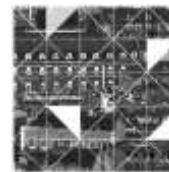


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# CIDADES, Comunidades e Territórios

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## Territoriality and Health Policy: Contributions to Research and Action

Magdalena Chiara<sup>1</sup>, Universidad Nacional de General Sarmiento, Argentina.

### Abstract

The significance of territory in health policy has been approached from different disciplinary fields without developing a conceptual body of work to register the complexity of the problems that exist at that critical juncture. This paper proposes to investigate the contribution that can be provided by a territorial approach to research and the practice of managers in primary health care, to throw light on the mutually conditioning relationship that exists in the two domains. This is a concept-based study that establishes links between the contributions from research on primary health care, the concepts provided by geography, and policy analysis. This approximation reveals two standpoints from which policies can be analysed: on the one hand the concept of care as a stage in a correlation involving differing notions of territory, and on the other, recognition of the fact that at the moment of implementation in the territory a process of institutional recreation at local level occurs where differing regulatory logic is put into play and negotiated.

**Key-words:** Territoriality, Health Policy, Primary Health Care, Interdisciplinary Research.

### Introduction

If community health workers, municipal secretaries, first-level nurses or doctors were to be asked about the problems they face in their medical practice, their replies would all be similar: territory is a central variable in primary healthcare management policy. Unequal living conditions, mobility processes, barriers to access, and the relationship between services are just some of the problems that stand out on the agenda of administrators.

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<sup>1</sup> [magda.chiara@gmail.com](mailto:magda.chiara@gmail.com).

Nevertheless, the relationship between health policy and territory is approached from very different disciplines and no conceptual corpus has been able to be formed enabling an understanding of the complexity of the practice and casting light on work carried out in healthcare research.

In this context, the purpose of this paper has been to determine the contribution that a territorial focus can provide for research and management of primary healthcare, to lend weight to the construction of a conceptual framework that throws light on the mutually conditioning relationship that exists between “territory” and “health policy.”

The work has been organised in four sections. The first section presents the methodological approach and the second one summarises the way in which territory has appeared in the guidance from the PAHO/WHO, contrasting with the matters on which the research has shed light. Based on the challenges presented by the debate between these two approaches (institutional and academic), the third section focuses on the need to conceptualise this relationship, to which end it tackles three areas of knowledge: studies on primary healthcare, geography and policy analysis. The conclusion summarises the contributions to analysis from this approach.

## **Methodology**

This study aims to provide a conceptual corpus to understand and analyze the problems that arise in the relationship between health policies and territory. To achieve this aim, it revises and problematizes categories generated in the context of different lines of research that approach the singularity present in the implementation processes of these policies in unequal territories. In such lines of research, a qualitative methodology is adopted, which consists in the generation of substantive theory based on data obtained in empirical research proposing categories, defining its properties and establishing different relations among them (Glaser y Strauss, 1967).

The path proposed in this study is the following. It starts revising the tenets elaborated by international organizations (in particular, by the Pan American Health Organization – PHO – and the World Health Organization – WHO) to guide the policies in the sector; appealing to documentary sources (official publications, recommendation documents, technical notes, meeting records and assembly declarations from both organizations). These proposals are questioned in the ways through which they problematize the territory and its actors.

The notions that result from this analysis contrast with the nature of the problems that emerge in the research; without claiming completeness, some examples of studies about ‘population health’, ‘inequalities derived from effects of service localization’ and ‘health policy analyses’ intend to show the features that the problems present in that predicament.

Given the inadequacy that the notions present in the PHO/WHO tenets to shed light on these issues may seem to have, this study questions categories generated in the context of different previous empirical research studies geared to enquire specific aspects of the relation between health policies and territory: local adaptation processes that take place in decentralization contexts (Chiara y Di Virgilio, 2005); the existence of intermunicipal gaps in primary health care (Chiara et al, 2005); health policy implementation in segregated territories (Chiara, 2012); the multiscale nature of the policies and the dynamics of intergovernmental relations (Chiara, 2016); and the organization of the health services networks in the territory. To approach the issues that emerge in the relation between health policies and territory, it is necessary to articulate different fields of knowledge since its complexity is not only determined by the specificity of the territories in which they unfold but also by the peculiarity of the policies themselves.

