

Governability of the Unified Health System in interstate regions

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Abstract *This study analyzed the governability of the Unified Health System (SUS) on Brazil's interstate border. This is a political analysis of health in a territory made up of 53 municipalities, two states, an intermanagement commission and a central interstate regulation committee. Data production included 499 documents and interviews with 35 actors linked to municipal management and influential organizations on the border. Governing the SUS at interstate borders has the following obstacles: the lack of institutionality for tripartite interfederative coordination; the lack of a regulatory framework with mechanisms for planning, financing and interstate management of the system; the low institutionality of agreements in the interstate collegiate; fiscal inequalities and financial dependence of municipalities with less economic power; the political-administrative alternation of management spheres and the low governability of the interstate regulation service in medium and high complexity hospitals in the studied territory. This research contributed to revealing the opposing political forces of the political-social system to SUS regionalization and interstate management projects.*

Key words Unified Health System, Regional Health Planning, Health Policy, Federalism

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Introduction

Interstate Health Regions (IHRs) are complex territories whose intergovernmental structure includes at least two states, in addition to the federal government and several municipalities¹. The regionalization of the Unified Health System (SUS) formally recognizes only intrastate territories, which have been organized into 438 health regions distributed among 26 states, the Federal District and 5,570 municipalities².

The IHRs have not been central to the SUS regionalization policy, and the system's legal and regulatory framework has emphasized management dynamics at the state-municipal level, but not at the state-state level¹. Although specific national investments have belatedly included two of the country's interstate regions to improve the management of the system, none of them has received legal approval at the federal level³.

The governance of the SUS in the IHRs is not unrelated to the adversities that already exist in the intrastate territories, given the complex political-institutional engineering that combines autonomy and power shared among three spheres of management⁴ and that differs from other countries that have adopted a federal organization with power centralized at the national level, such as France, Denmark, the United Kingdom and Japan, and others in provinces such as Spain, Italy and Canada⁵; Argentina, Paraguay⁴ and New Zealand⁶.

The autonomy of the federal entities does not eliminate the regional inequalities that condition the interdependence of political, decision-making and administrative power among them². In Brazil, the absence of regional health authorities to coordinate this relationship is a national reality⁷, which has led to historical obstacles in the consolidation of the states' role in mediating interfederal articulations in the SUS⁸. This calls into question the institutionalization of this process at interstate borders, where interfederal coordination is more complex, as they combine different local, state and macro-regional territories.

Between 2000 and 2011, various national initiatives were implemented to regionalize the SUS⁹, but nothing was done with regard to the interstate territories. Attempts to reassert the role of the state have not had the desired success, and the low institutionalization of agreements and local interests have prevailed to the detriment of regionalization policies¹⁰. Despite the creation of deliberative collegial bodies as

spaces for inter-managerial negotiation, the literature points to challenges in building consensus and agreements in the most unequal regions, such as the North and Northeast¹¹. These problems may be more complex at interstate borders, which may bring together several regional collegial bodies with unique dynamics and profiles in the absence of interstate co-management spaces, in addition to the strong reliance on federal participation to coordinate interfederal relations in these areas.

The regionalization of the SUS is also a political process involving multiple social actors and asymmetrically distributed power⁷. It involves subjects with different degrees of governability and financial, political, symbolic or technical resources, generating a complex and multifaceted decision-making arrangement¹². This multiplicity of actors makes interstate scenarios more challenging, given the dependence on interfederal coordination between actors from the municipal to the national level.

There is also the historical underfunding and, more recently, the defunding of the SUS due to Brazil's fiscal austerity policy^{2,13}, which exacerbates the challenges of managing the system at interstate borders, since these territories do not have legal and budgetary mechanisms to pay for inter-municipal migrations, but have to deal with the constant transit of people seeking health care, without any financial counterpart from border entities¹⁴.

