzed the minutes and observed the meetings of the Regional Intermanagers Commission (CIR) in a period of one year and also eleven interviews with municipal, regional, and state managers of Bahia, Brazil. The results indicate that PHC is an uncommon topic in the discussions of CIR, although the health region faces problems in common with other regions of Bahia and Brazil, such as the predatory dispute for doctors and poor coordination of care. The goal of forming Health Care Networks, coordinated by PHC, is still a distant goal against the urgent need to ensure access to specialized and urgency/emergency care in the health region, an issue that dominated the discussions of CIR, and PHC was limited only to city boundaries.

Keywords: Systems Integration; Regional health planning; Integrality; Health management.

Correspondence
Patty Fidelis de Almeida
Universidade Federal Fluminense. Rua Marquês do Paraná, 303 - 3 andar, prédio anexo ao HUAP, Centro - CEP: 24030-210 Niterói, Rio de Janeiro.

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Resumo

Este estudo tem como objetivo identificar e analisar o desenvolvimento de estratégias regionais para a integração assistencial no contexto das regiões de saúde, com especial foco no papel da Atenção Primária à Saúde (APS). Foi realizada análise das atas e observação das reuniões de uma Comissão Intergestores Regional (CIR) no período de um ano e também onze entrevistas com gestores/gerentes municipais, regionais e estaduais do estado da Bahia. Os resultados indicam que a APS é um tema pouco frequente nas discussões da CIR, embora a região de saúde enfrente problemas em comum a outras regiões da Bahia e do Brasil como a disputa predatória por médicos e fraca coordenação do cuidado. A meta de conformação de Redes de Atenção à Saúde, coordenadas pela APS, ainda é um objetivo distante diante da premência de garantir acesso à atenção especializada e de urgência/emergência hospitalar na região de saúde, tema que dominou as discussões da CIR, ficando a APS circunscrita aos limites municipais.

Palavras-chave: Integração de Sistemas; Regionalização; Integralidade; Gestão em saúde.

Introduction

Decentralization of health presented countless advances to subnational realms in the management of city health systems (Pasche et al., 2006) and, to some extent, increased the coverage and access of the population to health services, mobilized the organization of services based on local issues and on the incorporation of new social actors, besides enabling greater participation and social control in the definition and budget execution of health care expenses, strengthening the autonomy and responsibility of each subnational entity (Guimarães; Giovanella, 2004). However, it created some undesirable and paradoxical effects in the consolidation of the integrality of the Brazilian National Health System (SUS) care (Campos, 2006; Pasche et al., 2006).

Besides, the decentralization collides with the financial and managing asymmetry of different levels of government, as well as with the permeability of health institutions to democracy, by imposing constraints that mitigate the power of the remaining principles and guidelines of SUS and complicate the consolidation of a national health policy, whose federal model is triune, without a hierarchical binding between the entities (Federal Government of Brazil, states, and cities), often strengthening the competition against cooperation (Levcovitz et al., 2001; Santos; Campos, 2015).

Some evidences confirm this debate, from the analysis of decentralization in the management of SUS in five cities of Bahia selected as "*exemplary cases*" (Vieira-da-Silva et al., 2007), which show positive aspects, as broadening of health care coverage of primary actions and of access to services of medium and high technological density, but, much more tied to the ministerial induction than to local action, they suggest limits in the city propositional capacity or technical failure. Nevertheless, despite the advanced degree of decentralization, the "full system management" presented many heterogeneities between the investigated cities, not meaning "automatic improvements in the management, organization of practices, and their effects", i.e., "decentralization in itself was not able to ensure changes in local health systems" (Vieira-da-Silva et al., 2007, p. 366).

The picture forged by decentralization to the Brazilian health policy conceived a peculiar system, in which the city (minor instance with formal power in the Republic) is responsible for the organization and local management, differing, for example, from the national system of England, Portugal, and Cuba, or the provincial one of Canada and the autonomous of Spain (Campos, 2006). However, decentralization alone is not enough to enable the principles and guidelines of SUS, creating, even, paradoxical effects. On the one hand, it responds to the ethical-political value sought by the democratic spirit, in enabling the distribution of power and expansion of social participation mechanisms; on the other, the centripetal forces generated by decentralization can produce an autarchic operation, empowering the undesirable fragmentation of the system, "generating a municipalization process with low capacity for integration and solidarity between the parties" (Campos, 2006 , p. 427).

Indeed, such evidences expose the need for inter-city joints that make room for "the profusion of new forms of relationship between State and society, placing under public discussion the foundations of the power structure, organization and management of the existing political institutions" (Fleury; Ouverney, 2007, p. 11), providing a new governance model that combine decentralization with the need for a solidary integration of health systems.

