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HEALTH CARE NETWORKS: THE PERCEPTION OF MUNICIPAL MANAGERS

REDES DE ATENÇÃO À SAÚDE: A PERCEPÇÃO DOS GESTORES MUNICIPAIS

REDES DE ATENCIÓN A LA SALUD: LA PERCEPCIÓN DE LOS GESTORES MUNICIPALES

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ABSTRACT

Objective: to know the perception of municipal managers regarding the role of the Municipal Health Secretariat and the State Health Department in the process of regionalization and organization of Health Care Networks. **Method:** a descriptive, exploratory study with a qualitative approach. Data collection took place in the first half of 2016, with 13 municipal health managers from the state of Santa Catarina. The data collected were analyzed through content analysis. **Results:** as potentialities, it was evidenced the adequate support of the State Department of Health in the permanent education to the municipalities and the participation of the Municipal Health Council in the management and planning, as well as positive results in the assistance of Primary Care. Regarding the weaknesses, the main citation was referring to the insufficient transfer of financial resources. **Conclusion:** Cooperation between municipalities, the Regional Interagency Commission, regions and networks are important to sustain health in small municipalities

Descriptors: Health management; Local government; State government; Unified Health System, Delivery of health care.

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RESUMO

Objetivo: conhecer a percepção dos gestores municipais quanto ao papel da Secretaria Municipal de Saúde e da Secretaria Estadual de Saúde no processo de regionalização e organização das Redes de Atenção à Saúde. **Método:** estudo descritivo, exploratório, com abordagem qualitativa. A coleta de dados ocorreu no primeiro semestre de 2016, com 13 gestores municipais de saúde do estado de Santa Catarina. Os dados coletados foram analisados por meio da análise de conteúdo. **Resultados:** como potencialidades, evidenciou-se o suporte adequado da Secretaria Estadual de Saúde na educação permanente aos municípios e a participação do Conselho Municipal de Saúde na gestão e planejamento, bem como resultados positivos na assistência da Atenção Básica. Em relação às fragilidades, a principal citação foi referente ao repasse insuficiente de recursos financeiros. **Conclusão:** a cooperação entre municípios, a Comissão Intergestores Regional, as regiões e as Redes são importantes para sustentar a saúde nos pequenos municípios.

Descritores: Gestão em saúde; Governo local; Governo estadual; Sistema Único de Saúde; Assistência à saúde.

RESUMEN

Objetivo: conocer la percepción de los gestores municipales sobre el papel de la Secretaría Municipal de Salud y de la Secretaría Estadual de Salud en el proceso de regionalización y organización de las Redes de Atención en Salud. **Método:** estudio descriptivo, exploratorio, con abordaje cualitativo. La recolección de datos se realizó el primer semestre de 2016, con 13 gestores municipales de salud del estado de Santa Catarina. Los datos recolectados fueron analizados por medio del análisis de contenido. **Resultados:** como potencialidades, se destacó el apoyo adecuado de la Secretaría Estadual de Salud en la educación continua de los municipios y la participación del Consejo Municipal de Salud en la gestión y planificación, así como también resultados positivos en la asistencia de la Atención Primaria. En cuanto a las debilidades, se mencionó principalmente la transferencia insuficiente de recursos financieros. **Conclusión:** la cooperación entre municipios, la Comisión Intergestores Regional, las regiones y las Redes son importantes para mantener la salud en los pequeños municipios

Descriptores: Gestión en salud; Gobierno local; Gobierno estadual; Sistema Único de Salud; Prestación de atención de salud; Atención de la salud.