The first research questioned the ‘managerial’ perspective that adopted the focalized programmes during the 1990’s, embodied in the case studied by the Mother and Child Programme and Nutrition, an initiative financed by the World Bank oriented to carry forward basic health care actions intended for mothers and children in poverty. Through a case study in a municipality located in the Metropolitan area of Buenos Aires, this research analysed the adaptation processes that took place in the programme implementation and showed the ways in

which these processes were conditioned by the attributes of a local territory with the convergence of high levels of segregation and poverty and a complex and dense network of social and political actors. The study of the management processes that took place in the state organizations responsible at the local level was not enough to understand the adaptation processes that followed the implementation of this programme: it became necessary to understand the process of shaping the local agenda (in which context the implementation of the programme was intertwined) in relation to the urban, social and political characteristics of the local territory (Chiara and Di Virgilio, 2005).

The second study attempted to find out, through a survey of puerperal women, the conditions under which these women had performed their pregnancy controls at the primary health care centers and at the state hospitals. The results rendered deep gaps in access conditions and the quality of health care received among fourteen (14) municipalities in the northwest region of the Metropolitan area of Buenos Aires. Thus, the territory became a variable of the processes of health care analysis, when the mobility flows of women were reconstructed in relation to delivery (Chiara et al, 2007).

The third study investigated the organizing principles of local health policy and their consequences at the service level. It was about a comparative exercise of two local cases (municipalities located in the Metropolitan area of Buenos Aires periphery) that revealed the relative margin of autonomy that local governments have to guide the health service supply, even in the context of important restrictions. The cases analysed showed two opposing ways of conceptualizing the health issue and of addressing their problems, highlighting the strategic place of the local arena in the definition of the contents of health care: while one municipality seemed to bet to the first level strengthening and to a more general policy of improving living conditions, the other strengthened its local health system positioning itself –with an important hospital offer- as a provider of the region. This comparative analysis showed different ways of understanding the territory in health policies, of establishing their borders and appropriation mechanisms (Chiara, 2012). In the context of the same research, a study was carried out concerning the population's perceptions of their state of health and the conditions of health care (Ariovich and Jiménez, 2014).

The findings of this research allowed to explain the heterogenic organization of health policies at the local level in the Metropolitan area of Buenos Aires and, at the same time, showed the need to transcend the municipal borders in order to understand the dynamics assumed by the processes in each municipality. The evidence redirected the research questions to another territorial scale, the metropolitan area as a whole, opening up new issues such as the dynamics of intergovernmental relations that are put into play in the management processes (Chiara, 2016), the processes of developing networks and their modes of organization in the territory (Crojethovic and Ariovich, 2015).

The interest to capture this relation - in its singularity – in the context of the different research objects demanded to articulate three conceptual fields whose systematization is presented in the third section of this paper: 'public health', more precisely in primary health care; 'geography', through the conceptualizations about territory, its actors and the ways to conceive the local; and lastly, 'policy analysis' adapted to the study of the actors, processes and institutions in the health field. This theoretical approach aims to open new lines of enquiry in an increasingly relevant complex situation for the analysis of the ways inequality in access to health is constituted.

### **“Territory” in the approaches of the PAHO/WHO**

An unwary eye might conclude that territory has been absent from the guidance underlying health policy; nevertheless, reconstruction of the PAHO/WHO proposals help to qualify this assumption. Review of the last 60 years shows the various ways in which territory gradually emerged in the recommendations by these organisations. (Chiara y Ariovich, 2013)

In the middle of the last century, the fight against contagious diseases was responsible for organising health policy thinking and action. The notion of “eradication,” grounded in scientific progress such as the discovery of vaccines and DDT, encouraged action by the WHO and governments, with smallpox and malaria being identified as the illnesses to be eradicated. In this context, intervention models were forged known as “vertical programmes” which remains in effect and coexist with other ways of considering health policy (defined as “horizontal”).

