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Theoretical reflections on governance in health regions

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Abstract *This article analyzes governance in health regions, through the contributions of two studies: one on a governance model and the other on duties in the management of public policies networks. The former conducted a meta-analysis of 137 case studies in the literature on collaborative governance aimed at preparing an explanatory and analytical model. Authors identified critical variables that will influence the results: a previous history of conflict or cooperation, incentives for participation, power imbalances, leadership and institutional design. They also identified key factors: face-to-face dialogue, trust building and development of commitment and shared vision. The latter study examined networks of public policies in the analytic tradition and the perspective of governance, incorporating concepts from the field of political science, economics and interorganizational relations, in order to support the management of public policies networks. The study identified network management as equivalent to a strategic game involving functions: network activation, framework of relations, intermediation, facilitation and consensus building and mediation and arbitration. The combination of the two reflections provides a conceptual reference for better understanding of governance in health regions.*

Key words *Management, Public policy, Governance*

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Introduction

In the last two decades, studies on governance to overcome contradictions in the ways of formulating policies and managing their implementation have given rise to the term collaborative governance, whose strategy is organized by public bodies of collective forums with consensus-driven decision-making and participation of public and private stakeholders. It emerged in response to failures and high implementation costs, as well as regulation politicization. It has developed as an alternative to conflicts among several interest groups and to policy managers' accountability failures.

Ansell and Gash[1] formulate a general collaborative governance modeling highlighting the conditions under which such governance will be more or less effective as a strategy for the development of policies and public management. Calmon and Costa[2] identify a set of variables that can be used to increase governance capacity: social capital; institutionalization; sustainability; structure and tools; communication and information; and analysis.

Both studies have different objectives, but they allow a better understanding of the collective consensus-oriented decision-making process, with formal and informal rules in the Unified Health System (SUS) and in Brazilian health regions. We aim to analyze aspects of governance in health regions through the inputs of these studies.

Regional health governance as a strategy to establish intergovernmental co-management in health regions and the fair sharing of responsibilities among federated entities within the federative pact is a perspective and challenge to compliance with Brazilian constitutional principles and guidelines.

One of the main objectives of Presidential Decree 7508 of June 28, 2011 is regional integration. Despite advances in legislation and aspects such as reviewing and adapting health regions' geographical landmarks in intergovernmental agreement's documents, establishing regional collegiates as planned, programming supply of services, changes that promoted regional integration resulting from planning and agreements between managers induced by the public action organizational contract (COAP) have been little observed so far.

In the light of national and state guidelines, the Regional Interagency Commissions (CIR) are responsible for the agreement of:

I – Operational, financial and administrative aspects of SUS shared management, in accordance with the definition of the health policy of federal entities, based on their health plans, approved by the respective health councils;

II – General guidelines on Health Regions, integration of geographical boundaries, reference and counter reference and other aspects related to the integration of health actions and services among federative entities;

III – Regional guidelines on the organization of health care networks, especially in relation to institutional management and the integration of actions and services of federative entities.

With legitimation and institutionalization and collaborative leadership process, the conditions for good results are more favorable in CIRs. One of the important factors to this effect is the incorporation of regionalization in the agenda of the heads of executive powers and leaders of the state and municipal health secretariats. However, this condition is not in place in most health regions, which translates into institutional fragility in the implementation of regionalization, deriving from a governance process for the low-powered health region.

The agreement among public entities resulting from collaborative governance would strengthen their ties, defining better responsibilities and reinforcing institutionality in regional planning. Health regionalization relies on increased efforts of the three spheres of government, and will only occur with the strengthening of political-institutional tools within the regional federative pact.

Establishing foundations of collaborative governance in the health regions

The meta-analysis performed by Ansell and Gash through a successive approximation strategy using a sample of literature to develop a common language for collaborative governance analysis and successively testing this language against additional cases, gathered evaluative qualities from a quasi-experimental study and produced a collaborative governance model.

Authors define collaborative governance as a governance arrangement in which one or more public agencies engage with non-state institutions as stakeholders in a formal, consensus-oriented, deliberative, collective decision-making process that aims to make or implement public policies or public management of programs or

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assets. This definition of collaborative governance highlights six important criteria: (1) the forum is initiated by public bodies; (2) forum participants include non-state stakeholders; (3) participants are involved in decision-making and not only consulted by public agencies; (4) the forum is formally organized and operates collectively; (5) the forum aims to make decisions by consensus; and (6) collaboration is focused on public order or public management.