In 2006, the Brazilian Ministry of Health (MS) published Ordinance no. 399/GM, which contemplates the Guidelines of the Pact for Health, for Life, of Management and in Defense of SUS and brings back on the political agenda new bases of negotiation for funding, definition of responsibilities, health goals, and commitment among the three levels of management. This document proposes significant changes to the management of SUS, resuming the regional health planning as key guideline in the policies to enable the care integration in the territories. To this end, it revisits and updates the tools experimented in the Health Care Operational Norm (NOAS), such as the Directive Regional Health Planning (PDR) and the Agreed and Integrated Programming (PPI), consolidating them into a set of institutional reforms agreed between the three federate entities, replacing the habilitation process for solidary joining the Commitment Terms of Management (TCG), constituting regional planning and co-management spaces, represented by the Regional Management Collegiates (CGR), in a process of "living regionalization" (Brasil, 2006, 2007).

The regulation of this space, represented by the Regional Intermanagers Commission (CIR), was established by Decree no. 7,508, from June 28, 2011, which established its operation in health regions (Brasil, 2011). CIR aims at the agreement and solidary cooperation between participants so that the health region is strengthened (Vianna; Lima, 2013; Santos; Giovanella, 2014).

The success of the initiatives developed through CIR depends on how efficient is the progress of the negotiations and of co-management, i.e., it requires the commitment to public affairs in a solidary perspective (Lima et al., 2012; Santos; Giovanella, 2014). In this perspective, the strengthening of governance in health region "can clump what decentralization, by itself, fragments" (Santos; Campos, 2015, p. 441) and overcome the challenges to care integration in regionalized network.

The user's difficulty in accessing the medium density technology services would be one of the obstacles in the execution of the integrality principle in SUS (Spedo; Pinto; Tanaka, 2010). In addition to this, there is the fact that, in Brazil, the adoption of health policies based on the logic of installed supply is historical, i.e., epidemiological characteristics and health needs of the population not necessarily ground planning (Solla; Chioro, 2014; Paim, et al., 2011). By this aspect, the unarticulated demand of supply makes it even more difficult to access services of medium and high density, inflating the system, and this is one of the generating reasons of dissatisfaction, especially on the part of users (Dubeux; Carvalho, 2009).

Based on these reflections, this study aimed to identify and analyze the development of regional strategies for care integration in a health region, focusing on the role of Primary Health Care (PHC). The look on the topic of PHC is justified to the extent that its implantation, in all Brazilian municipalities, represents more convincingly the directions of the decentralization process in the country. However, we start from the premise that the construc-

tion of regionalized networks necessarily passes through the encounter of the local and regional realms in the establishment of a solution that is good, encompassing, and with potential to assume the coordination of care beyond the city limits.

Methodology

This is a case study (Yin, 2005), with qualitative nature (Flick, 2009), held in a health region of Bahia, which comprises 23 cities (Bahia, 2012). The study was part of a broader research, held between 2012-2013, called *O papel da Atenção Primária à Saúde na coordenação do cuidado em redes regionalizadas em regiões de saúde da Bahia* (The role of Primary Health Care in the coordination of care in regionalized networks in health regions of Bahia), funded by the National Council of Scientific and Technologic Development (CNPq), Edital Universal 14/2011.

The information sources of the study were observation of monthly sessions and analysis of procedings of the meetings of a CIR, in 2012; and 11 semi-structured interviews, 7 of them with city managers (City managers: 1, 2, 3, 4, 5) and regional managers (Regional managers: 6, 7) of the health region, and 4 interviews with state managers (State managers: 8, 9, 10, 11) of the State Secretariat of Health of Bahia (Sesab).

In 2012, nine meetings of CIR took place (ordinary and extraordinary), and the October, November, and December sessions were cancelled because of the election period. Five observations were carried out and the nine proceedings available in the Bahian Observatory of Regionalization were analyzed.

In the methodological-theoretical perspective, many concepts exist in the literature to designate the nature of the ways of organization of systems, services and health care. To minimize dispersion of interpretations, in this investigation, we adopted concepts of "Regional governance", "Health care Networks", "Care integration", "Primary Health Care", and "Health Region" that are widespread for understanding the regionalization in health, presented in Chart 1.