In the literature, research on the regional management of the SUS is concentrated in the intrastate sphere, with a significant lack of studies on the governance of the system at interstate borders. The studies that have been published are more exploratory and less evaluative, focusing on the implementation of regionalized management¹⁵ and the formulation of Interstate Health Network projects¹⁶.

This article analyzes the governability of SUS managers at an interstate border. The aim is to contribute to the analysis of the main obstacles to SUS management at interstate borders, based on the analysis of the pioneering experience of the Brazilian Interstate Health Network, with a political project consisting of an Interstate Health Co-management Commission (CRIE) and an Interstate Bed Regulation Center (CRIL).

Methodology

This is a health policy analysis study using a regional case study with an intensive approach

and a level of analysis centered on the IHR. “Governability” was adopted as a theoretical category of the government triangle proposed by Matus¹⁷ and understood as:

The power of social actors to govern a project, as a function of individual or shared control of decisive variables that will condition favorable, adverse or indifferent situations for the acceptance or rejection of a project¹⁷.

The main obstacles to the political project conceived for the regionalization of the SUS were identified at the interstate border studied, which consisted of 53 municipalities, two states and the federal government. The border included the macro-regions of Northern Bahia and the São Francisco Valley in Pernambuco, with 28 municipalities in Bahia and 25 in Pernambuco. All of them had Regional Interagency Commissions (CIRs), and the headquarters of the IHR were the municipalities of Juazeiro-BA and Petrolina-PE¹⁸. The scenario studied had about two million inhabitants¹⁹, a territorial extension of 127,887.91 km², and was home to the first national experience of an Interstate Health Network (started in 2008)¹⁸. There was a CRIE with a tripartite management proposal, established since 2010 as a deliberative space and composed of managers from the three administrative spheres. There was also the CRIL, implemented in 2011, financed and managed by the border states¹⁸.

Data production took place between October 2017 and August 2018 and combined document analysis, key informant interviews, and field diary entries. The period covered by the documents used was from 2008 to 2018, which corresponds to the main decisions on the implementation of the regional design and the completion of the research. A total of 499 documents were analyzed, including reports and projects of working groups in the IHR, state resolutions, federal ordinances and technical documents, minutes of the CRIL and CIR, the Bipartite Interagency Commissions (CIBs) and the CRIE, management plans and reports from the national level to the municipalities hosting the IHR, as well as the Regionalization Master Plans of the states.

The key informants included were involved in the process of formulating and implementing the Interstate Health Network, or were part of the decision-making and management spaces for health services in the IHR, or were those identified as influential in the regional political dynamics. The interviews were fully recorded and transcribed. Thirty-five actors were inter-

viewed, linked to the following spaces: from municipal to interstate management, the Federal University, indirect administrative organizations, the Federal Prosecutor's Office, influential economic groups in the health sector, and the doctors' union in the region.

The data were processed using QSR NVivo11, which triangulated documentary sources with interviews and field diaries. The information was coded according to the main obstacles to the interstate regionalization project of the SUS, according to the variables controlled and not controlled by the managers. The material was then compared with an analytical plan that guided the construction of the results (Chart 1).

The study was approved by the Ethics Committee of the Federal University of Bahia (CAAE 74178617.4.0000.5030), and the respondents signed an informed consent form.

Results

The results of this study have been organized into topics that correspond to the analysis criteria defined from the “governability” category (Chart 1). They range from federal coordination and articulation of federal entities to the governability of interstate bed regulation. For each section, illustrative excerpts have been systematized to support the arguments presented in the results (Chart 2).

Lack of federal coordination and interfederal disarticulation at the interstate border

In the political design of the IHR, the CRIE was established as a deliberative space for the main decisions concerning the SUS in the scenario studied. Its composition provided for tripartite coordination with the participation of the federal government, two states and 53 municipalities in the territory. The interviews and minutes analyzed confirmed the absence of federal coordination of the decisions made in the interstate management of the SUS. The only periods of action by the Ministry of Health in the territory studied were limited to the elaboration of the Interstate Health Network project, between 2008 and 2009, and the funding of the implementation of the QualiSUS-Rede Project, between 2011 and 2012.