This definition enables some observations on governance in health regions. SUS legislation brings Health Councils in each government sphere, where users, health workers and the private sector participate. However, assigning the role of governance to meetings of the Health Councils would be attributing to them the role of implementing health policies. In the SUS, managers are responsible for the administration of responsibilities for management, care and financing models, with the basic rule being the approval by the Health Plan Council, where all actions and these responsibilities must be included. In the case of the Brazilian health regions, CIR only involves public managers supported by technicians and guests. The CIR is deliberative, takes decisions by consensus and is formally organized through the publication of the ratification of establishment and internal rules, working collectively without hierarchy.

The interdependence of SUS managers is established in article 15 of Law 8080/90, with common responsibilities beyond the specific competences of each federated entity set forth in Articles 16 to 18. Every day, in the three spheres of government, non-state institutions and representations, representatives of health professionals and health system users, health education and research institutions participate through formal consultations and working groups of this debate, but collective decision-making with the aim of elaborating and agreeing on the implementation of policies only involves managers at all three levels of government.

In the case of health regions, collaborative governance is therefore a type of public governance in which public stakeholders work collectively and in different ways, using processes, establishing rules for the provision of public goods – services organized in regionalized health care network (RRAS). Even with this characteristic and counting on all municipalities in the health region, collaborative governance is never just consultative collaboration, since it implies two-way communication and influence between governments and non-state stakeholders, as well as opportunities for debates and propositions among managers. Federal, state and municipal governments meet at regular intervals for decision-making in a deliberative and multilateral process, respecting the autonomy and responsibilities of each federated entity.

In collaborative governance, stakeholders take responsibility for policy outcomes, with the condition that they must be involved in decision-making. This criterion is largely in the literature on collaborative governance. Freeman[3], for example, argues that stakeholders participate in the entire decision-making process, from design to monitoring and evaluation to implementation. In Health Regions, while accountability for implementation is in place, monitoring and evaluation processes are permeated by information biases, and there are frequent cases where policies are developed by one sphere, which makes transfers, inviting the other to join through accountability.

The interest of public groups and public entities has always been involved in bidirectional flows of influence. The difference between collaborative governance and conventional interest or group influence is that the former implies a public strategy of organizing this influence, as is the case of the SUS. In order to exercise health governance capacity in a collaborative way, the CIR requires organization and structure for regular functioning, although its decisions are strongly influenced by the agenda and directionality stemming from the State Bipartite Interagency Commission (CIB) and national Tripartite Interagency Commission (CIT). According to the model, responsibilities should be established specifically for each of the three entities, as well as the interdependencies between these responsibilities, since one municipality always relies on another and the technical and financial support of the states and the Federal Government.

All cases analyzed by Ansell and Gash[1] assume the effort to reach consensus or, at least, to discover areas of agreement in the deliberative forum meetings. This feature takes on importance because collaborative forums often fail to reach consensus. In the SUS, collaboration aims to achieve some level of agreement and share responsibilities among government spheres. Oftentimes, terms are not established due to hardships in the macro-organizational political and economic context of the SUS and power and structure asymmetry between federated entities.

Authors point out that terms "network policy" and "collaborative governance" can refer to

similar phenomena because policy networks imply cooperative methods of deliberation or decision-making. However, they differentiate collaborative governance as referring to a strategy of incorporating stakeholders into multilateral and consensus-oriented decision-making processes. Cooperation inherent to policy networks can be informal and remain largely implicit, unrecognized, unreported and unrecorded. They affirm that policy networks can operate through informal standards of technique and diplomacy, rather than formal decision-making standards and multilateral processes. In the case of SUS, such rules are formalized, but other aspects of the collaborative process must be developed, notably the initial conditions for collaboration, since their establishment through downstream normative acts does not promote adherence and credibility to decision on use of resources. It can also be understood as a policy network, where the public character of participants requires formal rules and standards.

The model proposed by Ansell and Gash[1] is an attempt, as authors point out, to simplify as much as possible the representation of key variables and their relationships, because in the formulation of concepts and in the evaluation process, variables and causal relations proliferated beyond useful levels for policymakers and professionals. This simplification helped researchers identify common and frequent findings among cases.