Chart 1 – Conceptual summary of terms used in the process of regionalization

Concept	Summary of some theoretical definitions	Adopted references
Regional governance	One of the components of a regionalized network. Understood as a process of participation and negotiation between a wide range of subjects with varying degrees of autonomy. It represents diversity of interests (public and private) in a stable institutional framework that encourages cooperation between governments, agents, organizations, and citizens, in order to establish links and networks between subjects and institutions. It must involve the ways of exercise of authority and the processes of integration of social interests in the government agenda, and it may be used as analytical tool for research and transformation of the policy-making processes and health systems management. The analytic use of governance allows one to describe and explain the interactions of actors, processes, and rules of the game and, thus, achieve better understanding of conducts and decision-making in society.	Hufty, Bascolo, Bazzani (2006) Mendes (2010) Santos, Giovanella (2014) Viana, Lima (2011)
Health care Networks (HCN)	Sets of health services, linked to each other by a single mission, by common goals, and by a cooperative and interdependent action, which allow to offer a continuous and integral attention to a particular population, coordinated by primary health care – provided at the right time, in the right place, with the right cost, with right quality, and in a humanized way –, and with sanitary responsibilities for this population, in a given territory. HCNs have as constituent elements the population, the operational structure, and the model of care. The focus on building HCNs with integrated services and coordinated care bases on the PHC teams the leadership to reorientate health systems.	Mendes (2010) PAHO (2008) PAHO (2009) WHO (2008)

continue...

Chart 1 – Continuation

Concept	Summary of some theoretical definitions	Adopted references
Health care integration	It is opposed to fragmented models, i.e., it is the search for fleshing out an organicity to health systems. It is supported on three axes: the service offer, continuously, through several points of health care; the integration of these health care points, by means of a clinical management system, and the existence of a registered population, whose health is unequivocal responsibility of the system. The main points of the health system integration mold a Health care Network.	Armitage and col. (2009) Mendes (2001) Vazquez and col. (2009)
Primary Health care (PHC)	PHC is the key component in the organization of HCN, and must be the communication center. It is up to the PHC to coordinate the system's flows and counterflows, be decisive, welcome and be responsible by the demands of the population, with power to coordinate the continuing care, through the appropriate chaining of the other components of the network. This is a set of services of first contact of the user with the health system, of easy access, directed to cover the most common diseases and conditions and solve most health problems of a population.	Ordinance no. 2,488 (Brasil, 2012) Giovanella, Mendonça (2014) Mendes (2010) WHO (2008)
Health Region	Privileged spaces for integration of health services, having as starting point the Regional Directive Plan, but doing the appropriate compositions that respond appropriately to the dynamics of the territories, encouraging intermanaging cooperative action. The region, therefore, is the result of the dialectic between two types of logic: one that is given by the internal arrangements of each regional division of labor (which is more the result of historical formation, spontaneous of regions) and another that is expressed by the increasingly acute influence of external vectors (whether they are standards, flows of information, of capital, of goods, of investments, etc.), which install on these pre-existing combinations their organizational nexus.	Almeida, Santos, Souza (2015) Contel (2015) Decree 7,508 (Brasil, 2011) Ianni et al. (2012). Machado (2009)

For results analysis, as a common step, we conducted the "ordering of data", which consisted in the first contact with the empirical material collected (proceedings, field journal reports of the observations, and transcripts of the interviews). Secondly, we did the "classification of material" collected, stage in which the proceedings and interviews were read exhaustively, and the parts with the relevant structures and main ideas (meaning cores) were selected, grouped, and classified. We conducted the confrontation of the relevant structures and then followed to compare the different data of the different sources of information. The analyses of the proceedings and meetings of CIR were guided by the main goal of identifying the most recurrent topics, indicating the health priorities guided by managers, the processes of negotiation, agreement, and planning for the reach of health care integration, with special focus on the role of PHC in regional context. Interviews with people of the many management realms of SUS complement the findings and seek to clarify nodal points to face the challenges to health care integration, as well as the advances in the formation of regionalized networks.

Finally, the results and discussion were grouped into four empirical categories: I) Organization of Primary Health Care in the regional context; II) Importance of CIR for regional governance; III) Planning of the Urgency and Emergency Network: revealing the functioning of the regional network; IV) Supply and regulation of specialized and hospital care in the health region.

The project was approved by the Research Ethics Committee of Faculty Maria Milza (Opinion no. 323/2011).

Results and discussion

Organization of Primary Health Care in the regional context

All cities in the region, according to the seat city manager, have achieved high coverage by the

Family Health Strategy (ESF) before the organization of any type of Health Care Network:

> *Primary Care was built before any formation of networks. So, all cities from micro to the formation of any kind of network, of urgency and emergency, for example, had to have at least 50% coverage from Primary Care* (City manager, respondent 1).