Inscribed within a “top-down” logic, the “vertical programmes” model sought to resolve a health problem within a limited time by means of a strategy that included the setting of standards of care, adequate organisation of resources, and rationalization of the use of technology. These central ideas were translated into a mechanistic concept of health organisation that prioritized power from the centre and sought a geographical deployment similar to the idea of a “military control of the territory”. (Tobar et al: 2006)

The success of the fight against smallpox validated this form of intervention but had different results in the case of malaria, with a switch from the notion of “eradication” to that of “control”; the disease was considered to be a problem of a local nature that affected particular areas. The relevance of the particular attributes of each territory began to be evident, and were difficult to resolve on the basis of uniform strategies. (Tobar et al: 2006)

Contrasting with this reasoning, another concept of health policy began to be outlined that had the advantage of greater sensitivity in order to embrace these differences.

“Horizontal approximation” dominated many of the PAHO/WHO proposals as from the end of the 1970s. The Alma Ata Declaration (1978) defined and granted international recognition to the concept of “primary health care (PHC)”, a strategy based on disease prevention and promotion of health. “Territory as the space for proximity and participation” by the community was present in those definitions. (WHO, 1978)

Subsequently there were different definitions of PHC: some were synonymous with first-level care, others had a selective scope, and others were integrated within the focuses of social determinant and service networks. (Rosenblat, 2007) These differences were shaped in the context of the changes that took place in the concept of social policy and the role of the State; PHC thus acquired different contents at the same time as it maintained certain common elements related to the notion of management of “proximity”, the prioritising of the “neighbourhood” scale, and the notion of “community”. PHC persisted in the design of the different successive strategies, showing the ability to permeate the discourse in policy guidelines and the organisation of the practice of health teams.

The role favoured by the PHC was and continues to be that of the health team backed by community social organisations. The proposal for Local Health Systems (“SILOS” - 1988) broadened the proximity area of the health team, taking it to a higher scale constructed on the basis of the decentralisation process: local government gained particular relevance as a political and administrative player.

At the conclusion of the neo-liberal decade in Latin America, in 1988 the Athens Declaration by the WHO summarised an experience that had begun some decades earlier, the proposal for Healthy Municipalities and Cities, which in Latin America was given the name “Healthy Municipalities, Cities and Communities”. In this proposal, the local area acquired a dual significance: it is the territorial unit, at the same time as it is the reference population group for the design of health promotion and prevention actions.

This proposal appears to be situated at a “watershed moment” in relation to another way of considering territory, more fruitful for analysis but less powerful from a political and institutional standpoint: the “Social Health Determinants” strategy. Although its roots go back to the Lalonde report (1974), it took shape in 2008 in a document prepared by the “Commission on Social Determinants of Health”. This report argues that the poor health of the poor, the social gradient in health and marked health inequities are caused by the unequal distribution of power, income, goods and services. The report states that the unequal distribution of health-damaging experiences is not a “natural” phenomenon but is the result of a combination of poor social policies and programmes, unfair economic arrangements and bad politics. The inter-sector approach contained in this proposal threatens to dilute the responsibility of health institutions. Although inequity has the territory as its

scenario, it relates to individuals and groups: in those cases where it converges with the proposal in “Healthy Municipalities, Cities and Communities”, the latter seems to acquire greater density.

More recently, the proposal of the “Integrated Health Services Delivery Networks” (IHSDN) also proposed by the PAHO/WHO, returns to the matter of services, capitalising on contributions from the PHC approach in relation to research on care performance. In response to the “fragmentation” that had been deepened by focussed programmes and decentralisation, the setting up of networks would make it possible to integrate health services, providing users with equitable and efficient services. (PAHO/WHO, 2005; WHO, 2008)

From this review it can be seen that there has been a transformation in the place assigned to territory in the health sector, although it shows certain inadequacies when it comes to understanding the conflict derived from its history and the relationship between players in tension, dynamics through which territoriality is established.

In line with this definition of territory, the results of research bring to light processes that reveal a different complexity.

At the level of “health of the population,” some research seems to confirm (or subscribe to) the social determinant approach. Studies on social inequalities in health show the impact of urban environmental and socio-economic factors on the health situation of the population. (Barata, 2005; Mackenbach et al, 2000).

The significance of the localisation effects and the way they affect the opportunities of the population and mobility as a factor for inequality are aspects that have been repeatedly dealt with by research into “services.” In this field, the work of Katzman (1999) stands out, in which he analyses how the neighbourhood context directly or indirectly has an impact on the structures of opportunities associated with life in the city, drawing various courses or “welfare routes”. The mobility studies by Gutiérrez show that transfers and cost in time and money are factors that intensify inequity in the distribution of health services in metropolitan areas. (Gutierrez, 2009; Paganini & Rossen, 2010). One perspective introduced by these studies concerns the way in which deterioration in universal services reinforces the effects derived from both the localisation of services and the living conditions of the population in a process of mutual determination that is built in the first level interface.

