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Partnerships in Health Systems: Social Organization as limits and possibilities in the Family Health Strategy Management

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Abstract *This is a case study in the municipality of Rio de Janeiro about management in the Family Health Strategy based on the Social Organizations model. The aims were to characterize and analyze aspects of the governance system adopted by the Rio de Janeiro Municipal Health Department and identify limits and possibilities of this model as a management option in Brazil's Unified Health System. A qualitative study was performed based on a literature review, document analysisand interviews with key informants. This management model facilitated the expansion of access to primary healthcare through the Family Health Strategy in Rio – where the population covered increased from 7.2% of the population in 2008 to 45.5% in 2015. The results showthat some practices in the contractual logic need to be improved, including negotiation and accountability with autonomywith the service suppliers. Evaluation and control has focus on processes, not results, and there has not been an increase in transparency and social control. The system of performance incentives has been reported as inducing improvements in the work process of the health teams. It is concluded that the regulatory capacity of the municipal management would need to be improved. On the other hand, there is an important and significant process of learning in progress.*

Key words *Family health strategy, Social organizations, Health management, Public-private partnerships, Contracts*

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Introduction

The transformations that have taken place as a consequence of economic globalization in the relationship between the state, society and the economy, have provided an impulse to design and implementation of administrative reforms inspired by *New Public Management* since the 1980s, in the central countries, and in Latin America, in the subsequent decade. In health policy, we highlight reshaping of the forms of intervention by the state through contracting of private organizations to carry out the services[1]. The focus was on reducing the state's activity in direct execution of activities considered not to be exclusive to the state, on the one hand; and on the other, an increase in the regulatory and promotion function[2].

In Brazil, while the federal government redefined the activities of the state in the economy and in society, in an environment of economic and fiscal crisis, the Unified Health System (SUS) was put in place with an emphasize on decentralization of actions to the municipal public sphere and, in the subsequent decade there was rapid and large-scale expansion of the services of primary healthcare with the Family Health Strategy ('FHS'). All this took place in an environment of restriction of spending on staff, imposed by the Fiscal Responsibility Law[3] which, while being part of an attempt at a wider reform of the State, left out of account the specificities of the health sector and of primary healthcare.

The incoherence was explicit – since limiting expenditure in the context of the need to absorb professionals to meet the new demands worked against feasibility of progressing with the SUS. This led public managers to look for alternative ways to make expansion of healthcare feasible, and ensure a minimum of governability in the face of the pressures from society for expansion of access to public health services – a right acquired in the Construction of 1988 – through partnerships with institutions of civil society. One example was the multiplicity of employment links, most of them precarious, without the protection of Social Security, used in the contracting of professionals of the Family Health Strategy outside the apparatus of the State and within some organization of civil society (residents' association, church, cooperative or support foundation).

Added to this context is the belief of various public managers that decentralization and de-concentration of action by the state, with the concomitant establishment of a competitive contractual model, would increase the capacity of the state to implement public policies efficiently.

In this scenario, several municipalities expanded access to health services by means of partnership with the Social Health Organizations (OSSs), entities of the third sector which provide services under management contracts made with the direct public administration, and which specify the objectives and targets to be achieved. This model was to have two principal characteristics. The first would be greater autonomy of decision in financial and organizational terms, in relation to the public proprietors – to encourage administrative flexibility and break the rigidity of the organizational structure by sharing in authority and responsibility. The second aim was to increase public control of those entities by strengthening of practices relating to the increase of participation by society in the formulation and evaluation of the performance of the OSSs[4].

In the federal sphere, the OSSs were regulated by Law 9637 of May 15, 1998 (Brazil, 1998), but their implementation took place primarily in the state and municipal spheres which, using their legislative autonomy, instituted local versions. A study published by Silva[5] found OSS Qualification Laws in 56 entities of the federation: 16 states and 40 municipalities: 15 in the state of São Paulo; 5 in Rio Grande do Sul; 4 in Paraná; 3 in the states of Rio de Janeiro, Minas Gerais and Mato Grosso; and 2 in Ceará – and in the municipalities of Goiânia (GO); Joinville (SC); Parnaíba (PI); Petrolina (PE) and Vitória (ES).

