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Cross-Border between Brazil-Uruguay: Power in Health Production by Municipal Management

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ABSTRACT

Introduction: The objective of the study is to describe the power relations used by managers in health production in twin cities and how they operate to ensure health, considering the reality of cross-borderation.

Methods: This is an exploratory approach and a qualitative method, carried out on the border between Brazil and Uruguay. The participants were six municipal mayors. Data collection took place from October to November 2016.

Results: By producing health in the border territory, managers have strategies and jurisdictions to enable local and, at the same time,

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international policy, which affects the daily, somewhat restricting local governance, involving binational decisions, such as complementarity in health services. The lack of recognition of national health systems and the interdependence of the need for health production in this binational space is a challenge for municipal management.

Conclusion: Managers use political power to realize binational actions and ensure foreigners access to the Single Health System; Agreements signed outside the reality of the administration interfere with law enforcement at the border. Managers need representation in decision-making spaces at the state and national levels that order the demands arising from binational border committees, as well as enabling better local governance in health cooperation in Mercosur.

INTRODUCTION

The health policy adopted in Brazil with the implementation of the Single Health System (SUS) has focused in recent years on decentralization, municipalization and networks of regional health organizations [1]. In this sense, any current public policy is territorial and expresses the power exercised by various political actors in the production of space, whether through the exercise of power, policies, strategic programs or the printing of new uses for the territory [2]. This border space at the southern tip of Brazil stands out as the most fluid and integrated Brazilian border with another Latin American country. Also called the "living border", the border area between Brazil and Uruguay has guided the agreements of both national governments, such as the recognition of border citizens with dual identities. The twin cities between Brazil and Uruguay have urban infrastructure and services that generally serve both countries, in the most notable case of health services [3]. Even with these advances, these municipalities present problems that affect the management of the area. Health care as insufficient funding, and increased foreign assistance in their systems. Something that deserves to be discussed in local, regional and national planning so that, in this way, it presents health production in this border context of Brazil with another country and that considers the flows of people who share these territories daily [3]. Social flows and population-based migration movements currently institute the construction of new regions with cross-border characteristics, also considered processes understood as territorial differentiations associated with state relations, border crossing and micro-regionalism, with the participation of actors and powers from two or more states [3].

In exposing the degree of porosity of a border, we perceive the facilities or difficulties in the flows of goods, services and people who cross it and enable the construction of complementarities [4]. It is important to understand the border interactions of other countries at the international level, as they allow characterizing the uniqueness of the border between Brazil and Uruguay [5]. Cross-border expression is intended to cite populations that frequently cross borders. It is therefore understood by the adoption of the cross-border term that the border is characterized by an intense dynamic between space and the social interrelationships fostered therein, being represented by the political subjects who cohabit there and who constitute a cross-border society. The constant pace between the boundaries offers the cross-border an overlap of life forms, making their living environments and identities peculiar [6]. Health and production were explained in the first version of the National Health Promotion Policy (PNPS), which required co-management and cross-sectorality for the implementation of actions. The key ideas of what is meant by health production point to health because of a complex set of factors, which require the participation of all subjects involved in their production, users, social movements, health workers, managers, revealing an inherent political dimension of management and this process [7]. The managers in this health production process operate by the power that encompasses decisions and defines the actions of the municipal administration. Political power emphasizes the ability to develop a mobilization, through a vision of reality, which originated in a different way, as an experience of the situation and as feelings provoked by this experience, and a reflection on it. By bringing this concept closer to the health sector, political power intersects with technical and administrative powers in forms of knowledge with the practice of domination and empirical knowledge with hegemonic practice [8]. Managers to carry out the planning, monitoring, implementation and evaluation of the health management of these municipalities with cross-border dynamics require a variety of knowledge, such as national and international legislation, as well as binational agreements, financing in the SUS, social protection legislation. The administration in a border municipality differs from the relationship of the national intermunicipal federation and involves, in this context, the local and the international in the field of deliberation of health care for this floating population [9]. In the scientific literature, there are few studies describing the health situation of border municipalities by the perception of managers and the power they use in health production, in general interviews are conducted with other participants, binational agreements and laws blocks of historical-critical countries, the main normative aspects of the management of the Single Health System, which often do not correspond to the crazy-regional reality [10,11]. This article aims to describe the power relations used by municipal managers in the production of health in twin cities, considering the reality of local cross-references. The question that guided the study was: How does the public administration of border municipalities seek through political power health production?

