Deadlocks in the process of health regionalization: local plots

Impasses no processo de regionalização do SUS: tramas locais

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Resumo

Regionalização do SUS visa reforçar e potencializar esforços e medidas envolvendo a organização dos sistemas local e regional de saúde, mediante articulação de todos os envolvidos. Os entraves que costumam dificultar o processo de regionalização estão relacionados às tensões e aos conflitos entre os objetivos, a integração e os fatores políticos. Este artigo se propõe a refletir sobre o processo de regionalização do ponto de vista político-administrativo, destacando questões relativas à autonomia local decorrente do processo de municipalização. Dito de outro modo, se o processo de municipalização da saúde ocorrido nas últimas décadas fortaleceu a autonomia política dos municípios, a proposta de racionalizar a estrutura de serviços por meio da regionalização seguiu uma lógica mais administrativa. Mas, como vimos na região do Grande ABC paulista, por exemplo, a dimensão política do processo se impõe de qualquer maneira, sobretudo nos jogos de poder na defesa de interesses locais.

Palavras-chave: Regionalização da saúde; Tramas locais; Articulação regional.

Abstract

Regionalization of the public health system aims to encourage and enhance efforts and measures involving the organization of local and regional public health, through coordinating all those involved. The barriers that often hinder the process of regionalization are linked to tensions and conflicts between objectives, integration and political factors. This article intends to reflect on the process of regionalization from an administrative and political point of view, highlighting issues of local autonomy due to the process of municipalization. In other words, if the process of municipalizing the health system in the last few decades has strengthened political autonomy in the cities, the proposal to rationalize the services structure by regionalization follows a more administrative logic. But as can be seen in the in the Greater ABC region of São Paulo, for example, the political side of this process will impose itself, one way or another, especially when each city tries to defend their own interests.
Keywords: Health Regionalization; Local Plots; Regional Articulation.

Introduction

The Brazilian public health care system - Sistema Único de Saúde (SUS) model of regionalization suggests that the state level plays a decisive role, as it is the responsibility of the state to create opportunities for the municipalities to fully and articulately perform their role as a federative body. This paradigm implies cooperation, manager by the Regional Management Board - Colegiado de Gestão Regional (CGR), which is a space in which decisions are made by identifying and defining priorities and agreeing on solutions for organizing a comprehensive and problem-solving regional network of health care actions and services.

Even before the ratification of the 1988 Federal Constitution, the then governor of São Paulo, Franco Montoro, created the Regional Health Care Offices - Escritórios Regionais de Saúde (ERSA) on 17th July 1986, based on Decree nº 25,519. Fifty-seven ERSAs were created around the hierarchized and regionalized integration of the health care services in the state of São Paulo. The following year, these 57 ERSAs were increased to 62.

In the following decade, on 15th May 1995, the governor Mário Covas abolished the 62 ERSA by Decree nº 40.082, and created the Health Care Coordination of the Metropolitan Region of Greater São Paulo - Coordenadoria de Saúde da Região Metropolitana da Grande São Paulo (CSRMGSP) and the Health Coordinator of Interior - Coordenadoria de Saúde do Interior (CSI). These organs aimed to coordinate and articulate health care planning and actions developed in the respective regions according to the policies and directives of the Department of Health. Twenty-four Regional Health Care Directorates were linked to these coordinators, five being in the Metropolitan Region of Greater São Paulo Região Metropolitana da Grande São Paulo (RMSP) and the remaining 19 in the interior of the state.

Seven years ago, to be exact, on 24th January 2005, the then governor Cláudio Lembo abolished the DIR by Decree nº 51,433 and on 28th December 2006 created the Regional Health Care Departments - Departamentos Regionais de Saúde (DRS), totaling 17 in the entire state (São Paulo, 1986, 1995, 2006). The abolition of the DIR II, which had been responsible

for the Greater ABC region, and for its transfer to the state capital, now in the form of the DRS I, seemed to be a step backwards in the search for more efficacy in health care activities in the Greater ABC area and, consequently, for improvements in the concept of the health care region, as recommended by the SUS.