The minutes of the CRIE showed that the only involvement of the federal sphere in the IHR corresponded to the directorate of the

Chart 1. Section of the study's analysis plan for the "Governability" category, its dimensions and analysis criteria.

Analytical category	Definition	Operationalization	Analytical dimension	Analytical criteria
Governability	Degree of control of the governing actor(s) over variables that are relevant and critical to their governing project.	Main obstacles or political resistance for managers from the three administrative spheres to govern the SUS at an interstate border.	Federal coordination	Federal participation in interstate interfederal coordination.
			Inter-managerial agreement	Institutionalization of agreements in interstate scenarios.
			Funding	Autonomy and fiscal interdependence of border federal entities.
			Alternation of party political power	Alternating managers in the administrative spheres.
			Interstate bed regulation	Management of the Interstate Bed Regulation Center.

Source: Authors.

Federal University Hospital in Petrolina-PE, through employees of the Brazilian Hospital Services Company (EBSERH), who sat on the CRIE but had no relationship with the Ministry of Health (MoH). The federal government did not participate in the meetings of the collegial body from 2013 until the end the study. This scenario contributed to the inertia of decisions in which municipalities and states were completely dependent on the MoH, confirming the interfederal disarticulation and the stagnation of tripartite agreements to make progress, for example, in allocating financial resources and ensuring the implementation of the Interstate Health Network project envisioned for the territory.

Finally, the regulations on the national regionalization policy led to the conclusion that the federal guidelines did not cover the management of the SUS at the interstate level and that there is a significant gap in the legal framework to guide the actions of managers in these territories.

Low institutionalization of interstate agreements

Both the interviews and the minutes analyzed confirmed the low institutionalization of interstate agreements, which compromised the possibilities of integrated regional planning. There were no legal and operational methods for integrating the physical and budgetary plans and schedules of each state, which contributed

to interfederal relations that operated informally through the exchange of health services between managers.

There were different political and bureaucratic timetables for updating the Agreed and Integrated Programming (PPI) of the two states (one stagnant and the other in the process of being updated), which made interstate agreements unfeasible and confirmed the fact that the programming of actions and services was limited to each state. The minutes and interviews confirmed the impossibility of each state's PPI keeping pace with the fluctuating needs of the interstate population, since these are unpredictable needs that are not included in the planning and agreement process formally established in the SUS regionalization policy.

Two obstacles to interstate agreement stood out. The first was the insufficient supply of specialized services in the network of macro-regional reference municipalities. The second was the stagnation of the reviews of each state's PPI, which contributed to the dispute between the prices practiced in the SUS table and those imposed by the private services contracting market, creating impasses for the complementation of the services included in the health programs.

The CIR minutes show that the prices practiced in the SUS table were unattractive to the private services market when negotiating contracts with managers. Contract proposals were constantly rejected by the private sector, which claimed that it was not interested in selling services at prices below those practiced by the

Chart 2. Summary of illustrative excerpts according to the analytical dimensions of the study and sections of the article.