The “policies” sphere is perhaps the one that requires the establishing of the greatest distance from the conceptualisations present in the guidance from the entities referred to in the previous section. The processes for the making of health policy decisions that take place for the setting of the agenda, the design of policies and programmes and their implementation engage differences, tensions and conflicts among the players deployed in the territory. The greatest contributions come from the studies on the reforms in general and decentralisation in particular, the nature of its processes and its outcomes (Almeida, 2002a & 2002b; Fleury, 2007; Ugalde & Homedes, 2008; Sojo, 2011). A significant portion of the research into health policy focuses on the study of PHC. (Almeida et al, 2006; Stolkiner et al, 2011).

These investigations reveal a complex territory as regards decisions, dealing with problems of mobility and structure on the basis of the network of players in policy implementation. In this context, reporting of this relationship is a challenge that is not only academic but also one for the management of the system.

### **An interdisciplinary approach to understand a complex relationship**

The review performed in the previous sections shows that territory has been and is present in the guidance from the PAHO/WHO, although with certain shortcomings when it comes to dealing with the complexity of the problems revealed by territorial health studies.

The analysis framework presented here is based on the contributions from research on “primary health care”, confronting them with the ways of conceiving territory contributed by the “geography”, taking studies on “public policies” for mediation purposes. It is of particular interest to propose a series of concepts capable of reporting on the decision-making processes that take place in the territory (in both design and implementation), paying

attention to the singularity faced by the health sector, and on the basis of this uniqueness, establishing “bridges” with the other areas.

### **Analysis dimensions of primary health care**

In analysing health services, Belmartino (2008) identifies three axes around which the problems of health systems are structured: the relationship between population and suppliers, the relationship between sources of finance and suppliers, and lastly, the interaction between the financing organisations and/or suppliers of medical care and the local and regional authorities. Given the purposes of the paper, focus will be placed on the first item, reviewing the dimensions organised by part of the studies on the performance of services on the basis of primary health care strategy. (Starfield et al, 2005)

Even when simplifying the various approaches provided by studies on performance, this analysis identifies six attributes as “care analysis dimensions”:

“Accessibility”: Those institutional factors with an impact on access by the population to health services, including the administrative procedures required in order to be attended to.

“Continuity”: Whether a health team exists that the patient sees on a regular basis, so that a relationship can be built.

“Longitudinality”: Scope of the services, whether preventive, diagnostic, treatment or for rehabilitation; implies a more timely and appropriate identification of problems.

“Comprehensiveness”: Whether the organisation of health responses is in accordance with the needs of patients, their family and the community.

“Capacity to resolve”: Determines the proportion of health problems that can be dealt with by the health team or by means of referrals.

“Coordination”: The capacity of health services to concurrently meet a common welfare objective for patients, without creating imbalances that end up harming them, all independently from the place where patients are being attended to.

These are attributes that were originally designed to standardise a model (PHC) that is adopted in this proposal as “pertinent dimensions for description and analysis” of the health care and its relation to the territory. These dimensions were operationalised in the study about the population’s perceptions about the access to primary health care, which allowed the reconstruction of different patterns in the use of health services and the analysis of the territorial offer (Ariovich and Jiménez, 2014).

In line with Belmartino, nine functions of primary care can be identified regardless of whoever takes responsibility for them and at what system level they are provided. These functions are: (a) to be the first point of contact by the patient with professional care; (b) responsibility for clarifying demand; (c) providing information, comfort and advice; (d) performing diagnosis procedures; (e) applying treatment; (f) involving other disciplines; (g) taking responsibility for coordination when other professionals are involved so as to ensure continuity ; (h) ensuring prevention based on knowledge of patients and their living conditions; and (i) recording the information on clinical records to ensure coordination and continuity for the care provided.

As can be seen, almost all the mentioned care attributes (“accessibility” “continuity”, “longitudinality”; “comprehensiveness”, “capacity to resolve” and “coordination”) are evident in these functions, regardless of “who” performs them or what “level of care” takes responsibility for them.

