Fragility in regional governance during implementation of the Urgency and Emergency Network in the Metropolitan Region

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ABSTRACT This article analyzes the implementation of the Urgency and Emergencies Network, its regional interfederative arrangements of agreement and policy management, in the Metropolitan Region of São Paulo, along the period of 2011-2016. Implementation is considered as a dynamic policy process, with constant interaction, negotiation and learning. This is a case study, based on qualitative health research and policy implementation studies, with 4 overlapping levels of analysis: implementation design; characterization of implementation actors; characterization of regional interfederative arrangements and disputes and interfederative challenges not overcome. The data were obtained from public documents of instances of agreement and coordination of the policy and participating organizations and actors. Based on the reflections of Power in health policies by Testa and the Paidéia method of collective management, it is analyzed how the results revealed the insufficiency of the political instruments and coordination arrangements developed by the implementation of the Urgency and Emergency Network. Thus, the fragility of regional governance, the need to strengthen health regions as a territorial unit, its relationship with health care networks and the proposals for regional and interfederative arrangements for SUS development are discussed.

Introduction

The urgency and emergency is a priority of health management and interferes in the evaluation that users, workers and society make of the guarantee of the right to health, of the care offered and its legitimacy. Studies indicate the relation of the dissatisfaction of the population with urgency and emergency care. However, in the Unified Health System (SUS), policies for this area have fallen short of their importance for public health.

The history of the Policies for Care in Urgencies and Emergencies in the SUS shows the fragmentation of its elaboration and its implementation. In 1998, the Support Program for the Implementation of State Systems of Hospital Reference was created for urgency and emergency care. However, in the Unified Health System (SUS), policies for this area have fallen short of their importance for public health.

The challenge of constitution of a complex network, with a multiplicity of points of attention and technologies, is amplified by the characteristics of the conciliation process between the entities of the federation, established in stages in the norms produced: Phase of adhesion and diagnosis; Phase of regional design of the network; Phase of contractualization of the attention points; Phase of the qualification of the components of the Care Network to Urgencies; and Phase of certification.

This article analyzes to what extent the implementation of the PNAU/RUE brought about changes in the existing inter-federative arrangements and in the processes and regional structures of agreement and management, starting from the case of the Metropolitan Region of São Paulo (RMSP), in the period from 2011 to 2016.

The relevance of this study stems from the fact that regional and interfederative pacts and cooperation are one of the major challenges of the SUS, already discussed by several authors. Mendes and Louvison analisa-se como os resultados revelam a insuficiência dos instrumentos políticos e dos arranjos de coordenação desenvolvidos pela implementação da Rede de Urgência e Emergência. Assim, discutem-se a fragilidade da governança regional, a necessidade de fortalecer as regiões de saúde como unidade territorial, sua relação com as Redes de Atenção à Saúde e as propostas de arranjos regionais e interfederativos para o desenvolvimento do Sistema Único de Saúde (SUS).

consider that the process of regionalization and decentralization has gained a strong technical-administrative component, losing political-social character. This process began with the Operational Standard for Health Care Organization (Noas), which presented rigidity of parameters and did not consolidate regional and inter-municipal governance. In 2006, the Pact for Health represented an effort to expand the integration of the SUS, but it still resulted in little change in regionalization, with the absence of qualitative gains in the articulation of regional planning and a dependence on state protagonism for the functioning of Regional Management Colleges (CGR). Subsequently, Decree nº 7.508/2011 brought advances through specific chapters on interfederative articulation, conceptualization of health regions, role of Regional Interagency Commissions (CIR) and Organizational Contract of Public Action, but without provoking a substantial change in this scenario because of a set of reasons. Part of them will be pointed out in this paper.