Analytical dimension	Article section	Main illustrative excerpts
Federal coordination	Lack of federal coordination and interfederal disarticulation at the interstate border	"I think the Ministry of Health is a bit far from reality, especially now." (Regional Health Manager) "Only in the beginning. I don't feel any representation from the federal government." (Municipal Health Secretary I) "The Ministry approved it and followed it up, in fact, but after that, it no longer took part in any meetings, you know? There's no longer this assiduous monitoring of the country's public policy in relation to this. It was a model that could even be used in other states, right? But today I feel especially that this absence of the Ministry of Health..." (Municipal Health Secretary III) "Then, in this discussion, right, of the network, there was thought of integrated, interstate planning, an integrated budget, but it seems that it didn't come to fruition. There was no interstate PPI; no interstate budget, because what some people say is: 'This isn't legislated. It hasn't been legislated yet.' How do I take resources from one state and pass them on to another? That is legislated at the state and municipal level." (Interstate Regulation Manager). "Until then, there was no legal way to transfer resources. So, at the time, the idea was to exchange services." (Interstate Regulation Manager)
Inter-managerial agreement	Low institutionalization of interstate agreements	"A lot of things haven't progressed in terms of funding and the PPI issue because we didn't reach an agreement. There was an exchange. I take my patient there because it's a reference. They bring them here from there because here is the reference. But that is not part of the PPI. It's a gentlemen's agreement." (Municipal Health Secretary V) "So there was no discussion about the PPI in the state of Pernambuco. And in Bahia there was already something more dynamic. How were we going to do the interstate PPI? Put the two documents together? Take the hospital resources from the PPI of the two states and then do the interstate PPI? [...]" (Municipal Health Secretary IV) "If I were to say what our collegial bodies were like; when they started... warm, the room full, everyone full of ideas, pointing out strategies for how we should behave... that was the scenario. Today, we spent 2015 and 2016 without the collegial body being able to meet [...] was this complacency, this lack of prioritization, just the state of Bahia? If I were to say that it was only the state of Bahia, maybe I wouldn't be telling you the truth. But we can see that Pernambuco hasn't prioritized this network either." (Regional Health Manager I) "How do you get anything done? And then comes what we think is the question of 'tidying up' or influence or influence peddling. I know someone who, if I call her, she'll get me an appointment for an ergometric test, an echocardiogram, an electroneuromyography." (Regional Health Manager I)

it continues

market. Entrepreneurs in the health sector were characterized by their concentration of power in contract negotiations, as they controlled the resources and means of producing health services in a scenario of insufficient public provision and the dependence of municipal and state managers on the private sector.

Inter-municipal fiscal inequalities and financial dependence

The fiscal inequality between the municipalities relativized the autonomy of the federal entities and conditioned the small local systems to a scenario of financial dependence on

Chart 2. Summary of illustrative excerpts according to the analytical dimensions of the study and sections of the article.

Analytical dimension	Article section	Main illustrative excerpts
Funding	Inter-municipal fiscal inequalities and financial dependence	"The municipalities complain that they don't have the resources and can't go it alone; I need support; always presenting themselves as the poor cousin. I can't do it and I always need support." (Municipal Health Secretary IV) "Petrolina has received a very heavy load of demand. Let's put it this way ... not only Petrolina, but all the main municipalities are taking on more and more responsibilities. And then we see that their condition of being a main municipality and being the headquarters for other municipalities is stagnating. It's been diminishing because of the lack of infrastructure in these municipalities, the lack of money, of resources, right?" (Municipal Health Secretary I) "What is passed on to these municipalities also leaves a lot to be desired, it doesn't cover them, and the municipalities in the region as a whole, recognizing this, recognizing the underfunding of health, have invested in outpatient therapy." (Representative of the Economic Group of the Region)
Alternation of party political power	Political-administrative alternation in management spheres	"Look, I realize that the two states have reached a point where, when there's a change of management, it seems that the projects belong to the manager. The PEBA project was the responsibility of Solla's administration and the responsibility of the administration in Pernambuco. It's as if that project no longer exists... And here in Bahia, it was the same party that kept it going." (State Manager for Medium and High Complexity) "Unfortunately or fortunately, there's the electoral period. And the electoral period in the municipality is different from that in the state. So what happens? This year's managers, for example, are all new. And what happens? Most of the managers are unaware of this interstate network and what has been agreed." (Interstate Regulation Manager II)
Interstate bed regulation	Low governability of interstate bed regulation	"The CRIL has no problem with the regulatory process. The problem is the shortage of vacancies, because we have no guarantee that the Regional Hospital of Juazeiro will perform the trauma and orthopedic surgeries that have been contracted. We can't expand the SOTE surgeries; resume the surgeries at the hospital in S. do Bonfim; regulate the patients to the CHESF hospital in Paulo Afonso, etc." (Interstate Regulation Manager II) "So what happens? In Bahia we use SUREN and in Pernambuco we use SISREG for ICU beds, but for urgencies and emergencies it's by e-mail. So we use several systems and they don't talk to each other, there's no interaction by unit." (Municipal Regulation Manager)