Literature on primary health care stresses two matters of particular relevance in analysis of the tensions that exist in the territory: the first relates to the “concept of working within a network” and the second to the “role of the general practitioner.”

The proposal for “Integrated Health Services Delivery Networks” is the most organic expression of the former. The setting up of networks is one of the strategies for effective implementation of a significant portion of the attributes characterising primary health care as a model: “longitudinality”, “capacity to resolve” and “welfare coordination” are care attributes that require the forming of networks in the territory.

Regarding the second matter, the general practitioner (together with the various members of the “health team”) plays a coordinating role in relation to the mentioned functions, being involved in both “bottom-up” relationships in hospital care, “laterally” with the emergency services, nursing and social services, or “top-down” in the case of school or workplace services. (Ariovich & Jiménez, 2014)

Over and above the emphasis placed on the figure of the medical professional (who appears as the sole protagonist in these multiple roles), “nodality” is a care attribute that does not appear to be determined exclusively by matters related to the field of medical science, but to the location where this takes place.

### **About the conceptualization of territory**

The second point of the analysis framework being proposed here concerns territorial studies and in particular the contributions from geography.

The ways of conceptualising the notion of territory in this field have steadily abandoned spatial approaches, moving towards concepts that reflect its historic character. Nevertheless, the mere invitation to denaturalise the given spatial nature of the territory does not seem sufficient to make it operational as a (territorial) dimension in the analysis of health policy.

From a perspective that highlights the historic, dynamic nature that is determinant and determined by the actions of the players, “territoriality (can be understood)... as the dynamic relationship between the social components (economy, culture, institutions, branches of government) and such material and immaterial elements that correspond to the territory where people inhabit, live and work” (Dematteis, Governa, 2005: 33). This perspective emphasises the intertwined processes that exist between players, social structure and territory at the heart of which lies the field of health policy.

With that definition of territorial, two analytical lines can be determined from these contributions: the way local elements are conceived of and the relational perspective of the territory.

Firstly, it is proposed to return to those proposals that view “that which is local as juxtaposed heterogeneity”, an expression of different scales and interests, “micro-worlds” trapped in space, the conflicts of which must be managed. Amin (2005) challenges the conventional perspective on regions that defines that which is local as the opposite of that which is global, conferring on these poles attributes that in the words of the author are in the nature of “caricatures.”

“...local (is) (...) perceived and the space of that which is intimate, familiar, close, incarnate; that is to say, as a space that is essential, separate and distinct from the global space, conceived as a place that is distant, abstract, virtual, invasive, hegemonic.” (In that debate he argues that) “... spatial configurations and limits are no longer necessarily territorial or scalar, as the social, economic, political and cultural interior and exterior are formed by means of topologies of networks of players who are becoming increasingly dynamic and diverse in their spatial configuration” (Amin, 2005: 77-78).

This perspective leads to the questioning of a view of local based on the idea of “common territorial environments or a cohesive territorial culture,” constructing, in the words of the author, “caricatures that are presented with a certain degree of veracity in relation to the public sphere” (Amin, 2005: 85).

It is of interest to return to his contributions to look at what is local, the scope of decentralisation and the closest territory of reference for health policy, as “heterogeneity juxtaposed within a narrow spatial proximity and as places of multiple geographies of affiliation, connection and flow” (Amin, 2005: 86). From this perspective, the field of local policy could be considered as a field of claims, agreements and coalitions (fragile and temporary) that are the result of changing and interconnected dynamics.

Based on these approximations, the very concept of “community” – so dear to the PHC approach – is placed in doubt. In this regard, Dematteis and Governa underline “the difficulty in talking of community, and at the same time, the urgency of the problems that (...) are concealed within this word and that are blurred in the ‘traces’ of trust, reciprocity and identity” (Dematteis, Governa, 2005: 36-7). That communitaristic perspective of local leads to a naturalised view of territory, that the authors themselves describe as “a territory without players.”

Unlike the more classical formulations on the way territory has been defined in the PHC proposal, these contributions question the naive view of local as that which is intimate or familiar, and call for untangling of the complexities included in the delimitation of a given grammatical area.

