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State health managers' perceptions of the Public Health Action Organizational Contract in the State of Ceará, Brazil

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Abstract *The Public Health Action Organizational Contract (COAP) / Decree 7.508/2011 aimed to seal health agreements made between federated entities to promote the cooperative governance and management of Health Regions. A qualitative study was carried out adopting a hermeneutic approach to understand state health managers' perceptions of the elaboration and effects of the COAP in the State of Ceará. Open-ended interviewees and documental analysis were conducted. It was observed that the COAP led to the strengthening of regionalization in the government sphere; institutional gains through the implementation of ombudsmen and the National System of Pharmaceutical Care Management; increased information about the state health system's workforce; and health budget transparency. The following problems were (re)visited: institutional weakness in the operation of the network; limited state capacity for regulation of care; and underfunding. Regional governance was restricted to the government sphere, coordinated by the state, and was characterized by a predominantly bureaucratic and hierarchical governance structure. The COAP inaugurated a contractual interfederative model of regionalization, but revealed the institutional weaknesses of the SUS and its lacks of capacity to fulfill its principles as the structural problems of the three-tiered model go unaddressed.*

Key words *Unified health system, Public health policy, Regionalization*

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Introduction

The Public Health Action Organizational Contract (*Contrato Organizativo de Ação Pública da Saúde* - COAP), prescribed by Decree 7.508/2011[1], provides the legal framework for the cooperative governance and management[2,3] of the Unified Health System (*Sistema Único de Saúde* - SUS), strengthening the logic behind Brazil's health care federalism[4,5]. The COAP is a plurilateral health agreement between federated entities that sets out responsibilities and functions that are defined through a process of integrated planning of health actions and services at Health Region (*Regiões de Saúde* - RS) level. The contract outlines organizational processes and flows and the operation of the system and the commitments and targets of the different spheres of management of the SUS as to ensuring the right to health[1].

The applicability of the COAP at regional level enabled the instrumentalization of federated entities in the management of a RS, whose territoriality does not enjoy a corresponding governmental conformation within Brazilian federalism. There is a notable lack of consensus among health service managers as to which sphere of government is responsible for ensuring access to higher technology services in the region[6]. Certain authors[7-8] have problematized the lack of a regional health authority, discussing the most appropriate institutional arrangements for managing the equipment used in the health region, while others[5] suggest possible ways to overcome these limitations through regional management models based on the COAP.

The proposition of the COAP raises issues relating to the modification of the Federative Pact (*Pacto Federativo*) in relation to health under a three-tiered and regionalized model for the cooperative governance and management of the health system tailored to local and regional needs and dynamics. The implementation of intergovernmental agreements is a crucial element of comprehensiveness in health care, given municipal interdependence and the network complementarity of services[3,9,10].

In the national context, the COAP has been implemented in the States of Mato Grosso do Sul and Ceará, accounting for 6% of the health regions set up in the country. In Ceará, the COAP has a 100% adherence rate across all health regions, providing fertile ground for studies that problematize and explore the regionalization of health care services linked to the implementation of the COAP in connection with Brazilian federalism. The regionalization of health care services in Ceará has been underway since the middle of the 1990s, meaning that it is a state that has a strong tradition of decentralization of the SUS[11].

In view of the above, this article aims to provide an insight into state health service managers' perceptions of the implementation of the COAP in the State of Ceará and examine their implications for the regionalization of health care services and ensuring the right to health in connection with Brazilian federalism. It is believed that the design of new bands of visibility and fields of readability to provide insights into the regionalization of health services in the light of experiences with the COAP, this study will encourage the discussion of possible ways to move forward in the regionalization health care services and in the production of the constitutional SUS.

Methodology

This investigation consists of a qualitative study carried out between 2013 and June 2015 in the State of Ceará. The state is made up of five Macro Health Regions (*Macrorregiões de Saúde*) and 22 Health Regions. Twenty of these regions signed the COAP in 2012, while the remaining two signed the agreement in 2014. Data was obtained through the analysis of the COAPs[12] and open-ended interviews conducted with state health service managers: five managers working at central level in the State Health Department (*Secretaria da Saúde do State of Ceará* - SESA) and 18 representatives from the Regional Coordinating Offices (*Coordenadorias Regionais de Saúde* - CRES). All interviewees were informed of the objectives of the study and invited to sign an informed consent form that indicated that their responses would remain anonymous and confidential.