The small size of the cities was also mentioned as a facilitator for the reach of high coverage.

The observation in the sessions and analysis of proceedings of CIR indicated that PHC was an uncommon topic, and little discussed in the meetings. According to members of CIR, since the cities had achieved high coverage by ESF, this would not be a priority topic for the debate on regional instance, and the urgency was posed by other topics, such as the implantation of the Urgency and Emergency Network. The moments in which the topic was part of the guidelines were the ones necessary for the approval of new Family Health Teams (EqSF) and Family Health Support Centers (NASF), besides some demands of permanent education in health (although limited to specific capacities).

We did not identify initiatives to build care lines structured in the perspective of the health region that ensured the continuity of care for the user, coordinated by EqSF. In this sense, the care lines for projects built regionally were limited to the urgency and emergency network, standing out the integrated services through the Mobile Urgency Care Service (Samu)

The rotation of professionals was also a topic present in the discussions about PHC in the region and it occurred, according to the managers, not only in the scope of ESF, but also between the professionals of other levels of care, aggravated by the precariousness of labor links and by the absence of a policy for labor management. Therefore, all efforts made by managers for training and permanent education that aimed at improving the work process, especially on PHC, were always starting over, compromising the continuity of care in the teams.

In addition, state managers highlighted that the teams remained long periods without doctors and, in that plot, the health secretaries needed to make the workload in EqSF more flexible. Thus, respondents evaluated that the ESF has been greatly damaged by the rotation, because the frequent changes in the composition of teams compromised the coordination and the continuity of care, requiring new educational processes to qualify the newly hired, since many professionals were hired without experience and/or without a suitable profile for PHC.

The precariousness of health work culminated with the dismissal of professionals in the pre and post-election period, also highlighting the lack of commitment with the continuity of public policies. Such issue was a topic of discussion in CIR, justified by the need of rendering of accounts to the Federal Court of Accounts (TCU) before the end of the municipal mandate, and it was not limited to the scope of PHC.

The lack of doctors was a problem mentioned by all respondents of Sesab, especially for the cities more distant from the seat of the health region. This issue ended up compromising the entire network structure, because a PHC without adequate coverage or unstructured reflected in overload for the remainder of health services, and in access by not appropriate ways. Interviews with managers and observation of the meetings of CIR confirmed the difficulty for fixation of doctors as a common problem among the cities of the region.

However, the predatory dispute for doctors prevailed, in a sort of "auction": "*You, doctor, come here, I offer you two more shifts off, I give you R$100 more than that city*" (City manager, respondent 1). Thus, cities, individually, were seeking alternatives for the provision of doctors, such as the creation of cooperatives, responsible for recruitment and capitation of new professionals. The offer of weekly days off was also an attractive, which put in disadvantage those managers who demanded the enforcement of the workload. The opening of new medical courses in Bahia, in which a historical deficit in the supply of job was mentioned, also proved to be an important policy

to face this issue, even if with results only in the medium and long term.

Besides, for the managers interviewed, the establishment of Samu and of the Regional Hospital was a factor that favored the attraction and fixation of doctors for the ESF, for the possibility to combine the work on PHC with the conduction of shifts and actions in specialties.

Another finding of the study was the lack of awareness of the managers of the seat city in relation to the dynamics and situation of PHC in regional context. When they were asked about issues relating to the functioning of PHC in the health region, as well as their possibilities to coordinate care at regional level, their speeches were systematically forwarded to the city context:

> *We do not agree with the neighboring cities on the issue of primary care, so it is more medium and high complexity. Thus, in relation to ESF with the neighboring cities there is not* [...] *health unit, health team, there is not much exchange, not a lot of, let us say, relation* (City manager, respondent 2).

Such evidence confirms the need of comprehension, by the managers, that PHC is a strategy that must involve all the cities, from the perspective of thinking the network from "end to end". Besides, even if PHC is a municipal responsibility, CIR could represent an area of planning and agreement of the quality of supply of services of first contact, in addition to share strengthening mechanisms of the clinic and of the working process of ESF professionals to minimize referrals and "unnecessary" spending for higher-density technology services.

The focus on building networks with integrated services and coordinated care bases on the PHC teams the leadership to reorientate health systems. In this direction, the World Health Organization (WHO) and the Pan-American Health Organization (PAHO) declare and recommend, in reports and documents, the building of health systems based on Primary Health Care, in a comprehensive and renewed perspective explaining the values, principles and core elements that characterize and justify such defense. Besides, they show paths from evidences and international literature review, which substantiate the discussion and allow coining a concept/approach on "comprehensive and renewed" PHC, seeking to distinguish it from other current interpretations (PAHO, 2008, 2009; WHO, 2008).

