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The city manager in the present phase of the SUS implementation: characteristics and challenges

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Luiz Carlos de Oliveira Cecilio
Departamento de Medicina Preventiva da Universidade Federal de São Paulo, São Paulo, Brazil
cecilioluiz@uol.com.br

Rosemarie Andreazza
Departamento de Medicina Preventiva da Universidade Federal de São Paulo, São Paulo, Brazil
rosemarie@medprev.epm.br

Ana Lúcia Medeiros de Souza
Departamento de Medicina Preventiva da Universidade Federal de São Paulo, São Paulo, Brazil

Claudia Elisa Belinazo Mercadante
Secretaria de Estado da Saúde de São Paulo, São Paulo, Brazil

Claudia Vega
Secretaria de Estado da Saúde de São Paulo, São Paulo, Brazil

Francisco Antonio de Castro Lacaz
Departamento de Medicina Preventiva da Universidade Federal de São Paulo, São Paulo, Brazil

Ligia Maria de Almeida Bestetti
Secretaria de Estado da Saúde de São Paulo, São Paulo, Brazil

Marlene Rizziolli Lima
Secretaria de Estado da Saúde de São Paulo, São Paulo, Brazil

Nicanor Rodrigues da Silva Pinto
Departamento de Medicina Preventiva da Universidade Federal de São Paulo, São Paulo, Brazil

Sandra Maria Spedo
Departamento de Medicina Preventiva da Universidade Federal de São Paulo, São Paulo, Brazil

Wanda Nascimento dos Santos Sato
Departamento de Medicina Preventiva da Universidade Federal de São Paulo, São Paulo, Brazil

Abstract

Since the creation of the Unified Health System (SUS), by law number 8080/90 and its subsequent regulation systems, all city governments have seen their responsibilities increase in terms of organization and operation of the local health systems. This article presents the result of a qualitative survey carried out with the managers of 20 different municipalities from a Regional Health Board of the State Health Secretariat in São Paulo. An attempt has been made to outline the managers' profiles, their professional careers, whether they develop heath projects for their municipalities, and if so, how, what the composition of their teams are, their strategies to guarantee access to health services which are not available in their municipalities, and how they deal with their state manager and the inter-managerial issues which are present in their region. The study reveals a great heterogeneity among the municipal managers. However, limited abilities for creating, implementing and evaluating city health policies predominate. The article points out the need for permanent training strategies for managers so that they can perform their duties.

Keywords

City manager, health policy, municipal health systems, municipalization decentralization, SUS (BR), health management

Introduction

Since the creation of the Unified Health System (SUS), by law number 8080/90 and its subsequent regulation systems, all city governments have seen their responsibilities increase in terms of organization and operation of the local health systems. Such decentralizing of an important set of responsibilities and resources of the system's higher levels to the municipalities is now recognized as a real state sector remodeling. Municipalization is an ongoing process and, therefore, needs to be better studied and understood in its positive aspects and in its advances, but also in respect to its limitations, contradictions, and difficulties so that institutional development and support strategies may be developed.

Since the 1990's, the Ministry of Health (MH) has been using operational regulations in order to guide the work of the SUS, mainly the increasing responsibilities assumed by the municipal governments and inter-managerial adaptation mechanisms. Two of them are especially important: The Basic Operational Norms (BON) 01/93 and 01/96.

The BON 01/93 established, among other things: regular and automatic transfers, from fund to fund, (from the MH to the municipal governments), by historic ceilings; the creation of grouped instances of system boards such as the Triple Intermanager Commission (*Comissão Intergestores Tripartite* - CIT), made up of MH representatives, the National Council of Health Secretaries (*Conselho Nacional de Secretários de Saúde* - CONASS) and the National Council of Municipal Health Secretaries (*Conselho Nacional dos Secretários Municipais de Saúde* - CONASEMS) in the national framework and the Double Inter-manager Commission (*Comissão Intergestores Bipartite* - CIB) made up of state representatives, by the State Council of City Health Secretaries (*Conselho Estadual dos Secretários Municipais de Saúde* - COSEMS), in the state framework; it reinforced the requirement of Law 8.142 which declares that the municipalities and states should create their own funds, councils, plans, reports and resource counterparts; it established city habilitation criteria concerning incipient, partial, and semi-ample management of municipal health systems.