The selection of the state health service managers was carried out bearing in mind that the elaboration of the COAP was coordinated by the SESA and that the CRESs are decentralized bodies responsible for the command, coordination, and execution of this process at RS level. The following inclusion criteria were adopted: the manager took part in and was directly involved in the coordination of the elaboration of the COAP; his/her functions in the SESA, both at central level and in the CRES, considering whether or not such functions broadened his/her responsibilities with regard to the elaboration of the COAP;

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his/her relationship with the regionalization of health care services in Ceará. An additional inclusion criterion was added for health managers working in the CRESs in the RSs to ensure the representation of all the state's macro regions: Fortaleza, Sobral, Litoral Leste/Jaguaribe, Sertão Central, and Cariri.

One of the strengths of the qualitative approach to research is that it enables a comprehensive and interpretative understanding of the lived experience[12]. In this respect, interviewees were asked to outline their professional background and experience before taking up their current post. The guiding question inquired about the regionalization of health care services and adherence to the COAP, thus enabling the interviewee to talk freely about the topic from his/her own perspective and experiences.

The interviewees were recorded and transcribed. These transcripts comprised the narrative texts of the investigation and were highlighted in the results as Interviewee 1 (E1), Interviewee 2 (E2) and so forth. Both types of interviewees were regarded as state health service managers, regardless of the level at which they worked (central or regional).

The hermeneutic approach was adopted for data analysis since it seeks to understand and interpret phenomena contextualized within reality and materialized through language, the central core of communication, in this case transcribed in text[12,13]. Interpretation involves a multiplicity of senses articulated through distanciation and appropriation. Through distanciation, the written word takes on autonomy in relation to the author's intentions, aimed at interpretation, while through appropriation the reader, once distanced from the author's original intentions, appropriates the "thing of the text", understanding not only the text but also him/herself[13].

The data was analyzed by reading the interviews transcripts and documental narratives, thus permitting the impregnation of this whole with meaning and enabling an in-depth and contextualized explanation, understanding, and interpretation, as hermeneutics recommends[12,13].

This article therefore embodies the tapestry of connections between the things and acts performed during the implementation of the COAP and their implications, based upon the state health service managers' perceptions within the context of the regionalization of health services and Brazilian federalism. Based on the understanding of the texts, the following main dimensions can be highlighted: regional governance; and the organizational performance and operation of health care networks and care regulation.

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Results

The following bodies and people were directly involved in the political decision-making process that led to the State of Ceará's adherence to the COAP: the health minister; state governor; the state's mayors, through the State of Ceará Mayors' Association (*Associação dos Prefeitos do Estado do Ceará* - APRECE); and municipal health secretaries, through the Municipal Health Secretaries' Council (*Conselho de Secretarias Municipais de Saúde* - COSEMS). To create an enabling environment for the decision-making process, in 2012, *the priority for all actions undertaken by the Department of Health, as a demand for the regions* (referring to the CRESs), *would be the elaboration of the COAP agenda* (E2), assigning the coordinators and their teams political and technical functions within the sphere of the RSs.

One interviewee mentioned that 2012 was an election year, meaning that, with respect to the schedule for the elaboration of the COAP, *technical time* was "bulldozed" by *political time* (E1). Managers recurrently felt that with the COAP *there was a date X for us to finalize (the agreement) and that date X was in under a year* (E15), shaping the feeling *Let's do it because the political moment is now; if we don't do it now perhaps we won't be able to tomorrow, so let's do it and after we'll make the necessary modifications and adjustments* (E14).

The supremacy of the "political moment" over the "technical moment" generated central problems in terms of the organizational dimension of the COAP. The first of these problems regarded the maintenance and use of Agreed Integrated Programming (*Programação Pactuada e Integrada* - PPI). A PPI that *we had to reformulate, make*

some changes and there was no new money [...] *and the municipalities changed few things* (E8). The logic of programming procedures and unrealistic projections of supply capacity was maintained, replacing the utilization of the National List of Health Actions and Services (*Relação Nacional de Ações e Serviços de Saúde* - RENASES) as provided for by Decree 7.508.