Importance of CIR for regional governance

The new Directive Regional Health Planning (PDR) has created 9 macro-regions and 28 health regions (Bahia, 2008). Micro-Regional Management Collegiates (CIR) were put into action in each region, being considered, according to state managers, a major breakthrough in terms of regionalization in Bahia:

> *the secretaries get together [in CIR], regardless of the size of the city, discussing face to face their issues, exposing their problems, although sometimes they just hang in mourning, but now it took a breath and is deciding. This is what is happening with thematic networks or with the Permanent Education Centers* (State manager, respondent 8).

CIR was considered, by managers, a regional forum crucial for the integrated regional planning, with regular meetings in the 28 health regions, and is the locus (in support to the Bipartisan Intermanagers Commission - CIB) for the monitoring of the regionalization process, even though it was recognized a wide disparity in their functioning. To accompany this process in the state, the Bahian Observatory of Regionalization was created. Other studies have pointed out the importance of CIR in the new management design for SUS in health regions (Assis et al., 2009; Vianna; Lima, 2013; Santos; Giovanella, 2014; Almeida et al., 2015).

The seat city of the analyzed health region was one of the first in the region to join the Pact for Health, although all, later, have held membership. According to the Municipal Health Secretary at that time, the Pact brought more autonomy to health managers, especially for the municipal secretaries, and he emphasized that: "*The Health*

Secretary, sometimes, was a mere figure in a management position, but, in reality, did not actually assume the management of anything" (City manager, respondent 1). When the cities assumed the agreed upon health responsibilities, there was a comprehension of the importance of the technical knowledge for the formation of the health managers frameworks, and this is one of the great advantages of the adherence to the Pact for Health.

CIR was appointed by health region managers as a breakthrough for the consolidation of regional health care networks and sharing of responsibilities, confirming the state managers assessment:

> *When we set the CIR, we set the other city managers of the micro as coauthors and co-participants of the whole process of building the network. For the seat [of the health region], to have the small cities strengthened is important for the network, because we have no way to solve all the problems of the microregion. So this was done on the PPI and on the Samu project, in which we achieved an alliance of the cities to a larger goal* (Regional manager, respondent 6).

For the interviewed Municipal Health Secretary, CIR has managed to build other forms of relationship between managers, especially in the comprehension of the role of the seat city in the accomplishment of the pacts. Although there was a lot of questioning and pressure in relation to services agreed upon, there was also greater understanding about factors that interfered in the accomplishment of the agreements.

The analysis the proceedings and observation of meetings of CIR showed that are constant discussions about the pacts held, both about their noncompliance and the request of services not agreed upon. Difficulties of access were often reported in the meetings, even for the negotiated procedures, which followed the formal flows of reference and regulation. Some managers of the region reported that professionals who acted both on the public (Regional Hospital) and private network gave priority to the care of their private patients over those referenced by the regulated network of SUS.

Nevertheless, the assumption of joint responsibility, including when it came to financing of some strategies and actions, was also singled out as one of the positive results of CIR: "*If the benefit is from the region as a whole, so we can discuss, we can make other managers understand this in a more objective way*" (City manager, respondent 4).

In the evaluation of Sesab managers, some regions stood out in relation to advances in regionalization, and one of the determining factors was the composition and provision of health equipment and the presence of an University, because, in a way, it ensured the education of new professionals. The profile of city management was appointed as a factor that influences regionalization:

> *So, some managers understand more, understand the process that has to be supportive, that no city alone, nor the great, neither the small, can structure themselves, because they are never self-sufficient, and those who are self-sufficient cannot be only for themselves, right?* (State manager, respondent 9).

It is, therefore, a major challenge for regional governance, since the network integration and coordination of health care presupposes a relationship of interdependence between social actors and different organizations, each possessing portions of resources needed to solve problems that are common to the entire network, involving conflicts of interests and power dispute (Almeida et al., 2010; Hartz; Contandriopoulos, 2004).

Urgency and Emergency Network Planning: revealing the functioning of the regional network

The analysis of the proceedings and observations of CIR meetings showed that the implantation of the Urgency and Emergency Network required from managers strategies of planning and of pacts of flows on a regional basis. Besides, CIR was a major space of agreements and decision-making, even if by ministerial induction. In the same perspective of the Pact for Health, the Ordinance no. 2,970, from December 8, 2008

(Brasil, 2008), established technical and financial guidelines to promote the regionalization of the Samu National Network, which, in addition to the infrastructure criteria, required that all projects were assessed and approved by the Regional Inter-managers Commissions.

