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SCALES AND TEMPORALITIES OF SUS REGIONALIZATION IN RIO DE JANEIRO

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Abstract

This paper is part of a broader research program examining the territorial contexts of public policy implementation, taking into account the different temporalities and spatialities involved in the processes of policy formulation, formalization, and execution. The object of analysis is the regionalization of Brazil's Unified Health System (SUS — Sistema Único de Saúde) in the state of Rio de Janeiro, and the study adopts a qualitative approach based on bibliographic and documentary research. The methodology includes semi-structured interviews with health system officials at different levels, as well as the analysis of official documents, legislation, and specialized literature. The findings highlight the numerous challenges faced in this process, such as persistent fragmentation and localism within the state. The study also revisits the political-territorial legacy of the state's formation to better understand the obstacles to stronger coordination among municipalities and between municipal and state governments. Unlike other political-territorial contexts, the state of Rio de Janeiro still experiences delays in developing a regionalized and cooperative health policy management system, resulting from disruptions in governance, competition over funding among municipalities and across government levels (municipal, state, and federal), as well as partisan political disputes.

Keywords: Brazilian Unified Health System; Scales; Temporalities; Regionalization

Resumo / Resumen

ESCALAS E TEMPORALIDADES DA REGIONALIZAÇÃO DO SUS NO RIO DE JANEIRO

O presente texto se inscreve em um programa de pesquisa sobre os contextos territoriais de implementação das políticas públicas, considerando-se as diferentes temporalidades e espacialidades dos processos de formulação, formalização e realização de agendas. Neste paper, o objeto de análise é a regionalização do Sistema Único de Saúde (SUS) no Rio de Janeiro. Trata-se de uma contribuição de natureza qualitativa, do tipo bibliográfica e documental. A metogologia se apoia na realização de entrevistas semiestruturadas com gestores de diferentes níveis do sistema de saúde, além da análise de documentos oficiais, legislação e literatura especializada. Os resultados revelam os inúmeros desafios enfrentados nesse processo, como a fragmentação e o localismo persistentes no estado. Recupera-se também a herança político-territorial do processo de formação do estado do Rio de Janeiro como forma de compreender os entraves para maior articulação entre municípios e entre esses e o estado. Diferente de outras realidades político-territoriais, o estado do Rio de Janeiro ainda enfrenta atrasos na gestão regionalizada e cooperativa da política de saúde, que resultam de interrupções na gestão do sistema, disputas por financiamento entre municípios, entre as escalas municipais, estaduais e federais, além de disputas político-partidárias.

Palavras-chave: Sistema Único de Saúde; Escalas; Temporalidades; Regionalização.

ESCALAS Y TEMPORALIDADES DE LA REGIONALIZACIÓN DEL SUS EN RÍO DE JANEIRO

Este texto forma parte de un programa de investigación centrado en los contextos territoriales de implementación de políticas públicas, considerando las diferentes temporalidades y espacialidades de los procesos de formulación, formalización y concreción de agendas. En este artículo, el objeto de análisis es la regionalización del Sistema Único de Salud (SUS) en el Estado de Río de Janeiro. Se trata de una contribución cualitativa, basada en investigación bibliográfica y documental. La metodología se basa en entrevistas semidirectivas con gestores de diferentes niveles del sistema de salud, así como en el análisis de documentos oficiales, legislación y literatura especializada. Los resultados revelan los numerosos desafíos encontrados en este proceso, como la persistente fragmentación y el localismo en el Estado. También se moviliza el legado político-territorial del proceso de formación del Estado de Río de Janeiro para comprender los obstáculos a una mayor articulación entre municipios y entre estos y el Estado. A diferencia de otras configuraciones político-territoriales, el estado de Rio de Janeiro aún experimenta retrasos en la gestión regionalizada y cooperativa de la política de salud, debido a interrupciones en la gobernanza del sistema, conflictos de financiamiento entre municipios y entre los niveles municipal, estadual y federal, así como rivalidades político-partidistas.

Palabras-clave: Sistema Universal de Salud; Escalas; Temporalidades; Regionalización.

INTRODUCTION

This article analyzes the implementation of Sistema Único de Saúde (SUS — Unified Health System) in the Brazilian state of Rio de Janeiro, a process that condenses multiple temporalities of government action within a context marked by deep inequalities as well as political-territorial disputes.

