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Process, Performance and Political Legitimacy in Public Policy

Title of the paper

*Measuring the concept of policy legitimacy: The
coefficient of legitimacy framework*

Author(s)

Fabiana C. Saddi, Federal University of Goiás (UFG), Brazil,

fasaddi@usp.br

Matthew J. Harris, Imperial College London, UK,

m.harris@imperial.ac.uk

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ABSTRACT:

This paper presents the ‘coefficients of legitimacy framework’ to assess the politics of public policies in distinct socio-political contexts. It explores the relationships existent between two macro and interpretatively constructed variables: ‘modalities of representativeness’ in policymaking and ‘levels of identification’ in implementation (frontline actors). It develops *a comprehensive type of measurement and comparison*, in which comprehensiveness requires a greater understanding. It will enable the production of evidences on how it would have been possible to promote higher levels of political reciprocity in public policy.

KEYWORDS:

Policy Legitimacy, Public Policy, Identification, Policymaking, Implementation, Policy Analysis

1. INTRODUCTION

The occurrence of two parallel processes, economic globalisation and democracy/democratic transition, present similar and politically significant regularities with respect to the politics of public health policies which are: the more progressive adoption of extreme forms of rationalization (non-contextualised ideas and forms of measurements) in policymaking decisions and the increasing importance attributed to frontline (local) actors and their relationships in the delivery of primary health care in particular. For expressing contradictory dynamics and the possibility of moving in opposite directions, both regularities bring the issue of ‘responsiveness’ (and relationships) to the heart of political concerns related to public policies, and to primary health care policies in particular (Meads and Ashcroft 2000; Hunter and Killoran 2004,

Peckham 2004, Saddi 2014). They also pose a first order question: How responsive has the politics of ideas/knowledge and interests of policymaking have been in middle income countries and in Brazil in particular?

This context highlights that politics (as a political practice aimed at promoting responsiveness between the rulers and the ruled) has not yet been comprehensively brought into the analyses of comparative policy processes. In the field of health policy and system research, and especially when related to low and middle income countries, this fact happens to be more politically significant: given the predominance of implementation research and still existent gap in policy process analyses that would focuses on the origin and development of policies, as well as on the relations existent between policymaking and implementation (Ghaffar; Gilson; Tomson et al. 2016). These facts suggest that aspects of political representation and legitimacy, that traditionally comes from the fields of Political Science and Sociology, could be regarded as analytical and/or comparative variables in the assessment of public services (Weber 1994; Coicaud 2002; Whitehead 2002 and 2004, Saddi 204 and 2014).

This paper presents the ‘coefficients of legitimacy framework’ to assess the politics of public policies in distinct socio-political contexts. It explores the relationships existent between two macro and interpretatively constructed variables: ‘modalities of representativeness’ in policymaking and ‘levels of identification’ in implementation (frontline actors). It develops *a new comprehensive type of measurement and comparison*, in which comprehensiveness requires a greater understanding. The framework is currently being developed in the analyses of health policy, and of primary health care policy more specifically. A pilot project is currently been carried on in the city of Goiania in Brazil, to be afterwards extended to other cities.

In Brazil, similar to other low and middle income countries, primary health care policies have played a more central role in the federal government agenda in the last decades, being re-formulated at every new term of the national government. Despite the emergence of some few policy process analyses, researches and evaluations have been focused on and privileged the implementation processes mainly, and therefore remains a lack of knowledge regarding the policy process, and more specifically concerning the establishment of correlations between policymaking and implementation.

1. THE PROBLEM OF SEPARATION IN PUBLIC POLICY

(POLICYMAKING-IMPLEMENTATION GAP): AS A POLITICAL AND ANALYTICAL PROBLEM

It was in 1998, in the context of a double political transition, with the adoption of economic stabilization and fiscal adjustment strategies during a period of redemocratization, that the Family Health Strategy (FHS) was implemented at the national level., So far it represents the main primary health care program (PHC) in the country (Escorel et there, 2007). The FHS consisted and still consists of a political strategy to accelerate the population's access to and inclusion in the Universal Health Care System (known as SUS). More recently two other Programs linked to the FHS have been adopted so as to improve and strengthen the adoption of the FHS in the country - the More Doctors for Brazil Program (MDP), and the National Program for Access and Quality Improvement in Basic Health Care (PMAQ-AB). Given the political credibility of the FHS, because of the high level of political commitment to the program already being implemented in several municipalities, the FHS continues to be used by the federal government in order to legitimize its power. (Silva, 2001) (Capistrano Filho, 1999) (Goulart, 2002) (Saddi 2004; 2014).

As emphasized by Macinko and Harris (2015):

“Brazil has made rapid progress toward universal coverage of its population through its national health system, the Sistema Único de Saúde (SUS)”
.... *“The pace of FHS scale-up has been remarkable: from about 2000 teams including 60,000 community health agents providing services to 7 million people (4% of the Brazilian population) in 1998 to 39,000 teams incorporating more than 265,000 community health agents, plus 30,000 oral health teams, together serving 120 million people (62% of the population) in 2014”* (Macinko and Harris, 2015).

However, in broad terms, this policy still faces certain challenges or barriers, such as the need to increase organizational capacity and closer relationships with policymaking and implementation actors, beyond the need to overcome a lack of coordination of care with more specialized levels and a deficit of professionals in the FHS multi-professional teams (Macinko and Harris, 2015) (Saddi, Harris and Pego, 2015).

This means that from the point of view of politics and its relation to the policy process, public policy - and primary health care in Brazil in particular - can be studied as a process of political responses and responsiveness, in which policies – that have been revised and legalized in distinct phases of the government – still need to be improved and made more responsive, not only in matters of efficiency and efficacy, but also in terms of relationships and legitimacy.