The Greater ABC area in São Paulo is nationally recognized for its leadership and also for its experience in regionalization, making the area the object of attention from international organizations. It was found that the formation of these actions in solving problems, including in the health care area, such as establishing the Hospital Mário Covas, cannot be called into question. The abolition of the DUR II made it difficult to view health care in that catchment area as a regional question, as it competed with the coordination of health care actions developed at a local level.

This constant change led the authors to create a study in order to produce this article, with the aim of describing the network of relationships of the process of regionalizing the SUS in the Greater ABC area of São Paulo, through the political and administrative deadlocks involved in its implementation, after the abolition of the DIR II. As regards the methodology, it was decided to use a case study, with the case being the Greater ABC area of São Paulo. In order to understand the situation in the region, 16 key interviewees, managers who had participated directly or indirectly in the regionalization process between 2005 and 2006 were interviewed. Data were collected between April and December 2010. Documents provided by the interviewees were also analyzed as were material published in the *Diário do Grande ABC* journal. We viewed the narrative as a structure of elements which crossed and interlinked with each other as if in a network, with intrigue, tension, confidence and collusion, a chain of events or storylines which constituted the action of the process of SUS regionalization in the Greater ABC area in 2005, the year in which the narrative occurred.

Most recently, in June 2011, Decree nº 7,508, regulating Law nº 8080/90 dealing with the organization of the SUS in Brazil, with health care planning and inter-federal coordination, reignited the discussion on the effective consolidation of SUS principles and directives in a national arena. Among these, the centralization, regionalization and hierarchization of the network of health care services stand out, these topics also being considered guiding principles in the technical literature. However, this Decree and its regulations do not explain the levels of the regionalization network, although they indicate the need to create health care networks. It can be seen that the organization of the networks should indicate these levels. (Brasil, 2011).

Key assumption in the regionalization of SUS: knowledge of the region

The key objective of regionalization is to guarantee quality service to its users, at the lowest possible social, economic and health cost. For Oliveira (2003), the regional health care system reconstructs the health care services on an appropriate scale by grouping together, into a cooperative system, a group of municipalities. But we cannot view regionalization solely as a guarantee of efficiency and quality. For Guerreiro and Branco (2011) regionalization can positively impact on equality, as it disregards resources exclusively coordinated in a few hubs in the state and thus determines increased satisfaction on the part of the users. It also reduces extremely high social costs, imposed by the long journeys SUS users outside of these regions have to make.

In a reading of Mendes and Almeida (2005), Stephan-Souza and collaborators (2007) and of Teixeira (2002), we can find other reasons why the SUS should be regionalized. Firstly, to raise awareness of regional belonging, followed by the need to adjust the health care services provided through cooperative action; another objective concerns overcoming the fragmentation of health care services trying to substitute inter-municipal competition with inter-municipal cooperation, changing the attitude of "every man for himself" for "all for all". And, finally, to improve the quality of public control of the health care system. The Greater ABC area is used as an example to set this scene.

Regional consciousness and identity, or regionality, involves inhabitants identifying themselves with their region, both inside and outside of it. We

want to highlight that regional identity is a premise for thinking about the region (Gil and col., 2007). In the Greater ABC area, the feeling of belonging to a region is not a consensus among the municipalities. It is common, according to the statement of one of the interviewees from the Health Department in São Caetano do Sul, "*that a citizen of São Caetano do Sul, when outside of the Greater ABC area, in another city or state, introduces themselves as being from the municipality of São Caetano do Sul, and not from the Greater ABC area*" due to "*that municipalities high economic and social level, which contrasts with that of other municipalities in the region".* This feeling of pride at belonging to the municipality has encouraged rivalries among the others, thus accentuating municipal pride.

It is a fact that strengthening the regionalization of the SUS is part of a Greater integration of all the municipalities and, above all, of a less passive and more engaged and proactive participation. However, it is not regional development cannot progress when there are deadlocks between the municipalities. We noted evident conflicts between municipalities in the region. According to the statement of an interviewee from the Department of Health in Ribeirão Pires, the conflict is mainly in "*the difficulty municipalities with smaller provision of services have in operating their systems*", meaning that citizens with health care needs "*invade neighboring municipalities seeking care*"; as is the case in Mauá, Santo André and São Caetano do Sul, due to the railway which crosses the four municipalities.