This movement meant the establishment of a new arena of activity by the government and by society which was referred to as the "non-state public space"[6]. Starting in the 1990s, the proliferation of various legal models, the expansion of the presence of the private sector in public services, and the consensus on the need for improvements in the performance of public policies, produced an important debate on public governance. Putting it another way, changes in the form of management of what is public led to expansion of the concept of governance, as an expression of those transformations.

According to Rhodes[7], the concept of governance, originally adopted in the context of large private corporations, began to be used also in the public sphere, with the idea of transfer to the public sector of the management knowledge and concepts developed in the private sector. It is related to the delegation of power, that is to say: any commercial company has corporate governance; any entity that employs sharing of power to a

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greater or lesser degree has by this means established some rules of governance.

Among the various concepts, which are not necessarily mutually exclusive, this study uses the conceptual structure of Matias-Pereira[8], who sees the reference point of governance in the public sector as being the management practices adopted by the public administration model. Good governance is defined, in this case, as expansion of the government's capacity to articulate actors and social forces, with a view to development of forms of public-private partnership.

Also, the "governance system" would be composed of mechanisms and practices of cooperation sustained by a policy of information, consultation and participation, as a guarantee of supply, to the population, of goods and services of quality. It would take place through collaborative and transparent means, in a new structuring of the relationships between the public administration, the private sector and the organizations of the third sector[9].

In this perspective, the implementation of the OSS model in primary healthcare institutes a new form of public governance between the State (financier, and regulator) and the third sector (provider of health services). However, the limits of these partnerships, the appropriate form for their constitution and functioning, and their results continue to give rise to debate. This study aimed to characterize and analyze aspects of the governance system of Primary Healthcare adopted by the Municipal Health Department (MHD) of the municipality of Rio de Janeiro, as a contribution to the debate on partnerships of the State with the third sector in executing public health policies.

We conclude that the complexity of the relationships of cause and effect inherent to the organizational and inter-organizational processes of the public sector would justify a permanent effort of monitoring, interpretation and assessment of the new management models in the SUS.

Methodological strategy

This investigation on the limits and possibilities of the OSS model in the Family Health Strategy (FHS) was a case study, with qualitative approach, to compare a structured theoretical model with an empirical reality. The subject itself is current, not yet consolidated, with various discourses in dispute. The aim was to assess and examine it with 'objectivity', a term defined by Sousa[10] as arising "from rigorous and honest application of methods of investigation that permit us to make analyses that are not reduced to anticipated reproduction of the ideological preferences of those who are putting them into effect".

Thus, a plan of analysis of the system of governance was prepared, based on the review of critical studies on the model of public-private partnerships in health[9]. The dimensions and respective categories adopted for the plan of analysis were: (i) in relation to the contractual logic: processes of negotiation; accountability with autonomy for the service provider; and the system of performance incentives; (ii) in regulation: the making of rules; monitoring; evaluation and control; and (iii) transparency and social control. This plan informed a theoretical model of the scope of good governance in the relationship between the State and OSS (Chart 1). For each aspect, an assessment was made of how closely it approximated to, or was distant from, the theoretical model. This was intended not as a rigid plan of analysis of the policy, but as a tool to help in the comprehension of the reality.

This plan of analysis oriented all the study: (i) analysis of the official documents of the Municipal Health Department – these mainly included: public tender documents for contracting OSSs; management contracts (MCs); the legal framework of creation and regulation of the OSSs; the management reports and documents of the Municipal Health Council (CMS); (ii) construction of the script for the interviews[9]; (iii) choice of the 23 key interviewees as sources for information. Chart 2 shows the management profiles and institutional positioning of the interviewees.

The interviews and the analysis of documents took place in 2013. There was further analysis of documents in 2015.

