Saúde e Sociedade
ISSN: 0104-1290
ISSN: 1984-0470
Faculdade de Saúde Pública, Universidade de São Paulo.
Associação Paulista de Saúde Pública.

Goya, Neusa; Andrade, Luiz Odorico Monteiro de;
Pontes, Ricardo José Soares; Tajra, Fábio Solon

Regionalização da saúde: (in)visibilidade e (i)materialidade da universalidade e integralidade em saúde no trânsito de institucionalidades1

Saúde e Sociedade, vol. 25, núm. 4, 2016, Outubro-Dezembro, pp. 902-919
Faculdade de Saúde Pública, Universidade de São Paulo. Associação Paulista de Saúde Pública.

DOI: 10.1590/S0104-12902016161198

Regionalization in healthcare: (in)visibility and (im)materiality of the universal access and comprehensiveness in health in changing institutionalities[1]

Regionalização da saúde: (in)visibilidade e (i)materialidade da universalidade e integralidade em saúde no trânsito de institucionalidades

Neusa Goya
Universidade Federal do Ceará. Faculdade de Medicina. Departamento de Saúde Comunitária. Fortaleza, CE, Brazil.
E-mail: neusagoya@gmail.com

Luiz Odorico Monteiro de Andrade
Universidade Federal do Ceará. Faculdade de Medicina. Departamento de Saúde Comunitária. Fortaleza, CE, Brazil.
E-mail: odorico0811@gmail.com

Ricardo José Soares Pontes
Universidade Federal do Ceará. Faculdade de Medicina. Departamento de Saúde Comunitária. Fortaleza, CE, Brazil.
E-mail: rjpontes@fortalnet.com.br

Fábio Solon Tajra
Universidade Federal do Ceará. Faculdade de Medicina. Departamento de Saúde Comunitária. Fortaleza, CE, Brazil.
E-mail: fabioludus@gmail.com

Correspondência
Neusa Goya
Avenida Rogaciano Leite, 200, apto. 703, bloco 2, Guararapes.
Fortaleza, CE, Brazil. CEP 06810-786.

Abstract

Regionalization is a strategy of organization and integration of services in national health systems, in a path to be followed toward comprehensiveness and universal access. However, its principles are still invisible in Brazilian society, and the forms of management in health regions are questioned, as well as its actual effects on the construction of health as a right. This article is dedicated to such questioning and falls as a production aiming to denature processes and enable the emergence of events put into invisibility because of the "discursive formations" of health regionalization. This study comprises the regionalization process of Ceará's health system since the 1990s. This is a qualitative study that examines the reports of 23 state managers of health, as well as the documentary narratives related to this issue. This study aims to build "bundles of relations", articulating the subjects and institutions in the production of "knowledge-power and truth-power", according to Foucault's reference, and in dialogue with public health authors. The regionalization of Ceará points to a reform of the health sector, delegating the management and provision of services to the Social Organization and to the consortium, on proce-

1 This article is one of the products linked to the study Model of Governance, Regionalization and Healthcare Networks in the State of Ceará: Context, Conditions, Implementation and Results, carried out between 2013 and June 2015, with financing from the Fundação Cearense de Apoio ao Desenvolvimento Científico e Tecnológico (Funcap), in the Program of Research for the SUS (Programa de Pesquisa para o SUS - PPSUS). It is also a result of the doctoral thesis in collective health developed by Neusa Goya with the General Association of the Federal University of Ceará, the State University of Ceará and the University of Fortaleza. It was approved by the Ethics and Research Committee of the Federal University of Ceará with report #137,055.

 DOI 10.1590/S0104-12902016161198

dural and productive contracting, strengthening the "entrepreneurship" of health and thus affecting the production of comprehensiveness and universality. We conclude that the Unified Health System's constitutional stratum is undergoing a breaking process, forging another "regime of comprehensiveness and universality", that can be observed in the fact that the Unified Health System is between institutionalities, and in the change from the right to health care to customer right in a reductionist shift.
Keywords: Unified Health System; Public Health Policy; Regional Health Planning; Health Care Sector Reform; Social Organization; Health Consortium.

Resumo

A regionalização é uma estratégia de organização e integração de serviços em sistemas nacionais de saúde, colocando-se como um caminho a ser trilhado para a integralidade e universalidade. No entanto, constitui-se como princípio ainda invisível na sociedade brasileira, problematizando seus modos de gestão nas regiões de saúde, assim como seus efeitos reais na construção do devir da saúde em direito. Este artigo dedica-se a essa problematização e inscreve-se como uma produção a desnaturalizar processos e a possibilitar o aparecimento de acontecimentos postos em invisibilidade e dizibilidade pela "formação discursiva" da regionalização da saúde. Toma como habitação a regionalização da saúde do Ceará em curso desde meados de 1990. A partir de uma abordagem qualitativa, adota em conexão e análise os discursos em entrevistas com 23 gestores estaduais de saúde e narrativas documentais afins ao tema. Busca a constituição do "feixe de relações", articulando sujeitos e instituições em produção de "saber-poder e verdade-poder", segundo referência foucaultiana, e em diálogo com autores da saúde coletiva. A regionalização do Ceará aponta para uma reforma do setor saúde, delegando a gestão e prestação de serviços à Organização Social e aos consórcios, em contratualização procedimental e produtiva, fortalecendo o "empresariamento" da saúde e afetando a produção da integralidade e universalidade. Conclui-se que o estrato constitucional do Sistema Único de Saúde (SUS) encontra-se em processo de rompimento, forjando um outro "regime de integralidade e de universalidade", que se pode visualizar no fato do SUS estar em trânsito de institucionalidades e na transformação da saúde de direito, em um deslocamento reducionista, para o campo do direito do consumidor.
Keywords: Sistema Único de Saúde; Política Pública de Saúde; Regionalização; Reforma do Setor Saúde; Organização Social; Consórcio de Saúde.

Introduction

Regionalization has been a strategy adopted to organize and integrate services in national health systems which are public and universal as a central path to be followed to ensure comprehensiveness in health and the universality of the access. However, there are principles of the Unified Health System (Sistema Único de Saúde – SUS) which are still invisible in the Brazilian society, making us question the forms of management of the regionalized system and its real effects to the transformation of health into a right.

Mendes and Louvison (2015) and Viana, Miranda and Silva (2015) warn that the frontiers of the public SUS, universal, comprehensive and with single management, are going through a rupture process, given the phenomenon of "entrepreneurism" being conceived in the regionalization of health, considering both – the regionalization and the "entrepreneurism" – as coexisting productions which are under tension.

Thus, it is necessary to question the regionalization of health, considering that this logic is placed at the center of the SUS, due its constitutional orientation for the organization of a regionalized and hierarchized network, called by Santos and Andrade (2007) an "inter-federative network of services", without which it is not possible to implement the comprehensiveness of healthcare (Santos; Andrade, 2013).