Another problem connected to the one outlined above was the lack of constant updating of the National Register of Health Establishments (*Cadastro Nacional de Estabelecimento de Saúde* - CNES). The impossibility of executing these two *basic pillars* hampered the identification of real care gaps and the system's real supply capacity, even when using the Health Map, which *is very far from providing the analysis defined in the COAP decree as an analysis of dynamic installed capacity that implies knowledge of the public and private networks when this knowledge is just not available* (E14). As a result, despite being regionalized, the system would not have the capacity to address programmed care flows and would be much less able to operate according to the logic that emphasizes the healthcare needs of a population.

Despite the bulldozing of *technical time* by *political time*, the elaboration of the COAP was assured by the technical and political cohesion created within the context of the regionalization of health care services in the State of Ceará. This cohesion was ensured due to the existence of a stable professional staff in SESA that had been operating the regionalization of health care services since the middle of the 1990s at both the central and regional levels, particularly during the 2007 and 2014 administrations, when the health agenda was directly overseen by the governor and the state's mayors.

However, this technical and political cohesion was not observed in relation to the Ministry of Health. According to the narratives, the process was overseen by the Department of Strategic and Participative Management of the Ministry of Health (*Secretaria de Gestão Estratégica e Participativa do Ministério da Saúde* - SGEP). The rest of the ministerial departments would become engaged *later* (E1), hampering both the elaboration of the contract and the ability of the three-tiered system to address the SUS's structural problems, as highlighted below.

The elaboration of the COAP was therefore an intense and complex process coordinated by state health service managers, where it was recognized that *we spent a lot of time stagnating and then suddenly the shaping of the care networks came along and the COAP, resulting in a turnaround for the SUS* [...] *because it was progressing really slowly* (E9). The COAP became a *learning experience* woven from *nights and nights of work* (E6). Once finalized, each document was on average over 300 pages, and some even reached over 500 pages. But what were the implications of the COAP with regard to the regionalization of health care services?

A view of the regionalization of health care services: what changes did the COAP make?

The COAP was considered to have made progress in relation to the Health Pact (*Health Pact*), notably for the positive implications of the three-tiered system in relation to accountability and the right to health. However, the joint assumption of regional targets remains a challenge, since it is subject to the interests of each federated entity and the limited financial resources available to meet the health needs of the population.

In contrast to the Health Pact, the COAP is recognized as an instrument that guides regional planning, where *we are no longer just agreeing indicators, we are proposing actions, investment, other situations; that's why it is a guide* (E11). In addition, given its contractual nature, it provides for monitoring and evaluation, which is required to (re)modify the pacts, targets, and processes. According to the narratives, the COAP is not the same as the Health Pact, where *often you would have those terms of commitment that the mayors used to sign* (terms of management commitments), *but they wouldn't; they would sign it and shelve it* (E18).

Health budget transparency was another aspect highlighted by the interviewees. In certain municipalities, recording budgets and financial forecasts did not result in autonomy in handling the "black box" of the budget and health spending, showing that this area is still not the domain of secretaries and thus impairing the development of what was planned.

The narratives that showed a higher degree of consensus suggested that there was institutional strengthening of the Regional Interagency Committee (*Comissão Intergestores Regional* - CIR) in terms of discussions and negotiations between federated entities. The COAP was one of its main agendas in 2012 and it was in this setting where agreements were reached as to its elaboration and subsequent implementation. The institutionality of the Technical Chambers was also strength-

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ened, notably through the creation of Auditing Chambers and Pharmaceutical Care Chambers in certain regions. These are areas promoted by the COAP through its Part 4, Monitoring, Evaluation and Performance and Auditing, and targets related to the Pharmaceutical Care Guidelines and involve the implementation of a National System of Pharmaceutical Care Management (*Sistema Nacional de Gestão da Pharmaceutical care* – HÓRUS).

Progress was made in the implementation of ombudsmen and municipal HÓRUS and in the recording of information about the network's workforce, which enabled managers to know *how many state workers we had in each of the regions* (E3), which up until that point had been invisible in the system.