The second line of analysis to be extracted from this approach relates to the “relational perspective of territory” approximation that proposes interpretation of social phenomena and demands by making a distinction between “territories of proximity” and “territories of connectivity”.

In the analysis of processes of configuration of territory, Catenazzi et al differentiate between a contiguous area (associated with the topographic metric) or a network (to the topographic metric); which corresponds – in the analysis of the players – with different logics of appropriation and accumulation:

“For those who argue in favour of a very strong link between territory and appropriation, territory is a single entity, strictly defined and limited by the control exercised over the space. On the contrary, if the spatial configuration that is adopted depends on the resources mobilised and different control modalities (material and symbolic), territory could be both a contiguous area or archipelagos or a cross-linked area”. (Catenazzi, Da Representacao, 2009: 122).

Similarly, Dematteis and Governa distinguish between the territoriality that is expressed in the form of an inclusive strategy that relates to local and control aspects, and a second meaning in which territoriality refers to the group of relationships that a society maintains in relation to the exterior and the remaining agents with the aid of mediators (Dematteis, Governa, 2005: 44).

Along the same lines, the idea of “connectivity territory” indicates not only the imprecise nature of the borders but also of the notion of “fractal” space used by Amin to characterise local, the multiplicity of connections, meanings and influences that take place within the territory, so that “inside and outside” are no longer defined locally. Returning to the words of this author, in the local arena “the different micro-worlds are trapped in the same plane, and the pressures and different interests must be managed and negotiated actively because there is no other plane” (Amin, 2005: 87).

In the field of health, this observation acquires even greater relevance as both the “inside” and the “outside” can be present simultaneously in medical care, which even when located in a peripheral neighbourhood, requires consultation with specialists, specialised diagnostic studies, and links with international scientific communities.

The studies carried out in the Metropolitan area of Buenos Aires showed the need to appeal to two notions of territory: on the one hand, the ‘territory of proximity’ that delimits its borders to the neighborhood or to the municipality jurisdiction (according to the scale of the problems under study) and which is the object of appropriation on the part of political and social actors; and, on the other, the ‘territory of connectivity’ which does not recognize accurate borders, but constitutes itself through multiple relations among nodes of the health



service network and depends on both material and symbolic resources that the actors in the health sector are in a position to mobilize in order to maintain their control.

Summing up, territorial studies are called upon to play a leading role in the denaturalisation of territory. The notion of local as “juxtaposed heterogeneity” that articulates scales and represents different micro-worlds trapped in a given space, enables a return to the “territory of proximity” reflecting its complexity, and in turn the conflict, later faced (in their management) by the health teams.

### **Public policies as a “bridge” between healthcare and territory**

In the approach proposed (in this work), the analysis of public policies acquires a mediating role between the contributions of primary health care and territorial studies.

The processes as from which this mediation is built enable identification of three matters around which the contributions are organised: the constructed character of territory in health; the interfaces that fit together in inter-government relations, and lastly, tensions with the sectoral logic.

The first matter shows that there is no predefined territory for public policy as it is subject to appropriation or construction by its agents.

In the field of health policy, this perspective invites inspection not only of how structural phenomena place in evidence the centrality of the territorial dimension, but also its opposite, that is to say, the capacity of health policy to “construct territoriality.” In this regard, the installation of health infrastructure produces “territoriality” in so far as it incorporates a greater stock of services for a given population, at the same time as it mobilises the development of other activities (transport, services, new infrastructure).

Without disregarding the material impact of these investments, note should be made of the relevance of the “intangibles” of health policy, which go beyond physical or human resources. Questions in relation to access (such as the gratuitous condition, for example) or the coordination mechanisms, define uses, condition the population’s mobility processes and mark boundaries. Through the action of public policies, they configure – in their different ways – an “outside” and an “inside” of the territory.

In a similar manner, a retrospective review of the decentralisation processes in Latin America (Jordana, 2001; Gomá, Jordana, 2004) shows that the transfer of functions to sub-national levels gave rise to very unequal services. Those processes drew a very diverse map as regards conditions for access, use of services and the coordination mechanisms that link them, differences leading to different “care models” through which citizens exercise their right to health.

The second matter dealt with by the contributions of policy studies concerns the interfaces that exist in inter-governmental relations. This is a complex area defined by the institutional framework as well as by the dynamic of relations between players in policy start-up and implementation (Jordana, 2001; Banting et al, 2002).