We analyze these changes from the understanding of implementation as a continuous and integral part of the policy process, in a negotiation perspective involving interactions between power structures, actors and agencies, as established by Barrett. A formulation in process, as Vianna records, with diversified decision steps and multiple negotiation arenas. We seek paths raised by Hjern and Porter, by identifying the formulators, implementers, groups, beneficiaries and their networks involved, understanding them as part of a learning network involving social actors and institutions. We sought to identify which socio-political coalitions supported the theme of the RUE in the agenda of the SUS and in which social arenas it has become a priority. We dialogue with the approach of choosing organizational, financial and regulatory policy instruments developed throughout the process, as pointed out by Bennett and Howlett. Finally, we analyze the norms of the policy, instances of agreements and/or co-management, institutions, entities or services of regional coverage and/or interfederative management, dialoguing with studies on arrangements for the implementation of territorial-based policies.

The Metropolitan Region of São Paulo portrays the complexity of integration in the SUS. It is composed of six Regional Health Care Networks (RRAS), 39 municipalities and 19.6 million inhabitants, and the city of São Paulo is a specific RRAS. In it, networks of state and municipal services coexist, with distinct institutional cultures and low cooperation, being the access and the quality in the urgency and emergency disputes between the municipalities and the state.

This debate dialogues with the problematizations brought about by Campos, regarding health regions and the challenges of the SUS, such as integrating what has been historically fractionated by health programs, networks of established service and low cooperation among federated entities.

Material and methods

This is a case study with imbricated levels of analysis, as defined by Yin, where we analyze changes in the pacing processes and interfederative and regional management in the SUS, from the implementation of the RUE in the RMSP, in the period from 2011 to 2016. It is an implementation study that, according to Champagne et al., values internal dynamics, contextual factors and characteristics of organizations that contribute (synergistic interaction) or block (antagonistic interaction).

The following levels of analysis and their variables were defined:

1) design of the implementation: participation of federal actors in the definition of the agenda, valorization of the health region as a priority territorial unit, respect for regional singularities and identification
of financial, regulatory and organizational instruments of implementation;

2) characterization of the actors of the implementation: positioning, motivations, disputes and identified challenges and constituted defense coalitions;

3) characterization of interfederative and regional arrangements: pre-existence, or not, instances of pacing or co-management of politics, verticality or horizontality in the relationship between federation entities, institutionality and the process of nominating members and scale gain;

4) disputes and challenges in the federative relations mentioned, characterizing them regarding the dimensions of management of the Health Policy, Network of Attention or Services.

We seek evidence in different sources of data: a) analysis of laws, decrees, ordinances, normative manuals and public official documents; b) minutes, records, public notices of instances and arrangements related to implementation; c) public positions of representatives and/or entities; d) analysis of technical or research reports; and e) notes, records, presentations, direct observations of the authors during participation in the cases studied.

The analysis is based on the qualitative research in health, established by Minayo17. In this, the social investigation contemplates qualitative aspects, of complex, contradictory object and in transformation, registering the relation of the authors with the studied case, having assumed different views and positions during the implementation process.

The interpretation and discussion of the data are based on two theoretical references in the field of collective health, which we consider to add analytical capacity to the studies of health policy implementation.

First, by the understanding of health as a social process, by Testa18, where the power category gains centrality, especially in institutional policies and practices. For this author, implementing a health action leads to achieve a certain displacement of power, having established the characterization of political, technical and administrative power for the reality of health services. This typification of power has an analytical value, by identifying resources for the exercise of power by each of the social actors in dispute and by identifying scenarios/spaces where it is exercised19.

According to an additional perspective brought by Campos20, health management, in addition to the administrative and financial aspects of an organization, must consider political, pedagogical and subjective aspects that pervade teamwork, health production, power distribution, circulation of knowledge and objects of investment of professionals, their values and culture. In this sense, implementing a new health policy also means to constitute new subjects, from or demanding new management arrangements.

**Results**

*Chart 1*, below, was produced from the Ministerial Ordinances regulating the RUE and its assistance components, the public registers of the bodies of agreement and management (Regional and Bipartite Commissions and Conducting Groups of the RUE), the Regional Plans of Action (PAR) of the RUE of the Regions studied and Reports of Implementation Evaluation21.

