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

Fragilidade na governança regional durante implementação da Rede de Urgência e Emergência em Região Metropolitana

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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.

KEYWORDS Health systems. Regional health planning. Governance. Emergency medical services. Federalism.

RESUMO *Este artigo analisa a implementação da Rede de Urgência e Emergências, seus arranjos interfederativos regionais de pactuação e gestão de políticas, na Região Metropolitana de São Paulo, no período de 2011-2016. Considera-se implementação como um processo dinâmico da política, com interação, negociação e aprendizagem permanentes. Este é um estudo de caso, baseado na pesquisa qualitativa em saúde e nos estudos de avaliação de implementação de políticas, com 4 níveis de análise imbricados: desenho de implementação; caracterização de atores de implementação; caracterização de arranjos interfederativos regionais e contenciosos e desafios interfederativos não superados. Os dados foram obtidos em documentos públicos das instâncias de pactuação e coordenação da política e das organizações e dos atores participantes. Baseado nas reflexões de poder em políticas de saúde de Testa e no método Paideia de gestão de coletivos,*

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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).

PALAVRAS-CHAVE *Sistemas de saúde. Regionalização. Governança. Serviços médicos de emergência. Federalismo.*

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[1]. 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 Im-plementation of State Systems of Hospital Reference[2] was created for urgency and emergency care, focusing on hospital performance, service typification and state coordination. In 2003, with the Mobile Emergency Care Service (Samu), prehospital care and urgency and emergency care regula-tion were organized in a network of regionalized and hierarchical services. In 2006, QualiSUS[3] emerged, an urgent care qualification program, focused on large hospitals and the National Human-ization Policy (NHP). In 2011, the National Policy to Urgency and Emergencies is settled, which establishes the Urgency and Emergency Care Network (PNAU/RUE), by Ordinance nº 1.600/2011[4], structuring care network guidelines.

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[5]

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[6]. 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)[7]. Subsequently, Decree nº 7.508/2011[8] 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 Barret[9]. A formulation in process, as Vianna[10] records, with diversified decision steps and multiple negotiation arenas. We seek paths raised by Hjern and Porter[11], 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[12]. Finally, we analyze the norms of the policy, instances of agreements and/or co-management, institutions, entities or services of re-gional coverage and/or interfederative management, dialoguing with studies on arrangements for the implementation of territorial-based policies[13].

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[14], 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[15], 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.[16], values internal dynamics, contextual factors and char-acteristics of organizations that contribute (synergistic interaction) or block (antagonistic interac-tion).

The following levels of analysis and their variables were defined:

1) design of the implementation: participation of federal actors in the definition of the agen-da, 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, in-stances of pacing or co-management of politics, verticality or horizontality in the relationship be-tween federation entities, institutionality and the process of nominating members and scale gain;

4) disputes and challenges in the federative relations mentioned, characterizing them regard-ing 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, nor-mative 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 Minayo[17]. 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 differ-ent 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 poli-cy implementation.

First, by the understanding of health as a social process, by Testa[18], where the power catego-ry 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 characteriza-tion of political, technical and administrative power for the reality of health services. This typifica-tion 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 exercised[19].

According to an additional perspective brought by Campos[20], health management, in addi-tion to the administrative and financial aspects of an organization, must consider political, pedagogical and subjective aspects that pervade team work, health production, power distribution, circula-tion 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 assis-tance 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 Evaluation[21].

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 Met-ropolitan Region) and local (referring to the city of São Paulo).