These facts, amongst others, similar to other policies adopted in other developing countries, have made decision-makers and international and national public policy experts begin to take politics into account in their assessments and analysis, leading to an increase in the number of political type¹ analyses concerning the health sector since

¹ Of course, the understanding of the meaning of the term "politics" varies widely in the literature. In the analyses of the World Bank, for example, as shown by the various figures of the World Development Report from the beginning 1990s, politics is still today mainly understood in the light of the new economic institutionalism; as rules that would allow the creation of stable and reliable institutions, accountability

the mid 1990s. Since then national political relations tend to be treated either 1) as an obstacle to market development (World Bank , 2003 and 2004) ; or 2) as a socio-political and cultural problematic related to developing countries, or still further 3) as problematic concerns regarding the political relations and / or micro professional and / or everyday life process in these societies².

It was during the construction of the SUS from the 90s therefore, during a period of economic stabilization, that a disconnection in decision-making and implementation processes can be observed. Parallel to this more evident disconnection between decision and implementation, we also perceive a process of specialization in the analyses and formulations of policy with the adoption of concepts coming from new public management theory. Concepts such as efficiency, performance (performance), and effectiveness have become more politically decisive, sometimes even being antagonistic to the principles and basic guidelines of SUS (universalization , decentralization, and completeness of medical care), as extensively highlighted by national literature on Public Health in particular³.

capacity (accountability) and transparency, right of democratic governance, and the provision of public goods. At present the issue of the implementation gap is shown as a central concern in various international institutions, and is part of the agenda of research institutes as a relevant policy theme (Harry et al. , 2013) (Foresti et there 2013) .

2 We refer to two types of analysis that stand in the public policy literature: 1) analysis of new economic institutionalism and 2) the sociological analysis that criticizes the use of non-contextualised analytical tools/concepts, which have been based on principles and arguments coming from Economics in order to understanding diverse and complex societies. Regarding the sociological critique, we refer to the works of authors such as Peter Evans or work that focuses on an analysis of daily life or local political relations , using the concepts of the so called new sociologies of social construction , represented by Pierre Bourdieu and Bruno Latour amongst others . See HIRSCH , Paul , MICHAELS , Stuart & FRIEDMAN , Ray (1994) "Clean models vs. dirty hands : why economics is different from sociology " .

3 While considerations of " public administration " were somehow present in the Brazilian reform (given that the proposal SUS emerged as critical to the hospital-centered and corrupt model INAMPS), it was mainly in the 90s that issues such as efficiency and performance occupied a prominent place in public policy analysis .

In the 90s, the decision-making process became less politicized and more technical (Seclen, 2003), given the political prominence acquired by economic stabilization, and the fact that the focus turned to the implementation process itself. The so-called period of institution of the SUS, during Sarney's years – at the beginning of redemocratization -, gave way to stages of constitutional regulation and implementation of SUS (Levcovitz, Lima and Machado, 2001) (Levcovitz et al., 2003) (Bueno and Mehy, 1997) (Iriart, Merhy and Waitzkin, 2000). In recent years, there have been few studies that begin to analyze the decision-making process during the period. Among them, we highlight the analysis of Gilson Carvalho on the conflict process related to health care financing. Therefore the so-called period of institution building has given way to the stages of constitutional regulation and implementation of the SUS (Levcovitz, Lima and Machado, 2001) (Levcovitz et al., 2003) (Bueno and Mehy, 1997) (Iriart, Merhy and Waitzkin, 2000)

At the same time, the analyses of implementation focusing on local authorities become privileged by numerous researchers in the health sector. In many states and cities, there are numerous analyses of the SUS implementation process as a whole. In different ways, these studies use concepts such as efficiency, performance, and social participation, as criteria for the assessment of the challenges posed in the realization of public policy at the state and municipal levels.

With regard to studies into the implementation of primary health care (PHC) processes, in most cases, they have sought to determine what the advances and limitations in the reorganization of management, labor, and services related to PHC were. One of the main concerns of these assessments is to see if / how the coordination of primary care with more specialized levels of care took place, and if / how the formation of an integrated health care service network was observed in the cities (regarding mechanisms of reference

and counter-reference). These studies also privileged the analysis of certain actors linked to implementation. Public opinion type research and surveys conducted with managers, health professionals, and family health teams, have produced assessments that allow us to understand what the difficulties of adopting public policies at the local level are (Escorel et there., 2007) (Almeida et ali., 2008) (Philibert et ali., 2009) (Camargo Jr et ali., 2008) (Stralen, 2008).

Therefore, as pointed out in the literature, since the 90s there has been a decrease of policy analysis focused on decision making *vis-à-vis* the considerable increase in the number of works focusing on implementation (Levcovitz et al, 2003), or *vis-a-vis* the decrease of analyses that seek to highlight the connections between the macro and micro level, between decision and implementation. Amelia Cohn (1992) was possibly the first among the authors who today assert the need to establish new connections between the macro and the micro levels as well as the need to employ a theoretical framework consistent with the specificities of the country in order to produce new knowledge regarding the challenges faced in practice in Brazilian public health.

This perception, however, is not unanimous in public health, or rather in the field of Collective Health in Brazil. Authors who have specialized in the implementation analysis of PHC in small and medium-sized cities tend to be skeptical about the decisions taken in macro policy, neglecting them in their analysis. This is due to the perception that new regulations cannot express the extent of the change that occurred in the implementation of the new family-centered and community-based programs, and that they therefore do not recognize the development of new medical practices and types of relationships / involvement (humanizing policies) conducted in daily life in the society/communities (Bodstein, 2002), (Pine & Mattos, 2001) (Pine and Mattos, 2002). The fact is that the more authors engage in analysing cases of successful implementation

of new health care practices in PHC, especially by municipalities of medium and small size, the greater their disenchantment regarding the standard of macro policymaking.

Regarding evaluations made so far, focusing on recent programs adopted within the FHS, such as the More Doctors for Brazil Program (MDP) and the National Program for Access and Quality Improvement in Basic Health Care (PMAQ-AB), they also favor the evaluation or analyses of implementation, rather than undertaking an analysis of policy process in which policymaking and its relation to implementation is taken into account.