Gerschman (2001) affirms that this is a recurring issue in some areas of health due to the municipalization of the SUS having appeared as an option for decentralizing health care activities at the beginning of the 1990s. The current situation suggests a model which integrates the network of municipal systems in a specific region, as is the case in the Greater ABC area, which has a low level of integration. Judging by the statements collected, the precariousness of the effective establishment of the regionalization process derives from the previous "stage" of municipalizing the system in the region, as the model there is characterized by managers still operating from the perspective of autarchic municipal systems. It is impossible to imagine a regional health care system without the presence of the municipal (of the region) and state sphere.

Although investments have been targeted at public health in the Greater ABC area – such as emergency care units - unidades de pronto atendimento (UPA), basic care units -unidades básicas de saúde (UBS), hospital centers among others, - we can see that the municipalities in the region are each focused on their own municipal health care network. If we ask whether these municipal investments demonstrate that the SUS model of municipalization has yet to be overcome, the answer is yes and no. Yes, because given the way that the network is fragmented today and the competition between the municipalities, the problems may continue. And no because, at the same time, these "enterprises" make it possible to provide more hospital beds in the Greater ABC area, thus decreasing the journeys inhabitants of the region have to make to receive health care. These journeys are such an important topic in the region that they attracted the attention of Bousquat and Nascimento (2001), who coined the term health care related journeys - viagens por motivos de saúde (VPMS).

For one of the interviewees from the São Caetano do Sul Board of Health, the difficulty in health care related journeys lies in "*the large number of individuals who travel from one municipality to another seeking health care, the so-called health care related journey*". It should be highlighted that this situation makes it more difficult for the health care networks to treat the citizens, as the challenge lies in knowing the total population of the area around the network. According to one of the interviewees from the DRS I, this occurs "*because the individuals who want to be treated do not necessarily belong to that region, further reinforcing the importance of a regional health care system which can care for residents of the region*"

Bousquat and Nascimento (2001) believe that inter-municipal competition makes it more difficult to balance health care service supply and demand in the region as the municipalities do not want to share resources with citizens who are not resident in their territory. Although citizens have every right to travel from one municipality to another, this causes problems for health care managers due to technical and adminis-

trative criteria. In the Greater ABC area, citizens from other municipalities are considered "invaders" seeking health care services, especially primary health care services. They are seen as "aliens" or foreigners who affect monthly and yearly health care indicators. It could be thought that this regional xenophobia is encouraged by the technical-administrative parameters adopted by the health care managers which, either concentrate more on supply rather than on demand, or only consider demand in their own municipality; or only consider the demand of those dependent on the SUS.

This issue is in line with what was suggested by Elias (2004) for whom managers, on establishing a regional health care system, should pay more attention to provision of services than to demand.

There can be no SUS regionalization without state government participation

Irrespective of the existing organization of the health care system in the state of São Paulo and of the location of the DRS I, the duties of each sphere of government based on the Health Care Operational Standards - Normas Operacionais de Assistência à Saúde (NOAS) and the more recent Health Care Agreements need to be made clear. In short, the municipalities are responsible for managing primary health care and the state for medium and complex care, mediated by social organizations (Brasil, 2005). How can the process of regionalization be strengthened among municipalities which have disparities in all of their plans?

One alternative is inter-municipal consortiums, which have led to some health care services agreements being brokered between municipalities and the state; in the region in question the Greater ABC Inter-municipal Consortium, created in the early 1990s, carried out this brokering. One of the interviewees from the DRS I indicated how to avoid possible partisan discord: "*at times, it is necessary to stop thinking that the State is not meeting a region's requests because it belongs to the opposition*". We can see that the issue of politics that colored the region in the 1970s and 1980s may be the same thing which prevented coordinated actions in the health care sector in the last decade.