The findings were organized according to the described variables and by the scope of agreement and comprehensiveness of the findings: national, regional (scope of the São Paulo Metropolitan Region) and local (referring to the city of São Paulo).
Chart 1. Valorization of the Health Region and federative entities in the implementation design

<table>
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<th>Regional</th>
<th>Local</th>
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<td></td>
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<td>Demand for managers for investment in Municipal Hospitals</td>
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<td></td>
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<td>Demand for municipal managers to readjust financial ceilings</td>
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<td></td>
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<td>Opening for agreement of PAR in other RRAS other than RM</td>
<td>Expansion of actions for the entire Municipal Hospital Network, regardless of federal induction</td>
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<td>Adjustments for small municipalities in the stabilization Room, Samu and UPA</td>
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<td>Adjustments for small municipalities in the stabilization Room, Samu and UPA</td>
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<tr>
<td>Incorporation of RUE into the National Health Plan</td>
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<td></td>
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<tr>
<td>Creation of a Network Support Department</td>
<td>Creation of a Network Support Department</td>
<td></td>
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<td>Protagonism of the Tripartite Conducting Groups</td>
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<td>Supporters of the State Secretariat and Cosems</td>
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<td>Policy instruments of implementation (regulation, financial and organization)</td>
<td>Forum of Networks in the intramunicipal regions</td>
<td>Creation of Reference Grid for Urgency</td>
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<td>Financial induction based on the Regional Action Plan</td>
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<td>New SO management contracts with RUE guidelines</td>
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<td>Decree 7508/2011</td>
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<td>Incorporation of RUE into the National Health Plan</td>
<td>Restructuring the Career of Hospital Workers</td>
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<td>Rules for habilitation and financial qualification of the services</td>
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</tbody>
</table>

Chart 1 shows the participation of federal actors in the entry of RUE to the agenda of the SUS. Whether through announcements and public summonses by the Presidency of the Republic and by the Ministry of Health; announcements of the implementation of urgency/emergency services, such as Emergency Care Unit (UPA) and Samu, by the rulers of the state and municipalities; the defense, by the Bipartite Working Groups (WG) for Assistance Regulation and by the Samu Regional Coordination, for greater regulation and integration of services; and the demand of the leaders of reference hospitals, together with the managers, to search for resources by accessing to the RUE.

This involvement contributed to the incorporation of regional suit to the design, such as the possibility of extending the RUE to all regions of the state of São Paulo, although initially restricted to the Metropolitan Regions. It also led to the singling out of accession criteria of the RUE, expand-ing possibilities, contemplating regional diversity and the prevision of
exceptions approved by the local CIR/Bipartite Interagency Commission (CIB), valuing the health region as a territorial unit.

The approach of Bennett and Howlett\(^2\), already mentioned, on the choice of policy instruments classifies them as financial, organizational, regulatory and informational.

*Chart 1* reveals that the financial policy instrument assumes, from the beginning, the health region, rather than the municipalities or states separately, as its territorial unit of implementation. Thus, it links the accession and the financial incentive to the PAR agreed in the regional collegiate. It shows, moreover, the emergence of initially unforeseen political instruments, reinforcing the characterization of implementation as a permanent process of interaction and learning. The fact that institutional acts of the federative entities, initially not foreseen, are developed throughout the process and become political instruments of implementation reinforces the protagonism of these actors throughout the process. In this category are the regulatory policy instruments: such as the incorporation of RUE into national and municipal health plans; Federal Decree nº 7,508/2011, already mentioned, which institutionalizes the Health Region; the new local hospital reference grid, redefining the relationship between the state and municipal regulatory complexes and between these and the points of attention; new modeling of contracts of local management with hospitals managed by Social Organizations (SO), incorporating indicators, clinic management devices and participatory management indicated in the normatives of the RUE. As organizational political instruments, at the national level, the new federal management structures, such as situation rooms and management bodies of the RUE appear, with the participation of the ministerial secretariat responsible for the federative interlocution and the development of regionalized institutional support. At the regional level, the creation of an interfederative matrix monitoring the implementation of the RUE and the network of specific supporters in the state secretariat and in the Council of Municipal Health Secretariats (Cosems). At the local level, the creation of the Regional Network Forums, with all the state, municipal and contracted services of each intra-municipal region of the city of São Paulo, and the creation, in the new public career and municipal tender, of a medical category exclusively for the points of the RUE.