Source: Authors.

the larger municipal entities and the state and federal entities. This situation contributed to the fiscal saturation of the main municipalities of the macro-region, which took on the greatest burden of providing regionalized services, thus compromising their financial and installed capacity to assume the role of reference.

As a consequence of the inter-municipal fiscal dependence, the managers of smaller municipalities adopted the acquisition of new am-

balances as a political strategy, which, according to the interviewees, became a compensatory dynamic to guarantee the referral of residents with a need for medium and high complexity services to the referral services located in the territories of the macro-regional headquarters.

In order to ensure the provision of high complexity hospital services (a critical point in the IHR), the minutes of the CIR revealed a constant reallocation of financial resources to me-

dium complexity services in the main municipalities. As a result, the provision of specialized outpatient care was compromised, exacerbating barriers to access for the population of the main municipality and neighboring local entities. The fiscal constraints of the municipalities were also exacerbated by delays in transfers and insufficient allocation of state resources for the investments needed in the IHR. State management reports showed that state transfers to municipalities were not being met, citing the national fiscal crisis and the financial inability of states to expand the regionalization of health services. As a result, the minutes and resolutions of the CIB ratified the constant reallocation of PPI funds intended for specialized care to high complexity urgent and emergency hospital care, making the scenario of inequity in financial transfers even more critical.

Political-administrative alternation in management spheres

The information in this topic refers to the states and municipalities that are the headquarters of the interstate border health regions (Juazeiro, Senhor do Bonfim, Paulo Afonso, Petrolina, Ouricuri and Salgueiro). The headquarters of the health regions were prioritized in this analysis because they concentrate the supply of health services and are a reference point for other small municipalities.

It was evident that the change of state managers affected the participation of the states in the decisions related to the interstate regionalization of the SUS. This has led to ruptures in the Interstate Health Network project envisioned for the territory in question, with the departure of actors from the decision-making spaces that contributed to its construction and the introduction of other actors who did not contribute to maintaining the power correlations favorable to the implementation of the project. In the state of Bahia, the interviewees were unanimous in stating that the reference services in the regional offices of Paulo Afonso and Senhor do Bonfim have been closed since 2015, following the change of actors in the state administration.

The Superior Electoral Court (TSE) reports between 2007 and 2017 showed that the state of Bahia had partisan continuity with the Workers' Party. However, the state health plans allowed the identification of important changes in the management team of the State Secretariat of Bahia (SESAB) and a rupture between the government project conceived during the Jorge Solla admin-

istration (2007-2014) and the agenda of a new project conceived by the Fábio Vilasbôas administration, starting in 2015. It is worth noting that the national scenario saw party discontinuity in 2016, following the coup against President Dilma Rousseff (PT), which may have deepened the interfederal disarticulation in the territory studied, due to ruptures in the correlation of forces between federal and state executive managers.

At the municipal level, the TSE reports confirmed that all the municipalities at the interstate border, with the exception of Juazeiro, had alternating political parties. Several interviewees said that this posed challenges to the consolidation of cooperative relations between municipalities and states. One example was the stalemate in negotiations between the SESAB and the administration of Senhor do Bonfim to expand regional reference services. This scenario of alternation between political parties and SUS managers, according to the interviewees, postponed important negotiations to advance an interstate health policy, since the introduction of new actors into the interstate political dynamic requires more institutional time for them to take on of the specificities of planning, articulation and decision-making.