Chart 1. Valorization of the Health Region and federative entities in the implementation design

	National	**Regional**	**Local**
Definition of the agenda	Political convocation by the President and the Minister of Health Theme of the Government Program - UPA Expansion	Priority on the agenda of the entities of state and municipal secretaries Interest of the head of government of SP in federal partnerships Announcement of Samu and UPA by mayors Regional regulatory WG and Samu stress regulation of urgency and emergency services QualiSUS project in ABC	Mayors defend federal partnership UPA announced as a novelty in the city of São Paulo Demand for managers for investment in Municipal Hospitals Demand for municipal managers to readjust financial ceilings
Region of Health valued as territorial unit	Plans and financial induction linked to the health region CGR/CIR valued as an instance of approval of the plans Regional (non-municipal) population criteria for Hospitals, Samu, UPA and stabilization Room	CGR/CIR/CIB valued as approval instances Priority on the agenda of CGR/CIR Protagonism of the regional WG of Regulation and regional Coordination of Samu	
Concern with regional singularities	Priority RM Incentive for amazon region and extreme poverty Adjustments for small municipalities in the stabilization Room, Samu and UPA Alternative to small-sized Hospitals	Demand for expansion of RUE financial incentives for all 17 RRAS Opening for agreement of PAR in other RRAS other than RM	Demand for specific care line (respiratory diseases) Expansion of actions for the entire Municipal Hospital Network, regardless of federal induction
Policy instruments of implementation (regulation, financial and organization)	Financial induction based on the Regional Action Plan Decree 7508/2011 Incorporation of RUE into the National Health Plan Rules for habilitation and financial qualification of the services Situation Room of the MH (includes the Federative Dialogue Secretariat) Creation of a Network Support Department	Protagonism of the Tripartite Conducting Groups Interfederative matrix monitoring the implementation of the RUE Supporters of the State Secretariat and Cosems	Incorporation as priority in the Municipal Health Plan Allocation of municipal resources Creation of Reference Grid for Urgency New SO management contracts with RUE guidelines Forum of Networks in the intramunicipal regions Creation of Public Career for Doctors of the RUE Restructuring the Career of Hospital Workers

Source: Ministerial Ordinances of the RUE and its assistance components, Registers of the Conducting Groups, CIR and CIB, Regional Action Plans and Report of Implementation Evaluation.

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 ser-vices, 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 acceding 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[12], already mentioned, on the choice of policy instru-ments 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 pro-cess 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 incorpora-tion of RUE into national and municipal health plans; Federal Decree nº 7.508/2011, already men-tioned, 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 So-cial 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.

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

	Positioning	Motivation	Content Defense of the RUE	Disputes and Challenges Aimed
Federal	Identification with user and non-attendance situation Direct monitoring, with cam-eras and visit	Induce Attention Networks with the available resource	Bet on the integration of ser-vices in network and in NHP	Low regional/local governance Rotativity of local/regional teams Poor care regulation Underfunding Insufficient Connectivity/electronic health record/Telehealth
Common States Munici-palities	Urgency and emergency in the daily agenda of managers	Possibility of Adjustment of the financial Ceiling of Me-dium and High Complexity	Investments in various ser-vices integrated in Network Support for regionalization	Federal underfunding Federal slowness for habilitation Multiplicity of standards More investments in Small-sized Hospitals

Chart 2. (cont.)

Specific States	State protagonism in CGR/CIR and conducting groups Incorporation of the goals of RUE into the state Plans SP: defense of federal partnership (inflection in relation to previous years)	Support for regionalization	Regionalization brings stability to RUE SP; RUE supports regionalization that has already been conducted	Tension with Institutional Support of the Ministry State co-financing
Specific Municipalities	Defense of the Tripartite conducting group	Hospital integration to the whole network	Integration of services, especially hospital services	State co-financing UPA not to dismantle Primary Care
Representatives Workers	Urgency as a critical area in working conditions, leading to poor quality of care	Defense linked to local priority to working conditions and care	Expansion of the network	Increased SO presence Hyper valuation of the Private Hospitals Model/Proadi (Institutional Development Support Program) Absence of Public Career Absence of Policy on Violence against Workers
Representatives Users	Criticism of disqualification and violation of rights	Expansion of access to the Network and Humanization	Humanization	Federal underfunding and regional/local inefficiency

Source: Public positions of the actors in the National, State and Municipal Council of Health and in documents of their entities, registers of the Conducting Groups, CIR and CIB; Conass Report (National Council of Health Secretaries) of Evaluation of Implementation.

