SUS Brazil: The health region as a way forward

SUS Brasil: a região de saúde como caminho

Lenir Santos
Institute of Applied Sanitary Law, Campinas, São Paulo, Brasil.
E-Mail: santoslenir@terra.com.br

Gastão Wagner de Sousa Campos
Universidade Estadual de Campinas. Faculdade de Ciências Médicas. Departamento de Saúde Coletiva. Campinas, SP, Brasil.
E-Mail: gastao@fcm.unicamp.br

Abstract

The present article addresses the need to have regionalization of decentralization, in order to cluster together what this could supposedly have broken apart. On revisiting the constitutional guidelines on decentralization, the authors propose measures to provide assurance thereof, in addition to administrative tools that allow the formation of health regions to supply at least 95% of the health needs of the regional territory, to ensure sanitary independence. The authors suggest solutions that include the establishment of regional and associative corporate institutions resulting from the clustering of the federative institutes operating in the health area. The authors also state what has not worked out in the Brazilian National Health System (*Sistema Único de Saúde* - SUS), due to mistakes that have originated in the best of intentions, as also the opportunism that these mistakes have generated. The authors defend the need to bring judicial and administrative answers to a SUS that is interfederative in character, both in management, which requires some sharing, as also in financing which also remains interdependent. The conclusion reached is that the only way in which the SUS can be national is to regionalize it, and to give the health region all the instruments that are necessary for shared, interfederative and responsible management.

Keywords: Regionalization; Health Region; Brazilian National Health System; SUS.

Correspondence
Lenir Santos
Rua Olympio Pattaro, 420.
Campinas, SP, Brazil. CEP 13085-045.

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Resumo

O presente artigo desenvolve o tema da necessidade de se regionalizar a descentralização no sentido de aglutinar o que esta supostamente poderia ter fracionado. Ao revisitar a diretriz constitucional da descentralização os autores propõem medidas que visem sua garantia ao lado de ferramentas administrativas que permitam a formação de regiões de saúde resolutivas em pelo menos 95% das necessidades de saúde do território regional, para garantir autonomia sanitária. Os autores propõem soluções que passam pela criação de pessoas jurídicas associativas, regionais, resultantes da aglutinação dos entes federativos em região de saúde. Apontam ainda o que não deu certo no Sistema Único de Saúde – SUS Brasil em razão tanto de equívocos originados nas melhores intenções, quanto do oportunismo que esses equívocos geraram. Advogam os autores a necessidade de respostas jurídico-administrativas para um SUS de caráter interfederativo tanto na sua gestão, que exige compartilhamentos, quanto no seu financiamento, que se mantém interdependente também. Concluem que o único caminho para o SUS ser nacional, é regionalizá-lo e dotar a região de saúde de todo o instrumental necessário à gestão compartilhada, interfederativa e responsável.

Palavras-chave: Regionalização; Região de Saúde; SUS.

In the SUS, we need to think of real goals that generate real services, responding to real needs.

Introduction[1]

In brief introductory notes, we want to shed light on how this article came about, considering the authors' notion about the need to have debates and discussions, and reach a consensus about how to reduce the current fragmentation of the Brazilian National Health System (*Sistema Único de Saúde* – SUS) and make it more effective, seeking the review of standards and legal provisions. In November 2013, Lenir Santos wrote an article called: "The health region as a way forward" [*A região de saúde é o caminho*], which was published in April 2014 in the Bulletin of Municipal Law, published by the NDJ Press. At that same time, Gastão Wagner also published an article about the same issue, "A possible utopia: the Brazilian SUS Health System" [*Uma utopia possível: o SUS Brasil*], published in Radis magazine, in the issue of October 2014. Each author defended similar ideas, but differed with regard to the processes of interfederative management models as thought of by both of them. In a dialogue between the authors, at an event in São Paulo, an agreement was reached to fuse together the two articles. From this merger came forth this third article (also combining the respective titles), which we think could be a significant contribution for SUS Brazil.