BON 01/96 kept adaptation and integration instances foreseen in BON 01/93 such as the CITs and the CIBs, which work as forums among SUS managers with the objective of adapting and programming health activities and defining financial ceilings of the state and city systems, and expands the functions of the municipalities in terms of health system management, by defining two management modalities: the full management of basic assistance and of municipal systems (BRAZIL, 1997).

The Operational Norm of Health Assistance (ONHA) 01/2002, in its regionalization chapter, institutes the Regional Guidance Plan (RGP), which is an instrument for organizing the regionalization process and is based on the formation of functional and resolute systems of health assistance aiming at guaranteeing the assistance's integrity and the population's access to health actions and services according to their needs. Based on the above, the following key-concepts are listed: health region; assistance module; headquarter municipality of the assistance module; pole city; and territory unit for qualification in health assistance (BRAZIL, 2002)

In order to investigate the extension of such reforms, it is necessary to evaluate city presence when performing the aforementioned functions, which implies the consideration of some characteristic features of those who are willing to assume health policy management and their relations with the regional and state levels of the system management. Such characteristics are related to matters of several kinds and involve

> "(...) administrative and financial capacities of local governments, [...] the result of previous policies, (...) new rules and (...) political and electoral dynamics [which impact] the production of public policies in the local environment (ARRETCHE et al., 2002, p.456).

Despite the recognized difficulties, the decentralization process of health management has been gradually and consistently implemented since the 1990's. The

concretization of the health decentralization guidelines in a country with continental dimensions and so many regional inequalities implies great challenges, such as: not losing the uniqueness of a national policy and respecting social-economic diversity, as well as the adoption of the service offer as a social construction. In this sense, the BONs and the ONHAs of the SUS have been considered essential strategic instruments, since they provide the regulation of the decentralization process, dealing with aspects concerning the sharing of responsibilities, managers' relationships, and criteria and mechanisms for federal resource transference to states and municipalities (LEVCOVITZ et al., 2001, p. 270-73).

Studies on health decentralization/municipalization, in selected Brazilian municipalities, provide indications of possible conditions of the SUS construction process in Brazil. One of such conditions regards financial and qualified staff autonomy in the municipality so that it incorporates, in addition to basic health assistance, full health assistance (VIANA et al., 2002, p. 484-87; MARQUES et al., 2003, p. 403-14).

On the other hand, it is known that most municipalities, due to their social, demographic, special and territorial characteristics, have a low degree of service and health actions independence and, for this reason, there is a great dependency on services which are located in bigger municipalities, which points out the need for an effective regionalization of the health services (NEPESS, 2005, p.149).

Health management decentralization should be part of a local health systems constitution process which, on the one hand, properly meet the population's needs and, on the other hand, are dynamic bonds and elements of regional articulation with the national region; however, it should not culminate with the constitution of isolated and independent systems (SCATENA et al., 2001, p.71-73).

This ongoing decentralization process has been providing great opportunities for basic and instrumental experimentation on the planning and organization of health services. The municipal managers have become important social actors in the SUS's political-institutional setting and, even though in a limited way, providing space for experimenting with new models and practices, aiming at overcoming the diversities which are present in the various Brazilian municipalities and regions.

The CONASEMS advocates the thesis that

> "the municipalization, different from what some process critics say, has not been an "autarchic municipalization"; it was an incomplete municipalization, which has been performed without overcoming all financial restraints which are necessary to properly execute the policies."