The analysis of the implementation of this process, which has been significant in scale and complexity, and in progress for six years in the Municipal Health Department (MHD), calls for prudent conclusions that would aim much more to help and assist the efforts of monitoring than to make any value judgements about the success or errors of decisions and government actions. There are some obstacles, but above all there is an undeniable process of learning in progress.

Chart 1. Plan for analysis of aspects of the governance system of the Family Health Strategy of Rio de Janeiro, 2013.

Dimension	Category	Practices expected
Contractual logic	Process of negotiation	The performance indicators and targets are agreed between the MHD and the OSS. Representatives of health workers participate.
	Accountability with autonomy, of the service provider	The OSS is given Autonomy to carry out the contract. The OSS adopts innovative practices in healthcare and in qualification of the workers. The managers of clinics and health professionals have autonomy in organization of the work process. The OSS has administrative flexibility to adapt the processes to the needs of the services.
	System of performance incentives	There is a system of incentives to good performance and punishment of the OSSs. The incentive system extends to individual health professionals and is linked to the payment system.
Regulation	Creation of rules	The Management Contract (MC) defines the group of services offered by each regulated unit, aspects of the quality of care and the role of the service contracted in the network of services of the SUS. The MC prohibits provision of services to the private healthcare system.
	Monitoring and evaluation	There is a periodic technical evaluation committee of the MC formally instituted under the Municipal Health Department. The OSSs receive feedback from the periodic evaluation, and also orientations for continuous improvement. The existing IT is appropriate to monitoring of the MC. The Municipal Health Department carries out regular audits of the accountability reporting of the OSSs.
	Control	Control is focused on the result. The institutional capacity of the regulatory instances is adequate.
Transparency and social control		The information on the MCs and their results is made available for public knowledge. There is representatives of the users in the Technical Evaluation Committees (CTAs). The Municipal Health Council monitors execution of MCs.

Source: The authors.

Results and discussion

Reorganization of Primary Healthcare

The municipality of Rio de Janeiro began the restructuring of its primary healthcare in 2009, in three complementary dimensions: (i) greater participation of health in the municipal budget and greater participation of primary healthcare in the health budget – with a significant increase in funds invested; (ii) change in the healthcare model through expansion of the Family Health Strategy (ESF) and institution of Integrated Healthcare Territories (TEIAS); and (iii) adoption of the management model with OSSs, which due to the use of the rules of private sector law,

made it faster to contract professionals, acquire input materials and equipment and build new health units.

The percentage of the municipality's own revenue applied in health increased from 15.7% in 2008 to 20.81% in 2014. In 2008, the percentage of expenditure on Primary Healthcare in relation to the other linked sub-functions (health supervision and hospital and outpatient care), was 13.5%, approximately R$ 240 million; in 2014 the percentage invested in Primary Healthcare was 31.8%, approximately R$ 1.23 billion[11].

In relation to expansion of access, the potential coverage of the ESF increased from 7.2% of the population (132 teams) in 2008 to 45.5% (843 teams) in August 2015[12]. These results are on a significant scale, if we consider the difficulties inherent in expanding the ESF in major Brazilian urban centers[13]. The interviewees attributed this speed to the OSS model, and emphasized the slowness of direct administration processes as an important obstacle to expansion of the services, as can be seen in the following speech by a manager at the central level of the MHD:

I am absolutely convinced that without the administrative tool of the OSSs we would not have managed to achieve this degree of transformation at the speed with which it was done. And clearly the tool would be without effect if there had not been an increase in the funding (GMHD).

The Rio de Janeiro health services are organized in 10 program areas (PAs) where the respective instances of primary healthcare management are located – the Primary Care Coordination units (CAPs). These coordinating units are responsible for inspection of the management contracts established with the OSS for each one of these program areas. These contracts were entered into as from December 2009 (Municipal Law 5026 of May 19, 2009, and Decree 30780 of June 2, 2009) and gradually, in the various PAs, up to 2011. The consequent expansion of the Family Health Strategy took place both by its implementation in pre-existing primary health units, and also by inauguration of new health units, called 'family clinics'.