INTRODUCTION

The three spheres of the government manage the Unified Health System (SUS): federal, state, and municipal. Competencies for each sphere are presented in Law 8,080 of 1990, which, in addition to providing for the conditions of health promotion, protection and recovery, and the organization and functioning of services, also presents the common and specific attributions of each federated entity. Aspects related to the decentralization of services, regionalization, and health care networks (HCN) are addressed in the law, determining them as the responsibility of the federal, state, and municipal governments.[1]

In the historical process of construction and organization of health actions in SUS, decentralization is a constitutional principle, giving health management autonomy to states and municipalities. In this context, the Basic Operational Norms and the Pact for Health

stand out, which gave municipalities the central role in the implementation of health policy and the provision of services to the population[2], and municipal managers the status of strategic political actors in defining and organization of health policy at the local level.[3]

However, greater municipal autonomy does not exclude the responsibility of States and the Union, which remain responsible for management and support, including the transfer of financial resources and political, administrative, legal, and technical instruments for the effective functioning of the system.[4]

The attributions of the three spheres of government extend to the organization of the HCN, which aims to promote the integration of health actions and services to provide continuous, comprehensive, quality, responsible, and humanized care.[5] The HCN is a set of health actions and services articulated at levels of increasing complexity to guarantee comprehensive health care, consisting of three elements: population, operational structure, and health care model.[5]

Given that the regionalization and organization of the HCN are organizational principles of SUS, fundamental to the achievement of integral care, and that its operationalization is sensitive to the perception of municipal managers regarding the roles of the spheres involved in the directions and decisions, we justify this study that aims to understand the perception of municipal managers regarding the role of the Municipal Health Secretariat and the State Health Secretariat in the process of regionalization and organization of Health Care Networks.

METHODS

This is descriptive and exploratory research, with a qualitative approach. Data collection took place in the first half of 2016, with the managers of the municipalities in the western region of the state of Santa Catarina, belonging to the Association of Municipalities in the West of Santa Catarina, resulting in 27 municipalities.

The managers of the municipalities who accepted the invitation through telephone contact and present at the meeting of the Regional Intergovernmental Commission - CIR in December 2015participated in this study. Thus, thirteen municipal managers participated, who were interviewed after their official acceptance by signing the Informed Consent Form (ICF).

Data collection was carried out through interviews, based on a semi-structured script with seven questions, which were recorded on audio and later transcribed. The research was initiated after

approval by the Ethics Committee on Research with Human Beings (opinion No. 1,297,364), following all the recommendations of Resolution 466/2012 of the National Health Council.

The organization and analysis of the collected data were based on content analysis.[6] Thus, we developed the following steps: pre-analysis; exploration of the material or coding; treatment of results, inference, and interpretation.

To guarantee the confidentiality of the participants, we identified them with the name of rivers that form the interior slope of Santa Catarina, composed of the hydrographic basin of the Paraná River and the Iguaçu River to draw an analogy between the formation of rivers and hydrographic basins with the construction of the HCN in the western region of Santa Catarina.

RESULTS AND DISCUSSIONS

HCN is the current form of organization of health care services in SUS, and the Union, the Federal District, and all states and municipalities are equally responsible, throughout the national territory and at all levels, for its implementation.[7] In this sense, the study participants reported aspects related to the municipality's duties in the management of SUS and also addressed the work developed by the State Department of Health (SDH), highlighting potentialities and weaknesses.

The duties and activities of the SDH

Regarding the role of SDH, the managers cited coordination, organization of services, and financial support:

The role of SDH is to coordinate and organize services. Moreover, to provide financial support because the municipalities do not have the financial conditions to establish some services alone [...] (Peperi-Guaçu River).

According to the National Council of Health Secretaries (*CONASS*)[8], one of the functions of SDH is to promote technical cooperation between municipalities and to monitor, evaluate and regulate the health services. The same Council addresses the state's role in co-financing Primary Care (PC), based on criteria and investment plan.

In addition to PC financing, the managers discussed the role of SDH in the context of medium and high complexity:

It (SDH) has the power to organize the flow of medium and high-complexity patients (Canoinhas River).

[...] co-financing is very low and what is medium complexity, which should be a function of the state, is not enough (Black River).