*Chart 2* was elaborated from the records of the social actors involved in the process, from the national and regional instances of social control of SUS and from the evaluation reports of implementation, revealing aspects of the positioning of these actors, characterizing four main movements.

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**Chart 2. Characteristics of the speech of managers, workers and users**

<table>
<thead>
<tr>
<th>Positioning</th>
<th>Motivation</th>
<th>Content Defense of the RUE</th>
<th>Disputes and Challenges Aimed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal</strong></td>
<td>Identification with user and non-attendance situation</td>
<td>Bet on the integration of services in network and in NHP</td>
<td>Low regional/local governance</td>
</tr>
<tr>
<td></td>
<td>Direct monitoring, with cameras and visit</td>
<td></td>
<td>Rotativity of local/regional teams</td>
</tr>
<tr>
<td></td>
<td>Induce Attention Networks with the available resource</td>
<td></td>
<td>Poor care regulation</td>
</tr>
<tr>
<td><strong>Common States</strong></td>
<td>Urgency and emergency in the daily agenda of managers</td>
<td>Investments in various services integrated in Network Support for regionalization</td>
<td>Underfunding</td>
</tr>
<tr>
<td><strong>Municipalities</strong></td>
<td>Possibility of Adjustment of the financial Ceiling of Medium and High Complexity</td>
<td></td>
<td>Insufficient Connectivity/electronic health record/Telehealth</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Federal underfunding</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Federal slowness for habilitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Multiplicity of standards</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>More investments in Small-sized Hospitals</td>
</tr>
</tbody>
</table>
First, the political convocation by the federative entities. It begins with the Ministry of Health, by transforming an electoral proposal for the expansion of the UPAs into a Thematic Care Network proposal, by establishing it as a priority agenda of the Tripartite Interagency Committee (CIT), when allocating budgetary resources, by linking accession to the RUE as a criterion for readjustment of financial ceilings for specialized attention of medium and high complexity and in leading the standardization of the accession process. The public launch of the program S.O.S. Emergencies, in national chain by the Presidency of the Republic, and the regional public visits by the Ministry of Health constituted instruments of diffusion and mobilization of the proposal.

Second, the priority of the RUE in the agenda of state and municipal managers. In the specific case studied, there was an inflection in the posture of the state and governors of the city of São Paulo, who began to consider partnerships with the federal government and make, from the RUE, their first suits of federal resources for the UPAs.

Third, represented by an encounter of agendas, not always constant in brazilian federalism. It combines some characteristics: subject of concern of the heads of government and priority of health managers; the understanding that the implementation of the RUE was the main federal offer to rebalance the financial ceilings of the specialized attention of middle and high complexity of states and municipalities and, finally, the federal support to potentialize and qualify the existing health services.

And the fourth movement is expressed by the positions, debates and approvals in the spaces studied of the social control of the SUS. Representatives of managers and users form a coalition of defense of the RUE. In this context, it is important to emphasize that, in the positioning of the representatives of workers, the qualification of the
urgency and emergency services would go through, mainly, the expansion of the supply, the structural qualification of working conditions and relations, with frequent criticism of the models of SO. We observed, from the sources of records of instances of social control and reports, that the involvement of the representatives of the workers in the implementation of the RUE varies locally, being higher the lower the degree of expansion of SO or other private models to the health network and the more the interventions of qualification of the services open protagonism to the workers and their questions.

Chart 3 characterizes the interfederative arrangements, based on the described variables and their intervention dimensions: service management, health care network or health policy. It has been systematized from regional and local public resolutions and ordinances, the registries of the instances of agreement and management of the RUE, of the PARs and the implementation evaluation reports.  