In this sense, one of the aspects being analyzed is the institutional design of the SUS constituting a "Brazilian sanitary federalism" (Dourado; Elias, 2011), since the configuration of its management, organization and operation mirror Brazil's federalism. Its legal proposition establishes an ordainment of the sanitary authority of each entity, circumscribed in responsibilities, prerogatives and competences directly related to its governmental representation. Thus, in the application of the regionalization, there is a lack of a sanitary authority in charge of the management of the health region, instituted by Decree 7,508/2011 (Brasil, 2011).

The managers of the SUS point out that there are no roles defined for the level responsible for ensuring access to services with higher technological density in the region (Shimizu, 2013). Santos and Campos (2015) point out some possibilities in the regional management models, such as the constitution of a special autarchy or of a regional associative entity, linking to it the Organizational Contract of Public Action of Health (Contrato Organizativo de Ação Pública – COAP). Mendes and Louvison (2015) state that the discussion of a new "institutionality", in the context of regionalization, should be carried out in order that a State reform in which the "SUS fits" is elaborated, in accordance with the Constitution with respect to its public, universal and comprehensive nature and its single management.

When we problematize and add to the debate about the management of the SUS in the health region, we bring the experiment of the regionalization of healthcare in the state of Ceará to provide an in-depth analysis of what has been happening, since it reflects a path that has been followed since the mid-1990s until today. As a result, the state has a strong tradition with decentralization and regionalization of the SUS (Lima; Viana, 2011). Mendes (2007) affirms that Ceará was considered the first Brazilian state to develop the regionalization based on the concept of Healthcare Networks. Recently, it was one of the states to implement in its regions the signature of the COAP (Brasil, 2011).

Hence, the ongoing experiment in Ceará constitutes a great foundation for the development of studies on the regionalization of healthcare. This article focuses on that theme, problematizing the "Brazilian sanitary federalism" of the SUS coexisting with regionalization, in accordance with article 198 of the Federal Constitution, with aims at an "inter-federative network of services". Thus, we ask: how does the management of the SUS take place in the health regions? What are its effects in the production of the constitutional SUS and of the idea of health as a right?

Methodology

The production of this article was based on a qualitative approach. It encompasses an analysis of the meanings produced in the practices, thus in

the creation in the common plane of life, and hence "being noticed in the plane of conflicts, in divergences, in actions that make a difference, that enable the production of other meanings, against the hegemonic meaning" (Rocha; Aguiar, 2003, p. 66).

It is an article inspired by Foucault, but it is also related to authors of collective health who focus their study on the regionalization of health. It is a scientific production to denaturalize processes, since it considers reality to be something that it is not given *a priori*, but an experiment that should be analyzed and problematized.

This perspective is strong for the appearance of "discursive events" which are put in a regimen of invisibility and utterability in the discourses about the regionalization of health. For Foucault (2006a), the "discursive events" scape the interiority of the discourse and overflows into creases by composing relations with other events that are from different domains of knowledges, scientific of not. The discourse, for the author, is then designed as a series of "discursive events".

Thus, as sources of information, problematization and analysis, we take the discourse of the regionalization of health, in a Foucauldian formulation, using institutional documents that are related to the theme and narratives of open interviews made with state health managers from Ceará, with five of them being from the central level and eighteen from regional coordinating bodies.

The criterion for choosing the interviewees was the fact that they were the political and technical leaders of the health regionalization in Ceará, positioning themselves then as "subjects of discourse" (Foucault, 2008, 2013). All of them were informed about the goals of the research, its approval from the Committee of Ethics and Research of the Federal University of Ceará, and were also invited to sign an Informed Consent. The Secrecy and anonymity of those involved were properly guaranteed.

In the interviews, the initial approach of the path of the person was asked, and as a guiding theme we asked the interviewee to talk about the regionalization of healthcare in Ceará in a free narrative, following their own viewpoint and experiment. Other questions were introduced to discuss more extensively some issues that were mentioned during the interview. They were recorded and transcribed, constituting discourses that we call Interviewee 1 (I1) and so on. We did not identify if the speaking subject was from the central or regional level, considering the condition of both as "subjects of discourse".

In the analysis and sharing of the experiment of the research, we highlight the work of the supervising group[2] of the research, as a device according to Barros (1997). Pozzana (2014) discusses the formation devices and points out that:

> when the events are narrated and shared, characters, places, talks, textures and images gain space in our lives. We are forced to think. Suspensions interrogate our positions of knowledge and power. Coherence and the closing of the ego fail, acts appear and the world positions itself (Pozzana, 2014, p. 61).

Thus, on the discussion of the supervised discourses, we were forced to think about the issue, which enabled us to see the present (but invisible) potentialities, i.e., dividing the "words and the things" of the discourses, in acts of extraction. We revealed what is put outside of the official knowledge about the regionalization. In other forms of illumination, we make the "object of discourse" of the regionalization, which "does not preexist itself, held back by some obstacle at the first light, it exists under the positive conditions of a complex group of relations" (Foucault, 2008, p. 50).

These groups of relations materialize the discursive relations which "are established between institutions, economic and social processes, behavioral patterns, systems of norms, techniques, types of classification, modes of characterization" (Foucault, 2008, p. 50). The discursive relations "determine the group of relations that discourse must establish in order to speak of this or that object, in order to deal with them, name them, analyze

2 Group of researchers that integrated the research of the PPSUS, systematically united in the period of its realization, between 2013 and June 2015.

them, classify them, explain then, etc.", constituting the "discourse as a practice" (Foucault, 2008, p. 51). Foucault brings attention to the "more" of the discourse in its practice "that we must reveal and describe" (2008, p. 55).

Then, we produce the group of relations that was created in connection with the things and the realized acts, between the subjects and the institutions that create the forms of management of the SUS in the regionalization of healthcare in Ceará. A group of relations that denaturalizes instituted truths and boots other visibilities and utterabilities, as "blocks of the invisible searching for a passage" (Barros, 1997, p. 186).

With that purpose, in the context of the regionalization of health in Ceará, we consider as analyzer the discourse in production and the coexistence of games of "knowledge-power and truth-power", according to Foucault (2006a, 2006b, 2006c, 2008, 2014). We add to the Foucauldian analysis the contributions of collective health that problematize the theme in question. In the analyzed dimensions, we highlight as results in discussion: (1) the discursive formation of the regionalization of health; (2) the production of knowledge-power and truth-power relations; (3) the reform of the health sector and the path of institutionalities[3]; (4) the relations between the Regional Commission of Managers and the Social Organization and Public Consortium of Health..

The "discursive formation" of the regionalization of health: from the bureaucratic perspective to the inter-federative contractualization

The institution of the SUS brought as normative orientation the guideline of the decentralization of health services, with great institutionalization in its development. Viana et al. (2009) point out the configuration of cycles of decentralization of health policies in Brazil, with an initial emphasis in municipalizing and then regionalizing. For these authors, the regionalization of health was inaugurated with the Operational Guidelines of Healthcare, constituting a normative and bureaucratic regionalization.

From 2000 to 2014, health policies tended to promote regionalization under the normative regulation of the Ministry of Health (Figure 1).

3 The term "institutionality" is here used to refer to the Health Organization and the Health Consortiums instituted in the regionalization of Ceará. Conceptually, we adopt institutionality following Barros' (apud Ferigato; Carvalho, 2009, p. 53) point of view of institution, which indicates "a productive character and denotes, in the human, the oblique way to satisfy the needs and desires, for when they are satisfied, they are also constrained, sabotaged, sublimated".