Minding politically significant gaps: politics and public policy analyses/research

In this contradictory context of democratization with economic liberalization, the process of implementation of SUS in Brazil brings up one of the greatest problems of today's public policy: as regards the separation between decision-making and implementation, or even the distance that exists between macro (formulation) and micro (re-definition / management and implementation) processes of policy. From the literature, we perceive that this gap is due to policymaking and implementation processes being affected by difficulties and tensions (of principles and interests) in conflict with decisions taken at the macro level. However we still know little about how political actors who hold positions of power in the different state institutions have participated in the process (decision and implementation) of public health care policy, responding to the challenges coming from the decision making process and implementation. We also know little about the extent to which local actors have identified or not with public policy values and guidelines in the implementation process, taking them on in different ways. We know even less about the effects that different political interactions (between decision-making

and implementation, between the macro and micro levels of policy) have on the dynamics of public policy processes.

As regards the political aspects, it should be noted that the problem of separation in public policy shows that public policy (as a political practice that aims to promote reciprocity between rulers and ruled) has not been incorporated in a comprehensive political form in the analyses and comparisons of public health care policy processes. It also suggests that aspects of political representation and legitimacy could be used as political variables for the evaluation of public services, particularly with regard to basic health care.

In this research the question of separation in public policy will be treated not only as a means of analyzing the decision-making process, or as a means of evaluating effectiveness or efficiency in implementation, not even merely to point out the difficulties and possibilities at the local level. In this work the question of separation in public policy will be treated primarily as an issue of political reciprocity from the perspective of macro authority in relation to the micro sphere of implementation, and more specifically as a legitimization issue of public policy.

From an analytical point of view, this issue of political reciprocity exists due to difficulties in establishing links between macro and micro processes and their actors. This fact shows the existence of two analytical challenges for researchers in order to make it possible to establish relationships between both levels (decision and implementation) and their actors. 1) The first challenge would be to go beyond the adoption of specialized concepts such as efficiency, performance, or even specific health sector concepts (arising from health economics and / or public health only), seeking to reconcile them with broader political and social concepts. 2) The second challenge would entail the use of a more sensitive type of analysis, inserting these concepts in a methodological framework

that aims to establish connections between the macro and micro levels (decision and implementation), as well as in the development of a form of interactive research between actors and researchers (coming from the practice, policy, and research realms).

As has already been widely emphasized by the international literature (Duncan 2005) (Meads et al., 1999), as well as funding agencies for research in England (ESRC Public Services Programme, 2004) (Duncan, 2005) (Hood & Bevan, 2005) in particular, the "collaboration between decision, practice (implementation), and research is imperative to obtain more solid evidence in public policy analysis, and health policy in particular" (Jansen et al., 2010). It is recommended, therefore, that research projects need to go beyond the adoption of a method in which the concepts and research agenda are fully pre-defined and closed in the project, where actors are analysed from a top-down academic perspective, without the interaction of respondents in the design of questionnaires, and in the review of the main concepts used throughout the research process.

This dual analytical challenge, beyond that of the political problem of reciprocity, with both of them being derived from the problem of separation in public policy, shall be included in this research. The problem of legitimacy in public policy, legalized and claimed as legitimate by the authorities, but hardly recognized and realized during implementation, will be related to the problem of identity: to the fact that the "new" will be constructed not only by new actors and institutions, but also by "old" actors and institutions that hold a cultural-historical and political identity and are therefore still identified with old concepts and values/interests dominant in the field. This problem will be investigated when we look at what terms which the values and guidelines claimed to be public in the decision-making process (macro-micro), have been accepted and carried

out in the micro policy sphere (political, administrative, and social sub-spheres), and thus recognized as legitimate in the implementation process.

2. THE FRAMEWORK: THREE MAIN INTER-RELATED STRATEGIES AND METHODOLOGICAL REMARKS

The research will entail an interactive process between interpretation and experience, in which the involvement of policymakers and micro frontline actors will be considered essential (Whitehead 2002; Fisher 2006). This interactive process will lead to re-interpretations and revisions of the main concepts and hypotheses. We will conduct interviews with national and local politicians and policymakers (authorities) and undertake surveys of three types of frontline actors in the city/cities selected. We will also analyse secondary sources including official documents and reports, research studies, and grey literature. Both subjective (to be collected and interpreted) and objective data will be taken into account in the analyses of the tensions that comprise the main variables. One type of data will be used to test the reliability of the other.

Experiences reveal that political commitment, effective management, professional accountability, and society participation (empowerment)/or patient involvement constitute pre-requisites for narrowing the *contested space* (Hill and Hupe 2000; World Bank 2003 and 2004; Hudson and Lowe 2004; Hunt and Killoran 2004; UN Millennium Project 2005; Wallerstein 2006). Those pre-requisites will be applied to different types of actors: national and local authorities – in policymaking -, local managers, health professionals and users/patient – in the front line.

Moreover, the implementation science and delivery research field considers that analyses focused on barriers/facilitators to implementation are prone to reveal the main tensions and possibilities involved in the accomplishment of those pre-requisites.

Therefore the analytical lens of “Barriers and facilitators” is considered an important instrument to examine motives/causes of distinct and specific achievement of results in public policy (Hunter and Killoran, 2004) (WHO, 2012) (DECOSTER, APPELMANS and HILL, 2013). Our assumption is that those pre-requisites will be increased whenever the main barriers to implementation have been responsively and/or interactively tackled/considered by policymakers.

In the pilot project, we will focus on one period of government at both the national and municipal levels. The research will be pursued firstly as a pilot project in the city of Goiania, and afterwards in other regional cities in family health units located in areas of different levels of inequality. We have selected the city of Goiania as it may constitute and awkward regional cases in terms of the possibility of narrowing the policy-making-implementation gap in the delivery of the FHS and its new primary care policies in the country.

The Family Health Strategy in Brazil - The case of Goiania (pilot research)⁴

The Family Health Strategy (FHS) consists the main PHC country program in Brazil. As already mentioned, recent initiatives, such as PMM and PMQA-AB, have been adopted in order to improve the implementation of the FHS.