The constitutional structure of the SUS

The main constitutional guideline of the SUS is that of decentralization, at the same time that, also through a constitutional provision (Article 198, header), it is established as the result **of the integration of public actions and services in a regionalized and hierarchical network**[2] (Silveira, 2007).

1 In 1994, in Aracaju, in the state of Sergipe, Conasems held its 9th annual congress, with the main theme being: Municipalisation is the path. [*Municipalização é o caminho*]. At that time, everyone was right, as without municipalisation, which was essential for the SUS, we could not regionalise health services. What happened was that we spent two decades without managing to leave municipalisation for the health sector, which should have been the next step. Without a health region there shall be no SUS, as set out in the Brazilian Constitution. Municipalisation was one step that should have followed the construction of the health region.

2 In the SUS, the slogan that should be used in relation to its organisational aspect is that of federative interdependency or death.

For this reason, in recent years, even though it is not actually something new, the debate about the health region issue has become deeper through the need for integration of what decentralization, allegedly in itself, has fragmented from the technical, operational and organizational points of view.

The integration of services – regionalization of the decentralization, thus making it more qualified[3] - has been a point to ponder among managers, people studying the issue, and researchers, as one single system which is fragmented into 5,568 municipal systems and 27 state systems is just unfeasible; together with this fragmentation, one must not forget that there is also a centralization of health policies at federal level, with such policies being split into federal programmes, as diverse as possible, and not always compatible with the health needs presented by certain health regions (Santos, Andrade, 2009).

The decentralization which is associated to an operative and budgetary decentralization and also the strong element of federal centralization, through the federal health programmes, makes the SUS a system which is, in itself, already highly complex and hard to manage within the general structure of the bureaucratic Government Administration – complex from the administrative standpoint (Santos, 2012).

What did not work out?

Our Laws have not been sufficient to protect the SUS from the Brazilian State's characteristics of *clientelismo* (a system where one person protects another in exchange for support), privatism and inefficiency. In addition, the anxiety to end centralism has led us to consider the municipality as the basic organizational nucleus of the system, forsaking for many years the figure of the Health Region, which is mentioned in the Federal Constitution but largely cast aside by health managers who, on the one hand, kept up the federal centralization and, on the other hand, the municipal executive fragmentation. It was therefore thought, in a somewhat biased way, that the integration of the services would be carried out by the States and by the Federation, in a purely idealistic way, without even thinking about *how* and also of *administrative models* that could establish the health region as the core nucleus of the SUS. The result of this option has generated paradoxical effects: both bringing about the existence of successful experiences in municipalities where the overall context is favorable, which served as proof that the SUS model was possible and effective, and also installing a fragmentation of the system, as each municipality has the autonomy to establish its own policy for health management and health care. This municipal fragmented construction, without the systematic view which is part of SUS, has generated iniquity and inequality, and has also jeopardized the sustainability of the SUS as a whole and even of the local networks.

This type of fragmentation arises for the difficulty for integration, within a network, of policies, programmes and services at federal, state and municipal levels, together with the effects of an old fragmentation which is typical of traditional public health services in Brazil, action through focus programmes, each aimed at one type of risk or illness and which was expanded throughout the existence of the SUS.

All that remained for the SUS was the challenge of putting together a system with thousands of different styles of Government in each location and in each State, while also trying to compose this with some two hundred sanitary programmes that operate with different rules and procedures for financing and also for provision of accounts. This formed a new Tower of Babel. Who, what institution, what manager would have the governability to bring together these pieces of the State with a high degree of autonomy of planning, decision-making and management, that has been expanded so much?

The Health Region

The Health Region is essential for one to overcome this impasse of the *fractioning* of health actions and

3 Decentralisation in the health sector is linked to the main contemporary factor which is subsidiarity, which requires that the executor of Government services is brought closer to the citizen, along the lines of the philosophy that the State should not do what the municipality is able to do, with the same rule going for the States in relation to the Brazilian Federation.

services, isolation, programmatic federal centralism, and without any view based on regional planning. It shall be through the region that there shall be the integration of the services now fragmented, in a network, bringing the municipalities together in a systematic way, to ensure the integrity of health assistance without loss of the constitutional principle of decentralization[4].