The study highlighted the institution of Regional Health Council Members' Forums (*Fóruns Regionais de Conselheiros*), which remain in operation. These forums hosted discussions between health council members and the respective region's municipal and state managers, highlighted as *major progress, after Decree 7.508, because, up until then I had no experience of discussions in Regional Health Council Members' Forums regarding the map of health, illness and disease in the region, and not just in that municipality, about the COAP* (E19). However, this interviewee also reiterated the lack of a decision-making body at regional level and highlighted that achieving the meaningful participation of council members was a challenge in the management of the SUS.

(Re)visiting the challenges posed by the regionalization of health care services: what was not made possible by the COAP?

The operation of the network, the regulation of care, funding, and continuing health education were highlighted as major challenges facing the system and the implementation of the COAP.

According to one interviewee, the notion of regionalization *we learn about at management level* (E9) and is thus limited to management; thus *frontline professionals do not have much of an idea about it. They are concerned with the territory they work in ... so there are very focused on the municipal level; beyond that the problem is with the Health Department* (E9).

The distance between what is planned and what is executed was perceivable, suggesting that the central problem is not the design of the network or its conception, but rather how things get done after, which is conditional upon the fulfillment of intermunicipal agreements, regulation, and logistical support, as well the necessary understanding on the part of the professionals who make up the network.

Continuing health education was mentioned as being necessary so *that everybody has information, which we call a basis, to ensure horizontal communication and the training and development of multidisciplinary teams* [...] *because his/her conduct has to be in the whole health facility* (E1). It was therefore suggested that the organizational performance and operation of a network depends on more than just healthcare planning undertaken by managers. The problem-solving capacity of thematic networks also involves specific and specialized knowledge and practice.

The regulation of care was raised as another major challenge posed by regionalization of health services in connection to the implementation of the COAP and Thematic Networks. It was suggested that *informal channels* are often much more effective in gaining access than *official channels*, thus revealing the real weakness of the regulatory role of the state; a *weakness that is very present in the pact, and throughout the process, in relation to Decree 7.508* (E1).

Another challenge posed by the regionalization of health care services is that "all the secretaries who adhered to the COAP will say the same thing; the problem is funding" (E10). Adherence to the COAP did not bring any new sources of funding with it. The possibility of raising new funds lay in the organization of the thematic networks, which itself faced a number of difficulties.

Other issues arise with respect to funding, (re)visiting old agendas such as the review of the SUS Scale (*Tabela SUS*), where all procedures agreed through the PPI are not fulfillable due to the shortfall between the amount and market prices. In this context, the study reiterates what has already been posed: *how can I be responsible for another population, if I am not able to provide the service and funding remains the same?* (E9).

Discussion

Political markers of the regionalization of health care services in connection with the elaboration of the COAP: the path towards regional governance

The meaning and materiality of governance should be understood and forged based on the capacity of the actors that are involved in the

policy to build a stable institutional framework that enables: i) participation and negotiations to be open a wide range of actors; ii) conflict management and the establishment of cooperative relations between actors (governments, organizations, and citizens); and iii) the establishment of coordinated actions aimed at meeting the goals and targets defined by the agreements[11]. In this respect, it is important to consider the linkages between the state, society, and the market, in their different representations, in order to establish "governance as the act of governing, including the exercise of power and the conduction of public policy, through a process that involves relations between multiple actors in specific institutional contexts"[14]. This perspective on governance is reiterated by Andrade[15], where governance requires "informal nongovernmental mechanisms".

However, the regionalization of health care services in Brazil has been shaped through the institutionalization of a model of governance that favors the participation of and dialogue between federated managers of the SUS. Among other things, this could be contributing towards the weakening of the coordination of the system as a network, considering the complexities of organizing health care provision and service delivery through a multiplicity of governmental/nongovernmental, public/private institutions and other actors.

In Ceará, the political markers woven throughout the regionalization process have sketched out a model of regional governance centered on government objectives and action. In this respect, the elaboration of and adherence to the COAP has not differed from this regime; not by the choice of managers at local level, but rather due to a set of norms that strongly induce this discursive and practical structure.