Pessoto (2010) pointed out that this situation may pose an obstacle to consolidating a regional system and for the subsequent improvement in the health care provided to SUS users. A region may have contain economically powerful municipalities, but that does not mean that they alone have the capacity to provide all health care services. A region cannot abdicate itself from the presence of the state, especially when that state is São Paulo, the "richest" of the Brazilian federation. There can be no regional health care system without the presence of the state sphere. However, taking the Greater ABC area as a reference, we can see that the state contribution to the health care budget for each city is no higher than 2%, with the majority covered by the city itself (Sanches, 2011a).

The number of health departments and health boards in the region may help to illustrate the situation as of 2011. In the health care planning for Santo André, the state is responsible for a 0.6% slice, compared with 67.4% for the municipal health department and 32% for the federal government, whereas in São Bernardo do Campo the municipality is responsible for financing 71.95 of health care, with 25.1% from the federal sphere and 2.9% from the state. In Diadema, 715 of the budget is born by the city hall (prefeitura), 28% by federal government and 0.4% by the state. In the 2010 health care budget for São Caetano do Sul, the state's contribution was no more than R$ 300 thousand of the R$ 128 million municipal budget. In the majority of cases, less than half of the sum is dedicated to improvements, with the majority being spent on upkeep of the SUS network, according to Sanches (2011a, 2011c).

According to Elias (2004), regionalization of the health care system is inconceivable without effective state participation. In those places where they work together with the federal government, state and municipality have a greater chance of their system prospering. It is evident that simply unifying the municipalities' health care systems does not constitute a regional system. Therefore, a regionalized and integrated health care system is inconceivable without the presence of the state, as it is the state which is responsible for coordinating the municipalities.

The role of the state is not only to open a social

organization in the region for medium and complex treatment but also to support the municipalities financially, as it is they who, in fact, manage the health care systems in a region. Turning our gaze once again to the Greater ABC area, one of the interviewees from the Health Department in Santo André explains: "*it is difficult to imagine that the sum transferred by the state is the limit of its contribution to the Greater ABC area*" and adds "*although the majority of people in the region have private health insurance, there is still a significant number who are completely dependent on the SUS.*" In the view of this interviewee, the Greater ABC area in São Paulo has been passed over compared with other health care regions in the state.

Despite state investment in increasing basic medications included in the "Correct Dose - Dose Certa" program, and in the distribution of more than 300 high-cost medications, the state government has not provided resources for training health care professionals or ongoing monitoring of health indicators which would enable timely action in those locations most in need of specific health care services (Ribeiro and Sivieiro, 2008).

Meanwhile, in the Greater ABC area in 2009, faced with a shortage of hospital beds, the state invested around R$1 million in two social organizations in the region (the Hospital Mário Covas, in Santo André, and the Hospital Serraria, in Diadema). Together with hiring 60 new health care professionals to improve services and upkeep of the new beds, R$200 thousand was added to the monthly hospitals costs, which accounted for around R$90 million (Ribeiro, 2011; Sanches, 2011b).

To give a better idea of the situation, if the entire population of the Greater ABC area with no health insurance had only the public health care network in the seven municipalities on which to rely, there would be enormous problems as the ratio between the population and the number of bed – public and private – in the region is 2.6 million inhabitants for 4,828 beds – base year 2010 -, which is the equivalent of 529 inhabitants per bed (IBGE, 2010). The Greater ABC area has an average of 1.9 beds per thousand inhabitants, below that recommended by decree in Brazil (2012), which is 2.5 to 3 beds per thousand inhabitants.

There is no question that there are municipalities, in a given region, which are more dependent on state resources than others. The role of the state has become fundamentally important for municipalities which do not have sufficient autonomy to become independent of state government. This is the case, for example, of two municipalities in the Greater ABC area: Ribeirão Pires and Rio Grande da Serra. In seeking to encourage cooperation with regards health care policies in a region, the DRS are relevant. We have to recognize that constituting a regional health care system needs the willing participation of the three parts of the federation, thus seeking to ensure comprehensive care for the citizen.