Low governance of interstate bed regulation

The IHR political project established a CRIL in 2011 with a proposal for interstate co-management. The main focus of the interstate regulation service was the management of high complexity urgent and emergency beds. The flows established for hospital regulation were agreed between the municipal and state managers, the CRIL and the managers of the executing and requesting units.

The expansion of emergency beds was one of the proposals conceived in the interstate regionalization project for the territory studied. However, even after years of trying to implement this project, the Annual Management Reports (RAGs) in Bahia showed records that confirmed the concentration of emergency hospital beds in the capital and its metropolitan region. The IHR studied had less than 2.0 beds per 1,000 inhabitants, according to CRIL minutes and CRIL reports. This scenario was also confirmed by the interviewees, who reported an insufficient supply of beds to meet the demands of interstate regulation.

Most of the beds for urgent and emergency care were concentrated in the border regions

(Juazeiro-BA and Petrolina-PE), to the detriment of other regions such as Paulo Afonso, Senhor do Bonfim, Salgueiro and Ourucuri. The impasses over the unequal supply of beds in Bahia's health regions, especially in Senhor do Bonfim and Paulo Afonso, were explained in the CRIE minutes. In the first case, there were political obstacles in the negotiations between SESAB and the municipal management, due to the fact that the only hospital in the city is philanthropic and has been under municipal intervention for more than a decade. The second was the fact that the regional hospital was private and owned by the São Francisco Hydroelectric Company, which created obstacles to allocating public funds or donating the hospital structure to SESAB. Both situations prevented the inclusion of these services as CRIL-regulated units.

The regional hospital management model also influenced the governance of CRIL managers. In the state plans analyzed, it was found that of the seven reference hospitals at the interstate border, four were public and under the direct management of the SES. In Bahia, of the seven regional reference hospitals, six were not public and the only one belonging to its own network was under indirect management by a social organization. In addition, one of the main high complexity units in the IHR was managed by the EBSEH. Against this backdrop, the CRIL reports pointed to a lack of administrative and political power on the part of the managers of the central regulatory body to prevent unilateral decisions by hospital management, which resulted in the disorganization of interstate regulatory flows. An example of this is the arbitrary decisions made by the managers of the University Hospital, who adopted new criteria for users to access the unit, in order to limit the regulation of those who did not fit the clinical profile defined by the institution's administration.

Interviewees pointed out that interstate regulation also lacked an integrated system between the states, making it difficult to standardize the regulatory process between the executing units located in different state administrative boundaries. In addition, the CRIE and CIR minutes agreed on the insufficient resolution capacity of small hospitals at the interstate border, which contributed to the constant occurrence of low urgency referrals to high complexity units and in disregard of the established regulatory flows. Many of these referrals were made without medical regulation and with varying information about the clinical condition, exacerbating conflicts in the provision of care between regu-

latory physicians, municipal managers and hospital directors.

Discussion

Governing requires political forces capable of overcoming the inertia, contradictions and adversities of circumstances that may be beyond the control of social actors¹⁷. It is important to note the diversity of actors at work at an interstate border, given that Brazil has established a complex political-institutional engineering system for the management of the SUS, combining autonomy and shared power between the federal government, states and municipalities⁴. In interstate scenarios, the articulation between the three administrative spheres becomes more challenging, as it involves at least two states in addition to the federal and municipal entities¹.

The lack of federal participation in the scenario studied was an important obstacle to interfederal coordination, given the tripartite interdependence. Authors have pointed out that the absence of federal participation even in intrastate territories is historical and reflects a legacy of the emphasis on municipalization of the system to the detriment of regionalization²⁰. The political representation of the national entity in health regions could better articulate subnational managers and reduce inequalities in the provision of public services²¹.

On the other hand, the lack of national guidelines for the management of the health system in the IHRs reveals significant legal uncertainty for managers and limits the implementation of proposals for border health care networks⁴. This scenario confirms authors who point out that Brazilian legislation is insufficient to cover all regional specificities^{22,23}. There are important challenges in the Brazilian legal framework to reconcile interfederal objectives in generally atypical scenarios that neglect the political structure of health management²⁴.