The establishment of regional Samu was widely discussed in CIR and demanded agreements involving all cities of the region, since there would be the resource approval for the plan of urgency and emergency care. In this sense, linked to the Directorate of Specialized Care of the Municipal Health Secretariat of the seat city, the Urgency and Emergency Technical Coordination was created to execute the regional coordination of Samu. The project predicted assistance to 32 cities, with about of 700,000 inhabitants, involving two regions and three Regional Health Directorates (Dires). The Technical Coordination would have the function to ensure standardization and regulation for the functioning of Samu, which required a joint work between managers and professionals of the various cities. According to the interviewed managers, this was the first experiment in Bahia of starting a regional Samu, and, for this reason, the functions of regional governance were still being built: "*It is a role that is still new and is being created. Our Samu was born out of a need of the region. I say our Samu is a solidary Samu*" (Regional manager, respondent 6).

According to the coordinator of Samu, the space of CIR was instrumental in enabling the regionalized implantation. For example, the regulation protocol was approved in CIR, which gave autonomy to the region toward the state regulation center, making the service to the population more appropriate. According to respondents, responsibilities firmed regionally also minimized clientelistic interferences in the operation of Samu. As the whole process of regulation was agreed between the secretaries, according to the regional coordination, there have been never, since the beginning of the implantation in September 2011, cases in which the regulating doctor has made a request for ambulance and it was not available at the basis of Samu. Although each team of the 17 existing bases were hired by their respective city halls, the regulation process was unique, carried out by the Regional Regulation Center located in the seat city, after agreements firmed in CIR.

It is noteworthy that, as Samu is part of a network of regional care, it was necessary to know the municipal health services offer in each territory. In this perspective, according to respondents, the health secretaries collaborated, telling which were the "real" location and time of operation of the Family Health Units (USF), for the conduction of referrals:

> *We asked at what time the doctor of the Family Health Program is in the unit: 'Oh, the doctor is there all day long'. No, in the regulation we want to know the time he is in there, to work with what is real. The importance of regionalization is to make this network known. Today, before our patient go to the Regional Hospital, for example, we tried to exhaust within the city the capacity that he has* (Regional manager, respondent 6).

The Samu team could only consider their service completed when the user was being treated in a health facility with capacity for solving the case.

Although the pact process has presented some failures, the regional planning of the urgency and emergency network revealed aspects unknown before about the functioning and conditions of the network infrastructure:

> *I always say that Samu came to show the real face of health services in the region. If you open the National Register of Health Facilities, you see many urgency hospitals, but when you forward the patient, you see that not even half of them meet the criteria for care* (Regional manager, respondent 6).

This network diagnosis, provided by the regional implantation of Samu, could improve the next pacts in unveiling the real situation of many health units.

We assessed that regional governance spaces served to dilute personal issues that would affect the service provided to the population. According to managers, before CIR, cases were

observed in which the referral of users was not carried out to a given city because of disagreements between health secretaries. In the evaluation of the regional manager, the agreement made the criterion of need for health prevail on issues of personal touch, because it required from each city manager to examine the local network and to set in which establishments users could be assisted, in the case of Urgency and Emergency Network. Such question required a large technical effort and negotiation capacity of those involved.

Supply and regulation of the specialized and hospital care in the health region

The Appointments and Examinations Scheduling Center of the seat city controlled the regional supply of the procedures of the Agreed and Integrated Programming (PPI). The cities made the request to the center by e-mail or telephone. When the scheduling was done, an authorization ticket was generated and collected via pouch. Unlike what took place in the seat city, it was not allowed to users of the agreed cities to appeal directly to the center. Even so, some exceptions happened. For example, users who arrived with material collected for biopsy directly at the counter of the Scheduling Center. In these extreme cases, the center would schedule the procedure, and would report the incident to the city of origin of the user. Save in exceptional cases, the regular flow was to inform that the user should seek the health unit of his/her city of residence. Such administrative flows were integrated, even if there was no informational flow directly with PHC units. It can be seen, therefore, that there was no involvement of the professionals with the continuity of care after requests of additional appoitmentes/examinations, leaving the user at the mercy of the administrative process.

Topics related to PPI were quite frequent in the discussions of CIR in 2012. Not all agreements were completed, for several reasons, including the lack of professionals and the provision of procedures beyond the capacity of the provider city. According to the regulation coordination, the PPI of 2010 allowed viewing what was being offered, unlike the previous one, whose planning was happening in blocks. Shortly after the approval of the PPI of 2010, according to state managers, a working group was formed with the participation of the Municipal Health Secretaries and Sesab representatives to discuss problems and seek joint solutions. In Bahia, the PPI, as one of the instruments and mechanisms adopted by SUS to promote decentralization and integration between the management authorities, besides being mainly a bureaucratic instrument, it was not able to ensure an effective sharing of the planning process between governmental instances (Molesini et al., 2010).

