

The concept of the regionalization of the Sistema Único de Saúde and its historical time

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Received on 6 Jan. 2018.

Approved on 19 Jul. 2018.

Translated by Rebecca Atkinson.

<http://dx.doi.org/10.1590/S0104-59702019000400006>

MELLO, Guilherme Arantes; DEMARZO, Marcelo; VIANA, Ana Luiza D'Ávila.

The concept of the regionalization of the Sistema Único de Saúde and its historical time. *História, Ciências, Saúde – Manguinhos*, Rio de Janeiro, v.26, n.4, out.-dez. 2019. Available at: <<http://www.scielo.br/hcsm>>.

Abstract

This essay assumes that from a simple administrative guideline, regionalization has become the main concept for enabling the doctrine of equitable and universal coverage behind the Brazilian Sistema Único de Saúde. At the interface between studies of the historicity of the concepts and extensive fieldwork, it is argued that the traditional concept of the regionalization of the Sistema Único de Saúde has reached the historical limits of its productive capacity. However, updating this term challenges novel perspectives for a clinical system integrated in networks within a broader intersectoral strategy of regional production clusters.

Keywords: regionalization; decentralization; concept formation; health policy; Sistema Único de Saúde (SUS).



This essay seeks to question the interface between the authors' theoretical work (Mello, Viana, 2012) with two broad-based field studies done recently in different regional contexts in Brazil (Viana et al., 2017a; Ibañez et al., no prelo). Its vision is spurred by ongoing interdisciplinary debate, where geography has proved essential for pushing back the limits of the field of sanitation in comprehending the problem of regionalization.

The aim is to problematize the concept of regionalization, while also working transversally with aspects of the historicity of concepts and their importance as theoretical inputs in production processes. Although part of the text deals with contemporary issues, the velocity of technology transition makes them all but elements from the past.

The main goal is to discuss the historical limits of the concept of regionalization of health in the production process behind the construction of the Brazilian Unified Health System (Sistema Único de Saúde, SUS). The aim is not to present an exhaustive exploration of the possibilities or to interrogate each argument, not just because of space constraints, but primarily because the purposes behind the idea of regionalization have grown in such size and complexity that they extrapolate the limits of the analytical capacity inherent to public health, unable to attend the demographic, economic, political, and social spheres involved (Viana et al., 2017b) – itself a central idea of the text.

On concepts and regionalization

It is widely agreed that a concept does not imply mere representation, but the most effective component of language, historically constructed in a constant tension between the linguistic and the extra-linguistic. More concretely, all production processes must be centered around concepts – which themselves take on the function of cognitive instruments. However, all concepts are temporally situated, in a relationship that can take shape in four ways: reality and concepts remain stable over a long time; they alternate simultaneously; the concept changes but reality does not; or reality changes but the concept does not (Koselleck, 1992; Jasmin, 2005). Irrespective of this, a concept may belong to a “time of ideas,” when it is circumscribed in avant-garde discourses, or to a “time of mentalities,” when it is already received wisdom and has permeated collective representations and attitudes. The actuality of the production process is therefore also determined by the historical time of the concepts involved.

The concept of regionalization in health dates back to the first half of the twentieth century, and is particularly linked to medical training (Grant, 1955). Integrated with the international scenario, public health thinking in Brazil at this time already embraced this idea in the organization of the country's rural public health (Candau, Braga, 1948). However, the discussion gained more traction in the sanitation debate, especially the planning processes in the 1960s and 1970s, stimulated by the World Health Organization and the Pan-American Health Organization (PAHO), on the one hand, and by new international conceptions about medical training (OMS, 1972; Chaves, 1977; Mello, Viana, 2012). A concept shaped within new thinking about bureaucratic administration (Costa, 2010) and saturated in the perspective of “service integration.” A reality that revealed regionalization in health services even in the pre-conceptual phase at the time, without a robust theoretical

framework to individualize it, especially when it came to its dependency on the concept of decentralization.