Figure 1 – The normative discursive formation of health regionalization

BUREAUCRATIC NORMATIVE REGIONALIZATION (Viana et al., 2008)	PLANNED REGIONALIZATION		INTER-FEDERATIVE CONTRACTUAL REGIONALIZATION OCPA – HEALTH REGIONS		
Without any formal instrument of contractualization of responsibilities	Term of Commitment of Management (TCM): individual adherence of each federative entity		Organizational Contract of Public Action of Health (OCPA): adherence of federative entities with shared responsibilities in the Health Region		
Regional organization: Microregion of Health and Care Module	Perspective: economic, cultural and social diversity to redefine "health regions"	Healthcare networks that cover the health regions	Health Region (HR): continuous geographic space constituted of a group of neighboring municipalities, delimited based on cultural, economic and social identities and on communication networks and infrastructure of shared transport		
Regional Comprehensive Plan and Comprehensive Investment Plan (RCP and CIP) Integrated Agreed Program (IAP – instituted by Norm 01/96)	Board of Regional Management (BRM): regional pact RCP CIP IAP BRM	Healthcare Network Organization and Operation with the definition of points of attention and flows of inter-municipal reference in the health regions (HRs)	Regional Commission of Managers (RCM): regional pact RCP – CIP National List of Medications (NLM) National List of Actions and Health Services (NLAHS) General Program of Actions and Health Services (GPAHS) Health Map HN	OCPA in the HRs of Ceará and Mato Grosso do Sul	Addition to the OCPA in the HRs of Ceará and Mato Grosso do Sul
2001/2002	2006	2010	2011	2012	2013/2014
NOAS	Health Pact	Ordinance 4,279	Decree 7,508	OCPA/HEALTH PACT/HN	
Lack of regional planning	Emphasis on the integrated regionalplanning and development to fight against socioeconomic inequalities of the area	HN Healthcare Network (HN)	Implementation of Thematic Networks: Rede Cegonha; Urgency and Emergency; Psychosocial; People with Impairments and Chronic Diseases Emphasis on the integrated inter-federative regional planning; technical-political pact and cooperative management Maintenance of the Health Pact in the HRs without adherence to the OCPA, and its use is also maintained for the HRs with OCPA.		

Source: Goya[4]

Each normative edition (Figure 1) elaborated concepts that, among other things, focused on: (1) the inter-federative relations in a triple management model through commissions of managers; (2) the cooperative, interdependent, complementary and systemic system through the Healthcare Networks; (3) the exercise of the solidary pact through the Health Pact; (4) the contractual negotiation between federative entities through the OCPA; (5) the new care and management territoriality around the constitution of the health region; (6) regional planning within a perspective of inte-

4 GOYA, N. *Regionalização da Saúde*: cartografia dos modos de produção do cuidado e de gestão do Sistema Único de Saúde. 2016. Tese (Doutorado em Saúde Coletiva) - Universidade Federal do Ceará, Fortaleza, 2016. No prelo.

grated and inter-sector development in the space of the region.

Each period had a conceptual emphasis that caused movements in the process of health regionalization, going from a context of normative and bureaucratic regionalization (Viana et al., 2008), to an agreed regionalization, and then to a contractual and inter-federative regionalization (Figure 1). However, it was not just a normative-conceptual guidance that enabled the classification of "types of regionalization"; it also led to forms of management of the SUS that is considered regional, composing the updating and repetition of "statements of order" (Foucault, 2006c) that guided the discourse and practices of the regionalization of health.

When talking about statements, Foucault (2008) highlights its link to a "complex set of material institutions", pointing out that they never present themselves in independence and neutrality. When they circulate, the statements produce a certain set of operation of things – and also of tensions, as they provoke those who are opposed to them.

The statements of order, reflected in Figure 1, ended up fabricating a regime of truth of the forms of management of the SUS, in conformity with its stipulation into norms and proposition of "types of regionalization", which induced the practices of regionalization. Foucault (2006c, p. 233) means by truth the "collection of procedures which allows in every moment and every individual to make statements which will be considered true". For him,

> these productions of truth cannot be dissociated from power and from mechanisms of power, because these power mechanisms make possible, lead to the production of truth, and because these productions of truth are, by themselves, power effects that unite us, bond us. These are the truth/power and knowledge/power relations that concern me. (Foucault, 2006c, p. 229).

In this sense, this discursive formation, in statements and practices, supports the creation of a regime of knowledge-power and truth-power, establishing in relations and interfaces the form of production and management of the regionally based SUS.

Regionalization of health in Ceará: the production of knowledge/power and truth/power relations

The regionalization of health in Ceará, coordinated by the Department of Health of the State (Secretaria de Saúde do Estado – SESA), was characterized by the document "Reorganization guidelines of the care and services of the Unified Health System of Ceará", approved by the State Council of Health in 1998. The text guided the institutionalization of the regionally based system, and its technical and political influences are still seen today. According to the state manager, the idealized design should be constituted by the *"basic care as a responsibility through family health groups, secondary care as a responsibility in the health region and tertiary care offered by the macroregion"* (E2).

The discourses indicated a system that was regionalized and hierarchized in levels of care complexity, in territorialities of micro and macroregions of health, proposed through a study that outlined the routes and centers of access of the population to the health services. A design of twenty microregions and three macroregions was created, focusing on the secondary sufficiency of the microregion and on the tertiary sufficiency of the macroregion, with the purpose of supplying healthcare voids. Their coverage and economy of scale had a strong role in guiding the regionalization of Ceará, as we will discuss below.

The regionalization model was based on the regional structures of the SESA called Regional Health Boards (Coordenadorias Regionais de Saúde – CRES). In each microregion which did not have a CRES, its implementation was ensured. The CRESs are in charge of *"assisting municipalities so that state, federal and public policies are guaranteed in the regional policy* [...] *established and implemented then, I am an extension* [...] *the spokesperson of the SESA for the municipalities"* (E13).

In this sense, the political administrative perspective and the management perspective gain strength, with a strong regional institutionality and centrality on the state level, which provides permeability and stability to the policies that are needed for the development of the SUS in accordance with the order of the officially proposed discourse. The operation of the regional SUS, by the municipalities and their managers, gains discursive power through the "spokesperson" that is in the condition of "subject of discourse". Araújo (2007) affirms that

> The discourse has a historical, institutional support, a materiality that enables or prohibits its realization. The subject of discourse is not the person who realizes an act of speech, nor the author of the text, nor the subject of the proposition. The subject is the person who can use (almost always exclusively) a certain statement through their training, due to the occupation of an institutional place of their technical competence (Araújo, 2007, p. 7).

But the position and production of the "subject of discourse", qualified to speak, induce practices and produce truths about the regionalization of health was not restricted to the CRESs. It was also instituted in the system of formative education for the SUS, in the form of the Public Health School of Ceará, which developed at the time the course Management in Microregional Systems, providing training for municipal health secretaries, their assistants and the technical staff of the SESA. Instead of being like other trainings, it was *"a project that aimed to train so that all social and professional subjects are involved and have the necessary information to propose a model of organization of actions of services in the regions"* (E1).