With Lula's government, it is necessary to emphasize that it was the first time that representatives of the sanitation movement occupied the department head of the Ministry for Health. Since 1974 they were introduced into various secretaries of the public administration and in the national congress. They had already occupied many times

⁴ Funded by the Brazilian CAPES/Ministry of Education. Linked to the PNPD National Post-doctoral Research Fellowship of the principal investigator.

leadership positions of state and municipal secretaries, but they still did not have a representative in command of the ministry and of its secretaries, simultaneously. Despite the discussions of reform/renovation for Basic health, it is during the Dilma government that its definitive formation can be seen, being published in the National Policy for Basic Care (PNAB) in 2012. The expectation of Social Medicine and/or Public Health in Brazil, beyond the expectation of the society in general in relation to the Rousseff's government, was that the new team creates a mechanism for the management and implementation of the PNAB, allowing in this manner the realization of Brazilian principals of the SUS.

The FHS was derived from the family health program (FHP), conceived by the Brazilian sanitation movement in the 1970's, and especially, by the "sanitarists" affiliated with the communist party, such as Capistrano de Abreu and Nelson Rodriguez dos Santos, and was already in an experimental phase in some Brazilian municipalities in the 1970's and 1980's. The great example of success of the FHP, originally implemented (1991-94) in some cities of the state of Ceara and in the city of Niteroi, and following (1996) in Sao Paulo⁴ with the project Qualis/FHP (Capistrano, 1999), is attributed to the fact of infant mortality having been reduced by half, as well for its having led to a considerable drop off of the number of hospitalizations (Capistrano, 1999). It is an internationally recognized project, just like the HIV-AIDS program, and recognized globally as a model to be followed for APS.

However, the PSF was implemented at a national level only starting from 1998, in a scenario of economic stabilization and financial management, as a policy strategy to accelerate the process of inclusion of the SUS, and the improvement of health indicators. It was the main policy strategy of the minister Jose Serra, official candidate of Fernando Henrique Cardoso for the presidential succession. In Brazil, we had an atypical

neoliberalism in health, with the constant increase of spending in the sector (Gouveia and Palma, 1999).

As stressed by Rassi Neto (2008) the health municipalization in Goiania happened in a later stage, in comparison to other capital/cities in Brazil, in a context of crises in health, where public health was considered one of the priority goals of the current government, especially with regard to Northwest and Southwest region of Goiania. These are regions located in remote areas of the city and characterized by lowest average income, where health challenges showed up higher since the implementation of primary health care in the capital (Rassi Neto, 2008).

Moreover, in Goiania the FHS was not constituted by a single or main strategy for the conversion of the model for health attendance, but translated itself into a program of basic attendance in which the Basic Family Health care Assistance Units act together with the Centres for Integrated Health Care (CAIS). Being the former ones located in more remote and poor areas of the city. Due to the singularities of the programs of Goiania's Basic attendance, which possibly included some type of re-elaboration of the FHS in the municipal political sphere, our analysis of the decision/policymaking process will take into account both the policymaking processes (federal government) and the re-elaboration (municipal government) of the basic attendance programs.

Regarding the implementation of basic attendance in Goiania, in a study undertaken by the Oswaldo Cruz Foundation in 2001, funded by the Ministry of Health (2005) (Escorel et al, 2007), Goiania includes not only one of the municipalities that had difficulties in the implementation of the FHS, but also showed itself to be one municipality in which the FHS is adopted in a parallel fashion with other types of PHC programs. The same study further showed that, in the cities studied, the great majority of the families who were members of the FHS (>90%) affirmed knowing the place of the

Family Health Care Unit, except in Goiania (60%) (Escorel et al, 2007, p 166).

Regarding problems with implementation, another study underlines that Goiania shares some common problems with other Brazilian cities: “For the majority of those interviewed, a deficiency in human and material resources, input and equipment, the non-existence of financial autonomy, and the inadequate physical layout of the Units were considered elements which impeded the work management process” (Ferreira, 2010, p. 4) in a way that presents similar problems to other cities in the implementation of PHC.

However, in a manner distinct from other big cities of the country, Goiania possessed politically significant particularities in terms of the model of PHC attendance adopted. Our proposition is that, from the political point of view, Goiania shows itself to be a differentiated case of basic attendance in the country as a city in which municipalization of health occurred in a delayed manner (Rassi Neto, 2008). The political analysis of the process of re-elaboration of the basic attendance in Goiania possesses programs of basic attendance parallel to the FHS, differentiating itself from other large municipalities of the country.

Main questions

One general global and two specific meaningful questions will guide the research work. What are the levels of responsiveness between the macro (and micro) politics of policymaking and the micro politics of implementation in primary health care policies? To what extent have political and health authorities (national/micro) managed to establish closer relationships with the micro political actors of primary care?

To what extent have local authorities/managers, frontline professionals, users, and civil society been truly identified with the new legalities (policy values and

guidelines/targets) built by health authorities (national/micro) in the recent government administrations in Goiania?

The research process will consist of three main inter-related strategies (Box 4.1). The construction of two of our main variables, ‘modalities of representativeness’ (MR) and ‘levels of identification’ (LI) will be closely associated with the concept of legitimacy.

Box 4.1 – Main Inter-related Strategies (Specific Objectives)

<p>CONSTRUCTING ‘MODALITIES OF REPRESENTATIVENESS’ (MR)</p> <ol style="list-style-type: none"> 1. Analyse the decision making process, at the federal (from 2011) and municipal (from 2012) levels, mapping the actors, institutions, and critical conjunctions related to those periods. Underline the way in which distinct actors participate directly and indirectly in the decision making processes in the federal government, and for re elaboration in the municipality. Verify which are the principal tensions existent between the ideas and interests, and in what way new/old actors (international and national), identified with different values and interests, lead and influence the political decision making processes (in the national, macro sphere) and of reelaboration (in the municipality) of the basic health care public policy. 2. Construct the “modalities of representation” variables in the decision making process, associated with the political period, and define six possible levels of “modalities of representation” with a base in the criteria “connections between possibilities and limits for realizing the policy”.
<p>CONSTRUCTING ‘LEVELS OF IDENTIFICATION’ (LI)</p> <ol style="list-style-type: none"> 3. Analyse the process of implementation, mapping the actors, institutions, and critical conjunctions related to the implementation of the policy in Goiânia since 2012. Underline the main limits and possibilities which emerge for three types of front line actors in the role out of the implementation, regarding the values and directives of the policy associated with these actors. They are 1) supervisors, administrators, and managers of basic health care, 2) health professionals and agents, and 3) representatives of civil associations, social movements, volunteers, and the target public. 4. Construct the “levels of identification” variables for each type of actor and sanitation district (West, North east, South east), having as a basis the “interrelation between possibilities and limits in the unfolding of the realization of public policy” criteria (Table 4).
<p>CONSTRUCTING “COEFFICIENTS OF LEGITIMACY” (CL)</p> <ol style="list-style-type: none"> 5. Explore the correlations existent between the two main concept-variables: “<i>modalities of representation</i>” and “<i>levels of identification</i>”, for each type of micro actor and sanitation district in the determined political period (Table 2 and 4) 6. Evaluate the size of the space of conflict existent between the processes of decision and implementation related to the basic health care policies, in the three sanitation districts during the political period, and construct the variable “coefficient of legitimacy” (CL) for each district and city/for the political period. 7. Stablish comparisons, highlighting the factors that allow a greater approximation, as well as a greater separation between decisions and implementation in the period studied.