In this case, federalism also demonstrated conceptual inconsistencies, with interpretations being subject to the historical circumstances of the day, since “few interpreters of Brazil were enthused by it” (Brandão, 2007, p.51). This indicates that the possibility of a conceptual elaboration of regionalization also remained limited by the very need to mature the concept of decentralization, a body of ideas with incomparable historical and political weight: “If federalism was rare as a reflection and ideology, federation ‘is a phenomenon from our whole past,’ as said Nabuco” (Brandão, 2007, p.51).

It is therefore no surprise that when the debate about regionalism was resumed at the turn of the century, elements of that founding representation of the SUS were brought into the received technical wisdom, whereby regionalization and decentralization were blurred in a broad spectrum of technical and administrative decentralization. Nonetheless, under pressure from the political and technological reality, the ideas of the regionalization of the SUS were gradually refined in terms of health policy, the visibility of which can be seen in its successive legal frameworks. This is what led to a marked accumulation of normative influence that proved unable to take account of a fundamental paradigm shift.

In a recent review of regionalization, a growing body of good studies in Brazil that systematize accumulated knowledge and practices came to light, reaffirming a number of common constraints: difficulties with the federal structure; heterogeneity of entities; underfunding, favoritism, and cronyism; and excessive difficulty in planning (Mello et al., 2017). Of greatest interest here, the review also exposes a clear saturation of the investigative gaze on the subject – a narrowing of perspectives that nonetheless still expresses the proximity of the time of ideas to the time of mentalities.

In fact, despite the close historical distance, the speed of the contemporary epistemological transition increasingly accentuates the perception that while the concept of the regionalization of the SUS has remained circumscribed to a consistent body of theories, the arguments about the debate of the preceding decades are somewhat predictable – still bearing an obvious debt to 1980s discourse (Marton et al., 1983). These are essential arguments, but they clearly fall short when addressing new social, technological, and disciplinary patterns. This state of affairs is consistent with the fourth possibility described earlier, when a concept remains stable in the face of a reality that has changed (not static, but accumulating around the same attributes).

It is therefore plausible to assume that this literature on the “classic” concept of regionalization – particularly derivative and reactive to the political time – defines frameworks and brings to a theoretical close a long intellectual process that has inevitably reached the historical limits of its productive capacity.

On extension, pragmatism, and conceptual induction

In its historical trajectory, a concept may be defined by “accumulation,” strongly refining and circumscribing its theoretical basis around the same set of attributes. A gain in intension, but it may compromise the extension needed for production processes and

research. Inversely, a concept may be defined by the “addition” of radial units (Sartori, 1970). The biggest problem here is that the addition of too many ideas may make its extension so great that any consensus and practical utility is lost, which is likely what has happened to the concept of comprehensiveness in the SUS.

In the case of regionalization, once accumulation is exhausted and stability is reached, in which new additions are of limited value, all that is left is the route of conceptual “redefinition.” Not as idealization, but with the purpose of remodeling in line with the “world of facts” and inspiring new production processes with a balance of intension and extension (Sartori, 1970; Fonseca, 2015).

One important consideration, as will be seen in due course, is that this redefinition tends to modify the operational pragmatism historically imprinted on the concept as of its emergence. Back in the 1960s, regionalization was put at the heart of the reforms of state administrations induced by the now well-known executive order #200 (Brasil, 1967). In the São Paulo reform, this meant, in particular, a reorganization of the state into “regional divisions,” which were themselves subdivided into “sanitation districts.” This definition permeated everything – albeit with greater or lesser visibility – from the great sector reforms like the 1976 program for the provision of health and sanitation in the northeast of the country (Programa de Interiorização das Ações de Saúde e Saneamento), the 1980 national basic health service program (Programa Nacional de Serviços Básicos de Saúde), the 1982 Conasp Plan (Conselho Consultivo de Administração de Saúde Previdenciária), the SUS plan, in 1988; and it even regained center stage in the 2000s with the operational norm for health care (Norma Operacional de Assistência à Saúde). More recently, the 2006 Pact for Health (Pacto pela Saúde) demonstrates a clear effort to reduce the normativity ingrained in the concept.

The point is that in recent times the theoretical frontiers of regionalization have expanded to levels of formulation and abstraction – networks, urbanization, region, complexity, intersectorality etc. – that are hardly conducive to an instrumental precept. From this perspective, the concept should gain more strategic meaning, while the most immediate managerial level should relate more directly to related operational concepts, like health care networks and patient flows.

