saúde EM DEBATE

ORIGINAL ARTICLE

Legal gaps and health responsibility in the regionalization of the Unified Health System: From territorial design to thematic networks

Vazios legais e responsabilidade sanitária na regionalização do Sistema Único de Saúde: do desenho territorial às redes temáticas

Vacíos legales y responsabilidad sanitaria en la regionalización del Sistema Único de Salud: del diseño territorial a las redes temáticas

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ABSTRACT The objective of this study was to analyze, from a normative point of view, the regionalization process in the Brazilian health system. This is a documentary study that gathered five legal and ten infra-legal regulations published between 1988 and 2023. As complementary documents, the National Policies for Primary Care, Specialized Care, and Hospital Care were analyzed. The following information was extracted: year, regulation, type of regulation, concept of network, territorial design and organization, making it possible to identify three phases in the regionalization process: The first (1988-2010) is marked by the concept of regionalization as a constitutional and organizational precept of the Brazilian Unified Health System (SUS); the second (2010-2017) is a transition phase, with changes in the concept of regionalization and a lack of mirroring between legal and infra-legal norms; The third phase (2017-2023) is the consolidation of sub-legal norms and the instrumentalization of regionalization, where Integrated Regional Planning becomes merely a formal product without direct consequences in the regionalization process. As a result, a legal and conceptual void is observed in the SUS due to the fragmentation of the territory into thematic networks; the lack of understanding of the health responsibility of hospitals; the separation between regional design and health planning; and the significant increase in the number of planning instruments. It is concluded that there is no mirroring between legal and sub-legal norms, and a review of legal regulations is recommended, aiming at the effective regionalization of the SUS.

KEYWORDS Unified Health System. Regionalization of health planning. Levels of health care. Integrality in health.

RESUMO *O objetivo do estudo foi analisar do ponto de vista normativo o processo de regionalização no sistema de saúde brasileiro. Trata-se de um estudo documental que reuniu cinco normativas legais e dez infralegais publicadas entre 1988 e 2023. Como documentos complementares, foram analisadas as Políticas Nacionais de Atenção Básica, Especializada e Hospitalar. Buscou-se extrair as seguintes informações: ano, normativa, tipo de normativa, conceito de rede, desenho e organização territorial, sendo possível identificar três fases no processo de regionalização: A primeira (1988- 2010) é marcada pelo conceito de regionalização enquanto preceito constitucional e organizativo do Sistema Único de Saúde (SUS); a segunda (2010-2017) é de transição, com mudanças no conceito de regionalização e não espelhamento entre as normas legais e infralegais; a terceira fase (2017-2023) é a consolidação das normas infralegais e de instrumentalização da regionalização, onde o Planejamento Regional Integrado passa a ser apenas um produto formal sem consequências diretas no processo de regionalização. Como resultado, observa-se um vazio legal e conceitual no SUS pela fragmentação do território em redes temáticas; pela não compreensão da responsabilidade sanitária dos hospitais; pela separação entre desenho regional e planejamento em saúde e pelo aumento expressivo do número de instrumentos de planejamento. Conclui-se que não há espelhamento entre as normas legais e infralegais, recomenda-se a revisão das normativas legais, visando a efetiva regionalização do SUS.*

PALAVRAS-CHAVE *Sistema Único de Saúde. Regionalização da saúde. Níveis de atenção à saúde. Integralidade em saúde.*

RESUMEN *El objetivo de este estudio fue analizar el proceso de regionalización en el sistema de salud brasileño desde un punto de vista normativo. Este es un estudio documental que reunió cinco regulaciones legales y diez infralegales publicadas entre 1988 y 2023. Como documentos complementarios, se analizaron las Políticas Nacionales de Atención Primaria, Atención Especializada y Atención Hospitalaria. Se extrajo la siguiente información: año, regulación, tipo de regulación, concepto de red, diseño territorial y organización, lo que permitió identificar tres fases en el proceso de regionalización: La primera (1988-2010) está marcada por el concepto de regionalización como un precepto constitucional y organizativo del Sistema Único de Salud de Brasil (SUS); la segunda (2010-2017) es una fase de transición, con cambios en el concepto de regionalización y una falta de reflejo entre las normas legales e infralegales; La tercera fase (2017-2023) se caracteriza por la consolidación de las normas sublegales y la instrumentalización de la regionalización, donde la Planificación Regional Integrada se convierte en un mero producto formal sin consecuencias directas en el proceso regionalizador. Como resultado, se observa un vacío jurídico y conceptual en el SUS debido a la fragmentación del territorio en redes temáticas; la falta de comprensión de la responsabilidad sanitaria de los hospitales; la separación entre el diseño regional y la planificación sanitaria; y el aumento significativo del número de instrumentos de planificación. Se concluye que no existe correspondencia entre las normas legales y sublegales, y se recomienda una revisión de la normativa legal con el fin de lograr una regionalización efectiva del SUS.*

PALABRAS CLAVE *Sistema Unificado de Salud. Regionalización de la salud. Niveles de atención sanitaria. Integralidad en salud.*

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Introduction

Regionalization, as an organizing principle of the Unified Health System (SUS), is a practice of regional territorialization involving the territorial reorganization in 'health areas', by grouping municipalities based on geographic proximity, population size, health service infrastructure, and cultural, economic, and political characteristics. The rational organization of health territorialization within the SUS must provide access and care aligned with the complexity of health issues, following a logic wherein the greater the reliance on 'hard technologies', the more these services are concentrated regionally, whereas the greater the need for 'light technologies', the more they are concentrated locally. Both the local and regional levels constitute the totality of the 'Health Region' and its capacity to foster quality and comprehensive care[1].

The regionalization of the SUS stems from European health models based on the territorial organization outlined in the 1920 Dawson Report, which was adopted as the model for the English system following World War I. That report remains relevant today due to its clarity and significance, particularly regarding the need for coordination between preventive and curative care within a structure organized into primary, secondary, and tertiary levels. The initial definition of a 'Health Region' – or health area – as set forth in the Dawson Report, is still used in the European model and must encompass: home care services, primary health centers, secondary health centers, hospitals, and supplementary services (specifically mental health services, orthopedic centers, hospitals for certain infectious diseases, and rehabilitation centers), as well as the requirement for a teaching hospital affiliated with a medical school to serve a population of approximately two million people[1].