Also, for such organization

> (...) the term "autarchic" municipalization is improper, when not considering the restraints which reduced the possibility for the municipality to expand its services efficiently enough to meet the needs of its municipalities and of the reference municipalities. It is also improper because the municipalities do not have higher management freedom; on the contrary, they have their autonomy reduced due to the tendency of fragmented and connected transference of financial resources to the municipalities. Actually, we have to construct urgent alternatives to guarantee the flow and access of users among the municipalities. The solution for this matter is not to intervene in the local management. On the contrary: it is to extend the autonomy that that efficiency construction conditions are created, which should be compatible with the different local realities – radicalizing the municipalization – and to construct management pacts in which all regional actors participate (pole-city, reference city, regional representatives in state management) which should adequate the regional model to the needs and should overcome, in solidarity, the difficulties of access to all assistance levels." (CONASEMS, 2005, p.15).

On the other hand, there are authors to whom one of the problems of the present SUS implementation phase would exactly be what they call "autarchic municipalization", that is, mostly the municipality being in charge of the management of the health service systems in the local sphere, with little or no participation of other government levels. For these authors, each municipality becomes a close system, with financial scale problems, service fragmentation and loss of quality (PESTANA et al., 2004, p.11).

For the CONASEMS, the municipalization process has had two phases. The first one corresponded to the beginning of the process, with the municipalization of basic assistance and implementation of semi-full managements, when the municipalities achieved management autonomy. There have been many advances in this phase, particularly the expansion of population access to assistance services, with positive impact on health indicators.

> "In the second phase, which started in the late 1990's, an excessive bureaucratic normalization started happening, which led to a reduction in the management autonomy. The municipal governments started to respond to centrally induced policies – with different degrees of participation due to the heterogeneity of such process – and to handle conflicts and difficulties of the valid model" (CONASEMS, 2005, p.14).

Consequently, studying and understanding the present phase of the SUS construction, mainly what is actually happening in the service supplied by municipal governments, necessarily involves the understanding of two interconnected issues: the management ability of municipal managers in facing their complex and increasing responsibilities, and regional articulation among municipalities, with intermediation and support of the state management, in its regional representation. Also for CONASEMS,

> "there has been an expressive reduction in the assistance role of the health state secretariat and indefinition about their roles in the access and flow regulation of patients among municipalities. Such difficulties, as could be expected, generated some complaints among local actors, disputes among municipalities and expanded the repressed demands on medium and high complexity

> areas in many Brazilian regions, which became even higher" (CONASEMS, 2005, p.15).

The Pact for Health (for life, in defense of the SUS and of management), issued in 2006, synthesizes the most recent policy by the Ministry of Health in such a way as to establish the attribution of several governmental institutions in the SUS configuration, including the municipalities. The pact intends to apply significant changes in SUS' execution, among them: the replacement of the present habilitation process by volunteer adhesion to the Management Commitment Terms; volunteer and cooperative regionalization with structuring axis of the decentralization process; the integration of several ways for the granting of federal funds and the union of several pacts which exist today (BRAZIL, 2006).

This presentation is closed by quoting a recommendation expressed in the CONASEMS document:

> "It is necessary to stimulate studies on decentralized managements in their different variables, even the ones which analyze the federative pact, governability and local governments, local power, democratization, efficiency of decentralized policies, etc. The existing case studies **are not enough to analyze such different dimensions**" (CONASEMS, 2005, p.16).

The current study is intended to give a contribution that will help to better understand such questions.

Methodology

This article has been organized by using the data obtained in a survey entitled "*The state manager and the city managers in the construction of the regional health system Challenges of the decentralized management of the Unified Health System (SUS)*" ("*O gestor estadual e os gestores municipais na construção do sistema loco-regional de saúde: desafios da gestão descentralizada do Sistema Único de Saúde – SUS"),* performed with funds from CNPq/FAPESP, between 2005 and 2007. This "mother research" aimed at identifying and analyzing the role of the municipality and the relationships which are set between the municipal managers and the state management in a Regional Health Board of the State Health Secretariat of São Paulo (SHS-SP) aiming at guaranteeing the wholeness of care and in the decentralization perspective of the SUS management. The specific objectives were: a) to characterize the political and administrative structure of the studied municipalities in order to compare them with the duties and attributions of the municipalization process, mainly the ability and governability to develop adaptations which should guarantee care wholeness; b) to characterize the view of state and municipal managers at the regional level concerning the role of municipalities, state management and other instances of SUS management, thus guaranteeing assistance wholeness. In order to develop this article, data concerning the municipal managers was used. The data and analyzes concerning state management will be presented in another article.