Figure 1 provides a visual representation of findings observed by Ansell and Gash[1]. The model has four main initial variables: conditions, institutional design, leadership and collaboration process. These general variables can be disaggregated into more fine-grained variables. Collaborative process variables are handled as the model core, and condition, institutional design and leadership variables are shown as critical conditions for the collaborative process. From the initial conditions of collaboration, the level of trust, conflicts and social capital becomes resource or debt during the process. The institutional design defines the basic rules under which collaboration takes place, and leadership provides mediation and facilitation.

From this model, Ansell and Gash[1] conclude:

(1) If there are significant power/resources imbalances between stakeholders, so that important stakeholders cannot participate meaningfully, then effective collaborative governance requires commitment to a positive empowerment and representation strategy. This conclusion calls for horizontal cooperation and support strategies between municipalities in the CIR, as well as on the part of the state and the Federal Government, but the debate about the organization of RRAS shows the asymmetry of power and resources. The participation of all municipalities and the state is vital to governance.

(2) If there are alternative spaces where stakeholders can pursue their goals unilaterally, collaborative governance will only work if parties perceive themselves as extremely interdependent. The relationship between managers has privileged dialogue and avoided the use of external decisions, given the interdependence between managers and the objective of ensuring comprehensive health care in the region.

(3) If interdependence is conditioned on the collaborative forum and an exclusive venue, parties must respect and honor the results of the collaborative process before seeking alternative forums (courts, legislators and executives). In Brazil, the forums of other powers have little rapprochement with relations among federated entities.

(4) If there is a prior history of antagonism between the parties, it is unlikely that collaborative governance will succeed, unless there is a high level of interdependence between the parties or positive steps are taken to correct low levels of trust and social capital. In CIRs, interdependence is high and the participation of all requires constant efforts to ensure cohesion and consensus in decisions.

(5) If conflict is high and trust is low but the distribution of power is relatively equal and the parties have incentives to participate, then collaborative governance will succeed by relying on the services of an honest broker that the parties accept and trust. This conclusion does not apply to health regions where often even a low level of trust is in place, but the distribution of power is not equal, there are no incentives for participation and no intermediaries in the negotiation.

(6) In the case of more asymmetric power distribution or weak participation incentives, collaborative governance is more likely to succeed if there is strong organizational leadership that commands with respect and trust of the parties at the onset of the process. Organic leaders are leaders who emerge from within the stakeholder community. The availability of such leaders is likely to be highly contingent on local circumstances. In the two states in which the COAP was elaborated and signed, such leadership is there right in the drafting process.

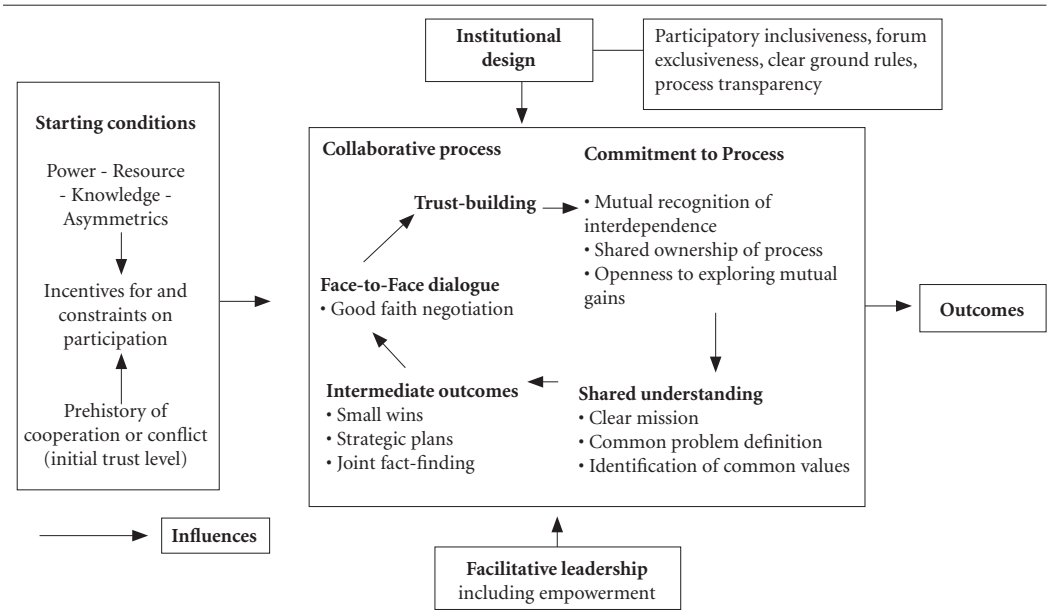

Figure 1. Collaborative governance model from Ansell & Gash.