The Dawson Report finds that the "organization of medicine has proven inadequate and fails to make the benefits of medical knowledge properly accessible to the population", addressing an "organizational deficiency" that had become "more evident with the expansion of knowledge and the growing conviction that the best means to maintain health and cure diseases must be made available to all citizens"[1(2)]. This implies a strong link between levels of care: hospitals have their referral health centers, and health centers have their reference populations; thus, the organization of primary, secondary, and tertiary levels constitutes a health area.

In Brazil, the decentralization of health services following the creation of the SUS by the 1988 Federal Constitution occurred detached from the process of regionalization and the construction of health areas based on territorialized hospitals. Whether university-affiliated or not, hospitals are not territorialized based on a specific number of Basic Health Units (UBS) – as in the European model; instead, Brazil opted for a regional organization via thematic networks rather than structuring a single, organic, SUS network. It was only in the 2000s that the Operational Norm for Health Care (NOAS) 01/2001 defined regionalization as a process that "must incorporate an integrated planning logic, encompassing notions of territoriality to identify intervention priorities and shape functional health systems, not necessarily restricted to municipal boundaries"[9(2)], while respecting municipalities as indivisible units. This approach aims to guarantee citizens' access to all actions and services needed to resolve their health issues, thereby optimizing available resources. However, the notion of territoriality, ranging from the micro-region to the macro-region, as introduced by NOAS, shifts during the publication of subsequent legal and infra-legal regulations[3].

Thus, in Brazil, the decentralization/municipalization process of the 1990s did not proceed *pari passu* with the regionalization of the SUS starting in the 2000s. This situation was exacerbated by the staggered release of the national structural policies that underpin the SUS's unified/organic network—namely, the National Policies for Primary Care (PNAB),

Specialized Care (PNAE), and Hospital Care (PNHOSP), thereby intensifying the challenges of combating regional inequalities and addressing the fragmentation of health actions.

This article aims to analyze the regionalization process within the Brazilian health system from a normative perspective. To this end, it examines the practice of regionalization in Brazil and the regional configurations developed based on the principle of territorial health responsibility. It also reflects on regionalization and its various phases throughout the three decades of the SUS's development, drawing on a timeline extending from the 1988 Federal Constitution to Resolution No. 01/2021 of the Tripartite Interagency Commission (CIT).

Methodology

The study employed a documentary research method involving an analysis of the legislation underpinning the SUS, covering all regulations regarding regionalization published between 1988 and 2025. Documents were selected based on criteria involving legal and infralegal regulations related to SUS management and regionalization from 1988 to 2023. Once the criteria were established, searches were conducted on various websites: the Virtual Health Library (BVS), the Health Legislation System (SLEGIS), and the Planalto Legislation Portal. Each regulation was examined for concepts regarding health networks, their respective planning instruments, and the proposed regionalization design. The analysis covered five legal regulations and ten infralegal regulations, which constitute the core of SUS regulatory frameworks. Additionally, the study analyzed key SUS structural policies—specifically those defining primary, secondary, and tertiary care levels: the National Primary Care Policy (2006, 2011, and 2017), the Specialized Care Policy (2023), and the Hospital Care Policy (2013). Data extraction focused on the following elements: year, type of regulation, network concept, territorial design, and territorial organization. As the documents analyzed are publicly accessible, submission to a human research ethics committee was not required. *Table 1* lists the legal and infralegal regulations analyzed.

Table 1. Legal and sub-legal regulations according to year of publication and type of regulation. Brazil, 2025

YEAR	NORM	TYPE
1988	Federal Constitution2	Legal Norm
1990	Organic Law No. 8080/903	Legal Norm
	Organic Law No. 8142/904	Legal Norm
1991	Basic Operational Norms (NOB 91)5	Sublegal Norm
1992	Basic Operational Norms (NOB 92)6	Sublegal Norm
1993	Basic Operational Norms (NOB 93)7	Sublegal Norm
1996	Basic Operational Norms (NOB 96)8	Sublegal Norm
2001	Operational Norm for Health Assistance (NOAS)9	Sublegal Norm
2002	Operational Norm for Health Assistance (NOAS)10W	Sublegal Norm
2006	Health Pact11	Sublegal Norm
	National Primary Care Policy (PNAB)12	Structuring Policy of the SUS/Sublegal Norm
2011	Decree No. 7,508/201113	Sublegal Norm
	Law No. 12,466, of August 24, 201114	Legal Norm
	National Primary Care Policy (PNAB)15	Structuring Policy of the SUS/Sublegal Norm
2012	Complementary Law No. 141/201216	Legal Norm

Table 1. Legal and sub-legal regulations according to year of publication and type of regulation. Brazil, 2025

YEAR	NORM	TYPE
2013	National Hospital Care Policy (PNHOSP)19	Structuring Policy of the SUS/Sublegal Norm
2017	National Primary Care Policy (PNAB)20	Structuring Policy of the SUS/Sublegal Norm
	Consolidation Ordinance on the SUS Networks No. 03/201721	Sublegal Norm
2021	CIT Consolidation Resolution No. 1/202125	Sublegal Norm
2023	National Policy for Specialized Care (PNAES)26	Structuring Policy of the SUS/Sublegal Norm

Source: Author's own elaboration, 2025.

Results and discussion

When examining the period from the 1988 Federal Constitution to CIT's Consolidation Resolution No. 01/2021 – specifically analyzing the core regulations governing the SUS and regionalization as an organizational principle of the system – a divergence becomes apparent between the actual practice and the constitutional understanding of the SUS's regionalized and hierarchical network. The definition of regionalization as a unified, organic, regionalized, and hierarchical network is established in the 1988 Federal Constitution, Law No. 8.080/1990, NOAS (2002), the Health Pact (2006), Presidential Decree No. 7.508/2011, and Law No. 141/2012. However, in the Network Consolidation Ordinance No. 03/2017 and CIT Consolidation Resolution No. 01/2021, the current sub-legislative norms guiding regionalization – although based on the understanding of a regionalized and hierarchical network, the concept shifts to Health Care Networks, in reference to the various thematic networks proposed by the Ministry of Health (MS). Regionalization is no longer conceived and implemented based on levels of complexity (primary, secondary, and tertiary) aligned with their respective structuring national policies (PNAB, PNAES, and PNHOSP); instead, it is operationalized through thematic care networks involving Regional Action Plans (PAR) and macro-regional health plans[2-21]. *Table 2* highlights the key aspects of the analyzed regulations.