The study pointed out that the "lack of new money", although having important value, does not explain all present and future difficulties in the regionalization process in the state of São Paulo. This article has presented and discussed some characteristics of the municipal management process which must be faced in the perspective of advancing SUS construction.

The methodological option was a case study, or multiple case studies, which is about involving more than one case with the same methodological structure of a one case study. In this kind of study, case choice is guided by the possibility that each case may foresee similar results or produce contrasting results just for foreseeable reasons (YIN, 2005, p. 68-70).

Also, from the methodological point of view, we have used the concept of **organizational isomorphism**, which would be the potential for a restricted study of a group or of a certain number of municipalities having to provide indications which may be generalized for a wider group. According to the institutional approach,

> "the organizations work according to the incorporation of orientations which have been previously defined and rationalized in society, which contribute for the legitimation of their activities and for their survival, no matter what kind of efficiency and demand their production may have." (FONSECA, 2003, p.52).

The concept of organizational isomorphism makes the point that under the pressure of certain common external factors, organizations become increasingly similar amongst themselves. **Coercitive isomorphism** is the type which originates from organizations which operate in the same legal, economic, and political context, and receive formal and informal pressures made by the state. In such contexts, the organizations adopt similar working strategies and become increasingly similar amongst themselves.

> "Isomorphism is advantageous for the organizations, since the similarity makes the inter-organizational transactions easier and benefits their functioning through socially acceptable rules. (...)As far as the institutionalists are concerned, what determines the organizations' survival is the conformity with social values and norms, more than with performance." (FONSECA, 2003, p.54-55).

The starting hypothesis worked with is that, based on the isomorphism concept, the municipal health managers, despite their municipalities' specificities and singularities, become increasingly similar, due to the fact that they face the same rules and norms, which may vary from The Revenue Responsibility Law to the several financing mechanisms which the Ministry of Health Ministry has been adopting; from the foreseeing mechanisms of social control to the same requirements of several information and accountability systems. The isomorphism concept permitted, in principle and as a methodological option, making generalizations based on the observation of a limited number of local health managers.

The study was made of a Regional Health Board of the State Health Secretariat in São Paulo. Eight municipalities were selected for the study. For each, a stratification of the municipalities was made based on

two variables: (a) **the municipalities' size** – population below 20,000 inhabitants, from 20,000 to 100,000 inhabitants and more than 100,000; and (b) **kind of management** – full management of the municipal system (WMCS) and full management of expanded basic care (WMEBC).

The stratification of the municipalities originating from the combination of both variables is shown in Table I.

Table I - Stratification of the municipalities according to population size and kind of management

Kind of municipality	Population	Kind of management
A	> 100.000	GPSM
B	20.000 – 100.000	GPSM
C	20.000 – 100.000	GPAB-A
D	< 20.000	GPAB-A

Two municipalities of each kind (A, B, C, and D) were chosen, totaling eight municipalities. The final selection of participating municipalities was made with the participation of regional board technicians, presented to, and approved by the Inter-rmanagers Regional Commission (IRC). One criterion used in selecting the municipalities was the fact that their managers are participating in two permanent education forums which are conducted by the regional board and which cover 20 municipalities.

Investigative empirical material was obtained based on two methodological procedures: semi-structured interviews with the managers of the municipalities which had been chosen and participatory observation of investigators in both permanent education forums (PEF) held by the studied regional board, in which the city managers which have been chosen participate regularly (4 in each PEF).

The PEFs are monthly meetings which happen in an itinerant way in one of the participant municipalities. The municipality which receives the PEF monthly meeting components is in charge of the organizational infra-structure (space, didactical equipment, food, among others). The meeting agendas are developed based on the managers' demands as well as on a theme supplied by the PEF coordination. During the meetings, the situations faced by the managers are presented, and, according to the group's necessities and experiences, new agendas are created. The themes are of common interest, ranging from the discussion of new ordinances, laws and decrees, to themes such as labor process organization, access difficulty to mid- and high-complexity procedures, labor management in health, and medical work management, among others. Based on such meetings, strategies for facing possible presented situations are designed, always with the perspective of increasing the conceptual and instrumental "tool box" of the managers.