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Characteristic</th>
<th>Interfederative Relationship</th>
<th>Indication Members</th>
<th>Gain of scale</th>
<th>Legal framework</th>
</tr>
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<tbody>
<tr>
<td>Samu Coord.</td>
<td>Service management</td>
<td>Co-management</td>
<td>Intermunicipal horizontal Municipal protagonism</td>
<td>Indication Secretary</td>
<td>Integration of services, administrative structures, logistics</td>
</tr>
<tr>
<td>WG Regulation</td>
<td>Network Management</td>
<td>Co-management</td>
<td>Vertical bipartite State protagonism (management of more complex services)</td>
<td>Indication Secretary</td>
<td>Integration of services and teams</td>
</tr>
<tr>
<td>Foundations</td>
<td>Service management</td>
<td>Co-management</td>
<td>Intermunicipal horizontal Municipal protagonism</td>
<td>Indication Heads of Government</td>
<td>Integration of services and administrative structures</td>
</tr>
<tr>
<td>Consortiums</td>
<td>Management and services</td>
<td>Co-management</td>
<td>Intermunicipal horizontal Municipal protagonism</td>
<td>Indication Heads of Government</td>
<td>Integration of services and administrative structures</td>
</tr>
<tr>
<td>CIR</td>
<td>Health Policy Management</td>
<td>Agreement</td>
<td>Horizontal bipartite Bipartite protagonism</td>
<td>State and Municipal Secretaries</td>
<td>No</td>
</tr>
</tbody>
</table>

Arrangements created with the implementation of the RUE

- Conducting Group RUE
  - Network Management | Co-management | Horizontal tripartite Variable protagonism | Indication Ministry, state and municipal Secretaries | No | CIB Resolution
- Forum of Networks
  - Network Management | Co-management | Horizontal bipartite Municipal protagonism | Indication of managers of State, Municipal Unities and OS | Integration of services | Ordinance and Law
- Regional Regulatory Complexes
  - Network Management | Co-management | Horizontal bipartite Variable protagonism | Indication Secretary | Integration of services and teams | CIR Resolutions and Ordinances |
- Management councils of regional services
  - Network Management | Co-management | Horizontal bipartite | Indication Secretaries, Workers, Users and Society | No | Ordinances and Laws

Source: Ministerial Ordinances of the RUE, Resolutions of the CIB, CIR, PAR of the RUE in the RMSP and Municipal Ordinances.
Its analysis shows that the implementation of the RUE strengthened previous regional federative arrangements and created new ones. Such arrangements are not restricted to the agreement function and assume the characteristics of interpersonal co-management of the health policy, the network or the services. The Tripartite Conducting Group, created after the accession and which remains in all stages of implementation, stands out as the only tripartite group.

The RUE, in the experience studied, assured the CGR/CIR protagonism and concrete content with the preparation of the PARs. In addition, visibility was added to the object of the pre-existing arrangements, establishing, with the new arrangements, complementarity for their own objects. Empirical evidence of this was the regional coordination of the Samu and the Groups of Regulation of the CIR, pre-existing, that have their objects evidenced with the RUE and begin to interact with the Regional Regulatory Complexes created. Or the Foundations and Consortiums, which already enabled the hiring of professionals for services, are taking on more services, contributing to hiring integration structures or regulation between the points of attention and occupy a wider regional dimension, this being most evident in the ABC health region, in the experience studied; or new arrangements, such as the Network Forums in the city of São Paulo, not provided for in the norms of the RUE, which involve all the attention points of a certain intra-municipal health region and produce interaction of pre-existing arrangements with the coordination of Samu, WG of Regulation and the Conducting Group of the RUE.

The data show that the composition of the arrangements is almost exclusively bipartite or intermunicipal, with predominance of horizontal relations between the entities, varying, between regions, if the main protagonism is of the state or municipalities. It was not possible to deepen the reasons for this variation in this study.

