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Modalities of representativeness and levels of identification in public policy: coefficients of legitimacy framework.

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1. 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 micro politics (frontline actors). It develops *a new comprehensive type of measurement and comparison*, in which comprehensiveness requires a greater understanding. Interviews are conducted with national/local policymakers and surveys applied to frontline actors. It is guided by one main question: What are the levels of responsiveness between the politics of policymaking and the micro politics of implementation? It is currently being applied (as pilot project) in the analysis of primary healthcare in Goiania-Brazil. Goiania is understood as paradigmatic case of implementation in regional capitals in Brazil.

This paper has been divided in three main sections. Firstly, we present how mapping of actors and institutions are used to classify distinct 'modalities of representativeness' (in policymaking) with respect to societies' values and interests in the formulation of new guidelines in primary healthcare in Brazil. Classification of four probable 'modalities of representativeness' are done taking into account degrees of tensions between ideas/interests and frontline actors' identity (institutional capabilities and institutionalised patterns of socialisation) in Goiania. Those tensions are associated with points in the obedience-rejection continuum, on a scale that ranges from null to full correspondence. These points are interpreted as possibilities of translating policies into effective practice, and used in the formulation of hypotheses and analyses.

Secondly, we focus on the construction of the second variable and its sub-variables: the general mean level of identification, attributed to front line actors, and the disaggregated mean levels of identification, related to the three micro dimensions selected (local managers, heath teams and users). 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 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.

We will afterwards explore how the *identification point* can 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. 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.

This method intends to construct evidences on how it would have been possible to promote higher levels of political reciprocity in public policy. It can be used to inform policy and anticipate problems to which policy will need to respond.

2. 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 micro politics (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.

3. THE PROBLEM OF SEPARATION IN PUBLIC POLICY (POLICYMAKING-IMPLEMENTATION GAP): AS A POLITICAL AND ANALITICAL PROBLEM

It was amid this context of double political transitions, with the adoption of economic stabilization and fiscal adjustment in the redemocratization period, that the Family Health Strategy (FHS) was implemented at the national level in1998 , and has so far represented 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 population´s access and inclusion in the Unifying Health 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 continued to be used by the federal government in order to legitimize the 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, as broadly recognized, this policy still presents some challenges or barriers, such as the need to foster organizational capacity and closer relationships with policymaking and implementation actors, lacks in the coordination of care with more specialized levels, and present deficit of professionals in the multi-professional teams of the FHS (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 policies - and primary health care in Brazil in particular - can be studied as a process of political response and responsiveness, in which policies – that have been

revised and legalized in distinct phases of the government – still need to be improved and more responsive, not only in matters of efficiency and efficacy, but also in terms of relationship and legitimacy.

These facts, among others, similar to other policies adopted in developing countries, have made decision-makers and experts from international and national public policies to begin to value politics in their assessments and analysis, leading to the increase in the number of political types[1] of analyses concerning the health sector since the mid 1990s. Since then the national political relations tend to be treated or 1) as an obstacle to market development (World Bank , 2003 and 2004) ; or 2) as socio-political and cultural problematic related to developing countries or 3) as problematic and concerns regarding the political relations and / or micro professional and / or everyday life process in these societies[2].

It was therefore during the construction of SUS from the 90s, in times of economic stabilization, that we can witness a disconnection in decision-making and implementation process. Parallel to this more evident disconnection between decision and implementation, we can also witness a process of specialization in the analyses and formulations of policies with the adoption of concepts coming from the new public management theory. Concepts such as efficiency, performance (performance) and effectiveness have become more politically decisive, being sometimes even antagonistic to the principles and basic guidelines of SUS (universal , decentralization and completeness of medical care), as widely highlighted by national literature on Collective Health in particular[3].