The investigators participated in the PEFs' meetings for more than one year, therefore such meetings became a privileged space to observe practices, problems, agendas and the difficulties lived by municipal managers today. In order to clarify the subject, it is reiterated that: the empirical material for the investigation, in terms of municipal managers, was gathered based on semi-structured interviews with eight municipal managers and on the participatory observation in PEFs, which cover 20 managers, including the 8 who were interviewed.

The investigation Project was approved by the Ethics Committee of the *Universidade Federal de São Paulo*. Both the city managers who were interviewed and those who participated in the PEFs signed a Free and Declared Consent Term, after having been duly informed about the investigation's objectives.

Results

Municipal management, idealized by the Brazilian Sanitation Reform project as the most effective one, since it would be "closer to the citizens", and more sensitive to their expectations, has been only partially accomplished. The diversity among managers is high, and those who are uneducated or inexperienced in public management prevail. They barely understand SUS as a public policy or that the city manager should have as the axis of his practice the guarantee of such policy at the municipal level. The study showed how city managers generally do not know the history of fights and of the construction of the SUS. Conceptions of the SUS vary from "SUS is prevention" to "SUS as a health insurance plan".

A great turnover of municipal managers was observed during the study. One of the municipalities which were studied had two modifications in health management, that is, three different managers in one year! Such situations, added to the lack of qualifications and the ideological non-commitment with the "SUS as a policy", is an important problem to be faced.

The municipal managers, mainly the ones from smaller municipalities, do not have anything similar to an able and experienced "government team" to plan and implement policies and evaluate their impacts on health management. The overload over managements with a set of increasingly imposed duties by the "higher levels" of the system is enormous.

The logic of the "professional nucleus" is imposed, regardless of a possible government project.

Most municipalities which were studied do not have a municipal health plan or do not know how to produce a plan, or do not use a health plan as a real management instrument for priority setting and for the evaluation and rendering of accounts of their activities. It is rare to find a municipality which, even minimally, uses indicators to know, in some way, the health needs of the population and, based on that, organizes its management.

The managers focus on an apparently endless demand for specialty outpatient care, procedures, surgeries, anxiously demanded by users and impatiently demanded

by health professionals, especially by physicians. A serious (and acute) event in smaller municipalities, which demands quick access to more complex health care, may take a manager a whole day of direct and personal work.

The managers are not able to formulate the "assistance model" which they would like to have in their municipalities very well. There is a certain "discursive consensus" which says that the Family Health Program (PSF) would be a good solution, but none of the interviewed managers considers it their "structuring axis". Several different health care models exist in a single municipality: PSF, "traditional" health centers (organized by gender and age groups), and the units which function as "emergency rooms". A few municipalities manage to have something like a "health program", that is, to recognize priority groups and to develop regular, programmed, educational actions developed by multi-professional groups, but they are exceptions. The municipalities which do have PSF teams are not able to evaluate their effectiveness, so the PSF functions more as a strategy to obtain federal funds.

All municipalities from both studied micro-regions which have private hospitals, mainly connected to "Santa Casas", and subsidize such hospitals without a clear idea of the hospitals' contribution to the municipal SUS. Hospital expenses are increasing, although the managers are not able to negotiate any complementing assistance, and do not even have any kind of control on how the hospital assistance is provided. Deeper studies on the relationship between the municipal managers and the hospitals are necessary.

All municipal governments hire specialists and carry out complementary exams, generally through third parties, similar to the way that several municipalities offer medical specialties in addition to basic health care. Although the monthly production, in many situations, is greater than the parameters established by the MH Ordinance number 1101, there is always the impression that "the problem is not solved". One of the possible reasons for that is the fact that specialist medical doctors generate a demand for procedures which are not made within the municipality. There are long waiting lists in all municipalities. There are indications of workforce precariousness in all regions which were studied and which could be better evaluated in other investigations. Precariousness has been considered in this study as the use of a workforce without formal involvement with the institution and, consequently, without the security of the labor rights which are guaranteed by law. The hiring of doctors through companies is a good example of such a situation. There are many outsourcing situations, both of professionals and of general services. Many small municipalities transfer the management and formation of their clinical staff to one doctor who "opens a company" and "hires" doctors to work in the network. The precariousness of this phenomenon is not considered a problem by the managers. On the contrary, it is the "solution".