(7) If prior history is one of antagonism, policymakers must invest time to build effective trust. If they cannot employ time and their necessary cost, they should not adopt collaborative strategy. In the health regions, the law established the collaborative process and managers should implement it. Individual competences of each entity are realized if common ones also are. Universal access by the population only occurs if comprehensiveness is in place in the region.

(8) Even when collaborative governance is mandatory, making commitments is still an essential element of the collaborative process. This has been a practice in collegiate health forums. Documents with theses, priorities and strategies are frequently made public and are often a reference for decisions.

(9) Collaborative governance strategies are particularly suited to situations that require cooperation in action. The RRAS requires cooperative action among the entities to materialize.

(10) If prior antagonism is high and a long-term commitment is required, intermediate results that produce small victories are crucial. If, in these circumstances, policymakers cannot anticipate small victories, then they probably should not embark on a collaborative process.

Although health regions fit the model formulated by Ansell and Gash[1], further study is required to analyze the collaboration and the circumstances in which it occurs. Initial conditions, interdependencies, power imbalances, existence of alternative forums, conflicts, antagonisms, intermediate results and establishment of commitments are local condition aspects.

Cases analyzed by the authors point out with great evidence that collaboration depends on activating a virtuous cycle between communication, trust, commitment, understanding and results. Activation of this virtuous circle in health regions relies on the participation and commitment of all municipal health managers. It also depends on the development of a political culture with such values and practices in intergovernmental relations so that governance can produce necessary collaboration to promote access, equity and comprehensiveness in health care.

Increasing governance capacity

Calmon and Costa[2] point out basic aspects that facilitate the management of public policy networks, studying the processes underlying the formulation, implementation and evaluation of public policies and government programs.

The nature of SUS regional management organization shows three spheres of autonomous federal entities that are interdependent with each

other but with great asymmetries of power and resources and that live a very different social, political and economic realities in collective action in a context marked by different stakeholders, with heterogeneous preferences, distinct and asymmetrically distributed power resources and who must solve coordination, cooperation and communication issues. Issues are managed in an environment marked by ambiguity and uncertainty, making it even more difficult to articulate collective action.

Although some models of analysis of the decision-making process may assume that these stakeholders are rational, meaning that their negotiations respond to the logic of consequences, there are prospects that understand that they process information in an idiosyncratic way and behave much more through the logic of adequacy than of the principles advocated in rational choice models. James March[4] identified four modalities about how decisions occur in organizations: decisions by rules; decisions in an environment of ambiguity, uncertainty and risks; decisions as systemic property of an interactive ecology and decisions as an interpretive activity.

In the decisions by rules mode, individuals seek to understand and classify the situation (recognition), then understand the personal conception within it (identity), and have appropriate attitudes towards their identity (rules). Thus, the decision-making process can be understood by the logic of consequence or by the logic of adequacy. The logic of adequacy encourages thoughts, discussion, and personal judgment about the situation, personal identity and rules. It requires capacity to understand the past and to form useful identities. On the other hand, the logic of consequence encourages thoughts, discussion and personal judgment about preferences and expectations. It requires the ability to anticipate the future and to form useful preferences.

In the decisions by ambiguity, uncertainty and risks mode, ambiguity of preferences and uncertainty regarding the consequences are in place. In the third modality, decision-making processes depend less on the interests or identities of individuals than on the systemic properties of their interactions. The emphasis is on inconsistent preferences over solitary decisions (establishment of coalitions, hierarchical structures of rules and identities, valuing trust and loyalty), and temporal order over causality in processes involving many individuals and interests simultaneously. This modality confers an erratic character to the decision process, explained by the Garbage Can Model[5].

In the fourth modality of decisions, decision-making shares meanings as they are shared, that is, the decision always generates meanings established in meetings, discussions, conversations between parties that fuel the decision-making process itself.