The production of knowledge of regionalization, in an educational formation, was repeatedly instituted and authorized, with contents specific from the health field to guide the production of their discursive statements. The knowledge refers to the "space in which a subject can assume various positions in order to discuss the objects it meets in its discourse [...] knowledge is defined by the possibilities of use and appropriation offered by discourse" (Foucault, 2008, p. 204). "Knowledge is to be found not only in demonstrations, it can also be found in fiction, reflection, narratives, institutional regulations, and political decisions" (Foucault, 2008, p. 205).

Therefore, the production of the knowledge of the regionalization of Ceará allowed the "trained" subjects to operate the organization and the functioning of the regional SUS, constituting a "will of truth" guided by a "will of knowledge" (Foucault, 2014). In other words, what should be known and what path should be followed in order to constitute the acceptable, measurable, classifiable truth, imposing to the "knowing subject (and in some sense prior to all experience), a certain position, a certain gaze and a certain function" (Foucault, 2008, p. 16).

Thus, a regime of truth of the regionalization of health to be adopted by all, that also constitutes power relations, since the production and acceptance of this truth ends up "exercising over the other discourses – I am always talking about our society – a certain pressure and something like a power of coercion" (Foucault, 2014, p. 17).

Another "subject of discourse" that gives visibility and utterability to the relations of knowledge-power and truth power is the municipal mayor, shaping the idea that the regionalization of Ceará *"is not only part of the health sector, it also involves mayors* [...]. *Today it is not possible to modify any territory that constitutes a health region without any political involvement"* (E1). It is a participation coordinated by the SESA since the first stages of the regionalization, not in an individualized way, but through the Regional Associations of Mayor, the Association of Mayors of the State of Ceará as central entity, and the State Council of Municipal Health Secretaries of Ceará.

Hence, there is the creation of processes that go beyond their technical-assisting dimension in the production and the circularity of games of knowledge-power, gaining volubility and permeability with its institutionalization in the associative entities of mayors, municipal secretaries of health, formative schools of the SUS, health departments, regional boards and others.

This technical-political constitution, based on things, acts, subjects and institutions detached

and linked compose lines in a set of relations of the regionalization of the health of Ceará and its discursive and practical institutionalization, forming a decisive positive ground for its continuity. The term "positive ground" (Foucault, 2008) is justified by the fact that the possibilities of use of the truth-power and the knowledge-power in the constitution of the object of the discourse of the regionalization were presented, and in the meantime a project to reform the health sector is designed, as we will see next.

Regionalization and reform in the health sector: the path of the institutionalities in the production of (in)visibility and (im)materiality of comprehensiveness – a possible paradox?

In 2015, the regionalized model of Ceará's healthcare was constituted by 22 health regions[5] and five macroregions. From the viewpoint of the regional design and the healthcare functions, the study indicated that few alterations were made from 1998 to 2015, pointing out that the strong political-technical guidance of the regionalized model of healthcare in Ceará was given by the SESA, in spite of the adaptations made at each normative orientation from the Ministry of Health.

The discourse of the state managers highlighted that *"the specialists from Ceará have this tradition, and at times they even go beyond creating norms, and what is done here ends up leading to federal norms later"* (E14). However, in addition to anticipating national norms, with the regionalization before the year 2000, a process to reform the health sector was designed in Ceará, under the command of the state through the SESA.

The expression "reform of the health sector", according to Costa, Silva and Ribeiro (2000),

> has been used to designate the initiatives of innovation in the organizational model of the healthcare of central economies over the last three decades. The reform has been defined as a continuous and systematic process of change in one or more segments of the health system (p. 210).

These authors point out the configuration of two waves of reforms in the health sector, each of a different nature. The first occurred in the 1970s and 1980s, and the second in the early 1990s.

> The first wave of reform of the sector was stimulated by the macroeconomic imperative of controlling national expenses with health. In recent years, the innovations have been defined by the incentives to the creation of an institutional environment that favors the improvement of the efficiency of care providers, whether public or private. The second generation of reforms has designed new roles and relations for public agencies and organizations, stimulating the provision of services through mechanisms of contractualization and through the quasi-market (Costa; Silva; Ribeiro, 2000, p. 210).

In this perspective, the reform of the health sector in Ceará, which witnessed these waves, constituted a regionalized model linked to the national norms that followed a logic of planning and execution of a series of state initiatives - initiatives that went from the expansion of the public regionalized healthcare network to the implementation of regional boards and the constitution of institutionalities to manage public health equipment that was regionalized, in a regime of contractualization of services.

In 2015, the health regions had recent physical structures of policlinics and Centre of Dental Specialties (CDS), both operating regionally. In two health macroregions, Cariri and Sobral, regional hospitals were instituted. It was a "social policy of expanding the average and high complexity", triggered by the *"politics of the governor* [...] *in the first term from 2007 to 2010* [...] *to extend, expand specialized care to the state of Ceará, especially in health regions"* (E21).

5 Terminology currently adopted to replace the health microregions.

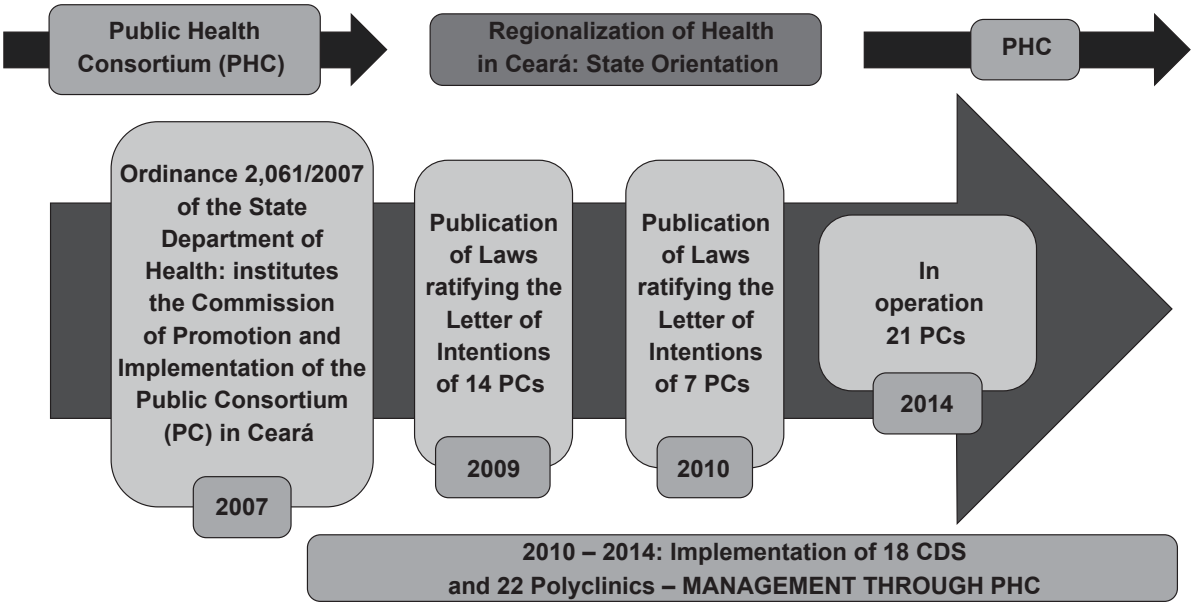
In the process of reform of the health sector, the management of polyclinics and CDS was under the responsibility of the institutionalities called Public Consortiums of Health, legally formed in each region, except for the region of Fortaleza. The governor of the state at the time played a central role in its implementation. A "subject of discourse" that gave value to the knowledge of the regionalization of health also in relations of power, which "do not obey the single form of interdiction and punishment, but that are multiple forms" (Foucault, 2006b, p. 248).