With the exception of the CIR, the Conducting WG of the RUE and the Management Councils of services of regional reference, the others lead to some gain in administrative scale, integrating services, hiring and management of teams and administrative or logistical structures. An other aspect, except the CIR, Foundations and Consortiums that are mandatorily created in Law and its members are directly appointed by elected heads of government, and the others are indicated by unelected levels and fruits of infraregal instruments, being a dimension of the institutional robustness of the arrangements.

In addition to the arrangements in chart 3, the RUE normatives recognized the Management Committees for Urgency and Emergency Care, provided for in previous national guidelines already mentioned, recommending their creation or maintenance in the territory that would join to them. They are intersectoral instances of articulation, with representatives of health, public security and transit policy managers, open to civil society. Although these Committees were created in the state and in the municipality of São Paulo, there is no record of functioning after accession to the RUE.

Chart 4 systematizes the disputes and interfederative challenges not overcome with the implementation of RUE in the experiment studied. It was systematized with data obtained from the public positioning of the actors, implementation evaluation reports and instances of agreement and management of the RUE. The data are organized from the federal, state and municipal spheres and from three dimensions: service management, health care network and health policy.
Among the results, there are particular characteristics of the experiment studied. We point out the absence of state co-financing, the conflict between the state administrative division and the health regions, the dispute between the Rescue and Urgency Care Group of the state, Samu and Reference Hospitals, including the prosecution of the Public Ministry (PM) and the low regulation of University Hospitals.

In an overview, the results show that, in the experiment studied, although the implementation of the financial, regulatory, organizational and policy instruments of the RUE and the strengthening or creation of regional arrangements were successful, such resources and governance mechanisms were insufficient to overcome disputes and interfederative challenges. In the records obtained, this negatively impacts the implementation of the RUE. Possibly, it impacted the care results, which were not object of this study.

### Discussion

The RUE has constituted in one of the inductive offers for the Health Care Networks in SUS. These have innovated in national guidelines for access regulation, clinical management, local governance arrangements, in the health region as a territorial unit and joint federal financing at multiple points of attention of a specific health region, integrated in a thematic network. The Thematic Networks of Health Care are characterized as one of the main federal offers in the studied period. Its implementation period interacted with the new legal frameworks of the Health Regions, such as Decree nº 7.508/201, already mentioned, and Law nº 12.466/2011, which institutionalized the CIR.

This study reveals the protagonism of federative actors in the incorporation of RUE in the agenda of the SUS and that its implementation design has organizational,
financial and regulatory policy instruments that, when implemented, create mechanisms for its integration, incorporate the Health Region as its territorial unit, value and create new regional interfederative arrangements. However, these resources are insufficient to overcome the disputes issues and challenges pointed out, understanding them as part of the contents and processes of regional governance, impacting on the consolidation of the RUE and the Health Region.

In this sense, the two theoretical references of Testa\textsuperscript{18} and Campos\textsuperscript{14}, already mentioned, contribute to the interpretation of the results, especially of the disputes and not exceeded challenges. This interpretation reinforces the understanding that the constitution of an integrated network of regional attention does not occur only from the implementation of resources by the authorities of the health system or flows of managerial integration of its points of attention. It helps to problematize the need for the generation of power displacements and renegotiation of the actors, who occupy different roles and power spaces in the points of attention, in institutions or management structures, which open more or less to the network interlocution, for the construction of new subjects and for the redistribution or construction of new relations of power.

In this experience, bringing the typification of health power to Testa\textsuperscript{18}, mentioned above, we observe the Technical Power present in the relations between professionals, between units of the same service, between services, between management and health care structures, such as low regulation of University Hospitals, between government spheres and between all these and the users. The Administrative Power, based here on the volume and the financing model, on the management of the organizations that make up the network, on work regulations and management and on disputes and challenges pointed out: federal underfinancing, non-co-financing by the state, conflict between the state administrative division and the Regional Health Care Networks, the cooperative instruments of management with indefinite sustainability and the management of the work with fragility in the careers and without regional mobility. Political power, on the one hand, by the power relations between the various actors, its political and party institutions and structures of the RUE, generating disintegration and competition between federative entities and their service networks and the instability of the managers of point of attention. On the other, by the different views of right to health, user rights and interprofessional interaction, all critical to urgency. This reading leads us to consider that regional governance and its regional interdepartmental arrangements will be more effective and sustainable if they are endowed or if they are, themselves, political instruments that can generate such displacements of power, which did not occur in this experience.