Generally speaking, the idea of a paradigm shift relates to a situation of such scientific accumulation that new knowledge can no longer adapt to the original field (including the linguistic field) and must break out in new directions. Without sufficient technological accumulation, the opposite can be envisaged: teleological, guided by intentionality, where a rupture is forced with the induction of subsequent technology accumulation (Mello, 2017). Such political induction on the field of science is perhaps best exemplified in recent years by the concept of “translational research” (Zerhouni, 2005; Guimarães, 2013).

It is clear that this conceptual redefinition elicits a rupture whereby the concept of the regionalization of health no longer supports, but accompanies and promotes elements of high-level political, technological, and social prospectation in this field.

Specific questions implied in the conceptual redefinition

Relationships between decentralization/municipalization and regionalization

This is one of the most demanding components of the conceptual discussion of regionalization in the country, whose development certainly calls for specialized competencies and space. It is not so much an epistemic rupture as a reinforcement of the relatively common misconception that municipalization is a consolidated characteristic around which regionalization should be molded.

This is not exactly an original question, and some confusion between these concepts can be found in the international literature (Fierlbeck, 2016). There is, however, no such thing as a static political dimension; indeed, federalism itself is assumed to be a state of dynamic equilibrium between vying social forces (Saltman, Bankauskaite, Vrangbæk, 2007).

In its conception as equitable, the regionalization of the SUS is also, by definition, a federative debate, and purely regional arguments can be seen as a merely didactic option. This lack of dissociation becomes explicit in the best designed theoretical system of this domain in the country, developed by Celso Furtado, as Chico de Oliveira points out, as reported by Brandão (2007, p.53): “According to Chico de Oliveira, the only ‘interpreter’ of Brazil [Celso Furtado] to take it seriously when he designed a ‘cooperative regionalized federalism’.”

Intersectorality as substance

The regionalization of the SUS is not a finished concept, nor is it just a matter of administrative efficiency; it is a means to assure equitable access to the resources needed to fight disease and its social determinants (not surprisingly, a principle given little priority in market-based systems). The scope of these overarching objectives – which are essentially linked to health, but also to social rights, education etc. – makes it absolutely impossible to limit the concept to a specific sector, making intersectorality another concept intrinsic to the regionalization of health. (This should not, however, serve as an obstacle in delimiting intermediate goals, such as ones linked to the sectoral integration of services.)

Defense of the intersectorality of health is nothing new, but historically this potential has proved refractive to development and consideration. In a thesis from 1972, the eminent sanitarian Reinaldo Ramos distinguished two forms of integration – intrasectoral and intersectoral – which have to do with including health in production policies for other sectors, geared towards increasing the country’s GDP (Ramos, 1972, p.5). The focus on the intrasectoral – justified as an inevitable first step – means the question of intersectorality has remained latent.

At the end of the 1970s, the idea was reinforced in relation to the new national health system:

The view of the four major dimensions of the health management process, which encompasses the whole national development project, reveals to us, in its essence, the fundamental need for intra- and intersectoral coordination. ... The 2nd National

Development Plan, as a national economic and social development project, is the reference framework for intersectoral coordination, in the same way that Law 6.229 is for intrasectoral coordination (Chaves, 1977, p.70-71).

The dimension of the initiative reveals that this was no simple task; indeed, the attempted rupture, through political induction, did not prove sufficient to shape a strategic production system involving the health sector.

The ensuing move to introduce a public health reform was hampered in this respect, seeing its efforts directed towards the intense and endless dispute for a universal health system and the assurance of public funding. Two long decades would pass until the emergence of consistent re-elaborations of intersectorality in health (Gadelha, Costa, Maldonado, 2012); in this case, the conception of an economic and social development and production complex whose due interconnection with the principle of regionalism would be mutually beneficial. A question that reveals the potential of the concept of regionalization to challenge ambitious theoretical systems that combine, as far as is possible, different regional designs, like health, citizenship, education, urban networks, division of labor etc.¹ (Monteiro Neto, Castro, Brandão, 2017).