The following political markers may therefore be highlighted: i) the participation of state and municipal government officials, including the governor and the state's mayors, in decision making regarding health agendas; ii) the coordination of the process by the State Health Department; iii) the strong institutionalization of the CIRs as a setting for agreement and interaction between the three tiers of government; and, more recently, iv) the institution of Regional Health Council Members' Forums.

This study points to the design of political markers that strengthen a "bureaucratic and hierarchical governance structure", characterized by "public authority to define priorities and the frontiers of law"[8], in face of the impotent institutionality of the State in the "governance of the network", enabling the "market-based governance" of relations of production within the SUS, thus strengthening the business logic.

There is therefore an urgent need to discuss current governance standards, drawing on the model of practical legal discourse currently being developed within the regional SUS. It is necessary to broaden the range of actors involved in dialogue and recognize the multiplicity of stakeholders involved in the formulation and implementation of health policy, through the adoption of a governance structure based on the production of "mechanisms – resources, contracts and agreements – that complement the authority and sanctions of the public sphere"[8], enabling their implementation to help "understand the multiple variables and multiple levels of actions that influence the performance of a given pubic policy"[8].

In view of this, it is necessary to reflect on the political markers of regional governance in the State of Ceará. The active participation of the governor and mayors in the institution of the COAP shaped a regional governance of the SUS, which was loosely-stitched together based on political agreements that were 'external' to the system's decision-making bodies, such as health councils and CIRs. Others studies have called attention to the fact that "various strategic issues and decisions involving health policy do not go through the Tripartite Interagency Commission (*Comissão Intergestores Tripartite* - CIT) or are addressed by the commission in a superficial manner"[16].

During the exercise of "bureaucratic and hierarchical governance" in Ceará, decision making was concentrated within the state sphere, at the time under the command of the governor, operationalised by the SESA and its regions, which played a strategic role in the coordination and mobilization of the mayors and municipal health secretaries around the elaboration of the COAP.

Studies addressing the regionalization of health services[17-19], despite their differing approaches, highlight the critical coordinating role played by the State Department of Health and its respective regional bodies. However, other authors[9] call attention to the challenges arising from the fact that the coordination of the regionalization process is the responsibility of state health managers, and suggest that, besides being devoid of political representation within Brazilian federalism, regional settings are on the whole permeated by municipal actors and institutions.

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A study that addresses regional governance[20] suggest that the low degree of autonomy among health managers in comparison to the local executive powers acts as a barrier to strengthening collective decision making. It is hoped that the leading role played by the mayors will lead to the empowerment of local government officials, thus influencing the relations between the different tiers of government established in the CIRs.

In this respect, the active participation of mayors in the COAP agenda was crucial to the regionalization process, not only because it legitimized the care agreements, but also because it created an enabling environment for shared and cooperative decision making.

Overcoming the 'individualistic culture' that permeates the elaboration and development of the COAP is not just the task of local government. It is the result of a federal rationalism that ended up producing a kind of "autarchic municipalism" within a decentralized system protected and controlled by the central government, particularly through funding, distorting the Brazilian federalist ideal centered on administrative, political, and cooperative autonomy among the federated entities.

There is therefore the need for convergence between "formal federalism" and "real federalism"[2], or even to overcome the "dilemmas of the Federative Pact"[16]. Authors[21] highlight that the Federal Constitution of 1988 "did not change the vertical structure of the distribution of authority of social policies inherited from the military regime".

In this sense, one may wonder *how can federative autonomy be ensured through the COAP when a large part of health care funding is centralized at federal level? How is it possible to operationalize the COAP and the network without the allocation of extra resources to implement the intermunicipal pacts?*

Persistent conflicts and regional-level governance – for example underfunding and the centralized control of spending at the federal level – are part and parcel of the relations among the three tiers of government. Regional governance requires the effective democratization of decision making, with equal distribution of powers among the three tiers of government[11,16].

The elaboration and development of the COAP strengthened the CIR as body that negotiates the organization and operation of regional services. However, a number of conflicts on the CIR's agenda related to intermunicipal care are difficult to resolve, meaning that the care network is one of the major challenges facing the development of the COAP in the context of the regionalization of health care services.

Another political marker of the elaboration of the COAP, which deserves further research, relates to the Regional Forum of Health Council Members (*Fórum Regional de Conselheiros*), whose operation brings up a strategic issue related to regional governance: the participation of representatives of civil society organizations, emphasizing the need to widen the participation of this group beyond the scope of the government[15].