RESEARCH METHODOLOGY

This research is a cut in the study carried out on the Brazil-Uruguay border, titled "Identification of indicators for monitoring and assessing the impacts of Uruguay's new policy of regulating the Cannabis market on public health and drug use in the Brazil-Uruguay border area", funded by the National Drug Secretariat of the Ministry of Justice (SENAD/MJ). In this study of exploratory approach and qualitative method, the data were collected through semi-structured interviews, conducted with six municipal mayors of twin cities between Brazil and Uruguay, being: Jaguar, Santana do Livramento, Chuí, Quaraí, Barra do Quaraí and Aceguá, which borders the municipalities of Uruguay respectively: Rio Branco, Rivera, Chuy, Artigas, Bella Unión, Aceguá. Interviews were previously scheduled, over the phone, by the team of researchers, while fieldwork took place in October and November 2016. Data analysis was performed using the content analysis method. To this end, the pre-analysis steps were followed, the phase in which the material to be analyzed is organized to make it operational, systematizing the initial ideas. Progress was made in material exploration with the definition of categories and the identification of the recording units and the unit of significance corresponds to the content segment to be considered as the base unit. The third phase concerns the treatment of results, inference and interpretation. This stage is intended to address the results. Therefore, condensation and the highlight of the information for analysis occur, culminating in inferential interpretations; it is time for intuition, thoughtful and critical analysis [12]. The theoretical reference used for analysis was based on strategic planning from which two central concepts are rescued: Power and Social Actor. For this study, political power highlights the ability to develop a mobilization, through a vision of reality that originates in a different way, as an experience of the situation and as feelings provoked by this experience and reflection on it [13]. According to the theoretical reference adopted, the Social Actor is a person, organization or group that participates in a social game, that has a political project, controls some relevant resource, has, accumulates or disarms forces during the game and, therefore, can produce facts capable of making his project viable [14]. In the reflection on decision-making as a health action strategy, the Postulate of Coherence is adopted as a basis, demonstrating that the feasibility of any proposal will depend on the relationships that can be established in each health project, where there must be coherence of three fundamental elements: the purposes of the Government; planning methods; organization [13,14]. The project was approved in accordance with office No. 13 of the Ethics Commission of the Institute of Applied Economic Research (IPEA) and the Ethics and Research Committee of the Faculty of Nursing of the Federal University of Pelotas- Brazil (UFPel), apparently: 1,757,934, CAAE 60173516.6.0000.5316. To ensure confidentiality, the names of the managers were encoded as Municipal Manager 1 (GM1), Municipal Manager 2 (GM2), etc., on the order of interview. This research noted Resolution 446/2012 on research involving humans in Brazil.

RESULTS

After the comprehensive reading of the contributing data, two categories of analysis were highlighted, which will be described below. Health production: social demand in the orientation of municipal political power; Local power and governance of the Social Actors: divergences between what has been lived and what have been stressed by the State.