Table 2. Organization and territorial design in the legal and sub-legal regulations of the SUS and conceptual changes over time. Brazil, 2025

Nº	Legal and sub-legal regulations	Territorial organization and types of planning instruments	Territorial design and concepts of regionalization
01	CF 88[2]	Multi-Year Plans (PPA) Budget Guidelines Law (LDO) Annual Budget Law (LOA)	Public health actions and services are integrated into a regionalized and hierarchical network. Conception of a single/organic regionalized and hierarchical network.
02	Law No 8.080/90[3]	Planning, programming, and organization of the regionalized and hierarchical network of the SUS, in coordination with its state management; Bottom-up planning; Health Plans.	Regionalization and hierarchical organization of the health services network; Conception of regionalization as an organizing principle of the SUS. Conception of a single/organic regionalized and hierarchical network.
03	NOAS/2001 and 2002[9,10]	Regionalization Master Plan (PDR); Investment Master Plan (PDI); Agreed and Integrated Programming (PPI); Integrated Planning.	Conception of regionalization by territorial areas from healthcare modules – microregions – regions to macroregions of health. Hierarchical networks; Specialized referral networks in specific areas; Intermunicipal referrals; Referrals to other states; State regionalization; The territorial organization space ranges from the territorial unit for qualification in healthcare – representing the minimum territorial base to be submitted for approval by the Ministry of Health and the Tripartite Inter-managerial Commission (CIT) for qualification in healthcare – to the healthcare modules; microregions, region and macroregion of health: Health Macroregion; Health Region; Health Microregions; Healthcare Modules; Municipalities that are headquarters of healthcare modules (GPSM or GPABA); Pole Municipality (GPSM or GPAB-A).
04	Health Pact (2006)[12]	Pact for Life – Health Commitments (Elderly Health, Cervical and Breast Cancer, Maternal and Infant Mortality, Emerging Diseases and Endemics, Health Promotion and Primary Care), commitment to priorities that impact the health situation of the Brazilian population; Pact in Defense of the SUS – Public Financing of Health as a priority, participation and social mobilization, Commitment to the consolidation of the political foundations and constitutional principles of the SUS. Management Pact – Clear definition of the competencies of the federated entities, Commitment to the principles and guidelines for decentralization, regionalization, financing, planning, agreed and integrated programming, regulation, social participation, management of work and health education. Territorialization of health as a basis for organizing systems Agreed and Integrated Programming (PPI) Management Commitment Agreement (TCG) Regional Management Boards (CGR) Management of Work and Education in Health.	Regionalization with territorialization of health as the basis for organizing systems. Management with commitment agreements signed by managers. The regional space as a privileged locus for building agreed-upon responsibilities, since it is this space that allows the integration of policies and programs through the joint action of the federal, state, and municipal spheres. Publication of the 1st PNAB/2006 and PNPS aligned with the Pact.

Table 2. Organization and territorial design in the legal and sub-legal regulations of the SUS and conceptual changes over time. Brazil, 2025

Nº	Legal and sub-legal regulations	Territorial organization and types of planning instruments	Territorial design and concepts of regionalization
05	Consolidation Ordinance No. 03/2017[21] NOTE: The Health Care Network Ordinance (Ordinance 4279/2010) was republished as per Consolidation Ordinance No. 3/2017, which consolidates the rules on Health Care Networks (RAS).	Regionalization and Investment Master Plan (PDRI) Regional Management Board (CGR) Regional Action Plans (PAR) State Action Plans (PAE) Care Lines (LC) Integrated Regional Plan (PRI) Some thematic networks have PARs by health macro-region, such as the Emergency and Urgent Care Network, the Alyne Network, and the Network for People with Disabilities. The Mental Health Network, however, has a regional PAR.	Regionalization by Healthcare Networks (RAS), thematic networks. Change in the concept of understanding the health territory from 2010 onwards. Understanding of RAS in: thematic, service and research: 1. Thematic networks: Stork Network, Emergency and Urgency Network, Chronic Diseases, Psychosocial Care and People with Disabilities. 2. Health Services Network: State Networks for Elderly Care and Burn Victim Care; National Network for Violence Prevention and Health Promotion and Comprehensive Worker Health Care (Renast); Brazilian Network of Drug Information Centers and Services (Rebracim); Network of Technical Schools and Training Centers linked to the management bodies of the Unified Health System (Retsus); Teaching Network for Strategic Management of the Unified Health System (Regesus) and Brazilian Network for Health Technology Assessment (Rebrats). 3. Research Network: National Health Research Networks (RNPS); National Health Policy Research Network (RNPPS); National Clinical Research Network (RNPC) in Teaching Hospitals; National Clinical Cancer Research Network (RNPCC); National Cardiovascular Disease Research Network (RNPDC); National Cell Therapy Network (RNTC); National Research Network on Neglected Diseases (RNPDN); National Stroke Research Network (RNPAVC); National Network of Experts on Zika and Related Diseases (Renezika); Interagency Health Information Network (Ripsa) and Evidence-Informed Policy Network (EVIPNET).
06	Decree No 7.508/2011[13]	Health Region; Interstate Health Regions; Health Map Entry Points Health Plan National List of Health Actions and Services – Renases Organizational Contract for Public Action (Coap) Regionalized and Hierarchical Network – Health Care Network Bottom-up and Integrated Planning Collaboration Agreement between entities Definition of the SUS's deliberative spaces: CIR, CIB and CIT.	Regionalization by Care Networks (RAS), thematic networks, with the Health Region as its territorial design space. The Decree regulates Law No. 8,080/1990 and provides the definition of Health Region in its Article 2: I - Health Region - continuous geographic space constituted by groupings of bordering municipalities, delimited based on cultural, economic and social identities and shared communication and transport infrastructure networks, with the purpose of integrating the organization, planning and execution of health actions and services. There is no definition of microregions and macroregions. Health Region is the space of territorial design where care networks, as a set of health actions and services articulated at increasing levels of complexity, must guarantee the comprehensiveness of health care. Important debate about the entry points to the SUS. It is seen as a way of implementing the Health Pact, but it does not follow the territorialization of health proposed by the pact.