SUS is well known for its grounding in the articulation of networks and regions across Brazil's territory. However, while its guidelines are established at the national level, its implementation and operationalization rely on subnational government capacities. These include technical, financial, and bureaucratic elements, as well as alliance making and consensus building at various levels of intergovernmental coordination mechanisms (SANTOS, 1996).

This study examines these challenges in the context of the state of Rio de Janeiro, taking into account intergovernmental relations and the political settings in which they unfold. The first section revisits theoretical debates about the multiple dimensions of public policy, emphasizing how short-term political processes and institutions become entangled at different temporal and territorial scales. These dynamics are shaped by ideational, structural, and geographical changes.

The second section turns to the institutional design of SUS, discussing how the universalization of social policies in Brazil was progressively consolidated through a series of regulatory changes until the adjustments brought about by the fiscal crisis, which altered the model of coordination among the various political-administrative levels. Finally, the third section examines the implementation of SUS in Rio de Janeiro, in connection with the state's territorial formation and the political processes that have shaped relations across decision-making scales. This analysis focuses on the state of Rio de Janeiro because it offers a compelling and representative example of the temporal and spatial dynamics involved in establishing a public action system built on political and territorial coordination and capillarity.

POLITICS, POLICY, AND POLITY: SPATIALITIES AND TEMPORALITIES

In Portuguese, the single word política encompasses several interrelated meanings, and it is worth spelling out their equivalents in English: i) the political processes involving interest-based conflicts, electoral competition, collective mobilization around demands, priorities, resources, and the strategies of agents and actors—politics; ii) public policy, its processes of legitimation and its outcomes—policy; and iii) the understanding of the values upheld by a political community and the foundations of its broader institutional dimension—polity (PALIER & SUREL, 2001).

In the first sense of política, "politics" refers to the domain of electoral competition, collective mobilization, and shifts in public opinion. The second sense, that of policy, focuses on bureaucratic logic and policymaking methods. The third sense, that of polity, refers to the notion of a political community—the ultimate embodiment of which is the nation-state. The word comprehends not just electoral competition or specific modes of legitimacy and participation, touching upon the very definition of a political community. Its elements include the sense of belonging to a political community, which binds rights-bearing subjects within a territory that hosts the conflicts and dynamics of electoral politics and public policy (PALIER & SUREL, 2001). The political, in this sense, is embedded in meaning-making processes: What is the public interest? What is the natural order of things? What should be done, and how? Policy analysis, therefore, concentrates on the cognitive matrices and global norms that tend to structure and give meaning to public policies.

Although geographers have engaged with public policy analysis, the field of Geography lacks systematic studies on how institutional design (polity) relates to the paths they take and the meanings they assume as they are implemented (RODRIGUES, 2014; BARBOSA, 2010). Many geography studies focus on policy outcomes, but devote less attention to their design and the broader interpretive frameworks in which they are embedded (BICHIR, 2020). These frameworks are not exhausted by outcomes; we are in agreement with Bichir (2020), who argues that analyzing public policies holistically is to analyze political processes marked by interactions that occur across multiple scales, temporalities, and spatialities, and are not at all limited by their results.

According to Bichir (2020, p. 23), the transformation of public policy into action is increasingly understood as a sequence of steps in the policymaking process, involving both horizontal and vertical relationships within spaces of conflict. From this perspective, the mapping of relational networks and of formal and informal structures that emerge around specific policy problems—across various decision-making chains and circuits—takes center stage.

The goal of this paper is not to retrace the theoretical anchoring of this approach within new institutionalism, but rather to underscore the importance of institutional trajectories (FONSECA & RODRIGUES, 2021) and their particular temporalities (HECLO, 1994; SUREL & PALIER, 2005). Historical new institutionalism centers on the trajectories of formal institutions—their design and formalization in state design; sociological new institutionalism emphasizes the temporal dimension of ideas and conceptions that shape individual and collective choices and underlie formal institutional design; and rational choice new institutionalism focuses on short-term political conflicts driven by cost-benefit calculations, often associated with electoral cycles and terms of office.