But we must not neglect to mention that the installation of new equipment by the state government may intensify competition between municipalities in a specific region, especially because they constitute the most visible way of obtaining political advantages for the municipalities which establish them. In the Greater ABC area, once again, we observe that each of the seven municipalities in the region prioritize themselves over the region, as they draw up their municipal health care plans in isolation, with little or no contact with regional bodies.

Difficulties in harmonizing federal interests

The State Plan for São Paulo (São Paulo, 2006) for the last decade included the organization of new health care regions, through inter-municipal agreement and forming CGRs, constituted by municipal health care managers from the region represented by the committee and by representatives of state managers. Together with the DRSs, the CGRs are responsible for altering directives, objectives, aims and indicators, according to the reality and peculiarities of the local areas.

Also according to the state plan, the CGR should qualify the regionalization process and guarantee cooperative actions between the managers of each health care region, with the participation of all municipalities of which it is composed, and with the State representation. Thus, constituting a CGR is a step in the SUS regionalization process which, in order to work properly, requires that the planning,

regulation, programming and action be coordinated between the managers and be effective and permanent. In this way, the CGR is configured as a permanent space of agreement, co-management and decision making, through the identifying and defining priorities and agreeing solutions for the organization of an integrated, problem solving regional network of health care actions and services (Brasil, 2006).

The CGR is an indicator of the movement of municipal health care managers and civil society towards a regionalization in keeping with the realities of the region, in a panorama of the increasing deployment of constantly renewed regional cooperation. For the interviewee from the ABC Foundation there is an "*optimism in advances in consolidating this space of inter-federative management, considering that recent health care policies have included the CGR as a space for formulating and executing its actions*". However, the obstacle lies in lags in complying with the political principle of access to citizen's rights adopted by the SUS.

As regards the health care region, it is necessary to consolidate regionalization not simply based on norms, but based primarily on practice, on the scope of actions and services and on respective responsibility. One of the interviewees from the Board of Health, São Bernardo do Campo gave examples of the limits of this practice: "*since the previous decade, the Greater ABC area has been trying to organize a network of health care actions and services, seeking to ensure compliance with the constitutional principles of universal access, equality and integration*". And added: "*but this was not a generalized effort*". According to the statement of an interviewee from the Board of Health, Santo André, *"there are difficulties in sharing the interests between the municipalities themselves and between them and the State",* as the process of regional government in the Greater ABC area is fragile – not to say "non-existent" – in diverse social areas, and the health care area is no exception.

In the view of an interviewee from the Hospital Nardini de Mauá *"the municipalities contributed little, and still contribute little, to forming and strengthening a supportive and cooperative process of regionalization".* There are divergences and conflicts of interest between the municipalities themselves, and between them and the State. Obviously, the diverse features of the conflict prevent, up to a certain point, the commitments agreed for the goal of regionalization from being met. Judging from the statement of an interviewee from the Board of Health, Rio Grande da Serra, *"on rare occasions, the municipalities act cooperatively with regards human, technological and financial resources".* This practice not only harms the agreements established in the CGR, but also weakens the municipalities' meeting of technical and financial obligations.

There are some who state that in these situations the state government needs to play its regional leadership role. Given that coordination between the municipalities themselves is essential, the state government needs to take on coordination of the SUS regionalization process, seeking to propose general directives and norms, through agreements in the Inter-managerial Bipartite Commission - (CIB), in coordinating the organization and updating of the Regional Plan - Plano Diretor Regional (PDR) in a region.

In the case of the Greater ABC area, what has made cooperation, agreement and governance impossible in the SUS regionalization is competition and "power games" between the municipalities, as some seek assistance from the state government (PSDB) and others from the federal government (PT), due to political party affinities on the part of some municipal governments. Political deadlocks are at the core of issues in the region. In Elias (2004) we can see that there are ways of reversing this situation: one is to overcome municipal competition and converge on common interests; another is to concentrate and intensify discussions on issues of real importance to the citizen, such as, for example, improving provision of services and ensuring their rights – leaving disagreements and partisan squabbles to be debated at the appropriate time and place.