In an article already mentioned, Campos\textsuperscript{20} talks about the construction of a co-government in the management of policies, organizations, collectives and health teams that will fulfill three basic functions: a) production of use values, especially, for users of policies; b) change power relations; c) a pedagogical and therapeutic character in producing subjects, understanding them as the individuals and social groups that interact, negotiate, learn and constitute themselves. For the aforementioned author, activating the strengthening of subjects, amplifying their capacities of analysis and intervention, would be decisive to change such relations of power. This reading brings us to the centrality so that the constituted arrangements are able to involve and articulate, in this communicative action, all those with varied exercise of power in the points of attention and management spaces, producing new subjects with the implementation of the policy. To this end, the arrangements would require mechanisms of permeability to the health network, to services, to users, to workers and to external actors, a characteristic little observed in the records of the studied arrangements.

Therefore, the arrangements should not be
limited to hierarchical-political representation or the functions of managerial integration of services. They should be able to establish temporary or permanent engagements with the actors that have a real effect on the work process of the teams at the points of attention and management. The learning here observed of the Forum of Networks in the intramunicipal regions of the city of São Paulo, with more or less maturity between the regions, brings the constitution of broader arrangements, including, according to the themes treated, actors external to the points of attention. This experience, in practice, brought the participation of the state attention points, which did not occur through the usual hierarchical flows or the arrangements established by the RUE. The more permeable, the better for the various administrations on the part of managers, workers, users, educational institutions interested in participating, temporary task forces and specific committees for thematic issues, as observed.

Because it is a subject of high public repercussion in society, because it requires a renegotiation of power between actors and institutions and the production of new subjects, RUE does not consolidate without public debate, without new interactions between the action of the government and the spaces of society where the perceptions about Health and new subjects are built. This is an important issue for governments today, in a society that builds their values, consensus, majorities and hegemony in an intense dispute of positions, diverse modes of interaction, in traditional and virtual public arenas.

Here we consider that, due to the findings presented, although the RUE started with signs of strong political and public summons by managers of the three spheres of government and on a theme with high repercussion in the day to day of the perceptions by the society of what is SUS, its implementation process did not maintain this same intensity of communicative action. Whether it is with users and workers, or with sectors that build opinions about SUS, or with society as a whole. Gradually, the implementation of RUE is being reduced to what Labra warns, that the SUS and its processes of political construction have become a set of own networks, in an increasingly restrictive and specialized political community.

There is the risk of reproducing the historic process of regionalization of SUS, the existence of a normative arsenal with little density of real political action. The maintenance or expansion of SUS, as it occurs today, is counter-hegemonic in relation to the agenda that drives initiatives of governments and parliaments in Brazil and in the world. The construction of the Care Networks and a non-fragmented care is counter-hegemonic in relation to the existing SUS. Therefore, it will not be possible to constitute commitments and attitudes capable of promoting changes towards the consolidation of Regional Care Networks, if their implementation arrangements do not provoke a high-intensity public debate with political and social actors, overcoming the conformation of restricted political community. New regional pacts and arrangements cannot be mistaken to become the exclusive locus of a certain bureaucracy, formally indicated by the manager, but that little interacts with the actual decision-making processes of health policy. Neither should they be distant from other governmental or societal sectors, which impact the reality of health, and not distant from public arenas, where the perceptions of society on health are consolidated.