Health managers engage in collective forums in health regions so as not to be held accountable for something not within their technical capacity and political competence, to obtain additional financial resources to meet the health needs of their population, and the four decision-making modes and their logics are usually there.

Calmon and Costa[2] point out that stakeholders are interdependent because they cannot produce the products and results of public policy alone. The financial, political, and organizational resources needed to produce outputs and results, as well as essential information to implement advocated actions, are distributed across a broad range of stakeholders and organizations within and outside government. Such is the reality of SUS, with a great power asymmetry among managers, as well as insufficient resources and the implementation of policies relying on a series of agreements with providers, health entrepreneurs, workers, health interest groups. In addition to not having a legal option of not regionalizing, there is no way to make SUS other than regionally. Therefore, however financially and technically independent a municipal, state or federal manager is, the level of interdependence between them is high because the level of interdependence in the RRAS is also high.

Authors say that governance in health regions requires discussing four fundamental elements: heterogeneity and interdependence between stakeholders, the existence of a public policy subsystem and the presence of a governance structure understood as a way of organizing the decision-making process.

Much of the referential used by various development and investment organizations, as well as internal and external control bodies, concerns to management analysis of an organization structured in a predominantly hierarchical way and with a monopoly of power, information and resources over a given area. In other references, a SUS image seems to dissociate politics and administration. It refers governance to health councils and assigns to managers just a managing role following decisions of councils. Such conceptions are inadequate to governance in the SUS, where there are constitutionally common responsibilities between federated entities that are in differ-

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ent institutions with distinct cultures and decision-making processes and are interdependent with each other, have a common health system and interdepartmental governance structure established by law. While there is some literature on intergovernmental management, research in this area is limited to organizational arrangements of executive operations. In the case of health, there is much debate about executive governance through public consortia and limitations established by the Brazilian administrative law.

Calmon and Costa[2], when listing functions performed in the management of public organizations, point out that studies have focused on functions characterized by POSDCORB (Planning, Organizing, Staffing, Directing, Coordinating, Reporting and Budgeting). However, these functions may not be transposed when talking about the administration of networks composed of multiple heterogeneous organizations as in the SUS, much less in view of the objectives of the health regions and their governance structure. This difficulty is expressed in several processes that must be developed in the CIR, such as integrated regional planning including service programming. Elaborating plans and budgets involving efforts aimed at aligning different organizations with heterogeneous values and principles is the challenge. Chart 2 summarizes three different perspectives on public policy governance: (i) the traditional perspective, based on a downward vision of public policies management; (ii) the participatory perspective, based on an upward vision; (iii) the perspective of public policy networks governance, in which heterogeneous stakeholders, interdependence relations and collective action issues prevail.

There is no way to adapt the downward or upward perspective to the context of network management and therefore there is no way to transpose POSDCORB principles to network management. Calmon and Costa[2] point out that attempts to characterize functions in network management, mainly based on works of Kickert and Koppenjan[6] and McGuire[7], point to network activation, establishing a relationship framework, intermediation, facilitation and consensus building and mediation and arbitration.

The analysis of functions associated with network governance allows identifying issues that managers should consider in the managing these networks. First, the network's environment. According to literature, five basic characteristics of a network's environment can affect its performance:

1. Consensus on objectives – a network with consensus about goals to be achieved tends to be more effective than a network where there is still

Chart 1. Three different perspectives on public policy governance.

	Traditional perspective	Participatory perspective Bottom-Up	Networks governance perspective
Object of analysis	Central government serves different segments of society	Central government serves local stakeholders who interact with society	Networks of heterogeneous stakeholders at different levels of government and society
Main focus	Hierarchical authority	Local stakeholders	Interrelation between heterogeneous stakeholders
Relationship type	Authority and control	Centralization vs. Decentralization	Interdependence
Implementation	Implementation of was has been planned	Representation of interests through norms and control of resources	Interaction with exchange of information, objectives and resources
Success criteria	Achievement of centrally conceived policy goals	Satisfying local preferences and obtaining resources for local stakeholders	Accomplishment of collective action
Failure criteria	Control failures, ill-defined or poorly monitored policies	Decentralization failures or little local engagement	Poor institutional arrangement hampers collective action
Recommendations	Centralization and coordination	Decentralization and participation	Management of the environment and of the infrastructure for the interaction in public policies

a need to define and agree on those objectives. In a network with well-defined and consensual goals, managers will spend more time activating the network, establishing a framework and intermediation. In networks where objectives have not yet been agreed, managers will devote more time to facilitation, mediation and arbitration. This analysis requires further study on CIRs, but some health regions, given the diverse situations and irregular deliberative forums meetings, seem to require a better definition of objectives.