Health production: Social demand in the orientation of municipal political power

By producing health in the border territory, managers have strategies and jurisdictions to enable local and, at the same time, international policy, which affects the daily, somewhat restricting local governance, which involves binational decisions, such as complementarity in health services. The measures operated by the municipal administration prioritize continuity of care and maintenance of service coverage, as indicated in the following statements. Due to the problem in the hiring of Uruguayan doctors, the municipality experienced major problems with the implementation [recruitment of Uruguayan doctors by the binational agreement]. This issue was audited through control audits, court of accounts, federal public prosecutor's office and federal police. So that contracts with these foreign doctors follow a regulation and this reassured the municipality. Here we have with Uruguay specific agreements of high level, with important experience to health. (GM2). So, just so you can see the health, as it is a problem. I attended here to a thousand people in the month, through the Single Health System. Of these, 300 are Uruguayans and government money only includes the 700 Brazilians served (GM3). Ideally if you could invest in different services, in different specialties and have greater coverage for both countries. I know that this is not easy, because the regulation of countries ends up being different, but creating a structure or conditions so that there can be a tune between health investments in both municipalities, could be a great improvement for the whole population, because we could get much greater coverage with a much smaller investment (GM4).

Local power and governance of social actors: Divergences between what has lived and what is stressed by the national state

The lack of recognition of national health systems and the interdependence of the need for health production in this binational space is a challenge for municipal management, which for decades has been working with this reality of intense flows of Brazilian and Uruguayan users between the two countries. Well, if we here are a large ethnic variable, we have many people of Uruguayan origin in our component, I think it is also a recognition of our origins. In general, people who decide on public policies in countries, both in Uruguay and Brazil, do not know the issue of the border. I believe that we, who are governors in Brazil, must have very well sized the peculiar characteristics of the municipality that we address so that we can discuss at the central level in

Brasilia these realities, which are often quite different from the national average (GM1). We have some difficulties in transferring financially and using the services. This is a debate that municipalities can do, but the regulatory system for normatizing depends on the central government of the two countries. And this normalization takes a long time due to international relations, from Brasilia to Montevideo. Therefore, there is a great difficulty for what we live in practice to be normatized, which happens most of the time is informal. (GM4). If we had, for example, the autonomy to regulate matters between the nearest municipalities (twin cities), we could establish regulations in a simpler and much more agile way (GM4). We have a big problem: Brasilia is far away, and Montevideo is also far away. They are people who make decisions about border personnel and are outside this reality (GM6). We would have to move forward, and it is still impeded by legislation, but we have already had a more active binational health committee. This health problem has been addressed for some time, with municipalities experiencing their daily needs through representative areas, such as the health secretariat, departmental health management, together with the positive agenda Uruguay and Brazil. But it is not the institutions that act for a formality; it is the people who make it possible. I think the biggest benefit is the understanding that we border residents have, while we can solve citizens' problems through actions, whether in health, or in any other area (GM5).