Table 2. Organization and territorial design in the legal and sub-legal regulations of the SUS and conceptual changes over time. Brazil, 2025

Nº	Legal and sub-legal regulations	Territorial organization and types of planning instruments	Territorial design and concepts of regionalization
07	Law No 141/2012[16]	Regional Inequalities Allocation Criteria to Subsidize the Financing of Health Regions Definition of what constitutes Health Actions and Services (ASPS) Focus on Management Instruments: Health Plans (PS), Health Programming (PAS), and Management Reports (RAG). Emphasis on Planning and Social Control and on the timelines for preparing planning instruments; Penalties for entities that fail to comply with the regulations of the Law; Regional Plan and Goals as the basis for promoting inter-regional and interstate equity. Integrated Plan and Health Indicators as a way to monitor resources.	Territorial design refers to the Health Region. It does not include microregional and macroregional health areas. The concept of regionalization that permeates Law No. 141 is a way to reduce regional inequalities. It does not specifically address care networks/themes. Emphasis on planning with social control. Possibility of Health Consortia acting as intermunicipal and interstate funds and promoting the necessary articulation for regional organization; Criteria for apportionment of health financing and definition of the minimum resources to be applied by the federated entities;
08	CIT Consolidation Resolution No. 01/2021[25]	Network of Health Actions and Services Integrated Regional Plan Governance of Health Care Networks (RAS) Executive Committees for the Management of RAS Health Macro-regions Programming of Health Actions and Services – PGASS National List of Health Actions and Services – Renases Expanded Regional Space Interstate Health Regions	Regionalization through Care Networks (thematic networks) where the territorial design is the health macro-region. The definition of Health Region is confused with the definition of the macro-region. There is no discussion of the micro territorial design. Operationalization of regionalization via PROADI, with the PRI as a product. Important debate about closing the network in the macro-region, but without discussion of micro spaces.

Source: Author's own elaboration, 2025.

Understanding the concept is the first challenge in the regionalization of the SUS. There is a gap between Article 198 of the Federal Constitution – which states that "public health actions and services form part of a regionalized and hierarchical network and constitute a unified system"[2] based on territory, and the shift toward regionalization based on thematic networks starting in 2010, with the publication of the infralegal regulation Ordinance No. 4,279 of December 30, 2010, which establishes guidelines for the organization of the Health Care Network within the scope of the SUS, subsequently incorporated into Consolidation Ordinance No. 03/2017[21]. Amidst this process of conceptual shifts, changing regionalization models, and evolving planning and management tools, it was possible to identify three phases of the regionalization process in Brazil (*table 3*).

Table 3. Phases of regionalization in Brazil and their respective concepts of regionalization, 2025

	Regulations	Characteristics of regionalization
Legal phase of regional territorial design (1988-2010)	CF 88 Law 8080/90 NOB 91,92, 93 e 96 NOAS 2001 and 2002 Health Pact 2006 PNAB 2006	Phase in which the legal regulations of the SUS and the concept of regionalization by territorial areas prevailed in a regionalized and hierarchical network consolidated in legal and infra-legal norms. Conception of a regionalized and hierarchical network. Territorialization of health as a basis for the organization of systems and management. Conception of Regionalization as an organizing principle of the SUS with planning and investment instruments with financial forecasting (Integrated Agreed Programming – PPI; Investment Master Plan – PDI; Regionalization and Investment Master Plan – PDRI; Five-Year Plan of the Ministry of Health for investments in the network). Regional Management Board (CGR) as a space for regional agreement; Bipartite Inter-managerial Commission (CIB) at the state level and Tripartite Inter-managerial Commission (CIT) at the federal level. The concept of regionalization by territorial areas ranges from healthcare modules – micro-regions – regions to macro-regions, with municipalities serving as headquarters for healthcare modules (GPSM or GPABA) and a hub municipality (GPSM or GPAB-A). The same logic of municipal territorialization is followed in regional territorialization; that is, there is an organization of areas of health responsibility with an assigned population, with a single territorial design logic that should be reflected in health planning. There is a territorial design from micro to macro, but the system does not clearly define the health responsibility of specialized care and home care, leaving this competence clearly defined only in PHC. Regional designs influenced by INAMPS (National Institute of Medical Assistance of Social Security) in medium complexity remain.
Transition phase involving changes in the understanding of regionalization (2010 – 2017)	Network Ordinance No. 4279/2010 (Consolidation Ordinance No. 03/2017) Presidential Decree 7508/2011 Law No. 12.466/2011 PNAB 2011 Law 141/2012 PNHOSP 2013 – Ordinance No. 3390/2013 and Hospital Contracting Ordinance 3410, both of December 30, 2013. CIT Resolution 23/2017 PNAB 2017	Definition of regionalization in a regionalized and hierarchical network consolidated in legal norms and practical organization of the territory by thematic networks in infra-legal norms. Loss of the micro-region and macro-region dimensions of health present in NOAS/2001 and 2002 with separation between regional design and health planning. The Organizational Contract of Public Action (COAP) does not have a segment in the health regions as foreseen in Decree 7508/2011. Lack of mirroring between the legal and infra-legal norms of the SUS. Definition of regional planning in legal regulations (Law No. 141/2012) and macro-regional planning in infra-legal regulations (CIT Resolution 01/2021). Also cited as Expanded Regional Space with a regional plan for the health macro-region resulting from the PRI. The Bipartite Regional Commission (CIR) as a space for regional agreement; Inter-managerial Bipartite Commission (CIB) at the state level and Inter-managerial Tripartite Commission (CIT) at the federal level. The contractualization decree for hospitals was published on the same day as the National Hospital Care Policy (PNHOSP), and the focus of discussions regarding hospital care remains within the scope of SUS contractualization and the need for inclusion and monitoring of quantitative and qualitative goals, without discussion of the sanitary responsibility and population assigned to MAC in the SUS. No revision of LC 141/2011, scheduled every five years, and the regionalization of the SUS continues to be conducted via MS Decrees and CIT Resolutions. The emergence of new planning instruments such as Regional Action Plans (PAR) for each Thematic Network. For the maternal and child thematic network, the chronic disease network, and the network for people with disabilities, the PARs have a macro-regional dimension, while for the mental health network, the PAR has a regional dimension.