Doctors continue being important in opening doors at the assistance levels. Most studied municipalities hire doctors "by contact" in order to obtain referrals for certain services. The managers clearly say that when they hire a doctor, what really matters is who they know. The managers call such parallel and informal regionalization networks "clandestine networks". Being in such network means, many times, that the patient will pay some kind of "complementary" fees. That is, they get in the service through the SUS, but they will have health care in a private way. The medical managers use their contacts and relations to refer their patients.

The municipal managers, whether they are doctors or not, are held hostage of the functional logistics of the Medical Institution and have no way to fight it. With very few exceptions, the managers are not able to do anything similar to the "medical labor management", that is, from the timing and production control to the quality of the service provided by the doctor. However, there are minor attempts in the sense of using clinical protocols in the basic health care with great doctor resistance. The managers do not have staff or "teams" to carry out such task. There are experiments, now in their initial phases, in developing some indicators like, for example, the relationships between the requested clinical examinations and the consultations made. The low adhesion of doctors to the "SUS Project" is considered one of the explanations for low network results and for the mid- and high-complexity referrals, which are considered excessive, more than due merely to "technical inexperience".

In this way, the advance of regionalization will greatly depend on whether the managers will be able to develop new relations with the doctors, mainly concerning the implementation of clearer "game rules" for their professional practices. These new rules should be developed through dialogue and negotiation, but may create new tensions between managers and doctors, as they imply higher control and demand.

The managers of the pole-municipalities feel overloaded with the health assistance of people from other municipalities and calculate that what they receive from the SUS does not cover their expenses. Attending the "invaders" (this is the term used) harms the attendance of the actual residents of the municipalities. These managers are the ones who have the most complaints concerning what they consider to be low participation of the SES/SP in the system's financing.

Concerning the Municipal Health Fund, there are several situations or arrangements in each municipality: there are managers who effectively control the application of the funds, and the Administration or Finances Secretary who is only in charge of "signing the check". On the other hand, there are managers who hardly have any access to the management of the fund. Consequently, the manager's governing power becomes even smaller in regard to conducting municipal health policy.

Conclusions

The initial hypothesis that there would be an "organizational isomorphism", that is, that the munici-

pal managers would be more and more similar due to external factors, in our case, the SUS guidelines and its functioning mechanisms, was only partly confirmed. Actually, on the one hand, the city managers ended up presenting an agenda which is very similar in terms of difficulties and attention focus when dealing with similar problems and facing a common group of political and administrative constraints. On the other hand, there are many different arrangements, devices, practices, team compositions, and management methods which are experimented with. What makes them similar is a very homogeneous "Problem agenda", pointing out the difficulty in guaranteeing the wholeness of citizens' care, mainly concerning mid- and high-complexity access. That seems to be the most dramatic and straining aspect of all managers' daily routines. It is what makes them more similar: the feeling of being prisoners to an endless demand for services which cannot be performed in their cities. This is the initial and recurrent focus of attention at all EPFs meetings.

On the other hand, municipality size, mainly the complexity of the available health service network, seems to be a determining factor in the variability which has been observed among the managers. However, it is not the only one: the local political context, mainly the city manager's status and governing ability, and, together with the mayor, a higher or lower level of political interference by the health secretariat, the formation and experience of its government staff (many municipal managers and "health departments" and not health secretariats), the manager's personal background and his/her ability to create a health project for the municipality, the presence of social actors with some control capacity over the SUS, the personal political project of the municipal manager and his/her local political and party articulation, all these factors result in a great variety of configuration of municipal management teams.