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 lead-ing the standardization of the accession process. The public launch of the program S.O.S. Emergen-cies, in national chain by the Presidency of the Republic, and the regional public visits by the Min-istry 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 spe-cific 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 rep-resentatives 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[21].

Chart 3. Matrix of characterization of interfederative arrangements in RUE, in RRAS/RMSP

	Dimension	Characteristic	Interfederative Relationship	Indication Members	Gain of scale	Legal framework
Samu Coord.	Service management	Co-management	Intermunicipal horizontal Municipal protagonism	Indication Secretary	Integration of services, administrative structures, logistics	Decrees and Ordinances
WG Regulation	Network Management	Co-management	Vertical bipartite State protagonism (management of more complex services)	Indication Secretary	Integration of services and teams	CIR Resolutions
Foundations	Service management	Co-management	Intermunicipal horizontal Municipal protagonism	Indication Heads of Government	Integration of services and administrative structures	Law
Consortiums	Management and services	Co-management	Intermunicipal horizontal Municipal protagonism	Indication Heads of Government	Integration of services and administrative structures	Law
CIR	Health Policy Management	Agreement	Horizontal bipartite Bipartite protagonism	State and Municipal Secretaries	No	Law
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	Service 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 feder-ative 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 con-tent 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, contrib-ute 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 Regu-lation 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, inte-grating 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 infralegal 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 im-plementation 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.

Chart 4. Synthesis of disputes and interfederative challenges not overcome

	Federal Sphere	Common Sphere States and Municipalities	State specific sphere
Management of Services	Does not apply to the case studied	Rotativity of care and management teams Connectivity/electronic health record missing	
Management of the Network	Does not apply to the case studied	Rotativity of management teams Low regional/local governance Poor assistance regulation, especially University Hospitals Connectivity/interoperability missing or insufficient electronic health record UPA not to dismantle primary care Expansion of the presence of SO and low public management of its services Competition between services and networks of different federative entities Disintegration between hospital services Dispute between Samu, State Service of Transport of Urgency (Grau/SP)	
Management of the Health Policy	Underfunding Slowness and complexity in enabling services and transfer of resources Low investment in small-sized hospitals Tension of states with institutional Supporters of the Ministry	Underfunding Rotativity of care and management teams Instruments of regional cooperation in management with indefinite sustainability Absence of public careers with regional mobility	Absence of co-financing of municipal services by the state sphere Conflict between state administrative division and RRAS

Source: Public positioning of the actors, public evaluation reports on implementation and instances of agreement and management of the RUE.

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 strength-ening or creation of regional arrangements were successful, such resources and governance mecha-nisms were insufficient to overcome disputes and interfederative challenges. In the records ob-tained, this negatively impacts the implementation of the RUE. Possibly, it impacted the care re-sults, 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[22]. 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[18] and Campos[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[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 regu-lation 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 dis-putes 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[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 anal-ysis 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 com-municative action, all those with varied exercise of power in the points of attention and manage-ment spaces, producing new subjects with the implementation of the policy. To this end, the ar-rangements 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[23], 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 renegotia-tion 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[24] 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[5]. 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 con-solidation 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 ex-clusive 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 oth-er 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 re-moving victims of homicides in police incidents; (b) the discussion in society and the disagreements between state and municipal instances of

government on the limits of road speed control and their impact on urgency and emergency; (c) the lack of inter-sectoral articulation about coping with violence against women.

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 be-tween municipalities, states and the Union, not through a geographical or administrative division[25]. 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 frac-tioned by the federal offers and by the emptying and the state omission, according to Santos and Campos[25], 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, pro-vided 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 reflec-tion, 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, edu-cational 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[25], 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[5], 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. ■

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