Legitimacy: in public policy

According to the theory of legitimacy (Weber, 1994) (Coicaud , 2003) , so that the values and guidelines created in the policy (macro) can produce belief or acceptance

in its legality and thus be realized and legitimated, two complementary pre-requisites of legitimacy should be considered: 1) the norm / rule created must be in consent with the constituent values of the identity of the actors and institutions involved, 2) thus being capable of achievement, taking social and concrete institutional forms . As stressed by Coicaud , " The rule of law is based on the belief that its legality is an expression of society's values. Only when the legality corresponds to the values of society would it prove to be legitimate. In this case acceptance or consent would take place in the reality" (Coicaud , 2003 , p.23) .

Although involving different forms of relationships between legalization and consent (values and guidelines), legitimacy, as a conceptual pair of domination, always converges to the question of the possibility (or probability) of concrete realization and, thus, pinpoints to an ultimate political question, concerning achievement of the expected results (Weber, 1994) (Cohn, 1979). This is because the claim of legitimacy has its counter-point on the issue of maintenance of the exercise of the power, as claimed. Legitimacy comprehends thus a category that allows us to analyze or evaluate the political process (decision implementation) in the micro sphere as probability of submission (acceptance) and actual implementation (compliance) of legalities (values and guidelines) created and claimed as legitimate by macro politics (Coicaud, 2003). Comprehends also an inter-relational concept that enables one to bring out specific problems concerning reciprocity and responsiveness, for example, between the social sphere and micro policy with regards to the macro policymaking decision. From the methodological viewpoint, this type of political analyses or evaluation requires the selection of variables that allow us to position the results achieved in different positions of the acceptance-rejection continuous (Coicaud, 2003); to which political authority is submitted during the execution of public policy.

Constructing ‘modalities of representativeness’

Mapping of actors and institutions will first be used to classify distinct modalities of representativeness (in policymaking) with respect to societies’ values and interests in the formulation of new guidelines in primary care: related to the Family Health Strategy (FHS), the National Program for Access and Quality Improvement in Basic Health Care (PMAQ-AB), and the More Doctors for Brazil Program (MDP).

The construction of four probable ‘modalities of representativeness’ will be done taking into account degrees of tensions between ideas/interests and frontline actors’ identity (institutional capabilities and institutionalised patterns of socialisation) regarding four main barriers (or facilitators) to the implementation of the FHS (Box 4.3).

Box 4.2 – Group of barriers to implementation used in the construction of the main variables – applied to policymakers and frontline actors (local manager, health team and users)

Group of indicators/barriers	Definitions
KT-WI	Actors’ knowledge and interests/ideologies in the policymaking-implementation of the FHS
ORG-CAP	Organizational capacity and cultural aspects involved in the policymaking-implementation of the FHS
INT-FRON	Inter-action between frontliners, and between frontliners and managers/district managers in the policymaking-implementation of the FHS
INT-GOV	Inter-relation between frontliners and the government

Revised and re-grouped from: Hunter and Killoran (2004); WHO (2012); DECOSTER, APPELMANS and HILL (2013); and with local policymakers, frontline actors and researchers.

Those four groups of barriers to implementation are considered important to understand why and how those pre-requisites for successful implementation - directed policymakers and to three types of frontline actors (local authority, health professional and civil society/patients) – can be observed in a public policy, and in the FHS in particular. Those barriers have been firstly selected from studies developed by Hunter and Killoran (2004), World Health Organization (2012), Yamey (2012) and Decoster, Appelmans and Hill (2013). Selection was narrowed afterwards with the help of

researchers involved in this project and with the involvement of local policymakers and frontline workers selected.

Those degrees of tensions between ideas/interests and frontline actors' identity (patterns of socialization + institutional capabilities) will be associated with points in the obedience-rejection continuum, in a scale that ranges from null to full correspondence. These points will be interpreted as possibilities of translating policies into effective practice (Table 4.1). Those tensions will be associated with points in the obedience-rejection continuum, on a scale that ranges from null to full correspondence (Table 4.1). These points will be interpreted as possibilities of translating policies into effective practice, and will be used in the formulation of hypotheses.

Table 4.1 – Criteria used to classify ‘modalities of representativeness’ (MR) of the micro politics of policymaking

<i>Modalities of representativeness</i>	<i>Criteria – relationships between possibilities and limits of translating policies into effective practice (tensions between ideas/interests and frontline actors' identity)</i>		
Perfect	<i>There are no conflicting ideas/interests in relation to frontline actors' identity. Result: There is an optimum use of knowledge/ideas available in policymaking. Ideas, knowledge and interests totally represent frontline actors identity (values/interests and possibility of action). New legalities are completely implemented (ideas/interests = frontline actors' identity)</i>	<div style="writing-mode: vertical-rl; transform: rotate(180deg);"> Acceptance-rejection continuum </div>	100%
High. (3 modalities)	<i>Possibilities are higher than the limits to translate policies into effective practice. High level of understanding in policymaking. Result: high probability to turn policies into practice.</i>		
Medium (3 modalities)	<i>Both limits and possibilities have more similar weights. Ideas and knowledge used with partial understanding; Result: probability to translate policy into practice tends to be partial. Policy process tends to be characterized by irresolution and procrastination.</i>		
Low (3 modalities)	<i>Limits are more dominant than the possibilities of change and realisation. Results: high degree of perverse effects, low acceptance and obedience (high rejection). The initiated process is interrupted.</i>		0%

Adapted from: Saddi (2004, 2014); Saddi, Harris and Pego (2016.)