The municipalization process after the approval of the Organic Health Law and of all the subsequent infra-constitutional legislation has been conducted in an indirect way between the Ministry of Health and the municipal governments, with little or no intermediation by the state health secretariats, which is different from what happened in the implementation process of the *Ações Integrais de Saúde* (AIS) and of *Sistema Unificado e Descentralizado de Saúde* (SUDS) in the 1980's. Such facts are responsible for today's minimal presence and lack of proper technical, financial and operational support for the municipal managers by the State Health Secretariat, through their regional organizations.

Consequently, the political and administrative discontinuity of the municipalities, the great turnover and inexperience of municipal managers, with little ability to formulate, implement and evaluate local policies, make the **low governability capacity of the municipal managers a strategic theme in the present phase of SUS implementation**, mainly because many times there are not even teams that can handle the complexity of the duties imposed for the municipalities nowadays. In view of this conclusion: what are the most adequate strategies to face such deficiencies? Who should be in charge of preparing the managers who are working nowadays and the ones who will come in a flood after the next elections?

If it is considered that 75% of the municipalities have less than 20,000 inhabitants, that they have very precarious organizational structures and suffer from all the problems which have been pointed out in this study – such as manager turnover due to their inexperience in performing their duties – it is believed that this study points to a set of issues of national concern, although having been performed with only 20 municipal managers.

By issuing ordinances 399 and 699 in 2006 which instituted the Pact for Health (for life, for the SUS and for management), the Ministry of Health is trying, somehow, to tackle the problems being presented here. The Pact can be seen as a great effort in contributing to municipal managers being able to set some guidance for municipal health systems based on the SUS principles and guidelines. Despite its legitimacy, created through long negotiations, with manager being' represented at all levels (CONASS, CONASEMS, *Conselho Nacional de Saúde* – CNS), the Pact risks becoming one more normative instrument, without the strength to effect the necessary modifications, if it does not take into account the real conditions in which the municipal managers are working today.

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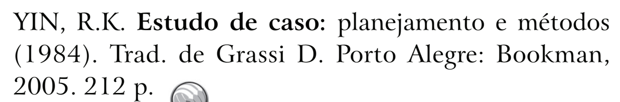

About the authors

Luiz Carlos de Oliveira Cecilio

Graduated in medicine from the Brasília University (1974), specialized in Public Health from the São Paulo Federal University (1977) and received his doctorate in Collective Health from the Campinas State University (1993). He has been an Assistant Professor of the Escola Paulista de Medicina (São Paulo School of Medicine) of the São Paulo Federal University, in exclusive dedication, since June of 2006. He was a Sanitary Doctor for the São Paulo State Health Board from 1977 to 2006, commissioned as a lecturer of the Campinas State University, Preventive Medicine Department and of the Preventive and Social Medicine Department of the Campinas State University (Unicamp) from 1994 to 2005. Furthermore, since the 80's, he has consulted for various public health institutions, always within the perspective of the implantation of more democratic and participative management methods. His current line of research is "Health Management, Planning and Policy". He works in the Health Sciences graduation program of Unifesp's DPM, lecturing "The Theory of Health Management and Organisation", guiding graduate works and coordinating research projects.

Rosemarie Andreazza

She is graduated in Nutrition from the São Camilo University Centre (1983), has a master's in Epidemiology from the São Paulo Federal University - Unifesp (1993) and received her doctorate in Public Health from the São Paulo University (2000). Since 1989 she has been a Professor of the Department of Preventive Medicine at Unifesp. She has been a member of the team responsible for the implementation/development of Collective Health at Unifesp, with an emphasis in the area of health management, planning and policy since 2000 as well as a member of the Health Management, Planning and CNPq Policy team. Furthermore, since 2001 she has followed up and worked at the institutional instances of curriculum reform; currently coordinating the articulation of the Health Services University nucleus linked to the National Programa of Re-orientation of the Qualification of Health Professionals (Pró-Saúde) for Nursing and Medicine courses. Her main areas of interest are: permanent education in health, processes of formation transformation of health professionals and health policy development aimed at the construction and strengthening of the *Sistema Único de Saúde* (SUS – Unified Health System).