These perspectives are not mutually exclusive. Rather, rational choice, culture, and structure complement one another to help us understand the connections between actors and institutions and how these influence policy outcomes. In seeking to understand the relationships between institutions, behavior, and political processes, new institutionalists offer subtly distinct contributions, one moment prioritizing the cultural and historical elements that influence behavior, the other emphasizing the calculating nature of political interactions. Drawing on categories first introduced by Fernand Braudel, these scholars argue that "ideas," "institutions," and "interests"—foundational concepts in new institutionalism—operate according to different temporalities: ideas, reflecting broad belief systems and conventions, belong to a long-term timeframe; institutions follow an "intermediate" temporality; and interests are associated with short-term, immediate interactions between actors.

This model provides a useful starting point to interpret the processes of public policy formulation and implementation in a given territory. In the implementation of SUS, political practices are driven both by different temporalities and by dynamics occurring at multiple geographic scales. At the national scale, changes in ideas or in institutional structures provide the regulatory framework and define the space of political possibility as well as the effects of inertia on political action. At a regional scale, social and economic change may encourage collaboration among agents and actors in the medium term. At a local scale, conflict-laden interactions among local actors underlie decision-making processes. In addition, incorporating the temporal dimension into policy analysis invites us to take learning mechanisms and opportunities for paradigm shifts into consideration.

Against this backdrop, how might we understand the spatialities and temporalities of political processes involving rule systems, organizational culture, procedures, and routines, as well as negotiation, decision-making, and conflict resolution processes? What spatialities do processes of territorial coordination and cooperation imply? Can these, even if unstable, generate environments conducive to learning and help overcome competitive or predatory patterns? These are some of the underlying questions that lead us to investigate the territorial systems capable of driving learning processes for political decision-making.

The next section addresses changes in the institutional design of SUS since the 1988 Constitution, with a particular focus on its transformation under a competitive federalism that increasingly promotes regionalization as a coordination strategy among multiple levels of government.

THE INSTITUTIONAL DESIGN OF SUS AND COOPERATIVE FEDERALISM: CHALLENGES AND OPPORTUNITIES

Changes in the institutional design of Brazil's Unified Health System reflect the adjustment processes the country's federalist system has undergone in relation to the various contexts of state action and reform. Starting with the 1988 Constitution and throughout the 1990s, scholars of the Brazilian federal pact have sought to understand both the potential and the resource constraints for ensuring the universalization of core social policies (ARRETCHE, 2000).

Initially, the 1988 Constitution established a model grounded in the principles of universalization of social policies, underpinned by the role of municipalities. However, the fiscal crisis and growing dependence on constitutionally mandated transfers changed the institutional design of social policies. Through the use of constitutional amendments, these arrangements shifted toward a model driven by coordination across multiple political-administrative levels. This shift, which assigns different roles to different levels of government, is a consequence of the challenges of ensuring the state's territorial reach in a wildly unequal country (RODRIGUES, 2006; 2010).

The 1988 Constitution was a landmark in this nonlinear process of expanding access to rights, turning universalization into a goal for the delivery of essential social policies and expanding the infrastructural power of the state and its capacity to impact routines by strengthening the ties between the government and the people under a democratic regime.

During the democratic transition, social policies were reorganized to make them more equitable and to promote social democracy. Decentralization was embraced as a way to bring the government closer to the population, and the universalization of public policies was accompanied by the establishment of mechanisms aimed at enhancing transparency and accountability (DRAIBE, 1989, p. 2).

It should be noted that the 1988 Constitution outlined a framework for cooperative federalism based on shared competencies among the federal government, states, and municipalities. This model of cooperative federalism would be characterized by joint and coordinated action across all three levels of government, underpinned by adherence to certain social policy designs. This shared competencies model would be knitted together by incentive mechanisms, reciprocal commitments, and federative bargaining.

Yet the difficulties of actually implementing this model of shared competencies became apparent amid a deep fiscal crisis of the 1990s. Constrained by limited resources, new arrangements were designed in an attempt to establish more stable intergovernmental agreements to ensure the sustainability of social welfare in a context of fiscal adjustment.