There are currently five OSSs contracted by the MHD to operate the Family Health Strategy: SPDM (*Sociedade Paulista para o Desenvolvimento da Medicina*), Viva (*Viva Comunidade*), IABAS (*Instituto de Atenção Básica e Avançada em Saúde*), the *Instituto Gnosis,* and Fiotec (*Fundação para o Desenvolvimento Científico e Tecnológico em Saúde*). Chart 3 summarizes the regional distribution of the OSSs and the timetable for implementation of the management contracts. The five program areas with family clinics inaugurated up to 2010 formed the empirical scenario of this study. They are the following PAs: 1.0; 2.1; 3.1; 5.2 and 5.3.

Below we present aspects of the governance system adopted by the MHD in the ESF. The discussion took place based on analysis of the interviewees' perceptions, and of the official documents of the MHD and the Municipal Health Council (CMS). Overall, the interviews resulted in important information for the description of the process. It should be noted that, inde-

Chart 2. Management profile of the interviewees, by place in the institutional hierarchy, and position.

Institution	Local level	Central level
Social Health Organization (OSS)	Managers of the two first family clinics, of each program area, inaugurated at least three years ago, who have been in the job for more than one year	Manager of each of the four OSSs
Municipal Health Department ('MHD')	Coordinators of the five program areas that have family clinics inaugurated at least three years ago	Coordinating Managers of (i) the Family Health Strategy (Primary Healthcare, Health Supervision and Promotion Sub-department); and (ii) Social Organizations Contracting (from the Management Sub-Department).
Municipal Health Council (CMS)	Three representatives of users	

Chart 3. Distribution of the OSSs in the PAs and period of contracting – Rio de Janeiro, 2015.

Program area	OSS	Period
1.0	Instituto Fibra	2011 – 2013
	SPDM	2013 to date
2.1	Viva Comunidade	2009 to date
2.2	Instituto Fibra	2011 – 2014
	Instituto Gnosis	Current
3.1	Viva Comunidade	2009 to date
	Fiotec*	2009 to date
3.2	SPDM	2010 to date
3.3	Viva Comunidade	2009 to date
4.0	IABAS	2010 to date
5.1	IABAS	2011 to date
5.2	IABAS	2011 to date
5.3	SPDM	2010 to date

* Manages only the territory around the Fiocruz Institute, in Manguinhos, operating as a teaching territory.

Source: Authors, based on data accessed[14].

pendently of the institutional place or context, type of employment link (Labor Laws or formal government employment); and time of activity in the MHD, the interviewees' perceptions about the various issues dealt with were really quite homogenous, in spite of having been expressed with greater or lesser depth, depending on each person's professional career and critical view.

Contracting: The process of negotiation, the system of performance incentives and accountability with autonomy

The process of contracting has the following steps: Identification of needs; establishment of priorities; verification of installed capacity; negotiation and setting of objectives and targets; monitoring and evaluation; and application of a consequences system (incentives and penalties). To be successful, these stages need appropriate information systems and an internal organizational restructuring, for both the financing agents and the providers of services[15].

The three categories adopted for analysis of the contractual logic – the process of negotiation, the performance incentives system, and accountability with autonomy – are interlinked and complementary. Negotiation between the parties and the incentives system helps create greater accountability of the provider, which in turn needs some autonomy for adapting processes to the needs of the services and expected scope of performance. As a question of presentation of argument, these aspects are discussed separately.

The negotiation between financing agent and provider, whether public or private, is an important step, because it would stimulate partnership in the quest for better performance of the services. However, the interviewees' perception and the analysis of the management contract (MC) showed that the process of negotiation is not very strongly present in the relationship between the MHD and the OSS, since only some targets are agreed with the health teams.

The indicators and targets are pre-set by the Primary Healthcare Sub-secretariat. We do not have governability over any target, but this year, the clinics were invited to a conversation about the second variable portion, since no unit had succeeded in achieving it in three years of expansion of the Family Health Strategy. (GCF)

In the public tender announcement for the OSSs there are performance indicators and targets to be complied with by the management of the OSS (management indicators), and by the health professionals (care indicators). That is to say, when an OSS competes for management of the ESF it knows in advance what performance targets it is expected to meet.