Constructing levels of Identification

The second inter-related strategy will involve the construction of the second variable and its sub-variables: the general mean level of identification, to be attributed to each administration of the national government, and the disaggregated mean levels of identification, related to the three micro dimensions selected.

Identification

In the proposed framework, degrees of conflict existing between guidelines and realization will be used as analytical criteria in the definition of four probable levels of identification (possibilities of implementing the legalities constructed by macro-politics) with macro/micro policy-making. Data gathered from questionnaires and national/international statistics will be organised so as to position actors in one of the four levels of identification, and to come up with an average level of identification for each sanitary district and city. ‘Levels’ will be connected with points in the acceptance-rejection continuum (Table 4.2).

Identification is conceptualised in a relational form as both perception/acceptance and effective action, and applied to the three types of frontline actors. In reality, policy identification as acceptance and real action always entails a separation paradox, or better, degrees of tensions between values/interests and actual action. Analytically speaking, levels of “separation paradoxes” (tensions) are combinations of possibilities and limits for the effective realisation of the legalities built at the state level. Similar to the construction of modalities of representativeness, those degrees of tensions will be classified regarding four main groups of barriers (or facilitators) in the implementation of the FHS. This means that LI to be calculated for each type of actor will be formed by four groups of barriers to the implementation of FHC.

Different combinations of possibilities and limits will be used as analytical criteria to identify four probable (probabilities of) levels of identification with the macro policy: perfect, high, medium, low, null, and negative. This means that Levels of Identification (LI), for each type of front line actor, will be decomposed into and associated to barriers/facilitators seen as different levels of tensions present in the implementation of the policy (Box 4.2 and 4.3).

Box 4.2. General Mean Level of identification (LI): associated to barriers/facilitators linked to three types of front line actors

LI/barriers/actors →	LI/barriers	→ LI (general)
LI / KT-WI (health team) LI / KT-WI (local manager) LI / KT-WI (users)	LI/ KT-WI (general)	General Mean Level of Identification (LI)
LI/ ORG-CAP (health team) LI/ ORG-CAP (local manager) LI/ ORG-CAP (users)	LI/ ORG-CAP (general)	
LI/ INT-FRON (health team) LI/ INT-FRON (local manager) LI/ INT-FRON (users)	LI/ INT-FRON (general)	
LI/ INT-GOV (health team) LI/ INT-GOV (local manager) LI/ INT-GOV (users)	LI/ INT-GOV (general)	

Table 4.3 - Criteria used to classify the ‘levels of identification’ (LI) with the macro public policy

Levels of identification	Criteria – relationships between possibilities and limits towards the realization of public policies (principles and rules: tensions between values/interests and actual action)		
Perfect	There are no conflicting values and interests. Result: full acceptance and obedience, full realization of values and rules decided (intention = result)	<div style="writing-mode: vertical-rl; transform: rotate(180deg);"> Acceptance-rejection continuum </div>	100%
High (3 levels)	Possibilities are higher than the limits to effective realisation. Result: public policy is seen as a success, high acceptance and obedience.		
Medium (3 levels)	Both limits and possibilities have equal weights; the policy process characterized by irresolution and procrastination. Result: concrete realisation tends to be partial, with medium level of rejection.		
Low (3 levels)	Limits are more dominant than the possibilities of change and realisation. Results: high degree of perverse effects, low acceptance and obedience (high rejection). The initiated process is interrupted.		0%

Adapted from: Saddi (2004, 2014); Saddi, Harris and Pego (2016)

The high, medium, and low levels of identification will be divided into 3 sub-levels (Table 4.2). We have assumed that the low and medium positions constitute “modal levels” applied to developing countries, with higher probabilities of being repetitively observable in medium income countries, with high social inequality. The null level is applied to situations of extreme political instability and/or low levels of income, and could be analytically associated to both developing and under-developed countries.

By assumption, cities/countries coming from a medium and especially from a low level position are unlikely to achieve the high level position, which could be applied to developed nations with little or lower levels of social inequality, and with higher levels of responsiveness. The perfect level, however, corresponds to a heavenly (or utopian) situation and is rather unlikely to take place in the real world, either in developing or developed countries. It would require a perfect match between ideas and interests involved in national politics, on one side, and societies’ needs, expectations, and effective practice in relation to legalities (and to health policies more specifically), on the other side. Both sides would have to be considered as one, with perfect identification and authentic political representation and responsiveness from both sides.

By attributing distinct levels of identification to each dimension and then aggregating those three dimensions of the sub-national process, we will come up with an “average level of identification” for each national political phase (term).

Constructing coefficients of legitimacy

The *identification point* will afterwards be associated to the *representativeness point* in the legitimacy continuum. The distance between both points in the continuum will be interpreted as coefficients of political legitimacy of the policy. Legitimacy is

defined in terms of levels of true acceptance and effective realisation, leading to distinct but closer proximities between macro and micro spheres/actors.

A coefficient will measure the magnitude of the variance of our contested space and according to two main inter-related concepts-variables: political representativeness and identification. Distinct 'levels of identification' and 'modalities of representativeness' will be anchored to points in the *acceptance-rejection continuum*, representing probabilities of translating policies into practice (0%-100%) (Tables 4.1 and 4.2). The distance between both points in the continuum will be interpreted as coefficients of political legitimacy of the policy. Legitimacy is defined in terms of levels of true acceptance and effective realisation, leading to distinct but closer proximities between macro and micro spheres/actors. The proposition is that the closer the representativeness point is to the identification point in the continuum, the higher the level of responsiveness and legitimacy construction of the policy would be (Table 4.2).