Table 3. Phases of regionalization in Brazil and their respective concepts of regionalization, 2025

	Regulations	**Characteristics of regionalization**
Phase of consolidation of sub-legal regulations and legal vacuum in the SUS (2017 – 2023)	Consolidation Ordinance of Networks No. 03/2017 CIT Resolution 23/2017 CIT Resolution 37/2018 CIT Resolution 44/2019 CIT Consolidation Resolution/2021 PNAES 2023	Regionalization through Care Networks/Thematic Networks. A new planning instrument emerges, the Integrated Regional Planning (PRI), and CIT Resolution 44/2019 revokes the COAP Decree 7508/2011, but without the possibility of revoking the decree as a whole. Regionalization governed by sub-legal norms with the concept of regionalization via Care Networks in six stages of the PRI: Analysis of the Health Situation, definition of priorities, organization of care points, elaboration of the programming of health actions and services, definition of necessary investments, and evaluation and monitoring. The process is conducted in the states through projects of the Ministry of Health with hospitals linked to the Program to Support the Institutional Development of the Unified Health System (PROADI-SUS). Understanding the PRI as a macro-regional planning method to be developed by the states and a product to be delivered to the Ministry of Health. PRI continues as a planning instrument without allocated financial resources, with financial resources shifting towards funding through PARs for each thematic network. The macro-region of health is reinstated in the CIT Resolutions, but without discussion of the micro-regional health spaces present in NOAS/2002, hindering regionalization by health areas within the health region due to the reorganization of medium-complexity services in small municipalities. The macro-territory dimension is reinstated as the point of closure for care networks, with PHC as its starting point. The debate on the organization of intermunicipal services outside the scope of the municipality that is the headquarters of the health region is weakened. Two logics of regionalization and management instruments result from this process: one for municipalities (division of micro-areas and areas and planning linked to the cycle of management instruments (PAS – PMS – RAG)) and another for the health region and macro-region (organization of thematic networks and planning linked to the PAR of each respective network). PRI is not consolidated as the sum and synthesis of the PAR and is not present in a systematized way as a planning cycle in the State Health Plans, with an effort by SUS managers to make the numerous instruments compatible. Regionalization without territorial design of micro to macro spaces: It does not regionalize by assigned and assigned population in each territory: micro-regional – regional – macro-regional via Health Policies: AB, AE and AH with health responsibilities of health services at all levels of care. Legal vacuum due to the non-revision of Law 141/2012 and the management of the SUS by sub-legal norms. Strengthening of CIT's publication of its Resolutions does not translate into the necessary updating of legal regulations in the unified health system.

Source: Author's own elaboration, 2025.

Subsequently, each of these phases is discussed, highlighting their timeframes and the normative acts that underpinned them.

Legal phase of regional territorial design

The first phase spans from 1988 to 2010 and encompasses the following regulations: the 1988 Federal Constitution, Law No. 8.080/1990, the Basic Operational Norms (NOB 91, 92, 93, and 96), the Operational Norm for Health Assistance (NOAS 2001 and 2002), and the Health Pact (2006), aligned with the publication of the first PNAB (2006). This phase is characterized by an understanding of regionalization based on its constitutional concept of a unified/organic network, specifically, a network that is regionalized and hierarchical according to legal regulations. It follows the European model of regional design regarding territory-based health service responsibilities (as proposed in the Dawson Report), although in Brazil, this mandate was focused solely on Primary Health Care (PHC).

During this first phase, regionalization emerges as an organizational principle of the SUS, involving regionalization by territorial areas – ranging from care modules (micro-regions) to health regions and macro-regions – with health territorialization serving as the foundation for system organization and management. The same logic of municipal territorialization applies at the regional level; that is, areas of health responsibility with assigned populations are organized according to a unified territorial design logic that must be reflected in health planning[2-11,21]. This period saw a major expansion of primary care in the country with the creation of the Family Health Strategy (ESF) in 1994. During this time, the municipalization of the SUS advanced alongside the growing power of service providers and public-private organizational structures, yet there was no definition of territories of health responsibility or assigned populations for Specialized Care (SC) in Brazil. The management tools to be employed encompass planning instruments linked to financial resources, such as the Agreed and Integrated Programming (PPI) and the Master Investment Plan (PDI), while the regional coordination forum, known as the Regional Management Board (CGR), is still in the process of being organized[9-11].

Transition phase involving changes in the understanding of regionalization

The second phase, from 2010 to 2017, is marked by the publication of the Networks Ordinance No. 4279/2010, later incorporated into Consolidation Ordinance No. 03/2017. During this period, in addition to Ordinance No. 4279/2010, there is the publication of Decree No. 7508/2011, Complementary Law No. 141/2011, the PNAB 2017, and CIT Resolution No. 23/2017 (included in CIT Consolidation Resolution No. 01/2021)[13,20-22]. It is a phase of transition of concepts and non-mirroring of legal and infra-legal regulations, with a distancing from the constitutional conception of a single/organic regionalized and hierarchical network in legal norms towards a conception of thematic networks in infra-legal norms.