In the context of primary healthcare in Brazil, if on the one hand the area of health shows indicators that are already consolidated, which is not frequent in the other areas of public administration, on the other hand, recognition of the subjective dimension of care and the existence of profound inequalities in health add a component of the intangible to the measurement of 'health needs'; 'adequate installed capacity', 'setting of objectives' and, principally, 'results'. Ney et al.[16] consider that in Brazil there is an "absence of a 'culture of evaluation' and negotiation between professionals and managers", and also little investment, and accumulated experience, in rela-

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tion to assessment of professional performance and contracting of targets for improvement of quality.

From this point of view, certain precautions need to be taken for the contracting to be characterized as a strategy of negotiation and cooperation, and not reduced to an instrument for demanding compliance with targets. This would limit the capacity for innovation, and the creativity, of the local teams in the exercise of healthcare. Here are some precautions[17]:

- The need for permanent adjustments in the indicators and targets chosen for the assessment. Unambitious targets would not reward good performance, and if they are very high, or cover only a small area of the work process, they could de-motivate the professionals, or, conversely, lead to focus on individual practices.
- Their gradual construction, in an environment of permanent learning and with the health professionals taking a protagonist part.
- Guarantee of transparency and implementation of the incentives system, and clarity as to the objectives and criteria for evaluation of the professionals/providers.

In this sense, it is considered that the non-participation of the health professionals in the decision on the indicators and on the targets reduces the potential of the incentive system as a device that aims, through a negotiated management model, to achieve better standards of performance[18].

While in the hospital environment the relationship between finance and results is the focus of the logic of the contract, in primary healthcare the central factor needs to be the exercise of a pact of agreement between managers and health professionals, since proximity to the users will be essential in the choice of indicators and targets that will be able to measure, with some sensitivity, the development and effectiveness of practices of health promotion, prevention and care. Negotiation would help to replace the traditional hierarchical relationship with a bilateral process of agreement.

The system of performance incentives for the OSSs adopted by the MHD comprises indicators and targets and is linked to quarterly pass-through of a variable part of the funding specified in the MC. It comprises three levels of incentive, also called *variable parts 1, 2 and 3*:

(1) Incentive to the management of the OSS: the aim is to induce good management practices and align them with the priorities set by the MHD.

(2) Incentives for the family health teams: related to achieving the targets for access, care performance, satisfaction of users and efficiency.

(3) Incentives for the health professionals: related to adaptation and quality of the accompaniment of users with certain problems or pathologies – this can be to up to 10% of the base salary of each member of the family health and dental health team.

From the point of view of Agency Theory, the system of incentives would avoid an opportunist behavior by the OSSs, and would stimulate standards of cooperation and collective rationality, to the detriment of patterns of behavior that preferentially serve sectorial or individual interests[19]. However, Melo[20] warns of the great complexity of the design of an incentive structure.

The interviewees pointed to the incentives system specified in the contracting as tending to induce: (i) improvements in the quality of planning of the team and stimulus to reflection on the work process; (ii) better alignment of practices between the services; (iii) positive competition and exchange of experiences between teams who have reached or did not reach the targets; (iv) reorientation of care in the logic of the Family Health Strategy; and (v) better use made of the user's computerized medical records. According to Agency Theory this is the objective of an incentives system: To induce the professionals (agents) to achieve the results desired by the MHD (principal).

The interviewees also said that the payment of a variable part of remuneration provided more motivation in the professionals in that the incentive part of the payment is considered as recognition of their work. The following comments express this perception:

Yes, it did create a change, it gave directionality. Previously, each area of the city did things one way. Today, now that we have the variable 2 and 3 indicators, the discussion has come out from management level and reached the teams. As from the moment when they reached variable 3, a very good effect emerged in the area, because other teams that had not reached it began to get moving, asking "What are they doing to succeed?" Then they began to see that the problem was in the organization of the work process. Then there was a positive competition, and they proceeded to adjust the processes. (GMHD).