In relation to the decision-making process, it becomes less politicized and more technical in the 90s (Seclen, 2003), given the political prominence acquired by economic stabilization, and the fact that the concerns turn to the implementation process itself. The so-called period of institution of SUS, during Sarney's years – at the beginning of redemocratization -, has given way to the stages of constitutional

[1] Of course, the understanding of the meaning of the term "politics" varies widely in the literature. In the analyzes 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 capacity (accountability) and transparency , right of democratic governance , 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 theme relevant policy (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 criticize 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. On the sociological critique, we refer to the works of authors such as Peter Evans or the work that focus on analysis of daily life or local political relations , using the concepts of call new sociologies of social construction , represented Pierre Bourdieu and Bruno Latour , among 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 have occupied a prominent place in public policy analysis .

regulations and implementation of SUS (Levcovitz, Lima and Machado, 2001) (Levcovitz et al., 2003) (Bueno and Mehy, 1997) (Iriart, Merhy and Waitzkin, 2000). In previous years, there are few studies that begin to analyze the decision-making process in the period. Among them, we highlight the analysis of Gilson Carvalho on the process of conflict related to health financing. Therefore the so-called period of institution building has given way to the stages of constitutional regulations and implementation of 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 analyzes of the SUS implementation process as a whole . In different ways, these studies use concepts such as efficiency, performance, social participation, as the assessment of the challenges posed to the achievement of public policy at the state or municipal level.

With regard to studies on the implementation of primary health care (PHC) process, in most cases, they have sought to determine which were the advances and limitations in the reorganization of management, labor and services related to PHC. One of the main concerns of these assessments is to see if / how was the coordination of primary care with more specialized levels of care taken place, and if / how the formation of an integrated health services network was observed in the cities (regarding mechanisms of reference and counter-reference). These studies also have privileged the analysis of certain actors linked to implementation. Public opinion type of researches and surveys conducted with managers, health professionals, family health teams, have produced assessments that allow us to understand what are the difficulties of adopting public policies at the local level (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* to the considerable increase in the number of works focusing on the implementation (Levcovitz et al, 2003) , or *vis- a-vis* to 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 do, to 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 the new regulations cannot express the extent of the change that occurred in the implementation of the new family-related and community-based

programs and 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 are authors engaged in analyzes of cases of successful implementation of new health practices in PHC, especially by municipalities of medium and small size, the greater is their disenchantment regarding the level of macro policymaking.

Regarding evaluations made so far focusing on the 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 the implementation, not making an analysis of policy process in which the policymaking and its relation to the 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 the decision-making and implementation, or even the distance that occurs between macro (formulation) and micro (re-definition / management and implementation) processes of the policy. The literature makes us know that this gap is due to the fact that the policymaking / implementation processes are marked by conflicts and tensions (of principles and interests) contradictory to decisions elaborated in the macro sphere. However we still know little about how the political actors who hold positions of power in the different state institutions have participated in the process (decision and implementation) of public health policy, responding to the challenges coming to the decision and implementation. We also know little about how local actors have been identified or not with the values and guidelines of public policies in the implementation process, adopting them in different ways. We know even less about the effects that different political interactions (between the 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 comprehensive political form in the analyses and comparisons of public health 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 to evaluate the 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 legitimation issue of public policy.

From an analytical point of view, this issue of political reciprocity exists due difficulties in establishing links between macro and micro processes and its 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 its 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 understanding 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 the development of a form of interactive research between actors and researcher (coming from the practice, policy and research realms).

As widely already emphasized by the international literature (Duncan 2005) (Meads et ali, 1999), as well as funding agencies for researches 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 ali, 2010). It is recommended, therefore, that research projects are beyond the adoption of a method in which the concepts and the research agenda are fully pre-defined and closed in the project, where the actors are analysed from a top-down academic perspective, without the interaction of respondents in the design of questionnaires, in the review of the main concepts used throughout the research process.

This dual analytical challenge as well as the political problem of reciprocity, both derived from the problem of separation of 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 check on what terms the values and guidelines claimed as public in the decision-making process (macro-micro), have been accepted and realized in the micro policy sphere (political, administrative and social sub-spheres), and thus recognized as legitimate in the implementation process.

4. 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)

The FHS was derived from the family doctor`s program, designed by the Brazilian health movement in the 70s, and in particular by health workers affiliated to the Communist Party, such as Capistrano de Abreu and Nelson Rodriguez dos Santos, and was already in a trial stage in some municipalities Brazilians in the 70 and 80. The great success story of the FHS, originally implemented (1991-94) in some cities in the state of Ceará and the city of Niterói, and then (1996) in São Paulo with the project Qualis / FHP (Capistrano, 1999), is attributed to the fact that infant mortality has been reduced by half, and for providing a considerable drop in the number of hospital admissions (Capistrano, 1999). The FHS consists of an internationally award-winning project, together with the HIV-AIDS program, and recognized worldwide as PHC models to be followed.