The quality of these processes depends not only on the capacity to build intergovernmental coalitions and alliances, but also on the engagement of civil society organizations (SANTOS, 1996). On one hand, this raises the issue of democratic control over governance processes; on the other, it sparks discussions about the institutional pathways that might improve decision-making processes (FERRÃO, 2013; SANTOS, 1996). Academic studies on the subject of federalism have increasingly focused on intergovernmental relations and the agreements that involve both government actors and civil society, rather than on federalism as an all-encompassing institutional framework.

In addition, after a period in which SUS was largely shaped by a fragmented and localist logic, new standards of action and decision-making were established, guided by conceptions of territorial governance and the consolidation of intrastate regionalization as a strategy for system operationalization [1] (FONSECA & RODRIGUES, 2021). These new approaches have mobilized healthcare council and committee coordinators, as well as local health officials in key positions. These actors not only negotiate among themselves and broker agreements to coordinate actions across territorial scales but also mediate and manage a wide range of conflicts inherent in all decision-making processes. Drawing on the case of the state of Rio de Janeiro, this paper argues that the trajectory of SUS encompasses both long-term processes and the short-term logic of political-party coalitions which influence territorial restructuring.

CHALLENGES OF THE REGIONALIZED IMPLEMENTATION OF SUS IN THE STATE OF RIO DE JANEIRO

The regionalized implementation of SUS in the state of Rio de Janeiro faces significant challenges, especially in terms of intergovernmental coordination (GERSCHMAN & CASTANHEIRA, 2016). To better understand these challenges, a two-stage literature review was conducted. The first stage sought to identify studies on healthcare regionalization in Brazil, while the second focused specifically on that process in the state of Rio de Janeiro. The articles, theses, and book chapters selected

were retrieved from the PubMed, the Ministry of Health's Virtual Health Library (BVS — Biblioteca Virtual em Saúde), Sucupira, and SciELO databases. The search terms used in the first stage were: "regionalização" AND "SUS" OR "política de saúde" ("regionalization," "SUS," "healthcare policy," respectively). In the second stage, the same terms were used with the addition of "Rio de Janeiro." In total, 20 studies were selected and reviewed, providing an overview of the national debate as well as positioning it within the empirical context.

The next step consisted of analyzing the minutes of the meetings of Regional Intermanagement Commissions (CIRs — Comissões Intergestores Regionais). CIRs are key spaces for regional coordination, bringing together officials from municipal governments and from the State Department of Health to plan, negotiate, and coordinate healthcare actions and services within each health region. For this reason, the minutes from 300 meetings of the nine health regions of the state of Rio de Janeiro, covering the period from 2013 to 2023, were analyzed.

Subsequently, twelve interviews were conducted in 2021 with regional advisors from the Council of Municipal Health Secretaries of the State of Rio de Janeiro (COSEMS-RJ)[1]. The interviews addressed different stages of the development of the 2001 Regionalization Master Plan in order to understand the barriers to implementing CIRs in the state.

The Council of Municipal Health Secretaries of the State of Rio de Janeiro (COSEMS-RJ), established in 1986, represents municipal health officials, provides technical support, and facilitates dialog among all levels of government. It plays a crucial role in healthcare regionalization, collaborating with CIRs at the regional level and with the Bipartite Intermanagement Commission (CIB)[2] at the state level in decision-making in the health system, thereby strengthening governance.

In Rio de Janeiro, these efforts face constraints rooted in historical trajectories that continue to shape the system's governance. Some studies indicate that the current configuration of the state's healthcare system is closely linked to the historical process of its territorial formation (PARADA, 2001; GERSCHMAN & CASTANHEIRA, 2013, 2016).

The merger of the states of Guanabara and Rio de Janeiro triggered conflicts at the state level, resulting in political processes that diverged from those seen in other states (VIANNA, 2012; GERSCHMAN & CASTANHEIRA, 2013; 2016). This process redistributed responsibilities among federal, state, and municipal governments, while federal agencies continued to operate in the state for extended periods, fueling friction between the various entities.

The redistribution of resources was impacted, widening inequalities in both access to and quality of healthcare services, particularly during periods of fiscal crunch. The lack of coordination strengthened local political groups, undermining collaborative arrangements and generating discontinuities in public policy, especially during electoral periods (PARADA, 2002). During the 1990s, decentralization worsened institutional fragmentation, sparking conflict among entities and agencies, especially with the State Department of Health. According to Parada (2002), the tension between states and municipalities resulted in municipalities bypassing state governments to establish direct relationships with the federal government, weakening the state's role.