An example of this, in the case studied, is the lack of regular functioning of the Urgency and Emergency Committee, an intersectoral instance with civil society, and the non-interaction of the arrangements established by the RUE in public debates occurred that dialogue with the profile of care in urgency and emergency. We cite here three examples related to the period studied: (a) the Decree of the State Government, which passes on to Samu the responsibility for attending and removing victims of homicides in police incidents; (b) the discussion in society and the disagreements between state and municipal instances of
The disputes and challenges observed in this study reinforce how fragile the health region still is as the territorial locus of the SUS. The path goes through the territory and health region to consolidate as the locus of integrality, with a single regional command, with co-management between municipalities, states and the Union, not through a geographical or administrative division. Specifically in the RMSP, in the researched sources, were observed: insufficiency of coordination capacity of the state government; conflicting coexistence between the municipal and state networks; dispute of protagonism between the municipal and state governments; heterogeneous relations of the RMSP cities, with greater or lesser accession to the federal offers and a conurbation process, producing a permanent flow of the users in the RMSP. The RMSP does not even have a regular college that meets all six RRAS. This is a complex exercise, due to the characteristics of brazilian federalism. It is not simple to strengthen and integrate what has never existed, what has been fractioned by the federal offers and by the emptying and the state omission, according to Santos and Campos, in a previously mentioned article, or by a dispute of protagonism between municipalities.

Therefore, we call attention to the financing structure of health policies by federal and state entities or to the mechanisms of sharing by municipal entities. It is necessary to set up regional health funds and not just for each individual entity. Due to the current situation of the tripartite composition of the financing of the SUS, this fund must have, substantially, federal resources with state complementation. In the case studied, mainly, the insufficiency of new federal resources, provided as regional incentives for the Networks, and the absence of new state resources were limiting the consolidation of the RUE in the RMSP and the contractualization with the points of attention incorporated in the respective PAR, especially in the components of hospital care and fixed or mobile prehospital care.

The records of disputes and unresolved challenges also show how it is necessary to insert in the health region the management of regional reference points of attention. Hospitals and regional referral services need to be from the region as a whole, to have it as an object of permanent reflection, regardless of the administrative nature or of the federative entity to which it is subordinated. Otherwise, they run the risk of being self-referenced, with a restricted view of the path of the user within himself/herself, not the regionalized network. We suggest that they adopt regional processes to choose their leaders, Management Councils with representatives of the CIR, municipalities, educational and research institutions, entities of the regional representation society, not just local.

That they be present in the federative regional instances of agreement or management of policies, as observed in some CIRs that call for consortiums and regional reference services or as the Forum of Networks of the City of São Paulo. It is necessary to reinvent their internal arrangements in the production of health care, such as teams or production units linked to regional assistance arrangements with the other points of the network, have a link with the territories that refer the cases, their interlocutors, often with networks of volunteers. They should, also, establish regional forums for therapeutic guidelines and case management, bringing together caregivers, specialists and research and teaching institutions in the region.

Conclusions

The process of implementation of the Thematic Networks of Health Care in the context of the SUS has raised a number of
issues to be studied, being of great importance the current opportunity to do so, based on our reality. Likewise, there are still limited experiences on how to induce and which administrative models can make the health region a priority locus of SUS. The recent process of initiatives to build the Public Action Organizational Contract (Coap), based on Decree nº 7.508/2011, and the implementation of the Care Networks have deepened the need for a political administrative organization of the health regions.

In this debate, it is fundamental to consider the legal frameworks of our triune federation and the diversity of regional contexts in an asymmetric federation of an unequal Country. Recently, Santos and Campos in a previously mentioned article, defended the constitution of a new institutionality for regional management and, in an administrative-juridical perspective, an interfederative authority to support the Coap, the result of a common regional design. Other authors, such as Mendes and Louvison in the aforementioned article, point to the risks of a new regional administrative institutionalization becoming an instrument of recentralization or specific individual interests.

The experience studied reminds us of two fundamental needs, that could compose the way for new governance arrangements for health regions: on the one hand, the need for strong and stable regional public structures, that have the health region as a territorial object, that promote power dis-placements, economic gains in scale, long-term planning and professionals with regional bond; on the other, a governance less attached to rigid structures and more in combinations between diverse public institutions and non-governmental actors, associating to solve common problems and produce subjects.

References