Yes, in variable 2 the indicators refer to the work of the team as a whole. If I am a doctor and I work according to the protocols, but the community agent does not do his work, our team will not reach

the target. So it brings this sense of a strong team that the Strategy is asking for. And variable 3 deals with the quality of care of each professional with that user, so it re-orients practices, it stimulates the notion of the territory (GOSS).

Among the interviewees, the perception on which work processes made the most progress varied, both in terms of the training and degree of maturity of the FHS teams, and as a function of the leadership and communication capacity of the local managers of the health clinics. The professional category where most improvement in performance was observed was that of Community Health Agents.

Yes it does change, it changed the work process a lot. I see the health agents more concerned. The health agents, although they have been here since 2009, in the past they didn't use to monitor the vaccination cards [...]. *But as part of variable 2, they began to have a point of contact with the vaccination card. At the beginning, they didn't give it much attention, but when they began to receive a little more money in their account they said "Hey!"* (GCF2).

As well as the positive points, the interviewees pointed to some limitations in the process: reports of deficiencies in the reports produced based on the user's computerized medical record; some teams' difficulty in understanding that reaching the targets or not is directly related to better organization of the work process; and imposition of the indicators and targets by the MHD, making it more difficult for the managers to mobilize the employees.

The results suggest that remuneration of health professionals linked to performance indicators is one more device for improvement in the quality of health services, but that it would only work adequately as part of a group of specific organizational strategies. These would include: adequate training of the professional; his/her ethical commitment; institution of permanent education spaces; communication and leadership capacity on the part of the local managers; and the existence of other, non-financial incentives[21].

Another aspect of the contractual logic is the delegation of authority, with granting of autonomy and subsequent monitoring of results, aiming to enhance the parties' degree of accountability. However, the autonomy granted to the OSSs is limited to that which arises from their private legal regime: contracting of staff; and acquisition of inputs, equipment and services in accordance with the rules that are specific to the third sector.

If on the one hand this is the principal motivation of the municipal manager for adoption of the OSS model in Rio de Janeiro, on the other, by limiting the autonomy of the provider only to the administrative sphere, it steps back from the logic of contracting, reduces the potential for partnership in the adoption of innovative practices, and impedes the exercise of accountability.

The managers of the HMD and the OSSs interviewed pointed to this reduced autonomy. The former agree with this practice because they believe that public funds need to be controlled and that there is not a relationship of confidence between the parties that would justify the granting of autonomies:

We are inspectors and monitors – auditors – of the contract; our function is to order and supervise the expense of the contract, it is we who monitor and oversee the indicators; we authorize the pass-through of the money; so we cannot let it all run in their hands. At the end of the day, if something goes wrong in the area the person responsible is the coordinator and his/her team. Understand? It's our telephone that rings morning, noon and night – and in the small hours. (GMHD).

The Coordinating Units of Primary Healthcare check everything, the electricity bill, the phone bill, how much was spent. This guy was fired, why did he receive that much? Yes they do go into that degree of detail. The OSS doesn't have any autonomy. Our relationship is one of subordination. Partnership implies a relationship of trust, and there really isn't one. What the coordinators of the CAP are worried about is: "If the Federal Prosecutors turn up here, I'm the one whose signature is on the line". (GOSS).

On this aspect, a study by Martins[22] on contractual experiences in the federal public administration indicate as a 'bad condition' the oversight relationship where the supervision follows a pattern of subordination based on the attribution of specific actions and demands parallel to what is agreed; and as a 'good condition' the agent-principal relationship based on calling for the results that were agreed in the contract.

Regulation of the OSSs: making of rules monitoring, evaluation and control

Regulation is an essential and strategic attribution of the State at the time of separation between financing and execution of services – whether it is because a strong regulatory capacity can prevent undesired behaviors from the entities contracted, or whether it is because the State needs to ensure adequate execution of public

policies. In the system of contracting with OSSs, having regulatory capacity means that the State needs to make rules, that is to say, define the rules for execution of the activities; grant autonomy of the processes; control the results through permanent evaluation; and make the OSSs accountable for the results achieved.