However, the FHS was implemented at the national level only from 1998, in a scenario of economic stabilization and fiscal adjustment, as a political strategy to accelerate the process of inclusion of SUS, and improvement in health indicators. It was the main political strategy of the Health Minister José Serra, official candidate of Fernando Henrique Cardoso for the presidential succession. In Brazil, we had an atypical neoliberalism in health, with constant increase in expenditure in the sector (Gouveia and Palma, 1999). Conflicts between the then Minister of Finance and the Minister of Health were repeatedly revealed in the newspapers.

As stressed by Rassi Neto (2008) the health municipalization in Goiania happended 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 Goiânia the FHS does not understand the single strategy or main strategy of conversion of the health care model, but translates into a primary health care program in which Basic Care Units of the Family Health (UABSF) act in parallel with CAIS and Care units Basic Health located in the Sanitary Districts.

Regarding the implementation of primary health care in Goiânia, in a study conducted by the Oswaldo Cruz Foundation in 2001 (Ministry of Health, 2005) (Escorel et ali, 2007), Goiânia comprises not only one of the municipalities that had difficulties in the implementation of the FHS, but also showed up as a municipality where the FHS is adopted in parallel to other primary health care programs. The same study also shows that, in the studied cities, the vast majority of families ascribed to the PSF (> 90%) claimed to know the location of family health unit, except in Goiania (60%) (Escorel et ali, 2007, p . 166).

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. 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 two of our main variables, 'modalities of representativeness' (MR) and 'levels of identification' (LI) will be closely associated with the concept of legitimacy.

Legitimacy

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'

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 3.2).

Box 3.1 – 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 3.1). Those tensions will be associated with points in the obedience-rejection continuum, on a scale that ranges from null to full correspondence (Table 3.1). These points will be interpreted as possibilities of translating policies into effective practice, and will be used in the formulation of hypotheses.

Table 3.1 – Criteria used to classify 'modalities of representativeness' (MR) of the micro politics of policymaking

Modalities of representative ness	*Criteria – relationships between possibilities and limits* of translating policies into effective practice *(tensions* between ideas/interests and frontline actors' identity)		
Perfect	*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)	Acceptance-rejection continuum	100%
High. (3 modalities)	*Possibilities are higher than the limits to* transle policies into effective practice. High level of understanding in policymaking. Result: high probability to turn policies into practice.		
Medium (3 modalities)	*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.		50%
Low (3 modalities)	*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%

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 3.2).

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 3.1 and 3.2).

Box 3.2. 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)**	

The high, medium, and low levels of identification will be divided into 3 sub-levels (Table 3.2). 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.

Table 3.2 - 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)	Acceptance-rejection continuum	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.		50%
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%

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%). 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 (Annex 2, Figure 3). 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 3).

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 3.1 and 3.2) – 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 (Annex 3, Table 3.3). 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 (Annex 2, Figure 3).

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 3).

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 present 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 programme 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 3.4 shows. The interviews were made soon after the approval by the UFG Ethics Committee.

Table 3.3: Interviews initially planned with actors from the decision making/elaboration process.

In health councils	1.	10
Municipal Health Secretariat (director, managers, technicians)	2.	12
Ministry of Health (Coordinators, director, managers)	3.	15
	4.	**37**

Table 3.4: Interviews undertaken with actors from the decision making/elaboration process

In health councils at the federal level (CONASS and CONASEMS)	5
Ministry of Health (coordinators, director, managers)	6
State Secretariat of Health - Goias	3
Municipal Secretariat of Health (director, managers, technicians)	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 (Table 3.5). Beyond preparing a questionnaire for the local manager, 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 ACS. In this way, two were elaborated for the formulators of the policy, and five for front line actors, making seven questionnaires in total, which were attached to the Brazil Platform:

Ii: Questionnaire applied with the people from the Ministry of Health/Councils
ii: Questionnaire applied with the managers of the SMS and the district supporters (DS) in Goiânia
iii: Questionnaire applied with the local managers of the units
iv: Question air applied with the unit doctors
v: Questionnaire applied with unit nurses
vi: Questionnaire applied with Health Unit Community Agents
vii: 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 3.5 below.

Table 3.5 – 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

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.

5. 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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