The complexification of the concept of urbanization

In a given field of research, the vision that the regional debate had lost much of its sense was defended by an important professional in the state management system, since “people live in municipalities.” If it was today, it would be possible to determine more clearly the heuristic value of the debate. According to the official Brazilian statistics institute, Instituto Brasileiro de Geografia e Estatística, in 2015 over half the Brazilian population lived in 294 urban clusters of 938 municipalities, commuting to work and to study (IBGE, 2016). In other words, if most Brazilians live in towns and cities, they actually live, study, and work in regions. A social reality that is completely inconsistent with the early theoretical conceptions of regionalization – closer to Afrânio Peixoto’s thinking when he said “our *sertão* [hinterland] begins at the verges of the Avenue” (cited in Hochman, 1998, p.70).

Despite the difficulty inherent to the concept of region (Contel, 2015), there is a move towards more profound inquiries into urban and regional networks. Roux (2015) regards cities as systems of production networks and flows, which means analyses have to be made of their different levels of organization. The problem of regionalism rises a few rungs higher in the problem. Municipal centers of different sizes and spheres of influence, modes of transport, flows (of materials, people etc.), and stocks (goods, population, services etc.) are jointly organized into different territorial scales in a heterogeneous, interdependent field of non-linear relationships that gives rise to unpredictable patterns that defy comprehension (Egler et al., 2011). Meanwhile, the recent cross-fertilization of urbanization and political theory adds new variables to the understanding of the multiple scales needed for the socioeconomic and regulatory spheres. Problems of the reduced scope of traditional tools and the need for innovative analyses, like the study of patterns of networks of relationships between different actors (Marques, 2016).

The context has to do with complex systems, which itself rapidly reveals that urban networks have become resistant to access by public health in isolation (even from the perspective of the impact that virtual relationships have on this process). New tools will likely manage to render more effective designs of health regions in the near future.

The component of networks and complex systems

Historically shaped around the vision of “services”, the idea of the organization of a health “system”, essential for the modern conception of regionalization, only started to take off in the 1970s and 80s, when the foundations for the concept were laid.² The idea even invaded progressive thinking at the time, in the face of which it seemed to bring back the contested perspective of social functionality.

Yet the maturing of the binary system, with its flow charts full of inputs and outputs, proved essential for comprehending and constructing more effective and efficient integrated processes, and became common knowledge. However, this conception is now yielding increasing ground to the idea of complex systems. The reason is that mechanical, stable, linear systems with responses proportional to their stimuli have run their course as models for explaining social systems (Plsek, 2003).

Complex systems, as health systems are, have organic characteristics. They are not entirely predictable, are constantly adapting to their environment, and are in a dynamic equilibrium between order and chaos, “as opposed to linear systems, in which the outputs are proportional to the inputs – each element has some freedom to act independently, and each element can change itself” (Sweeney, Mannion, 2002). This means, for example, that different arrangements can be made and different decisions can be taken for the same patterns of problems in different sequences, at different times, or involving different professionals in various spheres. Systems that take account of uncertainties, where local adaptations are routinely made in response to unforeseen circumstances or different preferences etc.

The applicability of this conceptual component is still little known. Although there is a growing body of empirical research on complex systems, it was recognized in a broad-based review that descriptive and exploratory studies still prevail (Braithwaite et al., 2017). While these indicate the limits of mechanical and linear models for comprehending social systems, some particular developments are noted, such as the model for chronic conditions and its primary focus on social, community, and self-management resources (OPAS, 2015); or the idea of translational research, involving the care setting (Zerhouni, 2005). Both cases lay bare the non-existence of clear dividing lines between research system, health system, and social system, all interwoven in a complex health network.

With this theoretical field taking shape, it is natural for the perspective of different levels of complexity of the system to predominate, expressed in the classic representation of the pyramid, with its linear, binary relationships. However, the representation of a single, discrete co-authorship subsystem exposes the distance between the model and the real complexity of society (Figure 1). Received wisdom about health care networks, however, is already fairly entrenched in practices on the ground. If on a theoretical plane these networks

can be designed as specialized complex networks within complex systems, in practice they are capable of conferring operational pragmatism with the necessary objectivity. Ancillary concepts like patient flows contribute to this intention by permitting even more specific operations within health care networks (e.g., the network of care for disabled people linked up by aural, physical, and visual flows etc.).