The *proposition* is that the closer the representativeness point is to the identification point in the continuum, the higher the level of responsiveness and legitimacy construction of the policy would be. The focus of the comparison, however, will be on the different LI according to the four groups of Barriers (Box 4.2 and 4.3) – sub-indicators that comprise each of those groups - and on changes occurring in the *magnitude of the contested space*, applied to cities in different stages of development, recognising their social and politico-institutional realities.

The *general hypothesis* is that changes in the magnitude of the *coefficient* (contested space) have been smaller than expected in each city. Specific hypotheses will be built and revised throughout the research process. A coefficient will measure the magnitude of the variance of our contested space and according to two main inter-related concepts-variables: political representativeness and identification.

Distinct ‘levels of identification’ and ‘modalities of representativeness’ will be anchored to points in the *acceptance-rejection continuum*, representing probabilities of translating policies into practice (0%-100%). The distance between both points in the continuum will be interpreted as coefficients of political legitimacy of the policy. Legitimacy is defined in terms of levels of true acceptance and effective realisation, leading to distinct but closer proximities between macro and micro spheres/actors.

The proposition is that the closer the representativeness point is to the identification point in the continuum, the higher the level of responsiveness and legitimacy construction of the policy would be.

Though in different magnitudes, the *general hypothesis* is that changes in the magnitude of the *coefficient* (contested space) have been smaller than expected. Our general hypothesis is that changes occurring in the magnitude of the coefficient (magnitude of the existing separation space between decision and implementation - questioned space) lower for each type of actor. Specific assumptions will be built and revised during the research.

This research intends to construct more comprehensive evidences (coefficients of legitimacy and levels of identification) on how it would have been possible to promote higher levels of political reciprocity (as a sum-up form of measurement), and higher levels of political commitment, professional accountability and civil society/user empowerment in public policy (as disaggregated forms of measurement) related to three type of actors: policymaking/managers, health team (doctors, nurses, community health workers) and users. Our assumption is that those levels will be increased whenever the main barriers to implementation have been responsively and interactively tackled/considered by policymakers. Coefficients of political legitimacy will be used to inform policy and anticipate problems and issues to which policy will need to respond in the future.

New (complementary) surveys and interviews

One of the singularities of the methodological framework proposed is that it requires a greater understanding of the values/interests and attitudes of the main actors involved in both the policymaking and implementation processes. Studies tend to focus on the perspectives and/or effective behaviour of one type of actor, representing either the policymaking or the implementation process. There is still little systematic research based on interviews with policymakers.

The Brazilian Ministry of Health has been more effectively monitoring and assessing the implementation of primary health programmes since the 1990s. A recent example of this is the Programme for the Improvement of Care and Quality in Primary Care, known as PMAQ-AB. In addition, the country presents a very active research community in the field of health, inter-connected through various networks. The Latin American and Caribbean Centre on Health Sciences Information (Bireme) plays an important role in the promotion of the use of scientific and technical health information. In addition, research projects programmes are developing surveys with frontline actors, or conducting studies that intend to measure the performance of health services. The results of those surveys and studies are expected to be complementary to this research project. Data and information available about one type of actor will be of great use in the elaboration of questionnaire surveys and in the analysis of results.

In order to assess how frontline actors have coped with the tensions existing between values/interests and their institutional capabilities (and prevalence of old forms of socialisations), a new survey needs to be undertaken. To evaluate the extent to which new policy guidelines (as a product of policymakers and politicians' knowledge and ideas/interests) have represented frontline actors' interests and identity (institutional

capabilities), new and complementary interviews need to be conducted. In short, this research will offer a politico-sociological interpretation of what the combination of objective and subjective types of data means for policy. The research will produce two types of qualitative data, modality of responsiveness and level of identification, and one type of quantitative data: coefficients of legitimacy.

Defining the Sample

Interviews were undertaken with the largest number possible of actors involved in the decision making processes and of the elaboration at the federal and municipal levels during the period analyzed, taking into account the time available for the research. To this end, we have the Consent of the Municipal Secretariat of Health in Goiania, and count on the collaboration of the Directory of Basic Attendance of the SMS to select the sample of the units and scheduling of interviews with managers from the SMS and district supporters. A total of 37 actors were interviewed in the decision making: six (06) interviews in the Minister of Health, 5 in federal councils (CONASS and CONASEMS). We realized a further 3 together with managers of the state Secretariat of Health of Goias (SES-GO), six (06) with managers from the Municipal Secretariat of Health in Goiania, and eight (08) with district supporters, as the table Table 5.2 shows. The interviews were made soon after the approval by the UFG Ethics Committee (Registration number at the National Ethics Committee/Health Minister: 26584514.3.0000.5083).

Table 5.1: Interviews initially planned with actors from the decision making/elaboration process.

In health councils	10
Municipal Health Secretariat (director, managers, technicians)	12
Ministry of Health (Coordinators, director, managers)	15
	37

Table 5.2: Interviews undertaken with actors from the decision making/elaboration process

In health councils at the federal level (CONASS and CONASEMS)	5
Ministry of Health, Department of Basic Care	6
State Secretariat of Health – State of Goiás	3
Municipal Secretariat of Health - Goiânia	6
District Supporters	8
Municipal and local health councils	9
	37

Regarding the questionnaires to be applied to the three types of front line actors at the Basic Family Health Units, they were directed toward the actors related to the **East, North east, and South east Sanitation Districts of Goiânia**. Beyond preparing a questionnaire for the local managers, and another for the clients, we prepared three distinct questionnaires for the health team: one for the doctors, another for the nurses, and another for the community health workers. In this way, two were elaborated for the formulators of the policy, and five for front line actors, making seven questionnaires in total:

- Questionnaire applied with policymakers at the Ministry of Health/Councils
- Questionnaire applied with the managers of the Secretariats and the district supporters in Goiânia/Goiás
- Questionnaire applied with the local managers of the units
- Questionnaire applied with the unit doctors
- Questionnaire applied with unit nurses
- Questionnaire applied with Health Unit Community workers
- Questionnaire applied with the users of the units

The number of actors interviewed in the health units (on the front line) are found described in Table 5.3 below.