> *So it is a state and municipal consortium* [...]. *The mayors are the presidents of the consortium, and there is an executive board that administrates the consortium, and the distribution was made, and the governor participated in person* [...] *he had a meeting with the mayors and with the Department of Health, he directed it, and the adherence was practically a hundred percent in the political force and the consortium is working* (E3).

The consortium is a public association of autarchic and inter-federative nature, a legal person of public law, presenting the state and the municipalities of each region as affiliated entities. The municipal secretaries of health are allowed to participate, but with no right no vote, and for regional coordinators the same occurs. They have no legal seat in the consortium, which is represented on the municipal level by the mayors and by the state secretary of health on the state level.

The idea of using this type of institutionality and form of management was not random (Figure 2), with the first initiatives dating from 2007 (Ceará, 2008a).

Figure 2 – The path of the institutionality of the public health consortiums



Source: Goya[6]

In the configuration of the consortiums, the exercise of power gains a more central role with the mayor through the institutionalization of his insertion in things and in acts of the regionalization of health, making him a strategic subject in agreements to ensure a comprehensive healthcare. This perspective strengthens the political dimension of the direct negotiation between the mayor and the

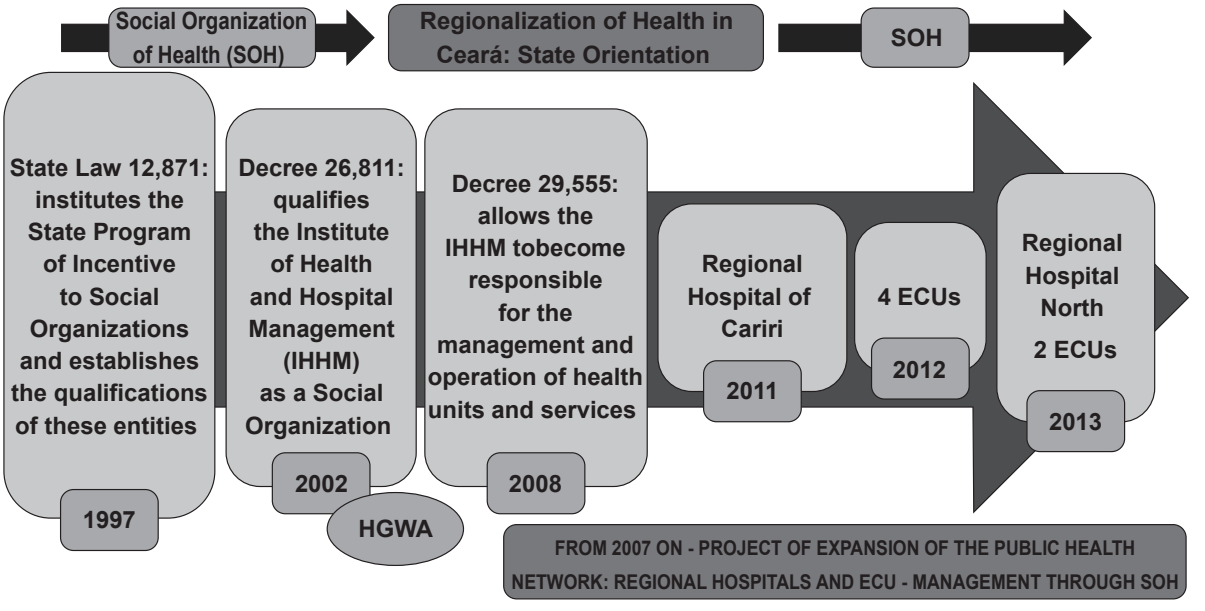
6 GOYA, N. *Regionalização da Saúde*: cartografia dos modos de produção do cuidado e de gestão do Sistema Único de Saúde. 2016. Tese (Doutorado em Saúde Coletiva) - Universidade Federal do Ceará, Fortaleza, 2016. No prelo.

governor, establishing tensions and disputes among the subjects of the regionalization: *"the part of the consortium comes from high above* [...] *the mayors get together with the governor and there they decide* [...] *what will be agreed and the polyclinic already met with the governor and* [...] *we* [CRES] *stay totally out of it"* (E8).

Foucault (2006c) discusses the production of power relations and the power relations between men and women, parents and children, a person who knows and a person who doesn't, circulating through society, shaping "thousands and thousands of power relations, and hence relations of strength of small confrontations, microfights, in a certain way" (p. 231). They are relations that coexist with the "great powers of the State", composing different ways of constituting power. In this sense, the tension around the consortiums is revealed to be a set of microfights established between the "subjects of discourse" which operate the organization and the functioning of the institutionality.

As for the management of regional hospitals and six Emergency Care Units (ECU), implemented by the state in the municipality of Fortaleza, state of Ceará, the model of management through the Social Organization of Health was chosen. However, in the agenda of the reform for the health sector, the choice of the management through the Social Organization of Health (Ceará, 1997) did not occur in 2002 (Figure 3).

Figure 3 – Regionalization of health in Ceará: the path of the institutionality of the Social Organization of Health



Source: Goya[7]

In 2002, the Institute of Health and Hospital Management, a legal person of private law, is qualified as Social Organization of Health by the state government, with the purpose of researching and producing knowledges and techniques in the areas of health and hospital management (Ceará, 2002). Still in the same year, Dr. Waldemar de Alcântara assumes the management of the General Hospital located in Fortaleza. According to Ceará (2008b), the range of his work is expanded through possibilities of working in the management and operation of many health units and services, which then occurs with the assumption of the regional hospitals and ECUs located in Fortaleza.

7 GOYA, N. *Regionalização da Saúde*: cartografia dos modos de produção do cuidado e de gestão do Sistema Único de Saúde. 2016. Tese (Doutorado em Saúde Coletiva) - Universidade Federal do Ceará, Fortaleza, 2016. No prelo.

Thus, in the experiment of the regionalization of health in Ceará, issues related to the constituted institutionalities were problematized. One of them is the form of management operationalized in a regime of contractualization which "formally defines the separation between financing and the direct provision of services" (Costa; Silva; Ribeiro, 2000, p. 210). And as such, following a healthcare logic, focused on quotas of procedures to be made.