The health region is also essential for integration of actions and health services of the federative institutions, for qualifying the SUS management, and also to ensure integrity; for this reason, it shall be established based on the sanitary standpoint rather than from a purely administrative point of view, and shall also, in order to be qualitative, not be conceived or considered as a mere administrative division but rather as the locus of integrity. It must be able to solve, if not all, almost all health needs shown by the population of the region; be part of a national, state and intermunicipal system which finds, in the health region, the space of its action for the user.

Only a consistent region may bring together what decentralization in itself fragments, not removing from the municipal manager its main non-transferrable role which is that of integrating the public health system and participate in it in a way that is politically, financially and technically effective[5].

The importance of regionalization so that the health care networks are systematic and solve problems, with the health region being the centre that integrates references between services from different federative institutions, cannot be denied. The question that now remains is that of how the articulated combination of asymmetric municipal individualities can generate an equitative regional unit?

Our answer to this question lies in the establishment of a unified instance of management and regional planning. A single regional command, with a collegiate control of municipalities, states and also the Brazilian Federation.

Much progress has already been made, initially in an almost informal way and now acknowledged by the terms of the Law, as is the case of mechanisms for co-management between federative institutions: the concept of collegiate management, which has given rise to the Tripartite Intermanager Commission, of nationwide scope, the Bipartite Intermanager Commissions which have governability with regard to projects in each State, and more recently the Regional Intermanager Commissions, which gather all the municipal managers within a region and also delegates from the respective State Government. In spite of the creation of these interfederative decision-making spaces, we have seen a trend for the Ministry of Health, and also the State Secretariats for Health, to use mechanisms for financial transfer to entice municipalities, and also certain programmes and priorities, to take part. The attempt to introduce the methodology of contracts or management agreements between the federative institutions is also quite recent. Despite the efforts, we well know that integration through a network that is regionalized is still low in our country.

Interfederative SUS

Therefore, it is always important to give ever greater value to the Regional Intermanager Commissions (CIRs), as set out in Decree No. 7,508 of 2011 and Law No. 12,466 (Brazil, 2011a) with its essential assigned roles of planning, in an *interfederative* (regional) way, the execution and financing of health actions and services of the municipalities and of the State, based on the criteria set out by Complementary Law No. 14/2012 (Brazil, 2012), in its Article 17[6]. It is an

4 Gastão Wagner de Souza Campos has highlighted, in lectures and articles, the need to grant judicial status to the concept of health region. The hypothesis that he has mentioned, for interfederative mixed-ownership institutions, is very complex. However, this idea combines with that of Lenir Santos, in relation to the need to give corporate status to the regional health management, through COAP. This is the hypothesis that this article shall address.

5 "This integration is so important that the SUS has instances for interfederative and consensual deliberation about its organisation and operation, as according to the provisions of Decree No. 7,508 of 2012 and Law No. 12,466 of 2011."

6 Article 17 of Complementary Law No. 141, from 2012 discusses the division of expenses from the Brazilian Federation to the States and municipalities. The criteria for such a subdivision shall be defined by the Brazilian Ministry of Health and, with regard to the methodology of calculation, should observe what has been decided by the tripartite intermanager commission.

essential element in the agreements with *solidarity* seeking the regional equality of the SUS. However, we are still perplexed by the aspects involving governance in the region which, even based on the consensuses and agreements reached at the CIR, is orphaned with the removal of the solidarity-based and articulated management of regular execution of the services for a *regional population.* Our judicial and political system does not facilitate the real establishment of the regional unit, and hence its governance, from the administrative and sanitary standpoints, seeks to find solutions that the health region needs and requires. One shall not lose sight of the fact that our process of municipalization allowed the breakage of the centralism that formerly existed in the health sector, but the process was highly competitive and with little solidarity (Mendes, 2009).