The cardiology and ophthalmology specialties, for example, were two major bottlenecks mentioned, mainly because of the lack of professionals in the region. This question was critical, because even with the opening of hiring by the private network, the offer could not be extended, because the services and professionals were scarce.

Requests for review of the PPI occupied then the agenda, especially by the difficulties for hiring service providers according to the amounts paid by the remuneration table of SUS, considered insufficient for most procedures, according to managers of the region. Respondents reported that the great difficulty for the provision of specialized care was not only the lack of integration between providers, but the insufficient offer: "*What is really missing are resources to offer the user that quantity of exams and procedures in a real way*" (City manager, respondent 5).

When hiring was done to satisfy agreed services, the municipality usually received less than was hired according to what was possible to "negotiate" with the private provider. For the manager of the regional Samu, the values paid by the SUS table had most serious repercussions in small cities because of the insufficient staff. He also highlighted what procedures were agreed upon with other cities when there was not even the possibility to assist the internal demand of the seat city of the health region.

Thus, the accomplishment of the PPI was a constant point of tension between managers in the region.

Specialized services, according to state managers, would have to be more resolutive and qualified, but the great reliance on the private sector would be an obstacle. According to the coordination of specialized care, the public-private relationship in SUS would be quite contentious:

> *I think we are evolving a lot, we have just had a very important management forum here in the Northeast, in which the private and public initiative were together* [...] *Because we understand that we have to be together, but sometimes, you know there are interests, we live in a capitalist world, then we have to cultivate SUS, which is a totally non-capitalist model. If we think about it, integral care gives what is needed to who needs it, for you to put this system to work within the capitalist system, with the aid of private sector, still generates conflict, I guess. These are the major problems* (State manager, respondent 10).

The coordinator mentioned that the problem of financing would be of SUS as a whole, making impossible the provision of integral care, as proposed.

State managers recognized that the regionalization process has not advanced the way it should because of the many health care gaps in Bahia. Besides the resources of PPI, new investments were needed, which would only start coming through thematic networks, since the cities have budgetary limits to finance SUS. The health care gaps ranged a lot in the state, although advancements are listed, with the introduction of the regional hospitals in areas historically deprived of services. The construction of the thematic networks would be a device for the actual creation of a plan of integral health care in the state: "*Until then the discussion had been always focused on the issue of PPI, and we are now experiencing a possibility, a new way of doing with the organization of the thematic networks, actually caused by the Ministry of Health*" (State manager, respondent 11).

Such situation would reflect the historic concentration of health equipment in the capital and the spraying of small hospitals with low resolution and occupation inland, without analysis of health needs. The regulation, according to state manager of the Care Regulation Directorate, should be organized at the level of health regions, which often did not happen because of the health care gaps. In these cases, the user had to be forwarded to the seats of macroregions. This was an unanimous evaluation of all the state respondents, highlighting that the gap was, also, of the health workforce.

As to hospital care in the region, the flow for elective surgeries was raised through the references of the health units of the cities. The request would reach the Appointments Scheduling Center of the seat city, responsible for the direction to the Regional Hospital, which, after evaluation of the General-Surgeon, including in what referred to the diagnostic procedures performed or that had not yet been requested, issued the Authorization of Hospitalization (AIH), forwarded to the Surgery Scheduling Center, located at the very hospital. According to state managers, the construction of the regulators complexes was happening very slowly in the state. Efforts were made to regionalize the solution of problems. However, except Vitoria da Conquista and Juazeiro, the state center was responsible for regulation of beds, even the seat cities of the regions did only the ambulatory regulation.

Part of the offer of specialized care provided to the region was also provided by the Regional Hospital. Although it was inaugurated at the end of 2009, only in 2012 about 60% of the offer of specialized appointments performed by the hospital clinic came to be regulated by the city, according to one of the managers interviewed. The integration process has been very gradual and difficult, and is one of the constant reasons of complaints and discussions in CIR.

