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Regionalization of health systems as a response to territorial inequalities: a necessary debate

Regionalização dos sistemas de saúde como resposta às desigualdades territoriais: um debate necessário

Regionalización de los sistemas de salud como respuesta a las desigualdades territoriales: un debate necesario

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It is increasingly important to analyze inequalities based on impasses and dilemmas in regionalization, as proposed by Ana Luiza d'Avila Viana & Fabiola Lana Iozzi. The wager on radical democracy in the SUS assumes a responsibility for decentralization that runs up against the scale and territorial flows to guarantee access for all. The technological supply is still heavily concentrated in the hub-municipalities, and the central focus on citizens and the territory is still far from a balanced relationship between supply and demand. Regional discrepancies challenge public policies, and territorial adversities combine important vulnerabilities with lower development [1]. In this process, which is always unfinished, Brazil is facing backstepping in the field of public social policies, with severe underfinancing, directly curtailing the possibilities for responding to the needs of different populations and territories throughout the country. Regional inequalities appear in territorial mosaics where it is necessary to identify both unequal inclusions and abysmal exclusions, severely aggravated by austerity policies.

This is an important point discussed by the authors: territorial equity as the greatest challenge for achieving the guideline of comprehensiveness in the SUS. Health regionalization consists of specific initiatives related to the implementation of specific services rather than regional territorial planning focused on building integrated healthcare networks and systems, as observed in other countries [2]. While some recent experiences in Brazil faced the structural problem of expanding the decentralized supply, they ran the risk of dismantling the government's own services, not strengthened as state policies. Added to this are the specific incentives for the expansion of supply defined in the so-called thematic networks, convening the actors in dialogue and planning, but failing to confront important structures or necessarily producing continuous and permanent effects in the realignment of regional health systems.

Intergovernmental relations vary as a function of government authorities' power relations and negotiations. The definition of responsibilities in the SUS faces healthcare juxtapositions and gaps, often insurmountable, given the distribution and diversity of Brazil's municipalities. The process of widespread recourse to court action to obtain medical care and medication illustrates this difficulty when it simultaneously holds accountable various levels of government to respond to citizens' demands and needs. Meanwhile, the Regional Inter-Managerial Commissions (CIRs) lose power and possibilities when they fail to call the set of political actors and their intentions to the round of

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negotiations, which can become either a bureaucratized instrument or one of shared innovations, not always sustainable.

The SUS is tripartite, which is the base for its sustainment as a social protection system for all Brazilians. However, decentralization will not materialize through federal incentives alone, without pursuing a more equitable allocation of resources to states and municipalities. States and municipalities are not passive actors, although they are found in a federative design that leaves little room in relation to taxes and the definition of policies for local governments, which nevertheless allow a daily and innovative production of public policies, regardless of their systems being federal [3]. The narratives built with municipal managers always relay solidarity and management networks as possible strengths [4]. It is essential in this process to acknowledge the weakness of the state-level body, with strong regional induction, but which historically does not assume the role of coordinating the regional governance process, considering the macro functions of planning, regulating, and assessing the networks and regions [5].

Finally, I identify a central question in the article, namely the process of commodification and the logic of capital that currently constitute the state reforms, with a weak regulatory process by the state, besides not confronting the inequalities detected here. On the contrary, commodification reinforces the inequalities by unequally building access, quality, flows of care, and incorporation of technologies. In a process of distribution and expansion of organizations with a market logic rather than needs-based logic in a country with possibilities for utilization of services that express inequities and exclusion, the fragile organization of regulatory processes prevents the organization of integrated networks and the role of health systems to respond to citizens' needs.

The debate on the context of neoliberalism and transformations in administration indicates the need for changes in the nature of management on its different scales worldwide. The assumption that the market logical can decrease public expenditures by increasing efficiency has not been confirmed in studies indicating the potential negative effects of these processes, producing both an explicit commodification in outsourcing and an implicit commodification by incorporating principles from the private sector into the public sector in business processes [6]. The experience of the city and state of São Paulo in hiring Social Organizations (OS) to manage health services, including primary care units, has indicated this effect in the impossibility of producing induced care via management contract targets. As indicated by the authors, these contracts require training for managers and regulators who advance along the system's logic beyond the classical logic of service providers that will hardly produce comprehensive care, no matter how good they are.

In a world of transformations, one cannot fail to take into account a revolution in longevity operating in the territories, making chronic conditions an important challenge for health systems organization. There is a necessary transformation of the modes of production of care with integrated social and health networks that effectively place primary care at the center of health services organization, with quaternary prevention that regulates the incorporation of technologies and avoids unnecessary risks from excessive interventions.

Deficient regulation can reinforce inequalities in access, related to the juxtaposition of instruments, fragmentation of information, and lack of specialized resources. Most countries work with regulatory processes in quality and safety of care, and the SUS still presents incipient processes in regulation of access, with a focus only on managing shortages and waiting lines. A regulation that produces care in health regions requires some form of interface with the needs and the territory, using planning, information, and protocols as soft technologies and designing maps of care that consider unique local management projects, aligned with the macro strategies.

The debate article provides in-depth reflections on the principal impasses and paths of inequalities and regionalization. As discussed, health systems that fail to plan and that do not seek to better accommodate the bottom-up and top-down logics fail to mobilize the former's power of diversity with the latter's coordination, exercising its strategic role on the national scale that acknowledges the multi-scale and trans-scale approach. Importantly, to reduce inequalities, to expand the concept of health, and to care for the people was and still is the wager by a universal health system in Brazil.

Additional information

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