Table 5.3 – Number of actors to be interviewed in the Health Units (micro actors)

Number of actors of the three districts	West	North East	South east	Total
Number of Health Units	4	4	4	12
Health professionals: 2 teams per unit (1 team = 8 members)	64	64	64	192
Coordinators: 2 per unit (completing the data collection)	8	8	8	24
Target Public	128	128	128	384
				600

Organization and treatment of the data collected: attributing qualitative and quantitative variables

The responses to the questionnaires will be quantified in terms of numbers, attributed according to the criteria of “possibility of the realization of FHS”, associated to the barriers selected. The data is grouped according to class intervals, that is to say: the data will be placed into distinct groups which present similar characteristics.

We attribute an average numerical value for each interval and a qualitative ordinal variable (order). The numerical value will correspond to a median number (of the interval), given (in the questionnaires by the actors) in reference to the four group of barriers, and associated to the specific actors.

In this way it will be possible to calculate a median number for each question (sub-barriers or sub-indicators) and section (group of barriers), by questionnaire, by the type of front line actor, and according to sanitary districts/city(ies). The median number (median distribution) will consist in qualitative terms, in 4 distinct levels (and sub-levels) of the qualitative variable: level of identification, applied to the four group of barriers, and as a sum-up will conform the general mean LI. The same procedure will be carried out for the variable: modalities of representation.

Modalities of representation and levels of identification will be associated to four classes of qualitative data concerning different possibilities and limits of acceptance of

the policy. This is because we have divided the rejection-acceptance continuum in four classes, which correspond to the different possibilities and limits of acceptance of the policy. For each class we will attribute a qualitative variable and a quantitative one associated to distinct LI and LR indicators

For the quantitative variable values between -1 and 1 will be attributed -, which will include possibilities for variation in the probability of the policy being accepted. Graphically and analytically, it will be possible to correlate the variables “modalities” and “levels”, associating them with points on the acceptance-rejection continuum, verifying to what degree they come together one with the other on the continuum (rejection-acceptance).

Quantitatively, owing to the fact of the MR and LI variables finding themselves to be associated, the numerical values, calculated in terms of median distribution (of the number of actors which attributed that number to the question), it will be possible to calculate the coefficient of the correlation between these two variables.

We will be working in this way with simple forms of data grouping, attributing quantitative and qualitative values/categories to them, always obeying the same scale of grouping of intervals of the data, in such a way that it will become possible to compare and correlate this data. The calculation to be realized will include medians of distribution of the previously grouped data, associated with the qualitative variables modalities of representation (MR) and levels of identification (LI). The advantage of carrying out some of the quantitative calculation owes itself to the fact that it becomes possible to make use of distribution and dispersion graphs, as ways of visualizing the problem of political separation dealt with in this research. It also becomes possible to use numerical evidence to underline existent variations between decision and implementation. One notes that we have already presented in this proposal some of the analytic tables, which make use of

qualitative variables (elaborated up until now).

Beneficiaries and expected results

The proposed framework presents public policy, and health policy in particular as a multidimensional (Marmor and Klein 2004 and 2006) as well as a double process of construction (social and politico-institutional) (Saddi 2004 and 20014), in which distinct types of actors play a significant and complementary role in the construction of the policy.

Academics, policymakers, politicians and frontline actors will profit from an analytical framework in which the motivations and institutional capabilities of different stakeholders, holding distinct responsibilities in the policy process, are taken into account. As aggregated and disaggregated forms of measurement, coefficients of political legitimacy and levels of identification could be used to inform policy and anticipate problems and issues to which policy will need to respond in the future.

In terms of contributions to academics, we will develop a new comparative method for the evaluation of public policies, to be applied to countries in distinct stages of development. In contrast to the mainstream type of political comparisons, variables will be constructed and measured in a meaningful and politically significant manner (Mair 1998; Hood and Bevan 2005). I will take into account local actors' motivations and perspectives and institutional capabilities

The coefficient would inform policymakers the extent to which the policymaking process has grown in responsiveness through time. Modalities of representation, as one of our politically determinant variables, will reveal the proportion to which the new set of ideas and knowledge influencing policy design has represented frontline actors values/interests (or national political interests), as well as taken into account their

institutional capabilities to deliver those policies. Policymakers will be able to propose policy designs based on meaningful types of evidence (Duncan, 2005).

From the perspective of politicians, coefficients will show how distant the process of policy justification has been from frontline actors' expectations and their institutional capabilities. The variance of the coefficient during the period, and over time (with re-application of questionnaires), will not only demonstrate how responsive politicians have been in terms of public health issues, but will also suggest how it would have been possible to speed up the pace of growth in responsiveness with respect to each type of frontline actor.

Research outcomes will be useful to managers and health professionals. They would have information on how subjective motivations and objective institutional variables, as well as the combinations of both variables, have affected their work in the delivery of primary care (Bevan, 2005). Managers located in less developed countries, likely to develop more creative forms of organisational change, would have the opportunity to partially transfer their experiences to managers located in developed countries, and vice-versa (when applied to countries with distinct stages of development). Patients and representatives of civil society organizations will have access to information on how they have grown in participation, actually influencing primary health care delivery. The evolution of identification (applied to patients and civil society) through distinct levels over time will reveal how far they are from reaching what is considered an optimal point of participation according to their perspectives and local reality.

3. CONCLUDING REMARKS

The proposed framework will guide the construction of evidences (coefficients of legitimacy and levels of identification) on how it would have been possible to promote higher levels of political reciprocity (as a sum-up form of measurement), and higher levels of political commitment, professional accountability and civil society/user empowerment in public policy (as disaggregated forms of measurement). Those measurements are associated to policymakers and three different types of front line actors (managers, health team - doctors, nurses, community health workers - and users), and will take into account their perspectives regarding barriers (or facilitators) to the implementation of the policy selected: the Family Health Strategy. Our assumption is that those levels can be increased whenever the main barriers to implementation have been responsively and interactively tackled/considered by policymakers *vis-à-vis* the reality of implementation. Coefficients of political legitimacy will be used to inform policy and anticipate problems and issues to which policy will need to respond in the future.

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