At this stage, two logics of territorial design and organization emerge: territorialization of the municipality into areas and micro-areas, and regional organization into thematic networks, abandoning regional territorialization into health areas or micro-regions. New planning instruments emerge at the regional level, such as the PARs for each thematic network. Thus, there are two regional designs: one of territorialization into areas for municipalities, and another for the region and macro-region in thematic networks. These are two logics of territorial organization with distinct management instruments: first, the Municipal Health Plans (PMS) linked to the Annual Budget Law (LOA), the Budget Guidelines Law (LDO), and Multi-Year Plans (PPA) in the budgetary cycle; and second, for the region/macro-region, thematic PARs aimed at enabling services at the federal level.

There is no unity in the reasoning behind the bottom-up planning of the SUS, and in practice, this complicates communication between existing planning instruments. Within each plan, there are different logics for understanding the territory, which are not yet aligned. In other words, at this stage there is a separation from what is fundamental to regionalization: the synergy between regional design and health planning, given that plans are produced from territorial design and not the other way around. The separation between regional design and health planning results in increased complexity in the way regionalization is carried out in Brazil, due to the existence of distinct logics of territorial organization, bureaucratizing the regionalization of the SUS and diverting the focus of SUS actors from the essential aspects of organizing the unified/organic network, through the strengthening of its levels of care in its respective structuring health policies (PNAB – PNAE – PNHOSP and a possible National Policy for Emergency Care – PNAU)[13,22,23].

In this logic of creating thematic networks and not organizing areas within the regional territory, the microregional territorial space present in the NOAS 2001 and 2002 was lost, in a country where more than 70% of municipalities have fewer than 20,000 inhabitants. Added to the difficulties of autonomous municipalization, this increases the difficulties faced by small municipalities in organizing themselves and joining together in health areas of a minimum scale and scope in Hospital Care (HC). The discussion shifts to the macroregional space, where thematic networks should 'be closed', without discussing the microregional level, the ascending structure in organized health areas with defined territories of health responsibility for services, both in PHC and SC and HC[9,10]. As an example, since 2012, municipalities in Paraná have been trying to reorganize themselves into health microregions, by joining 5 to 6 municipalities with fewer than 10,000 inhabitants, and provide more access and quality to users with a reorganization of Small Hospitals into Medium Hospitals, and they face numerous problems given that the 2013 PNHOSP was neither implemented nor updated, the PNAES does not address the organization of AH, and the health microregion is not included in current regulations[27].

Even within the scope of thematic networks, there is confusion between the concepts of thematic network and Care Production Lines (LPC)[28], which further hinders the discussion of the budgetary programming of thematic networks. The LPC is the user's itinerary within the healthcare network, articulating resources and practices of health services through clinical, care, and flow guidelines throughout the life cycle. It organizes health at different points of care and, therefore, the LPC will always be specific to a particular condition. In a fundamental design of a universal healthcare system, with a hierarchy of care between PHC, SC, HC, and Emergency Care, the LPCs should be thematic, such as the care production lines for maternal and child health, mental health, hypertension, diabetes, etc. The LPCs provide better healthcare because they define care flows, care protocols, and the scheduling of necessary examinations for the specific needs of the health condition being analyzed. These lines are agreed upon by managers and permeate the entire unified/organic network. The problem arises in the practice of regionalizing the SUS when the opposite occurs in this process: instead of the LPCs permeating the unified/organic network, based on their structuring policies (PNAB, PNAES, PNHOSP), it is the organic network that permeates the thematic networks. In other words, points of care for maternal and child health, points of care for mental health, and points of care for urgent and emergency care are organized without defining the points of care for outpatient and hospital care and their connection to their respective UBS.

Added to the challenges of the temporal mismatch between municipalization (1990) and regionalization in the SUS (2000), there is the temporal mismatch in the publication

of structuring policies, with seventeen years between the first PNAB of 2006 and the first PNAES of 2023 and numerous intermunicipal arrangements in the interim to respond to the demands of medium and high complexity. Not regionalizing via the single/organic network of the SUS and opting for regionalization via thematic networks is a significant cause of the fragmentation of care in the SUS.

During this period, the spaces for agreement: Regional Inter-managerial Commission (CIR), State Bipartite Inter-managerial Commission (CIB) and National Tripartite Inter-managerial Commission are strengthened by Decree No. 7,508 and Law 12,446, both of 2011, and the CGR is legally identified as CIR[13,14]. The Organizational Contract for Public Action (COAP) was created and died during this same period, and only the states of Ceará and Mato Grosso do Sul formalized the document[29].

Still, the year 2017 deserves a closer look: the revision of Complementary Law 141/2012, which should occur every five years, as cited by the law itself, did not take place in 2017 and, instead of revising it, publications began via CIT Resolution, revoking the COAP and inserting the Integrated Regional Planning (PRI), thus, the sub-legal regulations gained more space for discussion in the deliberative spaces of the SUS than the legal regulations. In this year, the new PNAB and Consolidation Ordinances were published (Consolidation Ordinance GM/MS No. 1, 2, 3, 4, 5 and 6/2017), the latter in an effort by the MS to consolidate the sub-legal regulations of the SUS.

Also in 2017, the Conasems-Cosems Network began, along with institutional support from the Councils of Municipal Health Secretariats (COSEMS) as strong arms of the National Council of Municipal Health Secretariats (CONASEMS) in regional territories throughout the country[30]. This second phase is marked by a period of defining regionalization in a regionalized and hierarchical network based on legal norms and the practical organization of the regional territory through thematic networks in sub-legal norms, where the dimension of microregions and macroregions already established in NOAS 2002[12] is lost. In the same year, CIT Resolution No. 23/2017 of August 17 initiated the discussion of Interstate Health Regions as a "regional space" that guarantees accessibility and operational sustainability[22].

The management instruments to be employed become planning tools detached from financial resources, as if the availability of financial resources were not essential for any planning that one wishes to implement. The discussion about the PPI and the Regionalization Master Plan (PDR) loses momentum, and the PARs of each thematic network become a source of regional financial resources via MS authorizations. In parallel, the regional agreement spaces are consolidated and are named CIR, CIB and CIT, according to Decree No. 7,508/2011 and Law No. 12,466/2011[13,14,21,31].