The dynamic established by players in the development of policies places in evidence decisions and justification systems that mobilise different concepts of territory, being able to establish non-linear differences between levels of government. On the one hand, the existence of an appropriation logic on a “contiguous area” referred to by Catenazzi et al (2009: 122) (associated with a topographic metric) involving in particular local players with an implicit interest in developing the four levels of complexity in care within the same jurisdiction. On the other, the concept of “territories in a network (associated with a topographic metric) that are open systems but that require the construction of inter-government articulations based on complex processes of coordination in their organisation, operating and financing aspects.

Last, one matter of great importance to be investigated in the relationship between health policy and territory deals with the singularity of the sectoral aspect and its differences with other logics such as the “territorial” logic.

According to Jolly, “sectoral logic” is characterised by three attributes that distinguish it from others that organise public policies: it is governed by the principle of specialisation; its intra and inter organisation dynamic is dominated by the legitimacy conferred on it by the legality of the regulations; and lastly, scientific and technical knowledge is of great significance in the justification systems. (Jolly, 2005) These attributes, strongly evident in health care (but which are also present in other fields of social policy) are reinforced by another that characterises as a sector, the fact that the image of medical professionals is the principal reference framework for the action of the policies.

“Territorial logic” puts pressure on that sectoral logic, revealing the horizontality of relations between the players and placing “in black and white” the integral nature of its demands.

Assuming this tension in the analysis of health policy implies consideration of the modes combining the dual role of the government: that of “governing agent” imposed by regulations and dominated by that sectoral logic, and that of “governing player” driven by the complexity of social and political demands expressed in the territory. (Jolly, 2005) The coexistence in tension of these two logics in the processes for the implementation of health policies, the “sectoral” (characterised by verticality, regulations and the partiality of the specialisation) and the “territorial” (horizontal, political, holistic, concerned with cohesions) require the analyst to consider the “hybrid forms of regulation” in which government and governance combine in the territory.

### **Conclusions: Core aspects for research “about” and action “in” the territory**

The approach being proposed here focuses on studies on primary health care, and taking distance from a regulatory approach, it seeks to build an approach from which to analyse and understand what is taking place in the territory with health policies.

The contributions by this paper to the discussion reveal at least two core aspects to be considered in the analysis and design of health policies in the territory.

First, that health care constitutes a “point” in a network of relationships that simultaneously involves two notions of territory, “proximity” and “connectivity”. This approximation enables interpretation of the dimensions of the performance (accessibility, continuity, longitudinality, comprehensiveness and coordination) on the basis of these different concepts of territory; far from being an isolated phenomenon, care practice appears to be linked – in an initial instance – with the notion of “territory of proximity” to the health centre, “access” to the system, space for realisation of “comprehensiveness” and “longitudinality.”

Notwithstanding the strong presence of the “territory of proximity” in primary health care, another version of this concept can be seen to be addressed – simultaneously – in the practice of the health team in so far as medical care requires a fluid relationship with other levels (for the performing of specialised diagnosis, referrals to specialists or for more complex interventions). As a result, “coordination” (another dimension of the development of health care) addresses the “territory of connectivity” or “territory of the network”. Consequently, in health teams practice, different notions of territory are mobilised.

This multi-scale approach to care leads to a second core aspect that lies in more classic problems of policy studies: at the moment of implementation in the territory a process takes place for the recreation of institutions at the local level, what Bifulco has called “quasi institutions” (Bifulco, 2005: 31). This concept recognises that legitimacy in implementation is not deposited exclusively in the institutions organised under “sectoral logic” (Ministry of Health, Secretariat of Health, Hospital, Health Centre Director), as there are interactions of a contractual nature that take place in these processes with political players (community leaders, councillors, secretaries, lawmakers, governors) who make up a considerably more complex network. As a result, in implementation two different logics for regulation are brought into play: the “sectoral” (vertical, regulatory and governed by the legitimacy conferred by scientific evidence) and the logic of “territorial” regulation (holistic and impregnated by the views and interests of the players).

The core aspects that this perspective illuminates indicate the existence of folds, cracks and tensions that do not tend to be visible in the more classic approaches to health policy, although their understanding would appear to be essential, by means of research to understand their dynamic, and from management, to see from where to convey change.

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