Final remarks

In Brazil, the mechanisms of integration of services and coordination of care account for general

principles (decentralization, regionalization, and integrality) and countless management strategies (health regions, thematic networks, care lines, consortium of health, health care networks, among others). However, we understand that the concordant point must be the implication in the production of health, in fact, converting the fragmented model, of low impact and high costs, to a model that conceive, mediated by the social ethos, "care as a value" (Pinheiro, 2009) and meets the basic criteria for care management (Cecílio, 2009). The defense of a health system organized in networks is justified, in the considerations of Mendes (2010), because there is a disruption in the coherence between the health situation of the population, in demographic and epidemiological issues, and the confrontation responses presented by health care models, on a global scale, that are "*focused to the care to the acute conditions and to the acute exacerbations of chronic conditions*" (p. 2,299), resulting in fragmented systems.

The results of the study indicated that the goal of formation of health care networks coordinated by PHC was still a marginal issue, especially against the need to ensure access to specialized care, urgency and emergency care, and hospital care – topics that dominated the discussion agenda of CIR. Tensions between "cities of the region" *versus* "seat city" around the scarcity of resources readily resonated in the relationship between managers, rousing the logic of "*ensuring things first for my city*".

PHC, in general, was an uncommon topic in CIR discussions, despite the problems faced for the consolidation of EFS at the local level, for example, insufficiency of physicians rotation. In this sense, the discussions did not care for the planning of regional and solidary strategies to face common issues related to ensuring coordinated care by EqSF.

The historical health care gaps in Bahia (Molesini et al., 2010) were also recognized as barriers to the formation of regionalized networks. These health care gaps turned into absence of services and into the availability of professionals for SUS throughout the state, and, at that time, the recent federal policies for provision, above all, of doctors, were being evaluated quite optimistically. The reform and construction of new regional hospitals represented an attempt to reverse the logic of a hospital network sprayed in small hospital units with low solvability, but also represented, in the assessment of managers, a possibility of fixing professionals and of decreasing dependence on the private sector.

Another component verified in the regional agendas was the ministerial induction, similar to that found in other studies (Santos; Giovanella, 2014). Although evaluated positively by state managers, we can inquire about possible dissonances between federal interests *versus* locoregional needs. In this direction, recent studies have incorporated the implications and contradictions of the Brazilian federative structure in the process of decentralization and regionalization in SUS (Dourado; Elias, 2011; Machado et al., 2014; Lima et al., 2015). Such studies indicate problems in the inter-federative coordination because of governments with legitimacy, visions, and different projects, not always in defense of SUS and, therefore, the need for intergovernmental negotiation instances. Besides, the principle of integrality in health care explained the organizational limits circumscribed to the municipal entity, requiring the sharing of federative responsibilities between the different entities. Nevertheless, health care networks of regional nature point to the comprehension of the health region as erasing borders and legitimation of common health territory, however, "in the region, there is the development of solidary and conflictive work in the copresence, in the contiguity, in daily life, that currently reveals the lack of coincidence between the technical scale and the political scale" (Silveira, 2010, p. 77).

In the evaluated context, the implantation of the Urgency and Emergency Thematic Network seems to have been appropriated by the managers of the health region and taken as a window of opportunity for the elaboration of a "real" diagnosis of health services, capable to support decision-making and unveiling the "critical nodes" to be faced in a solidary way.

The analyses of CIR, built on the observation and perception of managers, indicated a positive scenario in the constitution of a locus of regional governance. There was the possibility of a shared management of problems that affected all cities in the region, although it often collapsed against local interests and partisan-political crossings. There is the perception that the existence of this space can minimize clientelistic actions on health, and this seems to be a point that justifies its defense and strengthening (Santos; Campos, 2015).

Finally, it is necessary to emphasize some limits of this research, which at the same time indicate openings for further investigation. The very study of an object in the field of health in regional and non-municipal logic unveils the need to use of methodologies, techniques, and indicators sensitive to this dynamic. Interviews with municipal managers have proved to be insufficient to capture the complex regional movements. We inquire, also, what would be the sensitive indicators to reflect the constitution of regional networks, other than those that only group indicators traditionally used to assess the health situation in each city separately. The study also did not incorporate the user' perception, and this is one of its main limitations, since he is the main involved/affected by the constraints to the provision of integral health care and lack of care integration.

Finally, we understand that researches for understanding the processes of regionalization need sophisticated methodological apparatus for capturing data from different sources and scenarios. To this end, mixed (qualitative and quantitative) research methods, through triangulation of methods, comparative analysis between health regions, social network analysis, among other possibilities, can thicken the findings and contribute to increasingly robust research.

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Authors' contribution

Almeida, P. F. and Santos, A. M. coordinated the research, analyzed the data, wrote and organized the article. Santos, V. P. collected the data, participated in the conception, and revised the article. Roberto Moreira Silveira Filho participated in the conception and revised the article.

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