Parada (2002) examined healthcare management in Rio de Janeiro during the 1990s, noting that during the administration of Marcelo Alencar (1994–1998), party interests were prioritized over the development of more effective territorial governance. The State Department of Health focused primarily on hospitals, prioritizing direct care over playing a leading role in building a regionalized and unified system in the state.

It is important to recall that the implementation of SUS depends on a territorial referral network to provide services based on a regional logic. In order to overcome municipal constraints and promote regional interests, municipalities—especially those farther from the capital—formed intermunicipal healthcare councils and consortia[2]. Between the 1980s and 1990s, four consortia were established, expanding collaboration among officials. However, the effectiveness of these consortia was hindered by political, demographic, and financial disparities, as well as the lack of funding and challenges related to regional coordination (LIMA et al., 2016).

These experiences highlighted, on one hand, the obstacles of federalism within the state and, on the other, promoted a collaborative culture among municipalities, particularly those farther from the capital, thus facilitating the establishment of regional management boards beginning in 2009. According

to Parada (2002), the State Department of Health faced a dilemma between two models: the old one, focused on running state hospitals, and the new one, in which the state was expected to lead the construction of a regional system.

The challenge of healthcare regionalization went beyond a lack of clear regulations, also encompassing limited mobilization among state and municipal bureaucracies to negotiate political agreements that could foster greater cooperation and coordination of responsibilities. The deprioritization of regional governance by local and state governments, added to the fragility of intergovernmental relations and the limited interest in developing its own healthcare project at the state level, exacerbated the problem. It was only in the late 1990s that institutional efforts emerged at the state level to address these issues.

During the administration of Anthony Garotinho (1998–2001), regional integration gained prominence within the State Department of Health with the creation of the Center for Integration and Strategic Development (NIDE — Núcleo de Integração e Desenvolvimento Estratégico) in 1999 (VIANNA, 2012). The 2001 Regionalization Master Plan (PDR — Plano Diretor de Regionalização) marked the beginning of the "regionalization cycle," guided by the Basic Operating Standard 01/1996, which had established Integrated and Negotiated Programming (PPI — Programação Pactuada e Integrada) to coordinate municipalities under state leadership (GERSCHMAN & CASTANHEIRA, 2016). The process, however, laid bare the weakness of the state government and the strong power of inducement of the federal level.

The 2001 PDR was key to consolidating the regionalization strategy, adopting criteria such as intermunicipal contiguity, transportation, communication, care flows, and resource availability. However, these criteria were not fully implemented, and the model of regionalization adopted ultimately mirrored the overall regionalization of the state's administration, albeit with some adjustments[3], resulting in nine health regions: Baía da Ilha Grande, Baixada Litorânea, Centro-Sul, Médio Paraíba, Metropolitan I and II, Noroeste, Norte, and Serrana (Figure 1). By disregarding healthcare criteria, care flows, and microrregional specificities[4], this proposal diverged from the actual healthcare demands expressed at the local scale.