Regarding the medium and high complexity, *CONASS* affirms the important attribution of the SDH that acts as the main regulatory agents, who are responsible for coordinating and arbitrating the HDN,

allowing the patient access to the necessary services.[8]

Even though the state has a role in regulating services, encouraging the municipalization of HCN management comes up against difficulties in access, especially in medium and high complexity. Such a situation leads to external dependence, mainly on smaller municipalities and installed capacity, located in remote regions to large urban centers, a reality in western Santa Catarina. In this sense, bottom-up planning for the configuration of HCN is essential in the decision-making process and in shared responsibilities between municipalities, which should be mediated by the state.[7]

Aspects related to the non-fulfillment of state responsibilities related to financing were mentioned:

Some things would be the responsibility of the state and we are not 'getting it, and it will always end up here at our doorstep, in the municipalities [...] (Uruguay River).

And I think that when the municipalities do not reach it, it is because there is a lack of resources and that lack is that lack of state and union obligations [...] the state can spend only 4% of what it collects on health [...] (Canoas River).

Regarding the financial responsibilities of the state, Law No. 141/2012 establishes the minimum values of responsibility for each sphere of government. However, there is a serious deficit in investment in health by the state. This lack of financial support overloads and increases the responsibility of the municipalities, which need to pay for investments in PC, as well as in other areas.

Like decentralization and regionalization, financing is a fundamental resource for the advances and consolidation of SUS. As such, it must be tripartite and equitable to guarantee the implementation of the HCN and the integrality of care.[9]

Permanent education was cited as an assignment that is being properly developed by the SHD:

The Secretary of the State has to be the coordinator of everything, bringing the training to us managers, the new ones, those who have been there for a long time [...] (Jangada River).

I think the role of the state is very importantin directing courses, training, resources [...] (Rio Preto).

One of the main roles of SDH is to support and provide training to professionals and managers of the health network. This is also cited by *CONASS*[8], which reinforces the importance of promoting training in PC, mainly aimed at continuing education and advising municipalities on legal issues. In this perspective, the managers interviewed pointed out the potential of SHD, such as adequate support in training and support for municipalities:

We have very adequate support from the regional. [...] as for training, information on new laws, we have access to that (Pelotas River).

Regarding the offer of courses and legal support, the SHD is in line with *CONASS*, offering opportunities and adequate support to municipalities through decentralized units, the Regional Development Secretariats, cited by the interviewee as "regional".

Regarding the organization of services, the managers addressed the need to decentralize them:

There is a lack of effective action in this sense, to decentralize services, leave services in the capital and then the state is fundamental for resources, to regionalize resources [...] there are few, we know that 'there will always be few' and even less if we don't manage efficiently (Black River).

We perceived the need for greater decentralization of health services. However, states still face difficulties related to the fragility of the articulation and coordination of state systems and the HCN.[10] It is also evident that managers are aware of financial difficulties, but still perceive regionalization as a strategy to optimize financial resources, performing efficient management.

Another obstacle mentioned was political-party interference in the management of SUS:

[...] it gives the impression that everything they do and say is more to do politics than to want to do health (Canoas River).

There are often other actors in the middle of this play who go there to say that the government does not need to build a hospital here and needs to pay for the hospital there, it needs this, it needs that [...], without actually doing what would be most necessary (Black River).

These statements show that health is still considered a field of political party activity. This interference is present in decisions at the state level and also in small municipalities, and has been pointed out as an obstacle in other studies.[11,12]

Thus, we should reflect on democracy and the difficulty of understanding health as a right of citizenship and not a currency for the exchange of favors. In Brazil, democratic legitimacy is not exempt from the representation of interests and the support of civil society to the government is largely influenced by party issues, media, social networks, groups, and movements that fight for particular interests, which may or may not be collective.[13]

The direction of management and resources based on party interests does not fit in a health system like SUS, whose principles value the universality of access and care. However, the municipalities, especially the small ones, still seem to feel the political-party influences, which exert pressure on managers, legislators, regulators, and health professionals, directly reflecting on the service to the population. In this sense, it is clear how the hegemonic elite uses power for their purposes, making the people the basis for their legitimation[11], translating into the

domination of some political actors over health managers and professionals and the rest of the population.