Governing the SUS at the interstate level requires integrated interstate planning. However, this is still far from being realized, given the low institutionalization of the planning instruments in typical regional territories⁷. The obstacles to integrated interstate planning identified in this study only confirm the complexity of reaching consensus and agreement in scenarios that bring together several federal entities with tripartite interdependence. There are authors who explain the difficulties of regional planning from two perspectives: first, the excess of municipal

autonomy as an indication of the fragmentation of the system and, second, the limitation of municipal financial autonomy as a critical point for the establishment of intergovernmental agreements²⁵.

In interstate regions, the transient demands of users who cross the border in search of access to health services stand out. This is an unpredictable situation for SUS managers and one that does not find legal support in the system's planning tools to allow integrated physical and budgetary programming. This makes it impossible to set up an interstate PPI, since even in intrastate scenarios, authors point out that this instrument does not guarantee access to the agreed needs²⁶. The findings of this study are in line with other articles that have shown that regional agreement is a difficult process to operationalize²¹.

The institutionalization of the agreement on health actions and services in an IHR depends on the allocation of complementary and sufficient financial investments to meet the needs of these territories, given that this is not just a large territorial area, but a set of health regions with significant fiscal inequalities and inequalities in the supply of health services. There are studies that confirm the lack of new funding for SUS regionalization projects²⁷ and that even in regions with greater economic development, agreements are not feasible without complementary funding to expand the supply of services and the fiscal capacity of the federal entities²⁸.

In this study, two synergistic issues deserve attention: first, how the fiscal crisis in the states has limited the financial transfers intended to fund and expand regional reference services to the municipalities, affecting equity in the supply of services. Second, how the insufficient public supply of services in these regions promotes an imbalance between supply and demand for services at the interstate border and forces SUS managers to contract at prices inflated by the regional economy. Other authors point out that, in the second case, the imbalance between contracting capacity and regional demand contributes to providers having greater control over decisions that affect contracted services and, consequently, reverberate in inter-managerial agreements²⁶.

The constant violations of inter-managerial "agreements" revealed in this study draw attention to two issues highlighted in the studies that have repeatedly aggravated inter-municipal disputes in the IHR. The first is the fact that the requesting (smaller) municipality allocates resources to the reference municipality in advance,

without the certainty of guaranteed access²⁶. The second concerns the fact that this prior allocation of resources in the main municipality helps to give its management an advantage over the others, since it has the prerogative to manage the financial resources allocated monthly to its population and the population referred to it¹¹.

The inter-municipal fiscal inequalities identified in this study show that this scenario regressively affects the possibilities of cooperative and supportive federal relations between entities in the interstate management of the SUS. This is also a characteristic that exists in other Brazilian health regions⁴. Some authors point out that the grouping of municipalities into territorial areas is not sufficient to eliminate fiscal inequalities²⁹ and is an important contradiction of decentralization, which has not provided fiscal independence to local entities²⁷.

It is worth noting how local financial dependence can become more complex at interstate borders, which bring together several border towns that are economically unequal, as well as at least two states without any legal mechanism for financial compensation of health care needs. There are articles that advocate compensatory budgetary alternatives between border towns between countries that might be institutionally useful at interstate borders. These include complementary transfers for procedures carried out on people living outside the territorial boundary, the implementation of systems to record the needs of the floating population, and the creation of cross-border administrative and financial structures⁴.

The results of this study are similar to those of other articles that have shown how political-administrative change has contributed to the turnover of managers, altered the correlation of forces between federal entities, and fragmented the deliberative capacity of actors in regionalization policy^{2,4}. This turnover diversifies the contending interests and weakens the groups of actors already established in the health regions²³, while territories with administrative continuity find it easier to reach a decision-making consensus³⁰.