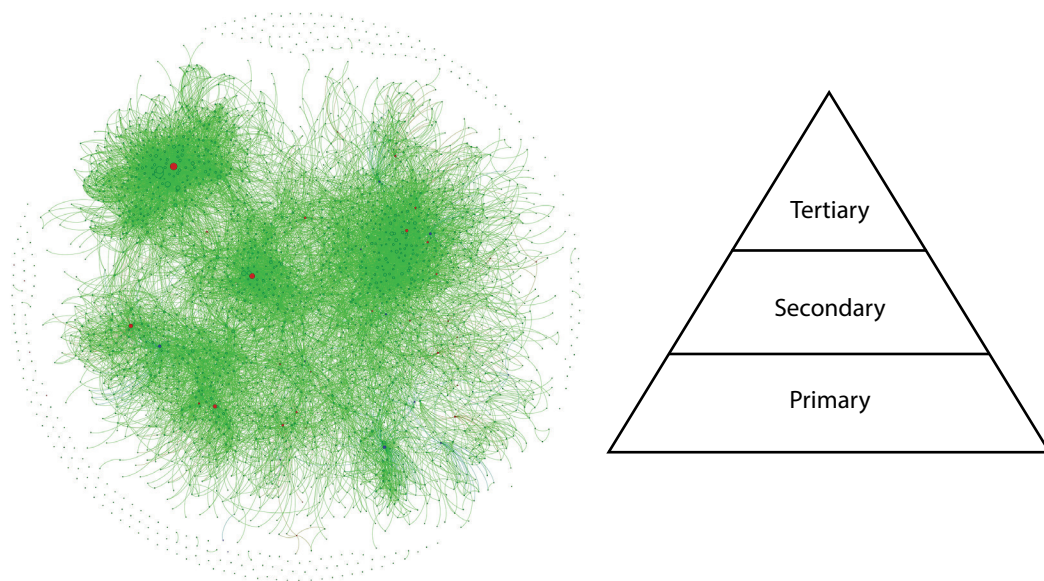


Figure 1: Left: the graphic of a single co-authorship network of coordinators of the National Network of Clinical Research in Teaching Hospitals, illustrating the idea of complex networks (Tenório, 2016); right: the classic model of levels of complexity of the health system, demonstrating its incapacity to represent the multiple interactions in the multi-scalar complex networks responsible for shaping the system

However, the question is not merely technological, as it may appear to be. The concepts are historically constructed on ideological planes that cannot go unnoticed. The most important detail in this case has to do with the fact that the health care system and regionalization are concepts that are not directly or even necessarily related. Actually, in their origins, health care networks were devised for the US market system (Shortell, Gillies, Anderson, 1994). This matters, because the concept of health care networks induced by the PAHO in Latin America literally reproduces that original definition, amended by the addition of the idea of “equitable and comprehensive:”

A network of organizations that provides, or makes arrangements for the provision of ‘equitable and comprehensive’ health services for a defined population and that is willing to be held accountable for its clinical and economic results and for the state of health of the population it serves (Tasca, 2010; emphasis added).

However, this adaptation fails to take account of the question at the heart of the regionalization of the SUS: the regulatory and funding role of the state, surely one of the most fundamental and complex of its characteristics (together, equitability and comprehensiveness are principles that confront state regulation of the market – a clash

between cost-effectiveness and social justice). The separation of the discussion of health care networks from the concept of the regionalization of the SUS tends to determine regionalization as a merely instrumental component for cost-effectiveness: “the reform of national systems, in its most recent phase, has come to use mechanisms and instruments similar to those developed in the American market” (Kuschnir, Chorny, 2010).

Short digression on the redefinition of the concept of regionalization and medical education

Here, the conceptual discussion penetrates the fertile territory of the encounter of the linguistic with the extralinguistic; the tension of the time of the avant-garde with the time of mentalities; the capacity of ideological elaboration and its diffusion to the system of value representation.