We also need to mention some harmful aspects within the process of fragmentation of services, such as the precarious policies for personnel and also the inappropriateness of management strategies. Without a shadow of doubt, this is largely due to the isolation of the municipality, which saw itself alone to organize a system which the municipality did not always know, particularly its constitutional and organizational form, thereby bringing some chaos with a dilution of the responsibilities of the State and the Brazilian Federation, which should be on the lookout for adaptation and organization of the health regions. However, there has always been a prevalence of the necessary systematic view of the SUS. A lot of improvisation, precariousness and ill treatment in relation to health professionals and also the care for the users. Unfortunately this standard based on simplification, a strategy of precariousness, has also been extended to cover infrastructure, the equipment involved and also the models for attention and care.

In this Babel, some questions come to mind: how to plan services for residents in neighboring municipalities, when the municipality acts with merely local interest – Article 30 of the Federal Constitution of Brazil (FC). How to finance and regulate the cost of these services of an interfederative ilk?[7] How to solve local impasses regarding the hiring of personnel in and for the region, involving issues related to salaries, careers, and caps on expenses with personnel; lack of scale in purchases and organization and support of services with greater technological density? How can the executive attributed tasks with solidarity be managed? Without losing sight of the fact that there is a strong judicialization of the health segment, which makes the difficult systematic organization of the SUS vulnerable and prone to other problems.

At this stage, we see that regionalization, apart from being a legal requirement, is also imperative as a key organizational component of the SUS, thus demanding a different way of thinking, a new look to achieve solutions that are adequate for the reality. However, it has not received assurance of judicial and administrative instruments appropriate for the regional configuration and management (Viana; Lima; Ferreira, 2002).

A regionalization that is translated as a formalized health region, which should be the result of the agglutination of asymmetrical and bordering municipal territories, capable of constructing the integration of network services, to solve problems, and structured in a way that ensures the effectiveness of the integrity of health care: from basic health care through to operations of high complexity (this last item being compatible with each health region in terms of its technological density), allowing a qualitative sanitary path trailed by the user. Only some regions (those which are largest in size and importance, and which have most financial and economic support, together with road and transport structure, communications etc) should take responsibility for the maintenance of the services of higher cost and sanitary technology. However, in a federative country (albeit with a track record of antifederative practices, which get deeper in the health sector, as seen in this work project), with the municipality being an autonomous federative unit, on equal terms with the member States and

7 Local interests shall prevail with regard to the interfederative financing of actions and services. The tripartite financing, as set out in Complementary Law No. 141 and the contract to organise public health actions (Decree No. 7,508) is of fundamental importance to solve the issue of who shall pay the bill for interfederative services.

also the Brazilian Federation, it sound almost like a farce to talk about a system with local and regional autonomy, which does not exist in SUS practice, due to the interdependence of one on the other, for the systematic configuration of the health area and also the lack of adaptation of Government administration for this purpose and the intense inequality between municipalities.

Decree No. 7508 of 2011

For this reason there is a need to think of solutions that do not go against the federative principle of autonomies, or the constitutional principles based on decentralization. Thinking of an organizational sanitary regional architecture is by no means an easy task, but at the same time it is far from impossible, which has been shown clearly by Decree No. 7,508 (Brazil, 2011a), which is a benchmark in the organizational explicitation made by the SUS.

This decree has shed light on these issues, on addressing the issue of the health region, defining it and also setting pre-requisites, marking it out in a positive light, as also about the intermanager committees, particularly that at regional level, later established by Law No. 12,466 (Brazil, 2011b). The SUS architecture was enriched on focusing on the organizational contract for public health actions as a judicial and institutional instrument of regional character, which could allow the federative units in any one health region, together with the Member State and the Union, to integrate their services and their financial resources in a management which negotiates, reaches consensuses and agrees on the essential aspects for the SUS, for example, with regard to which attributed tasks shall be the responsibility of each institution within the health region, and who shall be responsible for sanitary references and who shall finance them. The organizational contract thus affirms itself as a *space for regional interfederative negotiation* (and shall never be distorted to become a joining document, which is born already in the finished form, in only one Government sphere).