In this point of view, the municipality of Rio de Janeiro adopts three phases of standardization for the relationship between the MHD and the OSS: Qualification of third-sector entities as OSSs; public tendering; and formalization of the management contract. As well as these formal rules and others contained in the relevant legislation that governs the relationship between the contracting and contracted parties, another group of specific orientations on the process of work in the FHS is passed on as routine by the MHD to the managers of the family health clinics in periodic meetings and visits. Examples are: the organization of reception of the user; handling of care paths, and specific illnesses; and the regulation protocols for examination, procedures and hospitalizations.

According to the interviewees, the OSSs periodically report for examination on their financial execution; and performance is measured by the degree of attainment of the targets that are set in the contracting phase – which comprise the system of incentives. However, the MHD does not carry out an audit to test the reliability of the health care information sent by the OSSs; and we conclude that the information system, fed largely by the user's computerized medical record, needs to be perfected. The Municipal Audit Board (TCM) carries out periodic audits relating to proper conditions of facilities, systems of control, input materials, services contracted and offered, physical structure, and staff, and puts the reports that are prepared on its institutional website.

According to the official discourse of the MHD, the governance by OSS has a focus on results. The traditional way of evaluating contracts and the provision of services by correct use of funds would be replaced by verification as to the specified targets being met for the performance indicators. However, the comments of the interviewees showed a different situation: this is that the monitoring of the process and the legal conformity of the acts and procedures predominates.

In Rio de Janeiro it is the municipality that lays down the rules, that controls, that sees how it is working, and that demands compliance. If there is something that is wrong it will go there and state an order: "It has to be done this way" – not the way that the OSS wants it to be done. In São Paulo and other municipalities where we operate, we do everything, the municipality does not get involved, it wants the results, it wants the indicators, it doesn't get involved. In Rio de Janeiro, it's not like that, here it is really different. (GOSS).

If monitoring-control of results is an advance in the management of public policy, because that is what interests the population; on the other hand the control of processes should not be excessive, although it is important in that it increases the security of those involved in the contracting in relation to the use of public funds. Also, in the case of the FHS of a city the size of Rio de Janeiro, the monitoring that the MHD carries out on the work process of the teams conjugates two essential factors in providing public policies of a social nature: it allows the care model adopted by the MHD to have directionality; and it avoids opportunist or inappropriate behaviors by the OSSs to meet the targets 'at any cost'. Another argument in favor of control of the processes is the difficulty of measuring the impact of the actions undertaken in the domain of primary healthcare.

It can be highlighted that inspectors of the management contracts are public employees, who have always worked in the procedural control typical of direct administrations, and for a change of the culture required in the process of contracting, the accumulation of experience and the permanent learning of these professionals is important. What is desirable would be for the MHD not to confuse its responsibilities with those of the OSS so that the relationship of partnership could be established in reality.

Another aspect to be considered in the partnerships of the State with the third sector is the importance of differentiating between the function of regulation and the actual management of the final activities themselves, so that regulation is not confused with the interests of the contracting sector, and makes it possible for there to be an impartial value judgement of the performance of the partnerships[23]. In Rio de Janeiro the regulations exercised by the MHD itself, through the Technical Evaluation Committees (CTAs), a committee structure made up of professionals of the Management Sub-department, the Primary Care, Health Vigilance and Promotion Sub-department, and the Coordinators of the CAPs. There is a CTA for each MC.

When the CTA finds a need to punish the OSS, this demand is submitted to the Secretary's Office for the measures to be taken – which may be: warning; notification; termination of the

contract; or disqualification of the entity (removal of its title of OSS). In the FHS, so far two entities have been disqualified and replaced by the present ones. When this happens, the health professionals and the teams remain in the units and are re-contracted by the new OSS that takes over. This can be considered a good practice, in that it avoids turnover of professionals, and loss of link with the community.

Based on the results of this study, it is considered that the regulatory capacity could be much better developed by an instance that would be external to the contracting entity, with independence and autonomy to inspect and verify compliance with the execution of the management contract, and formed by public servants of high competency in the administrative, legal, accounting audit and clinical areas.