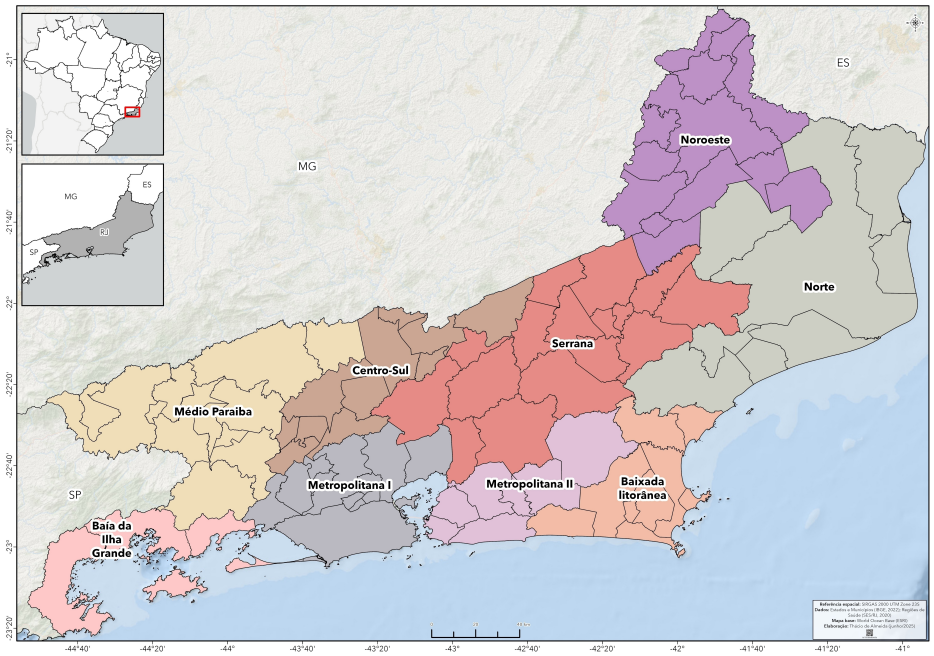

Figure 1 - Health regions in the state of Rio de Janeiro. Sources: States and municipalities (IBGE, 2022); Health Regions (SES/RJ, 2020).

In 2005, changes at the Ministry of Health brought the Workers' Party (PT) and the Brazilian Democratic Movement Party (PMDB) closer politically, resulting in a coalition for the 2006 elections

that aligned federal and state governments for several years. The election of Eduardo Paes (PMDB) as mayor of the capital in 2008 strengthened this alignment. However, the coalition exposed the fragility of intergovernmental relations, which were driven more by partisan affinities than by effective healthcare management agreements.

The regionalization of healthcare in Rio de Janeiro advanced with the state's adherence to the Healthcare Pact starting in 2007, propelled by the alliance between state and federal governments. The pact, an agreement among the federal, state, and municipal governments, sought to strengthen shared management and the quality of SUS services, organizing responsibilities across three dimensions: consolidation of SUS, strengthening of primary care, and guaranteeing resources and actions for healthcare. This led to the establishment of Regional Management Boards (CGRs — Colegiados de Gestão Regional) in 2009.

CGRs are political spaces for negotiation among municipal and state officials, aimed at regional planning and coordination of healthcare actions within SUS. In Rio de Janeiro, their implementation was delayed, hindered by challenges in small towns, technical inequalities, and financial conflicts, while more structured municipalities advanced quickly. Despite these challenges, CGRs consolidated the regional focus, though constrained by localism and lack of intergovernmental coordination.

One example of the barriers to integration was the separation of the city of Rio de Janeiro from Metropolitan Region I in 2011, with the creation of CGR Capital, justified by its self-sufficiency and the better organization of the remaining municipalities. After a debate mediated by the Ministry of Health, the capital was reintegrated into Metropolitan Region I, and the CGR began acting as an intermunicipal board.

In 2011, CGRs were renamed Regional Intermanagement Commissions (CIRs — Comissões Intergestores Regionais), incorporating new regional planning instruments, such as COAP[5] and, later, Integrated Regional Plans (PRIs — Planos Regionais Integrados). For some interviewees, this was the last significant effort to promote healthcare regionalization to be led by the state government. The regionalization cycle in the state ended in 2014, and the decade since has been marked by a multidimensional crisis (political, economic, institutional) that continues to produce significant backsliding in healthcare governance.

Unlike the period from 2007 to 2014, when political alignment among municipal, state, and federal officials enabled progress in regionalization, this context reveals the fragility of governance in the state. Events such as the arrest of former governor Sérgio Cabral in 2016 and the impeachment of governor Wilson Witzel during the Covid-19 pandemic in 2020, exposing weaknesses in the federal pact, further undermined healthcare management in the state. Without centralized and effective coordination, especially in managing sectoral policies like healthcare, political groups and local coalitions end up reinforcing their local bases of influence, limiting coordination strategies.

If the party coalitions crumble and the state agenda continues to prioritize service provision over the expansion and coordination of the federative system, the regionalized integration of SUS is once again compromised. Issues such as the judicialization of intergovernmental disputes and the disruption of PRIs reflect the fragility of governance amid political and economic instability.

Between 2014 and 2020, staff headcount fell significantly at the State Department of Health, undermining its technical capacity (PERES et al., 2020). As a result, the state government’s role was weakened, and PRIs for the 2017–2020 period stalled at the diagnostic stage. Without a PRI, municipalities end up acting independently, drafting their own plans and intensifying issues of localism and discoordination.