In the case of health consortiums, we have two types of contract, the sharing contract and the program contract, which materializes what *"those institutions* [polyclinics and CDS] *are committed to producing in terms of health: this number of consultations, this number of X-rays"* (E3). And that in agreeance with the annual share of each federative entity, according to the sharing contract. An instrument that stands out is the agreed consortium program, which names and quantifies the services which will be developed by the consortium through the polyclinics and the CDS.

With respect to the Social Organization, in the form of the Institute of Health and Hospital Management, we have the management contract, which presents as an object the operationalization of management and the execution, by the contracted, of health services and activities corresponding to a health unit.

For Viana, Miranda and Silva (2015), this contractual perspective between the State and institutions like social organizations, which focus on procedure and production, favors the business management, characterizing the public "entrepreneurism" of health and forming a "quasi-market". Miranda (2013) points out that

> the institution of segments of (quasi)market tends to relativize and render partial the human, social and civil rights; tends to reduce public policies of social nature and purpose to the procedural aspect (*policy*) and to the conformism of consumption (p. 3, highlights by the author).

Following the same line, Shimizu (2013) indicates that

> the managers reiterate that the Brazilian State is greatly influenced by macroeconomic rationality, which has modified the conception of the right to health, for it has been conceived as one of the pillars of the consumer right. The association between health and consumption brings to discussion the strength of the market, which antagonizes the development of the SUS. This new way of understanding the right to health has been limited to a conception of access to health goods and services. (p. 1111).

In a dialogue with these authors, we ask: are the procedural and productive focuses of the current contracts in Ceará contributing to the reductionism of the right to health, encasing it in the access to healthcare procedures stipulated by contract according to the capacity of supply?

Following this discussion, we highlight that the public equipment, recently implemented, follows the logic of secondary and tertiary sufficiency outlined in the first stages of the regionalization, focusing on occupying healthcare voids through the supply of services.

> *What we notice is that these polyclinics, even though they were designed following a logic of filling healthcare voids in specialized clinics* [...] *they were not elaborated as points of care of the network, but as an environment of specialized medical treatment, with a therapeutic and diagnostic apparatus so that they could fill the voids in the access to specialized clinic care, so that these people did not leave the region* (E1).

By proposing this problematization, we do not deny the right of the Brazilian citizen to access health services when he needs them, this is unquestionable as a dimension of the right to health. However, the constitutional proposition of the SUS goes beyond the axis sickness-service-health, indicating life as the production of health, and therefore it is comprehensive and not only supportive. Hence, in a care network, a strategy requires materialization still today: *"within the*

regionalization of the state of Ceará, the greatest difficulty was not to create the regionalization model, identify who should be in charge of what, it was to integrate it with the Healthcare Networks, that is the greatest challenge" (E14).

Together with the not functioning of the regional network system, does the existence of these institutionalities produce a certain regime of truth, socially naturalizing the invisibility and immateriality of the comprehensiveness? Does the coexistence of the "quasi-market" regime and the regionalization of health constitute a paradox, considering that regionalization is the path to provide visibility and materiality to comprehensiveness?

From an executing state to a regulating state: what now?

The forms of management the SUS OF Ceará has constituted a delegation for the non-state public sector of direct executive responsibilities for the provision of services, in the case of the Social Organization of Health. Thus, the perspective of strengthening a regulating state to the detriment of a directly executing state is designed.

However, in the experiment of regionalization in Ceará, the strengthening of the functions of the regulatory state did not occur, *"both the municipality and the state department* [...] *not even in care, with respect to the responsibilities of control, regulation and auditing, not even in mental and sanitary surveillances"*. (E1). Thus, in health regulation a *"door of informality"* was formed, being operated by many subjects and larger than the *"official door"* regulated by the system (E14).

The fragilities of the regulatory execution both of the municipality and the SESA, in a scenario in which the indicated institutionalities are strengthened, are worrisome with respect to the proper use of public resources available for the provision of health services and to the effective transformation of health into a right, in the exercise of state regulation.

Thus, what has happened in the regulation of the health services stipulated by contracts by the consortiums and by the Social Organization?

Initially, the supply of services provided by the polyclinics was not under the regulation of state. *"The polyclinics, many of them have been operating for more than one year, even two, and these polyclinics did not go through the regulation"* (E20). Back then, regulation was carried out directly by the consortium of each region, but recently the situation was altered due to a determination of the state secretary of health, who had *"defined that everything needed to be in the central of regulation"* (E20).

Hence, we problematize the tension that has been heating up in the relations between the SESA and the consortium with respect to the exercise of the regulatory functions in the region. Going beyond the technical issues and care flows that need to be agreed on, we highlight the political character which is in production, competing for the form and the central role of the regulation of the SUS. Does this function need centralization? Who should exercise it?

As for the Social Organization, the [solo] of problematization among the different operators of the regulation of the regionalization also occurs. When analyzing the discourses of state managers, we captured a manifestation referring to the technical-political tension between the "official door" of the regulation and the "informality door". The Social Organization has "regulated" through the "informality door" the access of users coming from ECUs to a secondary hospital unit which theoretically fulfills the role of rearguard for the tertiary hospital, which should prioritize treating the patients referred by them.

The access to the equipment – the ECU and the secondary hospital – is under the regulation of state, but its management belongs to the Social Organization. In this sense, a "game of knowledge-power" is designed, coordinated by the Social Organization: authorized by knowledge, which justifies its institutionalization in the system, the Social Organization ends up using the power provided by this condition to "manage" the hospital accommodation according to its own "regulation" criteria.

Even in the condition of "official" regulators, state managers often find themselves with no political possibilities to enforce the care flows agreed

on, given the power relations that obfuscate the technical norms constituted in a supposed knowledge. Foucault (2006c), however, states that "power relations are relations of strength, confrontations, therefore always reversible. No power relation is completely triumphant or has unavoidable domination" (p. 232).

Therefore, it is not just an issue of determining who regulates, but also of encouraging intermediations in resistance, in a way that creates other possibilities of "knowledge-power", especially in the constitution of micropolitics. Thus, it includes other subjects other than managers, such as the workers and users of the SUS, to provide flow and permeability to the regionalization in the constitution of "conversation networks" (Teixeira, 2003), in an exercise of microregulation (Santos, Merhy, 2006) which is carried out in the production of "living acts of health" (Franco, 2013).

However, regionalization is still discourse and practice more limited to management, in which

> *we learn this notion of regionalization when it is already in a level of coordination. I notice that the worker that is at the extremity is not very aware of this. He is concerned with the territory in which he works, and with knowing to where he will refer someone, to whom he will refer someone, it is mainly within the municipality, beyond that the issue belongs to the Department of Health, not to the worker* (E9).

Relations between the Regional Commission of Managers and the constituted institutionalities: new frontiers of regional governance?

The Regional Commission of Managers (RCM) stands out as a traditional player in the regionalization of health in Ceará. The discourse of state health managers brings recognition to the fact that *"the Regional Commission of Managers, if it is not strong, it cannot strengthen the region nor have the feeling of regionalization"* (E11).