2. Resource allocation – interdependencies in a network occur because of the distribution of resources among its members. Resources include the distribution of legal authority, material resources, information, expertise and experience. Participation in the network derives from the amount of funds available to each stakeholder. The good distribution of these resources will entail a vast network. Network tends to be more restricted if resources are concentrated in few. Health regions, as already pointed out, are quite diverse. Among the 438 established, we have great variations both in number of municipalities and in population, financial resources available, network of existing health services and human resources. The concentration of resources may be one of the explanations for the greater or lower participation of managers in the CIRs, but this analysis requires further studies.

3. Political support – Political support for the network and members in their organizations are key to the smooth functioning of the network. If network participants do not have the support of their organizations or society, then much of network management efforts will be geared towards their attainment. SUS managers exercise relative autonomy, since they were appointed by the heads of the executive branch, elected by the population. There is a constant effort to involve mayors, governors and Presidency of the Republic and it is necessary to further analyze the role of these stakeholders in the states that have signed the COAP.

4. Relationships – Trust and social capital are crucial to the smooth functioning of a network. If network members have interacted in the past, if they know each other well, then less time will be devoted to establishing a framework and intermediation than in a network of strangers or first-time interactors. This is a SUS characteristic right now. Managers who participate in a CIR do not always know each other, and there is a great turnover of these managers in the three spheres in their leadership positions. Oftentimes, this turnover appears in exchanges of positions in the interactions.

5. Guidance on public policies – If a public policy paradigm is shared among all stakeholders with an indication of priorities, objectives, goals and tools, then less energy is required in consensus building. On the other hand, if the network members adopt different paradigms for their performance, then the risk of conflicts will increase greatly. This is a feature that also deserves to be investigated since, while the SUS has several processes of downward agreement mediated by goals and indicators, there are many biases in the various information systems and in the process and agreement tools.

Final considerations

Health as a subsystem of public policies involves stakeholders in the Executive Branch, usually in different governmental bodies, in the Legislative Branch, including politicians and advisors, in the Judiciary, involving ministers, judges and advisors, interest groups linked to industries, companies, unions, employers' associations and social movements, representatives of international organizations and members of academia and the media, along with the participation of the community as one of its organizational principles, exercised through forums also established by law in the three spheres of government. The challenges for regional governance processes in the SUS will only be overcome with coordination, cooperation and communication. The organizational arrangements of the health regions, composed of formal (Ministry of Health, state and municipal health secretariats) and informal institutions, as well as the way the agenda is agreed, decisions are taken by consensus and the distribution of technical responsibilities are agreed are part of the governance structure in the various states and with varying designs. In addition to the CIR, CIB and CIT forums, there are several states forums in macro regions, which are fundamental for agreements related to access and comprehensiveness. There are also cases in which the deliberative character of the CIRs requires the approval of decisions by the CIB.

In order to increase health regions' governance capacity, strengthening relationships between managers, enormous efforts and actions in support have been developed by COSEMS – Collegiate of Municipal Health Secretaries in each state, CONASEMS – National Council of Mu-

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nicipal Health Secretariats and CONASS – National Council of (State) Health Secretaries. Such support is not an assumption of functions of the state and federal spheres, since it usually means horizontal manager-manager dialogue and in the form of a network of public policies.

According to Calmon and Costa[2], the notion of the capacity of public policy networks focuses not only on the volume of information transmitted, but also on the capacity to mobilize stakeholders in solving the problems faced by the community. In other words, it involves the network's ability to solve collective action issues, especially those focused on cooperation, coordination and communication between stakeholders, generate expected results and sustain actions over time.

To analyze governance capacity of public policy networks, authors propose six realms: social capital; institutionalization; sustainability; structure and tools; communication and information and analysis.