Phase of consolidation of sub-legal regulations and legal vacuum in the SUS

The third phase, beginning in 2017 and continuing to the present day, starts with CIT Resolution No. 23/2017 and expands upon CIT Resolution No. 37/2018, Resolution No. 44/2019, and Consolidation Resolution No. 01/2021, establishing guidelines and criteria for regionalization and the PRI, aiming at the organization of Thematic Networks of Health Care[28]. This phase is marked by a period in which sub-legal regulations override legal regulations, and there is an instrumentalization of regionalization; that is, there are changes not only in the concept of regionalization but also in the hierarchical normative structure, which hinders necessary revisions and guarantees of legal updates. From 2017 onwards, regionalization is conducted via sub-legal regulations through CIT resolutions and consolidated by Thematic Networks, with a return to the macro-regional territory of

NOAS/2002, but still without discussion of the micro-regional space. The PRI becomes a method for regionalization in six stages and a product to be delivered by the states to the Ministry of Health, with the process being conducted via the Program to Support the Institutional Development of the SUS (PROADI-SUS). According to the document 'Tripartite Guidelines for Integrated Regional Planning', the stages of the PRI would be:

> a) Development of the health situation analysis: Identification of health needs, Identification of installed capacity and care gaps, and Identification of access flows; b) Definition of health priorities: guidelines, objectives, goals, indicators and deadlines for execution; c) Organization of the points of care in the RAS; d) Development of the General Program of Health Actions and Services; e) Definition of the necessary investments[31(8-9)].

It is important to emphasize that the stages of the PRI have sparked important debates in the territories, but the disconnect between regional design and health planning deepens, and local health needs are rendered invisible by the need to choose a priority thematic network to be followed by the states during the stages. At this stage, the time required to organize a regional territory becomes immeasurable because, by organizing the regional territory through a priority thematic network each time, as is the guideline for a specific population, it prevents the analysis of the entire territory and the population assigned by levels of care (primary, secondary, and tertiary), and actions are significantly fragmented.

The PRI has fostered discussions on planning methodology and has been creating organized processes for analyzing the health situation and collectively constructing guidelines, objectives, goals, and health indicators, but it has made little progress because it lacks the power of bed and service authorizations from the PAR and is essentially organized by Priority Thematic Networks without clarity regarding financial programming in health, even for these specific populations already defined. The PRI is geared towards planning health macro-regions, anchored in the CIT Consolidation Resolution No. 01/2021, but it conflicts with, first, the definition of territory in the current legal norm (Complementary Law No. 141/2021) and, second, with the concept of regional planning and not macro-regional planning[22,31,32].

The PRI is born fragile because it lacks funding and does not stem from the territorialization of the health region/macro-region. It is considered a planning instrument for agreements between entities, but not a management instrument, even though it should be included in Municipal and State Plans and be part of their construction. The PARs, organized for the request for service accreditation at the federal level, are constructed according to each thematic network in a regional or macro-regional manner. The Alyne Network, the Emergency and Urgent Care Network, and the Network for People with Disabilities are organized through macro-regional action plans, and the Mental Health Network, via regional action plans. The sum of the PARs should be synthesized in the PRI and this in the State Health Plan (PES), but the PAR and PRI are not part of the management instruments of the budgetary cycle (Health Plans, Annual Health Programming – PAS and Annual Management Reports – RAG).

As mentioned above, Complementary Law No. 141/2012, the last published legal norm, should be in its 3rd revision, if reviewed every five years as the law itself states, having regionalization as a way to reduce regional inequalities, the basis of the regionalization of universal health systems[2,16]. In case of conflict between norms, the superior norm prevails and, in this case, Complementary Law No. 141/2012 is valid, even if not revised[33]. With this data, the SUS has been in a legal vacuum since the publication of Complementary Law No. 141/2012 and the lack of mirroring between legal and infra-legal norms, added to the lack of interconnection of its structuring policies.

The regional design is once again being discussed in terms of how it will compose the management instruments (PMS, PES and PNS), their respective PAS and RAG, and there is immense difficulty for state and municipal managers in associating regional design and health planning due to the displacement between the two in the last decade. There is a disconnect between planning and programming/budgeting, financing and management, with a PRI lacking financial resources and not integrated with the instruments of public administration: Multi-Year Plan, LOA, LDO.

It is, therefore, a phase of consolidating the separation between regional design and planning, with new instruments agreed upon without defined financial resources, with a strengthening of the CIT in the publication of Resolutions that does not translate into the strengthening of the legal norms of the system; with two logics of territorial organization, one municipal and the other regional/macro-regional and, therefore, two logics of regionalization: territorial areas and thematic networks; with an excess of management and planning instruments that do not produce defined health responsibility and competences for either the federated entities or the medium-complexity health services.

The definition of health areas of responsibility, as well as the competences of the federated entities and territorial competences of primary, secondary and tertiary health services, is a basic condition for the organization of a universal health system. In this phase, an inversion is observed: it is not the territory and its regional/macro-regional territorial design that is the basis of planning, but the planning instrument itself, the PRI, and its application method as the basis of planning. This inversion makes it difficult to reconcile management instruments and to effectively build health planning in a country that uses different logics for its health territories. Even though the health region and macro-region are not federated entities, the definition of health areas and the health responsibility of all levels of health, from primary to tertiary care, is essential for regionalization[1,2,34,35].

As a synthesis of these phases, there are significant changes in the construction of the territorial design and its organization since 2010. These different conceptions generate different ways of understanding the regionalization of the SUS. That is, there is a lack of conceptual alignment and mirroring between legal and infra-legal norms, with a change in the concept of territorial regionalization to thematic networks; discussion of the macro-region without discussion of the micro-region and ascending territorial design; conflict between the concepts of region in legal norms (Law No. 141/2012) and macro-region in infra-legal norms (Consolidation Resolution CIT 01/2021); creation of new management instruments such as the PARs for each thematic network with resources tied to accreditations via the MS and PRI, without provision for financing like the PDI or the Regionalization and Investment Master Plan (PDRI) of the NOAS (2001/2002). As a result, there is a fragmentation of health services, the management of the SUS by sub-legal norms, and a lack of conceptual alignment on regionalization among the federative entities.