In this respect, the fields of research reveal a limited managerial perception of the question, counting on scant influence and input from the academy in the debate about the regionalization of the SUS – the impact of the conceptual deficiency in the production process becomes visible when each point uses different nomenclatures for similar ideas and processes (Jesus et al., 2018).

The More Doctors for Brazil (Mais Médicos para o Brasil) program opened up a historical opportunity for the regionalization of health, since the original idea was for decades strongly linked to the system of medical education and teaching hospitals (Grant, 1955; Chaves, 1977). Indeed, Chaves (1977, p.71) says he became aware of the “expression ‘regionalization of teaching and care’ some twenty years ago, in relation to the National Health Service of Chile.”

As is known, the idea never gained a strong foothold in the debate about medical training. Even when the concept of regionalism in the SUS was brought back, it was not accompanied by any repercussions in education. In fact, it was only in 2014 that the national curriculum for undergraduate medical education was fully aligned with the ideals of the SUS. But the dialogue is still very specific when it comes to understandings about regionalization.³

This lack of interest reveals that regionalization has never been incorporated in concrete, specific, clinical terms into the medical curriculum. A particular problem when one is familiar with the difficulty of transforming big systems without the engagement of doctors (Best et al., 2012).

Some current-day historical conditions seem to favor the chance of more concrete clinical significance for regionalization. First of all, in a country where 70% of the municipalities have fewer than 20,000 inhabitants, there is no effective alternative for providing effective care except through regionalized networks. Even in metropolitan areas, the organization of health care networks has become imperative for dealing with cases of multiple chronic conditions arising from the ageing of the population (Mendes, 2012; Opas, 2015). Furthermore, innovations in the clinical model for addressing chronic conditions, compatible installed capacity, and the introduction in inland parts of the country of dozens of new medical courses make it propitious for the development of new systems of education in regionalized networks.

Final considerations

This essay defends the premise that regionalization no longer refers just to administrative guidelines, but has become the most important concept for making the doctrine of the SUS feasible. It also demonstrates that traditional concepts have reached the historical limits of their productive capacity. The arguments set forth serve merely as initial pointers in this respect – for instance, without yet considering the magnitude of “connected health” in this discussion. Recognizing these limits, the updating of the concept of regionalization challenges innovative perspectives for a clinical system integrated in complex networks with new processes, instruments, clinical models etc. The updated concept is part of an intersectoral conception that not only contributes towards promoting equitable and effective health care models, but also indicates the boundless inductive potential of the SUS in the development of intelligence networks and wide-ranging urban and regional development.

Paradoxically, this new conception helps diminish – or rationalize – the scale of organization and planning of the system, in that it enables the regional network to be sized as the smallest unit of systemic complexity in the SUS.

NOTES

¹ Intersectorality is a concept that has garnered less significance in the fields of research. Generally, discrete and personalized arrangements of health units and schools, churches, or associations are cited with some circumspection, and the question is generally accompanied by a sense of impotence of the services. Meanwhile, it is notable how intersectoral policies, like the Family Grant (Bolsa Família) and Early Childhood (Primeiríssima Infância) are quickly and effectively incorporated into public services. The Health at School (Saúde na Escola) program is another good example. Despite the difficulty of the analyses from within this field, it is clear that there is greater responsibility put on public policies to propose intersectoral actions, while at the point of service, competence in operationalizing and signifying these policies is revealed.

² Although for decades the Brazilian literature on health (Barreto, Fontenelle, 1935) has made use of the term *system*, its conception dates back to the creation of the National Health System (Sistema Nacional de Saúde), in 1975 (Brasil, 1975). Created in 1948, the United Kingdom's public health system still retains the word *service*: National Health Service (NHS).

³ This same set of guidelines promoted by More Doctors for Brazil describes the planning of new universities in a regionalized model, but first impressions are misleading, as it presents a concept that does not correspond to the SUS regionalization policy, but to international medical education: a “model of regionalized medical courses, like those proposed by the universities of Western Ontario, in Canada, James Cook, in Australia, and Walter Sisulu, in South Africa” (Costa et al., 2015, p.178).

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