In summary, despite the expansion of SUS regulations and the state’s capacity to coordinate healthcare policy in recent decades, these capacities in Rio de Janeiro remain limited due to the fragility of the political coalitions underpinning the model. This is expressed in the continued insularity of the capital, the persistence of localism, and a lack of intergovernmental coordination. Overcoming these challenges will require joint efforts by civil society and government to build a shared vision for improving healthcare for the people of Rio de Janeiro.

CONCLUSION

This paper revisited the issue of the regionalization of Brazil's Unified Health System (SUS) at subnational scales. To that end, we selected the state of Rio de Janeiro as a representative case of the multiple temporalities involved in decision-making processes involved in the system's implementation within a specific political-territorial context.

In the first part, we addressed the different dimensions of politics, which comprises: i) political processes involving interest-based conflicts, electoral competition, and collective mobilization around demands, priorities, resources, and the strategies of contending agents and actors; ii) public policy, its legitimacy processes and its outcomes; and iii) the understanding of values upheld by a political community and the principles of its institutional framework.

In the process of defining health regions, the federated states took on the responsibility of leading the structural reform of Brazil's healthcare system, tasked with reconfiguring the fragmentation that characterized the system's earlier decentralization. This led to a series of problems, including technical and bureaucratic issues as well as political challenges.

In the state of Rio de Janeiro, local structures remain relatively isolated and lack the capacity for coordinated governance necessary to establish intermunicipal health networks. Moreover, the operationalization of healthcare services often becomes the target of political campaigning by administrators, leading to the personalization of public policy amid party interests and disputes.

In short, a set of factors helps explain why Rio de Janeiro was relatively late to adopting a more regionalized and cooperative approach to SUS governance. These include frequent disruptions in management and the turnover of key technical and political personnel responsible for driving interstate negotiations, disputes between the State Department of Health (SES/RJ) and the Federal Government over healthcare funding, the insularity of the state capital and the localism that hinder inter-municipal cooperation, and partisan conflicts that undermine federative coordination.

It is worth noting that the establishment of new decision-making spaces that engage diverse actors in discussions of issues that affect life in society can create opportunities for long-term learning. Despite contradictions and discontinuities, reflecting on the role of ideas and principles embedded in these spaces—beyond the short-term horizon of interest-based conflicts—remains a compelling endeavor. In this context, what kind of forward-looking strategic vision could be forged among public administrators, technical staff, and advocacy groups mobilized around issues affecting access to public goods and services?

Beyond the shortcomings in fulfilling the original promises of equity and universality, more protracted and less visible processes may be embedded in experiences that unfold within the various spatial and temporal fractions in which public policy is developed. This is the fundamental challenge that compels us to construct future objects of inquiry.

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NOTES

1 - We discuss the institutional trajectory of SUS in FONSECA & RODRIGUES (2021).

2- Between 1980 and 1990, four consortia were established: Hemolagos in 1988, CIS Noroeste in 1998, CIS Centro-Sul in 1998, and CIS Médio Paraíba em 1998, as well as two ongoing initiatives in the Baixada Litorânea and Northern regions (SCHNEIDER, 2001).

3- Metropolitan Region I was redefined to include the municipality of Itaguaí, previously part of the Baía da Ilha Grande region, and to exclude Paracambi and Guapimirim, which were reassigned to

the Centro-Sul and Serrana regions, respectively. Similarly, the municipalities of Maricá, Rio Bonito, and Silva Jardim, originally assigned to Baixadas Litorâneas, were added to Metropolitan Region II, while Cachoeira de Macacu was reassigned to the Serrana region (Kuschnir et al., 2010).

4- The following criteria were used: geographic proximity, similarity in healthcare demand, and service capacity.

5- The Organizational Contract for Public Action (COAP — Contrato Organizativo da Ação Pública) is a healthcare planning instrument that sets agreements among different levels of government for SUS management within health regions. While it has spurred meaningful debates on regionalization and interstate coordination, its effective implementation has been limited. As a result, COAP has failed to consolidate as a structuring mechanism for regional health governance, both in the state of Rio de Janeiro and in several other states across Brazil (OUVERNEY; RIBEIRO; MOREIRA, 2017).

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