There has been a clear distancing, over the years, from the constitutional concept of regionalization by territorialization in areas of health responsibility to regionalization by thematic networks, without the necessary discussion between ascending regional design, health planning with budgetary forecasting, and the health responsibility of the AH, as postulated by the Dawson Report, in linking Hospitals to their respective Health Centers (1920). The AH must have direct responsibility for the PHC, understanding that the concept of hierarchization is within the scope of different technological densities, the hierarchical organization of the complexity of care, and not a greater or lesser valuation between levels[1,35-40], where the health responsibility of hospitals would expand the ordering of the network and coordination of care by the PHC.

Final considerations

What is the hierarchical structure of the 1988 Constitution and what is the problem with regionalizing through thematic networks? Is the problem the thematic networks themselves; have they disorganized regionalization? The thematic networks, important for increasing the number of health services in the country, are also the result of a regionalization without sanitary responsibility on the part of hospitals, without due discussion of AE and AH in Brazil.

Understanding the concept of a network is the first challenge of regionalization at this time, because the constitution deals with a single/organic, regionalized, and hierarchical network composed of services in PHC, SC, AH, and emergency and urgent care, permeated by health surveillance and pharmaceutical assistance actions.

Like other countries with universal health systems, the regionalized and hierarchical network proposed by the Dawson Report in Brazil refers to structuring policies of the network: the National Primary Care Policy (PNAB 2006, PNAB 2011, PNAB 2017), the National Specialized Care Policy (PNAES 2023), the National Hospital Care Policy (PNHOSP 2013), and a necessary recovery of the National Emergency Care Policy (PNAU 2003), with clarity in the points of care and emergency/urgent sanitary transport and integration with the other policies. The PNAU, published by Ordinance No. 1863/2003 of September 29, was revoked by Ordinance 1600/2011 of July 7, which, according to the ordinance itself, reformulates the PNAU and establishes the Emergency Care Network in the SUS[37]. This fact aligns with the findings of the article, which points out that there has been a change in the concept of network definition since 2010, with the publication of Ordinance No. 4279/2010 of December 30. It was observed that there are significant changes in the concept, forms, and instruments of regionalization during this period.

The Dawson Report proposal did not refer to thematic care networks as its initial design, such as the Maternal and Child Network, Chronic Disease Network, Disability Network, Mental Health Network, and Emergency and Urgent Care Network, citing the main thematic networks discussed in Brazil, because this produces duplication of services and fragmentation of health care. It is noteworthy that the mismatch in the publication of policies for the unified/organic network of the SUS – with a decade's gap between the PNHOSP and the PNAE, or the publication of three PNABs for one PNAE with seventeen years between them, or even the publication of national policies without concrete implementation, financial resources, monitoring, evaluation, and revision of the policy itself, such as the 2013 PNHOSP – encourages a fragmented regionalization through thematic networks and the failure to construct health areas with the competencies of the levels of care defined and structured.

The 2013 PNHOSP does not clarify hospital typologies in Brazil and does not organize the hospital network with the necessary medium-sized hospitals; it does not promote discussion about the public-private relationship in hospital care and, mainly, it does not address health responsibility in hospital care in assigned and ascribed territories, leaving this responsibility exclusively to the PNAB. Although it should organize the network and coordinate care, the PNAB needs an integrated, planned and financed PNAE and PNHOSP, where care lines with specific programs permeate, and not via articulated Thematic Networks, because this process complicates and ties up regionalization, which is essentially simple.

The American model analyzed by Kuschnir & Chorny[35], where health responsibility does not derive from a territorial basis, but from voluntary affiliation to a market-regulated service in an attempt to organize "integrated care", makes sense based on specific care lines or a thematic network. However, this logic does not work in universal health systems, where the organization of a regionalized and

hierarchical network is the most cost-effective and, primarily, rational form of organization for expanding access and reducing inequalities. The reproduction of the American model of system organization through integrated care pathways in Brazil, without defining and interconnecting micro-level spaces (defined and forgotten in NOAS 2002) to macro-level spaces (defined in CIT Consolidation Resolution No. 01/2021), coupled with the lack of definition of territorial health responsibility with assigned and unassigned populations at all levels of care, generates more obstacles to the regionalization process than the desired production of integrated care.

By not establishing health areas that include services of PHC, AE and AH, guided by the single/organic network of the SUS and permeated by thematic care lines, it is not possible to clearly understand regional territorialization and the demand for intermediate services, such as Medium-Sized Hospitals, resulting from the union of smaller municipalities in ascending intermediate health areas/microregions that connect from the micro to the macro. In a country where more than 70% of municipalities have fewer than 20,000 inhabitants, the discussion of the health responsibility of hospitals for the construction of intermediate health areas is one of the paths to improving care and territorial reorganization of municipalization processes disconnected from regionalization. This involves balancing the autonomy of municipal entities and the regional health responsibility to be built in Brazil.

Like the COAP, the PRI has so far been finalized in only a few states and without a defined financial program. The discontinuity of legal processes demonstrates the need for a National Regionalization Policy aligned with long-term legal norms, with regional plans associated with long-term Investment Plans, based on projections of the population over 65 years of age. It is considered that the PNAB, the PNAE, the PNHOSP and a possible PNAU need to be articulated in each Health Region in a logic of ascending construction of assigned and restricted health responsibility areas for both PHC, AE and AH, systematized in territorial designs: microregion, region and macroregion of health for the ascending and intermediate construction of services.

We lack the intermediary, the filter, the unified/organic network of the SUS, the construction of health areas with sanitary responsibility for services in their respective territorial designs for all levels of care and not only for primary care, along with corresponding legislation that is revised as knowledge expands, as the Dawson Report of 1920 already warned us.

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Authorship contributions

Welz L (0009-0003-1806-6710) is responsible for the ideas, writing, organization, and revision of the text. Pereira AMM (0000-0002-2497-9861) is responsible for supporting the revision of the text, suggesting readings, and debating regionalization. Rizzotto MLF (0000-0003-3152-1362) is responsible for writing and revising the text. Mendonça FF (0000-0002-3532-5070) is responsible for writing and revising the text. ■

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