An update of the challenges related to the regulation of care and the organization of the health care network within the COAP

The development of the COAP came up against structural problems inherent in the system that were not fully addressed because the "technical time" was bulldozed by "political time", jeopardizing interventions aimed at overcoming the fragmentation of health actions and services.

This study has pointed to weaknesses in the planning and coordination of the thematic networks, weakening bonds and accountability with service users that require treatment outside the municipality, thus compromising the user-centered approach and network integration.

It is therefore crucial that actors beyond management, including health professionals and service users, are involved in the formulation and operationalisation of networks in order to promote permeability across regionalization through the constitution of "networks for dialogue"[22] and the exercise of microregulation[23], which result in "real health actions", with the continuing challenge of investment in the "micropolitics of living work in healthcare"[24].

Another important aspect is the nonadoption of mechanisms that should be associated with the COAP, such as the RENASES and General Planning of Health Actions and Services (*Programação Geral de Ações e Serviços de Saúde* - PGASS), replacing the PPI[1].

According to Decree 7.508, the first RENASES should be the sum of all health actions and services directly or indirectly provided under the SUS[1]. It consists of a limitation to health needs, bearing in mind that historically health production has not been sufficient to ensure comprehensive care. In addition, underfunding and the gap in the amounts of the SUS scale are highlighted as chronic problems, particularly in

relation to the provision of medium and high complexity services[20].

The use of the PPI as a management instrument encompasses health care. It is elaborated by a federated entity and is restricted to the Procedures Table and focuses on the delivery of procedures, which are far from meeting the health needs of the populations and limited to the existing budget ceiling.

Normatively speaking, the PGASS is aimed at creating a care model that incorporates health surveillance and pharmaceutical care, in addition to conventional care, thus going beyond the scope of the care model. The identification of needs is consistent with regionalization and networks. With respect to its structure, procedures are grouped together, thus broadening the perspective of health care, which is not restricted to procedure, but rather comprises a set of actions and services grouped together with a view to providing comprehensive care[1].

Another aspect that differentiates the PGASS from other instruments is the use of parameters to define fiscal targets that are dissociated from resource allocation. This means that it is not restricted to the existing budget ceiling, suggesting a certain flexibility in terms of increases in funding to meet identified needs.

In this respect, the continued use of the PPI ended up weakening agreements within the COAP relating to the flow of intermunicipal care and the systematic organization of networks, and jeopardized the effective regulation of health by health service managers, as shown by the findings of this study.

The logic behind health planning at a regional level was limited to health care and centered once more on the 'undersupply' of installed capacity, given the lack of knowledge in relation to the real capacity of the complementary sector, thus emphasizing the need for the effective regulation of the private sector health.

In light of the above, the fulfillment of the right to comprehensive health rests with "informal channels", unveiling the weaknesses of federated entities in relation to their regulatory responsibilities, suggesting that system lacks a strong regulatory state, which is necessary for a SUS that advocates, on a complementary basis, contracting with private the private network.

Final Considerations

In terms of the regionalization of health services, the COAP gave visibility and readability to the legal dimension in connection to the technical and political dimension, strengthening regional governance through institutional arrangements restricted to the government in order to strengthen its capacity to manage the SUS. In this way, a governance regime that may not be 'governing' was put in place, leaving gaps so that other actors in the SUS would be placed in power relations, given their political strength and influence on care, to determine rules that had implications on the provision of services and the production of the constitutional right to health.

Other forms of regional governance should therefore be introduced. The experience of the Regional Health Council Members' Forums, although based on the logic behind the governance of the system, stands out as a possibility to displace old meanings and weave new models of governance and further research is necessary to examine this question.

The modification of federative pacts, under the mantle of the COAP, broadened the subnational governments' perspective of the regionalization of health services, institutionalizing the Health Region. However, our findings demonstrate that a contractual agreement does not suffice to ensure meaningful cooperation between the different tiers of government and effective organization at a regional level. The contract is not enough, particularly if there is no political and technical consensus as to its use, as the experience in Ceará in relation to the institutional engagement of the Ministry of Health shows.