Nevertheless, with respect to the exercise of the role of the RCM and its relation with the constituted institutionalities, we highlight the differences and variations between the relations established between this commission and the consortiums and the Social Organization. With respect to the consortiums, we point out the predominance of relations of technical-assisting nature, manifested by the participation of the directors of the polyclinic or of the CDS in the meetings of the RCM. The political, administrative and financial aspects are put forward for the discussion of mayors and in the executive office of the consortium. In the discussion of themes that imply financial decisions, the task of convincing the mayor is delegated to the municipal secretary of health, so the mayor can intervene in the decisive level of the consortium, in which only he has a seat and the power of vote.

As for the Social Organization, we highlight the distance between the direction of regional hospitals and the RCM, and the non-participation of its directors, or even of other representatives, in the meetings of the RCM, including for technical-assisting discussion.

Thus, in both situations, in spite of the proximity between the polyclinics and the CDS with the RCM, we highlight the prevalence of the consortiums and of the Social Organization in the decision-making process and in directing the management of the health units under their responsibilities.

In this sense, the forms and structures of management of these institutionalities ended up constituting new governance frontiers for the regional SUS, not encompassed in the RCM. We point out the constitution of other knowledges while the functions of the known "subjects of discourse" are reinvented, such as the municipal mayors – given their insertion in the health consortiums – or even new subjects set by the Social Organization. The impermeability of access of the latter in the relations in the health region stands out.

The knowledge-power strategies are modified in the game between these institutionalities and the other subjects and "traditional" institutional arrangements of the SUS, such as the RCM. Thus, it makes sense to (re)think the governance processes,

given the materiality of new forms of management of the SUS in a regional context.

Final remarks

The relation between "Brazilian sanitary federalism" and the materiality of the health region as a scenario for the Healthcare Networks is under tension and seeks concrete answers. The production and the path of the institutionalities adopted in the regionalization of health in Ceará are an answer to the "supposed" lack of a sanitary authority in charge of the management of the region, including the public equipment and the provision of health services.

This answer is not a mere conjuncture that results from the current state of the regionalization of health, given its constitution into a regime of knowledge-power and truth-power in the SUS. Instead, it is a discursive event – hence its interface and coordination with other events related to different domains of knowledge.

In Ceará, a project to reform of the health sector is currently taking place, occurring in consecutive state governments. This reform does not move away from the "games of knowledge-power, truth-power" built in accordance with the waves of reform in the country and abroad. The daily production of the SUS is traversed by interested and disputes, with multiple tensions. It is part of the context of capitalist production, generating forms of business management for health and disseminating practices that benefit the market and its privatization, in a strategic alliance with capital.

The forms of management of the regional SUS, based on a contractual model which is procedural and productive, put at stake the universality of access to health as a social right, which is currently being replaced by universal coverage, ensuring part of the services in the wide range of health needs of the population. Thus, a certain "proposition" of comprehensiveness and universality that make the constitutional proposal impracticable.

Hence, special attention should be paid to the possibilities that break with the constitutional stratum of the SUS, forging a different regime of comprehensiveness and universality in the forms of management of the regional SUS. It is a history of the regionalization that differs from the path of the institutionalities of the SUS, and from the transformation of health into a right, with reductionism and a shift toward the field of consumer rights.

The production of a regime that differentiates the constitutional SUS is the main axis of the problematization of the forms of management of the regional SUS. New studies are necessary to reveal possibilities in resistance and tension for the constitutional SUS.

The games of "knowledge-power" with the new subjects and institutionalities at times "swallow" the process of fighting for the maintenance of the constitutional SUS. Devoid of political authority, in many situations the state health managers, subjects of this study, often have their hands tied when in the face of political decisions that scape their governability and the forum of the RCM.

Thus, going beyond the precepts of triple agreement and tripartite social control, such as the RCM, other forms of management and governance of the SUS should be created, expanding the political foundation of its (SUS)tentation. They are facing tensions with the new decisive arrangements of the consortiums and of the Social Organization, outlining new frontiers of SUS governance.

Lastly, we point out the urgency of the expansion of the debate of regionalization. The inclusion of new subjects, such as workers and users of the SUS, is a strong strategy for the production of other relations of knowledge-power and truth-power, strengthening the idea of the constitutional SUS.

References

ARAÚJO, I. L. Formação discursiva como conceito chave para a arqueogenealogia de Foucault. *Revista Aulas*, Campinas, n. 3, p. 1-24, 2007. Dossiê Foucault. Disponível em: <http://www.ifch.unicamp.br/ojs/index.php/aulas/article/viewFile/1924/1385>. Acesso em: 3 set. 2015.

BARROS, R. D. B. Dispositivos em ação: o grupo. In: SILVA, A. E.; NEVES, C. A. B.; RAUTER, C. (Org.). *Subjetividade*: questões contemporâneas.

São Paulo: Hucitec, 1997. p. 183-191. (Coleção SaúdeLoucura. Volume 6).

BRASIL. Presidência da República. Decreto nº 7508, de 28 de junho de 2011. Regulamenta a Lei nº 8080, de 19 de setembro de 1990, 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] República Federativa do Brasil*, Brasília, DF, 29 jun. 2011. Disponível em: <http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2011/decreto/D7508.htm>. Acesso em: 14 jun. 2013.

CEARÁ. Assembleia Legislativa do Estado do Ceará. Lei nº 12781, de 30 de dezembro de 1997. Institui o Programa Estadual de Incentivo às Organizações Sociais, dispõe sobre a qualificação destas entidades e dá outras providências. *Diário Oficial do Estado*, Fortaleza, CE, 30 dez. 1997. Disponível em: <http://www.al.ce.gov.br/legislativo/tramitando/lei/12781.htm>. Acesso em: 27 abr. 2015.

CEARÁ. Governo do Estado. Decreto nº 26811, de 30 de outubro de 2002. Qualifica como Organização Social o Instituto de Saúde e Gestão Hospitalar (ISGH). *Diário Oficial do Estado*, Fortaleza, CE, 31 out. 2002. Disponível em: <http://imagens.seplag.ce.gov.br/PDF/20021031/do20021031p01.pdf>. Acesso em: 27 abr. 2015.

CEARÁ. Secretaria da Saúde do Estado. Portaria nº 2061, de 8 de novembro de 2007. Cria, no âmbito desta Secretaria, a Comissão de Fomento e Implantação de Consórcios Públicos de Saúde no Estado do Ceará. *Diário Oficial do Estado*, Fortaleza, CE, 3 jan. 2008a. Disponível em: <http://www.jusbrasil.com.br/diarios/5264148/pg-34-caderno-unico-diario-oficial-do-estado-do-ceara-doece-de-03-01-2008>. Acesso em: 31 out. 2016.

CEARÁ. Governo do Estado. Decreto nº 29555, de 21 de novembro de 2008. Altera o Decreto nº 26811, de 30 de outubro de 2002, e dá outras providências. *Diário Oficial do Estado*, Fortaleza, CE, 25 nov. 2008b. Disponível em: <http://imagens.seplag.ce.gov.br/PDF/20081125/do20081125p01.pdf>. Acesso em: 27 abr. 2015.