Recognizing the advances in inter-governmental relationships in the health care sector means clearly defining the contradictions, difficulties and limits of this process. A key difficulty concerns defining an agenda of agreement. The multiplicity of social and institutional interests to be included in the agenda for the sector mobilizes different techno-bureaucra-

tic groups in defence of projects and actions aimed at different segments or groups of the population, and the priorities are not always defined based on rational criteria or needs. This is expressed in the priority given to discussion on the organization of health care to the detriment of debate on policies promoting health and the prevention of diseases and health problems (Dourado and Elias, 2011).

The regionalization process exposes one of the facets of the tension which manifests itself in the defence of federal entities, due to their marked socio-political differences. This situation can be observed in the Greater ABC area, where small sized municipalities, in other words Ribeirão Pires and Rio Grande da Serra, are less able to mobilize than medium sized (such as Diadema and Mauá) and large municipalities (Santo André, São Bernardo do Campo and São Caetano do Sul). The "smaller" municipalities do not always feel included in the negotiated agreements, as they question allocation of resources concentrated on their "richer" counterparts. When uneven use of resources in order to enforce the agreement is associated with the difficulty – almost impossibility- of including the range of interests in dispute it impacts on the legitimacy of the agreement and compromises the success of its implementation.

Regulation of the Regional Health Care System: a model with weaknesses?

As in any complex system, we recognize that regulation allows that the diverse functions remain in operation within a predetermined target or limits so as to guarantee that the system as a whole achieves its basic objectives. In this respect, the interviewees in this study indicated three fundamental considerations in the Greater ABC area: one are the basic objectives of the system; another concerns the expected performance parameters for the system's multiple function; and the devices and mechanisms of adjustment and corrections of these functions and respective effects. We can see, in the case of the Greater ABC area, that this regulatory role is not so clearly viewed on the part of health care professionals. According to an interviewee from the Board of Health of Diadema, the aim of regulation "*is to ensure that the greater social objectives of the health care system are achieved, with the aim of counterbalancing or counteracting the numerous State and municipal failures in the sector*".

The importance of regulation as a tool to improve the functioning of institutions within the health care sector needs to be recognized, given its role in minimizing the opportunism of the agents and the difficulties inherent in rationality as regards the functioning of the health care system. According to our interviewees, the regulatory mechanisms in the Greater ABC area are fragile, as are the aforementioned agreements. For one of the interviewees, from the Board of Health of São Caetano do Sul, these mechanisms should include a wide range of possibilities to be developed by the regulator, "*from the definition of legal frameworks to price caps, formal commitments for investments, cost formulas - or funding - and licensing policy*".

The primary objective of developing such strategies and regulatory mechanisms has to be compatible with the introduction of innovations and "entrepreneurship" in the functioning of the health care systems in a given region, it falling to the state to guarantee better results. In this case, regulation should include everything from guaranteeing equality and universal access to health care to the residents of a region, to promoting health with the aim of ensuring the effectiveness of health care and the quality of the services, reducing inefficiency and waste of resources, enabling the patient to choose doctor and health care service, taking into account the available resources, and the managing of internal and adjacent interests which eventually make these things function improperly and without regulation (Ibanhes and col., 2007).

In the case of the Greater ABC area, in order to guarantee that these wider health care objectives are met, quantifiable intermediary objectives are needed, as well as the desired effect of the regulation. According to the statements we heard, some of the expected effects would be: protecting investments in health promotion: decreasing the enormous inequalities in costs with preventative care; correcting poor distribution in the area of human resources and health care equipment; establishing transpa-

rent relationships between the diverse health care "subsystems" and the Ministério da Saúde; correcting inequalities in access, aligning the performance of the various health care service providers with overall aims of effectiveness; and providing adequate care at all levels of the system.

According to Viana and collaborators (2006), strengthening the control and assessment functions of SUS managers should concentrate mainly on the following dimensions: assessing the organization of the system and the management model; relationships with service providers; quality of care and user satisfaction: results and impact on the health of the population concerned. Therefore, regulation is aimed at providing care alternatives more appropriate to the needs of the citizen, in an even, orderly, timely and qualified fashion.