1. Social capital – The level of governance of a network relies on the existence of a social capital. In other words, it depends on: (i) establishing a climate of credibility and mutual trust; (ii) broad participation in decision-making processes; and (iii) transparency, monitoring and accountability of actions. The existence of values common to the various members can facilitate the coordination of actions. Some networks are more integrated than others are. Others are so poorly integrated that it is hard to perceive their members as part of a network. This may explain differences between CIRs, by the criteria of participation and accountability, but also points to ways to increase governance capacity.

2. Institutionalization – A well-structured public policy network must be institutionalized, implying the establishment of norms and procedures, which define decision-making arenas and distribution of competencies and attributions. Some networks establish regulatory frameworks, highlighting the competencies of each of the stakeholders involved. Formally institutionalized networks can have a greater level of governance. However, excessive rules and formalities can hinder participation and coordination of these networks. The tripartite resolution that established guidelines for the conformation of health regions is very broad and does not establish how each region should be. It indicates a resolution in the CIB and CIR's internal rules as the regulatory framework for the decision-making process and governance in the regions, with reference to Decree 7508. Some regions have not yet elaborated their internal regulations, others have no regular periodicity or have no decision flows and harmonization flows of decisions between CIR and CIB, but there are also many regions where access issues have improved greatly after the organization of shared management.

3. Sustainability – Oftentimes, actions in a network are interrupted by government swaps, ministerial changes, administrative reorganizations, financial flows disruption or other external factors. As a result, networks are subject to a dynamic process, with continuous adaptation to transformations and a constant search for improvement. The level of governance of a network depends on its sustainability. That is, the ability to carry out continuous actions, even if with long-lasting adaptations. This is the typical situation of the SUS, with high turnover of its managers. There are several initiatives underway by CONASEMS and CONASS to welcome new managers and ensure fewer changes in decisions, but SUS financial flows have always suffered fluctuations. System financing is a much more complex issue than explained here. At a meeting of the CIT in April 2016, the President of CONASEMS said that tackling it requires more than demonstrating the need and requesting more funds. It requires qualifying the discussion on financing based on structured data and considering regional costs, ensuring the rearrangement of federal government funding before the evident exhausted capacity of allocating municipal funds in health, establishing commitment of state governments to co-financing of the structuring and operation of RRAS, among other actions and political takes.

4. Coordination structure and tools – The design and implementation of actions in a network imply the existence of a coordinating structure that articulates the actions of the different stakeholders. Some networks establish coordination structures. In other networks, coordination is carried out by collegiate bodies with broad stakeholder participation. In any case, the coordination structure should enjoy legitimacy among stakeholders in the network and have adequate tools for its activities. The level of governance of a public policy network also depends on the quality of these tools. Planning, guidelines and cooperation contracts are some of the main tools for coordinating networks. Several health regions have reasonable coordination structure and tools, besides having CIR with wide participation of the managers that bring great legitimacy to the

decision-making process. In addition, face-to-face and distance support activities developed by COSEMS, CONASEMS and CONASS affects this capacity.

5. Communication – Communication between stakeholders in a policy network is fundamental to decision-making and implementation of actions. That is, the level of governance of a network depends on the quality of interactions between stakeholders. Communication is analyzed in two realms: (i) internal (between government stakeholders) and (ii) external (between government and society). Good communication between stakeholders implies the exchange of information and the existence of mutual consultation systems. In the health regions, discussion about communication is still incipient. This does not mean bad quality managers' interaction, but gives clues as to how a communication policy could increase governance capacity.

6. Information and analysis – The planning and implementation of actions require a flow of reliable and detailed information, which has to be analyzed and disseminated in a timely manner to support the decision-making process. The level of governance of a policy network depends on the quality and reliability of the information disseminated among stakeholders. This is another fragility of the SUS, which has more than 130 information systems, but developed for different purposes, with fragmented business rules in health service programs ordinances, as well as fragmented actions, with low interoperability, non-adherence to the work processes of the health teams in the municipalities and that do not provide information for the decision-making process.

The combination of these concepts from the fields of Political Science, Social Sciences, Sociology and public administration associated with those in the health field can define hypotheses about governance in Brazilian health regions, since both the collaborative governance model and public policies network governance show analytical and variable realms that can be easily observed in the SUS.

Collaborations

N Bretas Júnior worked on the paper's design and writing. HE Shimizy worked on the paper's design and writing.

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