The sanitary responsibilities shall be made explicit and also brought into line with the demographic, socioeconomic and geographical structures of the federative units that cannot handle equal responsibilities in relation to the guarantee of integrity of health care, with regard to service provision, lest there shall be the promotion of federative inequality. Federative equity in the SUS requires the addition of sanitary responsibility to the conditions under which the federative unit is in activity. The fragmented integrity in the municipality becomes unified within the region, as established by Law No. 8,080, from 1990 (Brazil, 1990), in its Article 7 paragraph II, which stresses that the execution thereof occurs within the scope of the health *system* and not in each federative unit *per se*. Solidarity is therefore within the system, rather than in each constituent element thereof (Silveira, 2007).

For this reason, the region is the space for promotion of equity between federative units: on showing solidarity towards each other, to effectively make sure of real equality, they acknowledge each other and act in solidarity, in the name of municipal inequalities. However, this solidarity must be set out in the contract, and taken on through a document, with judicial security and also in a systematic and hierarchic way in relation to the complexity and opportunity of this service.

The organizational contract of Government health actions

These elements are essential for the governance of the region which, however, does not count on a corporate person, even though it may virtuously have the interfederative contract (COAP), the body defining the responsibilities as agreed with regard to the organization, execution of services, finances, and budget and finalistic control.

The contract is a step forward and needs to be prioritized at the level of the results which it can produce concerning the definition of the federative regional responsibilities and the resulting organization of the regional health networks.

The contract is an element that brings the responsibilities together, that brings judicial security to the contracting parties, and can also make an important contribution to the *dejudicialization* of health, being strongly centered on the concept of responsibility with solidarity in the systematic

sense and not on equal responsibilities among unequal institutions[8], which seek away true systematic solidarity to open way for an individualization of incompatible commitment between the real conditions of the federative institution and the systematic essence of health.

However, we continue, albeit in a way that is milder through the solidity of the contract for organization of Government action (COAP), with the issue of depersonalization of the health region. Could a solution for this difficulty be possible without affecting the three-dimensional nature of our Federation?

A regional management model: what to propose?

There was some thought given to the existence of a special mixed-ownership institution of national scope, created and established by the three federative units, and which could be the organizational institution that would bring together the services of all the institutions, in a regional format. This mixed-ownership institution would also seek to reorganize public management in the health sector, seeking to overcome the excessive interference of the executive power in sanitary programmes, as also allow the establishment of policies for personnel, investments and organization of such care, compatible with health needs. Here, we shall not dig deeply into the issue of the judicial and institutional feasibility of this reform work, which as we see it appears incompatible with the model of a Federal State. We are a federation with 27 states and 5,570 municipalities. On the contrary, this would depend on a real process for reorganization of management and practices in the health sector; who knows, possibly even a deep constitutional reform, remembering that the federative model is an unchangeable clause.

Among other difficulties, this situation comes up against our State model, which is federative, with the municipality as a constituent part thereof. This model makes our federation extremely complex and consisting of thousands of autonomous entities, independent of each other, even though they appear as interdependent when we are discussing the public health sector, which could count the deep economic and technical difficulties for the exercising of other constitutional responsibilities. In any case, whether or not the path to follow is that of creating a three-party mixed-ownership institution to face the judicial and constitutional difficulties, the challenge is now that of establishing an organizational Corporation – which is feasible within the Brazilian judicial and constitutional order – that ensures integration and unified management for the health regions, which shall always mean the sharing of power among the federated organizations, being a new judicial status for SUS in Brazil.

The SUS already has political governance in the intermanager commissions, and it shall suffice to deepen it. We now need to evolve and, apart from political governance, make it possible for a regional institution to put services in operation in the health region. The management process is still moving very slowly at the SUS in Brazil, and this has enabled the significant penetration of private companies in the public health area.

Another possibility for creation of a SUS centered on health regions would be the creation of a regional association in support of the institutions, for the management of the organizational contract of public action in the health area, with characteristics aimed at the specificities of health. Thus, we could also make significant progress in the collegiate governance of the regional SUS.