It is therefore necessary to invent a "movement-process" that not only (re)visits the challenges faced by the SUS, but also triggers new proceduralities to address the problem. Some, induced by the COAP, represent gains in terms of institutional development, such as the implementation of ombudsmen and HÓRUS in municipalities, regional information about state workforce, and health budget transparency. However, the incipient institutionalities of the operation of the network and the regulation of care continue to jeopardize the potential to integrate the region and network, which is essential

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to address the fragmentation of health actions and services and ensure comprehensiveness.

Thus there is an urgent need to review a federalism that remains more formal than real, the bulldozing of the "technical time" by the "political time" in the relations of production within the SUS, the governance regime, whose borders are the very arms of the State, and the chronic underfunding and growing commodification of the relations of production of health and service provision.

The actual appearance of possible virtualities, produced in the inner link between region and networks, still requires proceduralities for the operation of the network, cooperative governance and management, regulation, and the funding of regional services. This is a challenge posed by the conjugation of Brazilian federalism with the regionalization of health services.

It can be concluded that the COAP inaugurated a contractual interfederative model of regionalization, positivizing the discursiveness of regionalization combined with federalism, but revealing the institutional weakness of the SUS and its lacks of capacity to fulfill its principles as the structural problems of the three-tiered model go unaddressed.

Collaborations

N Goya participated in the design and delineation of the study, analysis and interpretation of the data, essay writing, critical review and approval of the version to be published. LOM Andrade, RJS Pontes and FS Tajra participated in the design and delineation of the study, analysis and interpretation of data, critical review and approval of the version to be published. ICHC Barreto participated in the design and delineation of the study, critical review and approval of the version to be published.