The results of this study show how the lack of coordination between states at the interstate border significantly affects the implementation of interstate collegial management bodies and makes interstate regionalization projects for the SUS uncertain. The participation of the states is a fundamental point in the regionalization processes of the system, given the diversity of actors and organizations that make up regional deci-

sions⁸. In regions with little state action, management processes focused on service delivery predominate, to the detriment of the coordination of regional systems³¹, while in regions with active deliberative forums there is a greater possibility of progress in the regionalization of the system²¹.

The difficulty of establishing active deliberative forums is also a characteristic of intrastate regions. The similarities between the results of this study and the other Brazilian regions mainly concern the dynamics of the deliberative spaces, which are predominantly formalistic and bureaucratic, with low decision-making capacity and a lack of coordination between the states and the federal management in supporting the regionalization policy^{27,32}.

There are studies that support the findings of this study in regions with similar characteristics in terms of the predominance of private beds and indirectly managed hospitals^{27,33}. The interstate regulatory barriers identified in this study are similar to regulatory challenges in other health care regions, albeit with intrastate configurations. There are similarities in terms of the insufficient supply of high complexity beds³⁴; the lack of an integrated regulatory system and the interference of private and philanthropic providers in regulatory governance^{24,33}; and the political interference of mayors and health secretaries in care flows¹¹.

There is a significant influence of pressure from the private sector on the dynamics of health regulation, resulting in poor governance by managers and professionals at the interstate regulatory center. The predominance of hospitals under an indirect management model or contracted by the SUS directly compromises public control over previously agreed regulatory flows, generating a conflictive and uncertain scenario. This confirms Matus's¹⁷ theoretical propositions on governability as a reflection of the unequal power that social actors have to carry out their governing project through the coexistence of other contested projects. Governability is therefore the relationship between the variables controlled and not controlled by the actors and refers to the influence that these actors have over the decisive variables and the degree of control they share with other actors, so that the greater the number of variables controlled by an actor, the greater their freedom of action and, consequently, their governability over idealized government projects.

Thus, by analyzing the interstate management of the SUS, this study has contributed to

what Matus¹⁷ points out about the possibility of the category of "governability" revealing the opposing forces exerted by the "socio-political system on a given government project and the actors in that project." It is worth highlighting the limited time that has elapsed since the data were collected, despite the low probability of changes in the study scenario, given the government's inertia in making progress on interstate regionalization.

Recently, the creation of Interstate Health Macro-Regions was approved in an agreement reached at the Tripartite Interagency Commission in September 2024. If this creation is accompanied by effective measures to strengthen the federal and state levels in the management of these macro-regions, with an increase in financial resources and the establishment of planning, agreement and regulatory mechanisms, it may be possible to reduce the population's problems of access to medium and high complexity services in these areas. However, the political issues identified in this study will not be overcome simply by increasing the efficiency of interstate regional management.

The obstacles to SUS management identified in this study reveal the limited possibilities for governing the system across interstate borders without tripartite interfederal coordination with a legal framework that includes mechanisms for integrating planning, physical programming, and budgeting between the states. SUS interstate regionalization projects involve purposes with significant redistributive objectives among multiple actors from different scenarios and institutions, requiring correlations of forces sufficient to overcome contradictions that cut across federal and municipal scenarios, without detaching them from those imposed by the power of the private sector.

In short, there are three important relativizations of the "governability" category highlighted by Matus¹⁷ that help us understand the obstacles to interstate management of the SUS summarized here. The first refers to the fact that the system has unequal conditions of governability, since the actors do not have the same control over the number and types of variables. The second relates the governability of the system to the propositional content of the government project, where more modest goals increase the likelihood of better governability conditions, as opposed to very ambitious goals. The third is that the governability of the system is directly proportional to the governing capacity of the actors.

Collaborations

All authors participated equally in the conception and drafting of the study, production of data, analysis and interpretation of results.

Data availability statement

The data sources adopted in the research are indicated in the article's body.

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