However, in order for all of this to be achieved, some basic assumptions have to be adhered to. One, carrying out a prior evaluation of the health care and planning and programming needs, which includes epidemiological aspects, care resources available and access conditions to the units in question. Another is defining a regionalization strategy which outlines the responsibilities and roles of the various municipalities and the inclusion of diverse care units in the network. Next, delegation of health care authority by the appropriate manager to a medical regulator, who will take responsibility for the regulation of care, using technical-operational protocols. Finally, defining the interfaces of the strategy for regulating health care as a process of planning, programming and other control and evaluation instruments (Ibanhes and col., 2007).

Thus, the great concern in developing regulatory mechanisms lies in conceiving regulatory policies based on evidence, seeing what works in what contexts and with what advantages and disadvantages.

Final considerations

As a political process, the regionalization of the Sistema Único de Saúde involves distributing power in a delicate system of inter-relationships between different players – governors, public, private and citizen organizations – in a limited geographical space. Establishing this health care system is complex, as it implies constructing a set of planning which takes into account the integration, coordination, regulation and financing of a network of health care services in the area, in a process of continuous negotiations of all types. Moreover, it should include elements of differentiation and loco-spatial diversity, going much further than the boundaries of the municipality. Regionalization involves the entities organized within this fabric, such as the health care districts and regions, in intra-municipal and inter-municipal designs or even bordering health care regions, able to be administered under a regime of co-management. A regionalized system should still be capable of coordinating the various fields of health care in a specific territory in a coordinated way, aiming to ensure the comprehensiveness of the actions and of the access to health care services.

It is known that both decentralization and regionalization of health care are alternatives recommended to improve the administrative efficiency and participation of the services, with the emphasis on local participation and autonomy, together with the redistribution of power and reduction of loco-regional tensions. We also know that the processes should be made viable through financial and administrative mechanisms. We can see that Decree 7,508/11 seeks to clarify the instruments for promoting SUS regionalization through an integrated health care network. However, it does not clarify how to structure it at level accessible to the citizen.

We can see that political-administrative deadlocks which make the regionalization process more difficult, related to disagreements between the authority and responsibility, to tensions and to conflicts between objectives and horizontal and vertical integration. Strengthening of SUS regionalization is through better integration of all of the municipalities and, above all, through a less passive, more engaged and proactive participation. There can be no SUS regionalization without the presence of all municipalities in the region and without the state. For this reason, it is not possible to advance towards regional development while conflicts between municipalities themselves and between them and the state overcome the highlighted objectives. These deadlocks are present in the Greater ABC region, which make regional health care cohesion difficult.

It was not difficult for us to perceive the difficulties municipal health care managers have in overcoming the municipal context of the difficulties, reinforced by the diverse forms local interest takes vis-à-vis the area of health care. One way or another, the political dimension of the SUS regionalization process imposes itself, above all when municipal health care managers seek to defend local interests, in other words, in "power games". We can see that the region needs to advance and mature regional cooperation so that regionalization can occur, if not, the current model in its current form will persist: uneven, fragmented and with insufficient provision of services.

We can see that in the SUS regionalization process in the Greater ABC area, there are three issues which need to be tackled. One, that the health care service network and actions take into account the loco-territorial diversity together with seeking to overcome inequalities. Another, that public responsibility be formally undertaken, with the participation and involvement of civil society and of the diverse players who make up the health care system in the territory. Finally, to guarantee centralized regulation with maintaining the autonomy of local governments.

The deadlocks surrounding the regionalization process lie in economic interests, political deadlocks, competition between municipalities and the state and governance. The latter is concerned with coordination, relationships and leadership based on the social players, something which does not occur in the Greater ABC area due to the "power games" existing between them, meaning there is great difficulty in its operation, as one municipality will not cede its interests to others. In this case, it falls to those coordinating the process of governance to define the "rules of the game" so that the players can "play". It is here that the local plotslie, in the political-administrative issues.

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