References

1. Brasil. Decreto nº 7.508, de 28 de junho de 2011. Regulamenta a Lei n. 8080/90, para dispor sobre a organização do SUS, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências. *Diário Oficial da União* 2011; 29 jun.
2. Santos L. *Sistema Único de Saúde: os desafios da gestão interfederativa*. Campinas: Saberes Editora; 2013.
3. Santos L, Andrade LOM. Rede Interfederativa de saúde. In: Silva SF, organizador. *Redes de Atenção à Saúde*: desafios da regionalização no SUS. Campinas: Saberes Editora; 2013. p. 35-74.
4. Dourado DA, Elias PEM. Regionalização e dinâmica política do federalismo sanitário brasileiro. *Rev. Saude Publ* [periódico na Internet] 2011 fev [acessado 2014 Set 30];45(1):[cerca de 8 p.]. Disponível em: http://www.scielo.br/pdf/rsp/v45n1/1944.pdf
5. Santos L, Campos GWS. SUS Brasil: A região de saúde como o caminho. *Saude e Soc* 2015; 24(2):438-446.
6. Shimizu HE. Percepção dos gestores do Sistema Único de Saúde acerca dos desafios da formação das Redes de Atenção à Saúde no Brasil. *Physis*, [periódico na Internet] 2013 Out-Dez [acessado 2014 jun 10];23(4):[cerca de 22 p.]. Disponível em: http://www.scielo.br/pdf/physis/v23n4/05.pdf
7. Mendes A, Louvison M. O debate da regionalização em tempos de turbulência no SUS. *Saude e Soc* 2015; 24(2):393-402.
8. Viana ALD, Miranda AS, Silva HP. *Segmentos institucionais de gestão em saúde: Descrição, Tendências e Cenários Prospectivos*. [Textos para discussão Saúde Amanhã na Internet] 2015 [acessado 2015 abr 04] 2:[cerca de 18 p.]. Fundação Oswaldo Cruz. Disponível em: https://saudeamanha.fiocruz.br/sites/saudeamanha.fiocruz.br/files/u35/2%20-%20PJSSaudeAmanha_Texto0002_final.pdf
9. Fleury S, Ouverney AM. *Gestão de Redes: a estratégia de regionalização da política de saúde.* Rio de Janeiro: FGV; 2007.
10. Santos L, Andrade LOM. *SUS: O espaço da gestão inovada e dos consensos interfederativos - aspectos jurídicos, administrativos e financeiros.* Campinas: Instituto de Direito Sanitário Aplicado; 2007.
11. Lima LD, Viana ALD. Descentralização, regionalização e instâncias intergovernamentais no Sistema Único de Saúde. In*:* Viana ALD, Lima LD organizadoras. *Regionalização e relações federativas na política de saúde do Brasil*. Rio de Janeiro: Contra Capa; 2011. p. 39-63.
12. Minayo MCS. *O desafio do conhecimento: pesquisa qualitativa em saúde.* 7ª ed. São Paulo, Rio de Janeiro: Hucitec, Abrasco; 2000.
13. Ricouer P. *Do texto à acção: ensaios de hermenêutica II*. Porto: Rés; 1986.
14. Lima LD, Albuquerque MV, Scatena JHG. *Quem governa e como se governam as regiões e redes de atenção à saúde no Brasil?* Contribuições para o estudo da governança regional na saúde. [material na Internet] 2016 [acessado 2016 maio 20]. Novos Caminhos, n.8. [cerca de 13 p.]. Disponível em: http://www.resbr.net.br/wp-content/uploads/2016/02/Novos-Caminhos-8.pdf
15. Andrade LOM. Inteligência de Governança para apoio à Tomada de Decisão. *Cien Saude Colet* 2012; 17(4):829-832.
16. Lima, LD. A coordenação federativa do sistema público de saúde no Brasil. In: Fundação Oswaldo Cruz. *A saúde no Brasil em 2030 - prospecção estratégica do sistema de saúde brasileiro:* organização e gestão do sistema de saúde [material na Internet]. 2013 [acessado 2015 abr 10];3: [cerca de 69 p.]. Rio de Janeiro: Fiocruz/Ipea/Ministério da Saúde/Secretaria de Assuntos Estratégicos da Presidência da República. Disponível em: http://books.scielo.org/id/98kjw/pdf/noronha-9788581100173-05.pdfhttp://books.scielo.org.
17. Ianni, AMZ, Monteiro, PHN, Alves, OSF, Morais, MLS, Barboza, R. Metrópole e região: dilemas da pactuação da saúde. O caso da Região Metropolitana da Baixada Santista, São Paulo, Brasil. *Cad Saude Publica*, [periódico na Internet]. 2012 maio [acessado 2015 jun 10]; 28(5):[cerca de 10 p.]. Disponível em: http://www.scielo.br/pdf/csp/v28n5/11.pdf
18. Silva, EC, Gomes, MHA. Regionalização da saúde na região do Grande ABC: os interesses em disputa. *Saude Soc* [periódico na Internet]. 2014 Out-Dez [acessado 2015 jun 10];23(4):[cerca de 14 p.]. Disponível em: http://www.scielo.br/pdf/sausoc/v23n4/0104-1290-sausoc-23-4-1383.pdf
19. Kehrig RT, Martinelli NL, Spinelli MAS, Scatena JHG, Ono P, Silva MJV. Antecedentes históricos da regionalização da saúde em Mato Grosso. In: Scatena JHG Kehrig RT, Spinelli MAS, organizadores. *Regiões de Saúde: Diversidade e processo de regionalização no Mato Grosso*. São Paulo: Hucitec; 2014. p. 111-133.
20. Santos MAS, Giovanella L. Governança regional: estratégias e disputas para gestão em saúde. *Rev Saude Publica* 2014; 48(4):622-631.
21. Arretche M, Vasquez D, Gomes S. As relações verticais na Federação: explorando o problema da descentralização. In: Arretche M, organizador. *Democracia, federalismo e centralização no Brasil*. Rio de Janeiro: Editora FGV, Editora Fiocruz; 2012. p. 145-202.
22. Teixeira RR. O acolhimento num serviço de saúde entendido como uma rede de conversações. In: Pinheiro R, Mattos RA, organizadores. *Construção da Integralidade: cotidiano, saberes e práticas em saúde*. Rio de Janeiro: IMS-UERJ/Abrasco; 2003. p. 89-111.
23. Santos FP, Merhy EE. A regulação pública da saúde no Estado brasileiro – uma revisão. *Interface (Botucatu)* 2006; 10(19):25-41.
24. Merhy EE. *Saúde: a cartografia do trabalho vivo*. 4ª ed. São Paulo: Hucitec; 2014.

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