COSTA, N. R.; SILVA, P. L. B; RIBEIRO, J. M. A experiência internacional de reforma do setor saúde: inovações organizacionais e de financiamento. *RAP*, Rio de Janeiro, v. 34, n. 1, p. 209-227, 2000. Disponível em: <http://bibliotecadigital.fgv.br/ojs/index.php/rap/article/view/6259>. Acesso em: 2 abr. 2015.

DOURADO, D. A.; ELIAS, P. E. M. Regionalização e dinâmica política do federalismo sanitário brasileiro. *Revista de Saúde Pública*, São Paulo, v. 45, n. 1, p. 204-211, 2011. Disponível em: <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102011000100023>. Acesso em: 31 out. 2016.

FERIGATO, S.; CARVALHO, S. R. O poder da gestão e a gestão do poder. In: CARVALHO, S. R.; FERIGATO, S.; BARROS, M. E. (Org.). *Conexões*: saúde coletiva e políticas de subjetividade. São Paulo: Hucitec, 2009. p. 53-73.

FOUCAULT, M. Diálogo sobre o Poder. In: MOTTA, M. B. (Org.). *Estratégia, poder-saber*. Tradução de Vera Lúcia Avellar Ribeiro. Rio de Janeiro: Forense Universitária, 2006a. p. 253-269. (Coleção Ditos & Escritos. Volume IV).

FOUCAULT, M. Poderes e estratégia. In: MOTTA, M. B. (Org.). *Estratégia, poder-saber*. Tradução de Vera Lúcia Avellar Ribeiro. Rio de Janeiro: Forense Universitária, 2006b. p. 241-252. (Coleção Ditos & Escritos. Volume IV).

FOUCAULT, M. Poder e saber. In: MOTTA, M. B. (Org.). *Estratégia, poder-saber*. Tradução de Vera Lúcia Avellar Ribeiro. Rio de Janeiro: Forense Universitária, 2006c. p. 223-240. (Coleção Ditos & Escritos. Volume IV).

FOUCAULT, M. *A arqueologia do saber*. 7. ed. Rio de Janeiro: Forense Universitária, 2008. (Coleção Campo Teórico). Disponível em: <http://www.uesb.br/eventos/pensarcomveyne/arquivos/FOUCAULT.pdf>. Acesso em: 4 ago. 2015.

FOUCAULT, M. *A ordem do discurso*: aula inaugural do Collège de France, pronunciada em

2 de dezembro de 1970. 24. ed. São Paulo: Loyola, 2014.

FRANCO, T. B. As redes na micropolítica do processo de trabalho em saúde. In: FRANCO, T. B.; MERHY, E. E. *Trabalho, produção do cuidado e subjetividade em saúde*: textos reunidos. São Paulo: Hucitec, 2013. p. 226-242.

LIMA, L. D; VIANA, A. L. D. Descentralização, regionalização e instâncias intergovernamentais no Sistema Único de Saúde. In: VIANA, A. L. D.; LIMA, L. D. (Org.). *Regionalização e relações federativas na política de saúde do Brasil*. Rio de Janeiro: Contra Capa, 2011. p. 39-63.

MENDES, A.; LOUVISON, M. O debate da regionalização em tempos de turbulência no SUS. *Saúde e Sociedade*, São Paulo, v. 24, n. 2, p. 393-402, 2015. Disponível em: <http://www.scielo.br/scielo.php?pid=S0104-12902015000200393&script=sci_arttext>. Acesso em: 15 jul. 2015.

MENDES, E. V. *A modelagem das redes de atenção à saúde*. Belo Horizonte: Secretaria de Estado de Saúde de Minas Gerais, 2007.

MIRANDA, A. S. Pluralismo agenciado da política e gestão pública de saúde em institucionalidade híbrida e dinâmica de (quase) mercado. Rio de Janeiro: Cebes, 2013. Disponível em: <http://cebes.org.br/2013/07/pluralismo-agenciado-da-politica-e-gestao-publicas-de-saude-em-institucionalidade-hibrida-e-dinamicas-de-quasemercado/>. Acesso em: 4 abr. 2014.

POZZANA, L. A formação do cartógrafo é o mundo. In: PASSOS, E.; KASTRUP V.; TEDESCO, S. *Pistas do método da cartografia*: a experiência da pesquisa e o plano comum. Porto Alegre: Sulina, 2014. p. 42-65. v. 2.

ROCHA, M. L.; AGUIAR, K. F. Pesquisa-intervenção e a produção de novas análises. *Psicologia, Ciência e Profissão*, Rio de Janeiro, v. 23, n. 4, p. 64-73, 2003.

SANTOS, L.; ANDRADE, L. O. M. SUS: o espaço da gestão inovada e dos consensos interfederativos: aspectos jurídicos, administrativos e financeiros. Campinas: Instituto de Direito Sanitário Aplicado, 2007.

SANTOS, L.; ANDRADE, L. O. M. Rede interfederativa de saúde. In: SILVA, S. F. (Org.). Redes de atenção à saúde: desafios da regionalização no SUS. Campinas: Saberes, 2013. p. 35-74.

SANTOS, L.; CAMPOS, G. W. S. SUS Brasil: a região de saúde como o caminho. *Saúde e Sociedade*, São Paulo, v. 24, n. 2, p. 438-446, 2015. Disponível em: <http://www.scielo.br/pdf/sausoc/v24n2/0104-1290-sausoc-24-02-00438.pdf>. Acesso em: 15 jul. 2015.

SANTOS, F. P.; MERHY, E. M. A regulação pública da saúde no Estado brasileiro: uma revisão. *Interface: comunicação, saúde, educação*, Botucatu, v. 10, n. 19, p. 25-41, 2006.

SHIMIZU, H. E. Percepção dos gestores do Sistema Único de Saúde acerca dos desafios da formação das Redes de atenção à saúde no Brasil. *Physis*, Rio de Janeiro, v. 23, n. 4, p. 1101-1122, 2013. Disponível em: <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-73312013000400005&lng=en&nrm=iso>. Acesso em: 10 jun. 2014.

TEIXEIRA, R. R. O acolhimento num serviço de saúde entendido como uma rede de conversações. In: PINHEIRO, R.; MATTOS, R. A. (Org.). *Construção da integralidade*: cotidiano, saberes e práticas em saúde. Rio de Janeiro: IMS-UERJ: ABRASCO, 2003. p. 89-111.

VIANA, A. L. D. et al. Novas perspectivas para a regionalização da saúde. São *Paulo em Perspectiva*, São Paulo, v. 22, n. 1, p. 92-106, 2008.

VIANA, A. L. D.; MIRANDA, A. S.; SILVA, H. P. Segmentos institucionais de gestão em saúde:

descrição, tendências e cenários prospectivos. Rio de Janeiro: Fundação Oswaldo Cruz, 2015. (Textos para discussão. Número 2). Disponível em: <http://saudeamanha.fiocruz.br/wp-content/uploads/2016/07/2-PJSSaudeAmanha_Texto0002_final.pdf>. Acesso em: 31 out. 2016.

Authors' contribution

Goya, Andrade, Pontes and Tajra participated in the conception of the project, in the problematization and in the analysis of information, as well as in the critical review and final approval of the published version. Goya was the person responsible for writing the article.

Received: 03/16/2016
Approved: 10/13/2016