SUS Brazil, in any of these possibilities, would be organized based on health regions, as according to the constitutional provision, with the service networks generated by the regions (that would not become federative institutions, it must be said!) The careers and management of personnel could rest with SUS Brazil in regionalized form and not with each federated institution, with the possibility of allocation of personnel from the federalized bodies to the regional health association.

8 Article 23 of the Brazilian Constitution, on saying that it shall be a common responsibility of the three Government spheres to care for general health care, cannot be interpreted in isolation, detached from the provisions of Article 198 therein, which says that the SUS is the result of the integration of Government actions and services in the health sector, in a network that is regionalised and hierarchised, in relation to the complexity of the services.

We have always thought that there shall always be new solutions for new problems. Indeed, the contract of public action has not yet managed to prove that it could be powerful for the solution of the issue of integration of services in the health region with equitative distribution of sanitary competences. However, we could advance if the federative bodies could establish an association between themselves through COAP, thus acquiring a judicial personality, in a type of regional health association with characteristics that are specifically of the SUS, of a judicial nature similar to that of a consortium.

A regional associative institution with properties typical of the health sector, such as the requirement to integrate services that are shared in a network in the region; that of financing the regional networks, in a tripartite manner, and so forth. Thinking of a special architecture for the health sector, making it possible for a regional associative corporate person to be established to operationalize COAP, to meet the needs of the segment; an institution that would be of a contractual nature, associative but in its own clothing, considering the specificities of health and of the region. This would be an organization that, once and for all, would cater to all the regional peculiarities of the SUS.

Regional governance would find a new format, giving the local institutions the power to come together in the health sector and manage their services in a shared form, with the support of the State and the Brazilian Federation, as set out in COAP, which would have a corporate person in support of the execution of certain regional actions and services to be subjected to shared management[9].

Relevant aspects such as political interference in regional management, the privatization of public services in an unqualified way, and many others, could be reduced with the qualification of shared management, the creation of regional careers through a special entry competition and with the movement of personnel within the region, also with the possibility of assignment of employees between different regions, when necessary. Each region could have a regional sanitary authority, following a Rota system between the municipal institutions in the region, according to agreements at the Regional Intermanagers Committee (CIR) and also the Bipartite Intermanager Committee (CIB).

Here it is important to remember that the current health regions shall be reviewed, as they are not really health regions in the true sense of the term, being unable to meet 95% of the health needs of the local population. Maybe the regions should be at least half of those that exist today.

Conclusion

We can consider that the debate about a new institutionality for the SUS is essential. In this article, we look at several possibilities of change, some involving major constitutional and structural reorganization and others which are possible within the current normative structure of the SUS. In any case, this *innovation, however extensive it may be, must be centered on* the regionalization of health, together with integration of services, regional governance, regional sanitary authorities, and their responsibilities, planning and regional financing. We understand that only in this way shall it be possible to construct the figure of the health region in a robust way and always as the result of the agglutination of municipal institutions at the CIR which would decide on the management of COAP by common agreement, and also the necessary administrative support and their forms of management. What must not continue any longer is the fragmentation of the SUS, which does not always articulate itself or act in a systematic way. Something must be done to save SUS from its current ills, which seem to be deepening. There is a need to find solutions that place it on the route to integration, and also to sharing at regional, state and nationwide levels.

This could all add a high value to the health region and also to COAP itself, as this is an instrument for

9 In the work here mentioned, 'Brazilian National Health System (SUS): challenges of interfederative management' [*Sistema* Único *de Saúde: desafios da gestão interfederativa],* there was already the consideration of aspects that could support the governance of COAP in the health region, having proposed the possibility of the Regional Intermanager Commission *(Comissão Intergestores Regional - CIR)* having an Executive Board whose main role would be that of giving life to the consensual decisions made by the CIR.

the integration of health services and actions of all the federative institutions in the health region and also for the definition of sanitary responsibilities.

Last but not least, the equitative division of state and federal financial transfers, the planning and the regional ascendant-integrated budgeting, as established by Complementary Law No. 141, from 2012, would gain more regional weight.

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