The municipalities are autonomous and eventual state policies are only viable under an eminently cooperative logic. However, in the absence of a hierarchical relationship, the cooperative relationship becomes strongly conditioned by political-party relations, as the Brazilian Federation does not have the state dimension of control of these policies.[14]

The process of decentralization of SUS management to the municipalities directly contributed to improving the population's access to health services.[10] However, it removed states from regulating regional systems, making their function abstract, demonstrating that the political exercise needs to be improved.

The attributions and performance of the SMS

Regarding the role of the Municipal Health Secretariats (MHS), the interviewees highlighted aspects such as care of the PC, organization of medium and high complexity, needs of the population, and financial responsibility:

MHS's role is to organize care in the PC and medium and high complexity flows and to assist in structuring urgent and emergency networks (Canoinhas River).

Identify the needs of the population when implementing services. Help both financially and in terms of structure (Peperi-Guaçu River).

The municipality has a primary role in the regionalization and organization of the HCN, as it is the sphere of management closest to the population. This position gives it greater responsibility concerning PC, developed in a decentralized and capillarized way, being the patient's preferred gateway to the HCN.[15]

In addition to developing quality PC in each municipality, it is necessary to have common goals and cooperation between different municipalities to form a regionalized health care network. In this regard, some reports stand out:

I believe that the participation of all municipalities is very important. That is why we have our meetings, the CIR meetings, the collegiate meeting [...] (Jacutinga River).

Our role is to be part of it, to make the municipality available and make the health services that we have in our municipality available to others, and not only to worry about our municipality, but also to make our municipality participate in the networks, and seek this regionalization as a way to improve service, improve access and also improve costs of these services (Jangada River).

As these are similar conditions among the municipalities and most of them are small, the interviewees addressed the need to work in regionalized networks, focusing on cooperation between municipalities and participation in collegiate and CIR, which are important

spaces for negotiation and agreement. Thus, the cooperation between municipalities and the construction of HCN has been the way to sustain health in small municipalities in the western region of Santa Catarina.

Considering the highlighted duties, we highlight the responsibility of the municipal health managers, together with the Municipal Health Council (MHC), for the political and administrative conduct of the system. Among these responsibilities, we can highlight the articulation of the MHS with the legislature and the municipal executive, and with other community organizations. This articulation is essential for the MHS to plan, program, conduct, control and evaluate the municipal health system; negotiate with the private sector or with SUS; organize the health care model in the municipality and manage the human, financial and material resources that make up the structure of the municipal health system.[4] The role of the MHC in municipal management was mentioned by some of them:

[...] some particularities are municipal, so we sit down and discuss at the MHC and through the plan, which is a priority (Jacutinga River).

We have the Council and from there all the decisions we make we take it to the Council, sit down with the Council, discuss and see the best way to plan and work (Uruguay River).

According to the participants, it is clear that the municipalities have MHC active in the management of SUS. Municipal health management is not only carried out by the figure of the health secretary but includes participation and social control, which was legally instituted in 1990, through Law No. 8,142.

The managers also reported other actions developed in their municipalities, highlighting the coverage of the Family Health Strategy (FHS) and the performance of PC as something favorable in the region:

[...] the municipalities in the region, in terms of primary care, all do very well, they do good primary care, good quality (Canoinhas River).

We have 100% FHS coverage, we have good oral health coverage, we have health programs in place (Black River).