DISCUSSION

Difficulties in accessing, reaching and establishing the right to health of foreigners according to stakeholders reflects the low funding of the sector, which, together with the difficulties of decentralizing care processes and medical technologies, offers low coverage [15]. Moreover, the legislation is dubious in terms of universal coverage, and does not clarify whether foreign assistance is also involved, leading to divergences in the interpretation of the law [10] and the multiplicity of interpretation and implementation. Social Actors, referring to complementarity between services offered between twin cities, to increase regional performance in terms of reach and access, move towards the production of what can be called binational health regions, as reality has a inequality geographical distribution of resources and service structures, but at the same time contextualizes the challenges of operating with different health systems and legislation , which creates obstacles in cooperation between the two countries. For managers to develop health care and promotion actions, some border municipalities carry out the recruitment of Uruguayan doctors, this represents a breakthrough and was possible from the Complementary Adjustment to the Residence, Study and Work Permit Agreement for Brazilian and Uruguayan Border Nationals, for the Provision of Health Services, signed in Rio de Janeiro on November 28, 2008, approved by Legislative Decree No. 933/2009 and promulgated by Decree No. 7239/2010 [16]. These agreements allowed the border municipalities of Brazil and Uruguay to have a cross-border in professional procurement and to fully meet the repressed demand of medical professionals, expanding to other professionals such as the nursing area, allowing the formation of health teams that enabled the organization of a Primary Care Network [16-18]. Social actors in the position of public managers point out that the method of financing the system differs from their local reality of care, as it never provides for the provision of health services to foreigners, in other words, this cross-border flow is not considered in other instances of the SUS. Through the financial transfer through the Primary Care Floor, municipalities receive from sus a per capita value, depending on the resident population. This SUS transfer mechanism may be leading to a type of consideration requirement only for Brazilians and possible distortions in their redistributive role, which adversely affects the municipalization of health and the expansion of access [19,20]. In this sense, the health care offered to foreigners is established by the local political power, in this case, the social actors, are conditioned by the form of perception or a certain vision of reality, and generated with daily experience [8-13]. Therefore, when analyzing by the postulate of coherence [13-14], one perceives a world vision of these managers, who define the organization of services conditioned on history, culture, the purposes of local government, supra prioritized by other levels of health management, then, this political power of the social actor is presented as discretionary. There is the historical and cultural component that focuses on some decisions of municipal managers in the recognition of binational family ties, in Gaucha culture, which unites eating habits, clothing, labor forms of livestock rearing and agriculture, characterizing, in several municipalities, a common and fluid inhabited space between the two countries. Studies describe that there are historical relationships before MERCOSUR and that border communities exhibit varied profiles of sociocultural and economic transactions [19-21]. The political affinity of the governments of Brazil and Uruguay in recent decades has in some way defended the definition of the universal right to health and recognized the intrinsic value and equality of each human being to ensure their access to health services, without discrimination, which impacts on the treaties signed to legalize the flows of border citizens through cross-border intensification. In practical terms, this study verified that it is guided by health needs and is part of the construction of the social citizenship of this territory [22]. Social actors still claim that many treaties and agreements are carried out away from the lived reality and that in this way applicability presents delay in all aspects, either understanding the combined in federal agencies or the other bodies working in the border region to be on par with what was agreed. Bilateral agreements and pacts signed between the governments of Brazil and Uruguay have had a low impact, including in some cases the total lack of knowledge of health managers and professionals [9], so that health production is conditional on the perception of managers, agreeing in social control with their community the possibility of actions more integrated with the neighboring country, even if in some cases the assistance provided to foreigners does not have a well-deserved recognition of the health system. Municipalities participating in binational committees succeed in advancing some adjustments and agreements, agreeing to joint actions and reciprocity in health services, but it is very incipient for a border that has such population and territorial integration [23]. Therefore, what really makes health care available in border cities, in addition to the flow of users, are the social actors who recognize the most recognized social actors in this experience,

which seeks viable alternatives to complement the financial gap. There is, in fact, the need to regulate network flows with a focus on the reception, information, assistance and directing of the cross-border [24], which allows integration that considers the historical, cultural and social aspects of coexistence in twin cities. A study conducted [25] states that a viable solution for managers in these locations would be bilateral health integration agreements. These strategies concern government policies and programs, as well as the participation of health actors, especially the public health manager in the border region.

CONCLUSION

Brazilian managers, as social actors, recognize that municipalities have in their historical and territorial constitution a strong interaction with Uruguay, and their decisions come from this screen. However, they face the low recognition of the collegiate managers and other governmental areas of higher legal and administrative bodies to face, with quality, the peculiarities of these municipalities. The alternative would be to create agreements that identify innovative proposals or pilot projects that allow a shared or cooperative management model between two countries. Current agreements tend to articulate specific actions to mitigate the asymmetry of service delivery, but in everyday life managers still face challenges in operating the administration of municipalities. Municipalities need representation in decision-making spaces at the state and national levels that order the demands arising from binational border committees. Similarly, there is still a need for a closer dialogue channel with the Ministry of Health, in the search for resolution and guidance to binational executions. It urges the need for articulated political action in all three areas of government to move forward and enable better local governance in health cooperation in Mercosur.

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