The municipalities must be responsible for the PC since it constitutes SUS's 'preferential gateway' and a level of care closer to patients and their real needs. In this sense, Brazilian states and municipalities are the main actors of decentralization, as they are closer to the population and know the reality, becoming able to define the dynamics of the spaces and the actions that will be developed in this territory.[16] The municipalities are the protagonists of this process, remembering that the states must fulfill their function of regional articulation, providing support to the municipalities.[17]

It is important to highlight that not only the municipal managers but the professionals who work in PC such as the nurse who needs to recognize the

functioning and the importance of the RHCN to value the support and logistical systems and seek to guarantee the integrality of care and articulation strategies between services to consolidate the principles of SUS.[18]

Participants also referred to the overload of municipalities, which need to allocate resources for high and medium complexity care, harming the PC:

[...] the municipality is assuming a very heavy burden and not only ours, but we see the whole region, the municipalities end up taking resources from PC to put it on average complexity. This should not happen. How are we going to improve the quality of PC if we take resources to put in medium complexity? (Black River).

The SUS decentralization process was very strong and the municipalities increased the most in terms of health expenditures. Thus, many municipalities have evolved towards the universality of the system, but they are powerless and unable to progress alone in health actions.[17]

According to the participants, municipalities also suffer from a lack of autonomy to decide the destination of resources:

I think that more [resources] could come for the municipality to manage ... We are in the municipality and know the needs [...] so I think it should come so that I could decide more (Pelotas River).

The transfer of federal resources, at the time, occurred through six financing blocks: PC, outpatient, and hospital medium and high complexity care, health surveillance, pharmaceutical assistance, SUS management, and investments in the healthcare service network.[19] The reports indicate the difficulties at work and reduced autonomy in the allocation of resources according to local realities.

We noticed that the main difficulties faced by municipal managers refer to financing, both the lack of autonomy and the lack of support from other spheres of government, resulting in a snowball effect, in which they need to invest their resources in medium and high complexity actions, damaging the PC, which can destabilize the HCN.

The old demand of municipal health managers for the extinction of the blocks was approved by Ordinance No. 3,992, of 12/28/2017[20], and the transfers from fund to fund started to be consolidated in costing and investment, which allowed states and municipalities to reallocate resources following their planning.

The new ordinance represents greater operational flexibility in the use of resources. However, there is a need to define what will be the criteria for allocating resources, as this measure may generate distortions, withdrawing necessary resources for PC and health surveillance actions, for example, to reallocate them in medium and high complexity.

CONCLUSION

Despite the guidelines for shared management and full access within the scope of SUS, there are gaps in their implementation, especially evidenced by health managers in smaller municipalities with installed capacity, who daily experience difficulties in decision-making and access in a limited-service network, a reality in western Santa Catarina and other regions of Brazil.

Despite the decentralization of health services to the western region, the concentration of medium and high complexity services persists in the state capital, whose displacement of patients represents additional expenses to MHS.

In addition, political-party interference in decisions affects local and state administrations, instigating reflections on health as a constitutional right versus an instrument of power since it commonly became the object of political self-promotion, guaranteed to the patient through voting.

Despite the weaknesses, they also cited advances such as the participation of the MHC in management and planning, and the positive results in the assistance of the PC, whose coverage of the FHS is 100% in many municipalities studied. In this scenario, we observed that the priority in the region is the improvement of secondary care.

As for the duties of the SHD, they mentioned potentialities such as adequate support in the provision of training courses for managers and support for updating legislation and regulations in force. However, health financing is a key point. The managers highlighted insufficient resources to meet the demand, especially in the medium and high complexity and their lack of autonomy in decisions at the regional level.

Despite the difficulties pointed out, there is a great evolution in the regionalization and decentralization of SUS management. In this way, cooperation between municipalities, CIRs, health regions, and regionalized HCNis reaffirmed as alternatives for the survival of small municipalities in western Santa Catarina.

The lack of coverage of all municipal managers in the studied region was a limitation of this study since different perceptions may have not been captured and considered in the results presented. In this sense, we suggest the continuity of research and the permanent discussion of this theme, involving those directly involved in health decisions and management, for the qualification of care and consolidation of SUS at local and regional levels.

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