Public transparency and social control

Public transparency consists of: disclosure of data and information by the bodies and entities of the public administration as part of the responsibility for accountability for their acts to the citizens, in a voluntary manner. It is an important dimension of good governance, because it increases accountability, as well as being a necessary condition for the citizens effectively to exercise social control. Promotion of public transparency can avoid undue and arbitrary acts by people in government and public administrators.

On this aspect, transparency should be present in all the stages of the process of contracting between the MHD and the OSSs, with publication of basic information on the management contracts and their results. This information should be appropriated, at least minimally, by the legitimate instance of social control in the SUS, which is the Municipal Health Council.

The findings of this survey point to the difficulty of access to information. Only the public tender invitation notice for partnerships with the OSSs is published – in the Official Gazette of the Municipality. And the web page of the MHD dedicated to publication of Management Contracts was not updated between 2011 and October 2015, when the field work of this study ended. Reports of monitoring and evaluation of the MCs are not published by the MHD – only sent to the various control bodies: the General Controller's Office (internal), and Municipal Audit Board – TCM (external), for their information. This finding can be exemplified by the answer given by one manager to the question "In relation to society, what instrument of transparency does the Municipal Health Department use in relation to the making of contracts with the OSSs?"

The quarterly reports of reporting and accountability, based on performance, are not published anywhere at all, and not even the Municipal Health Council has access. (GMHD).

In relation to social control, the municipal law instituting the OSSs is timid, stating only that "Any citizen, political party, association or union entity is a legitimate party for making accusations of irregularities committed by Social Organizations to the Municipal Administration, to the Audit Court or to the Municipal Legislature[24]. According to the members of the municipal health council interviewed, the OSSs do not comply with the requests of the Municipal Health Council to provide statements of account. It is done by the MHD, and with little discussion.

We don't have access to anything, anything at all: I take part in the meetings of the Council, I fight, I ask for information. Management contracts? I have never seen them. (CMS)

A good practice would be participation of users in membership of technical chambers to assess the Management Contracts – some municipal legislations have these, but they are absent in the municipality of Rio de Janeiro.

In this scenario, it was found that the degree of transparency and social control existing in the relationship between the MHD and the OSSs is low, and is not different from the one that exists in the processes of direct administration of the SUS[25]. This goes against the requirements of the public administration management that this partnership model should lead to more transparency and social participation.

Final considerations

The analysis of implementation of this process, which has significant scale and complexity and has been in progress for six years in the Rio de Janeiro Municipal Health Department – a time that can be considered short for maturation of a new organizational approach of this complexity – calls for prudent analysis aiming to provide inputs for the efforts of monitoring. Case studies on interventions that have not yet been consolidated make it possible to explore the difficulties of practical application of certain concepts and the relations that exist between the assumptions for an intervention and the real context in which it is situated.

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The Municipal Health Department adopts a contracting model in which the OSSs are considered to be an administrative tool for facilitating acquisition of goods and services and the provision of health professionals. To this effect, it establishes a relationship with these entities that is closer to subordination and further from partnership and cooperation, which would appear to limit the development of management innovations to be introduced by the adoption of the contractual logic and of the institutionalization of evaluation of results.

This dynamic requires permanent evaluations for adjustments and correction of direction, both in relation to the difficulties inherent to the implementation of the FHS in large urban centers, and also in relation to the process of contracting with the OSSs that establishes a new interaction between the players. However, organized efforts were identified in the MHD to improve the partnership with the OSSs, confirmed by the successive adaptations made to their organizational structure. There is an important process of learning in progress.

It is believed that there is no single model of partnership with an OSS, but different variations, originating from the combination between institutional rules, socio-economic singularities, the degree of institutional development and the factors determining by interplay of local political events.

Summing up, and in the light of the study carried out, it is concluded that the OSS model still needs to be improved as a management option in the ambit of family healthcare in the SUS, because the State does not have the necessary regulatory capacity – this factor includes weaknesses in the technologies for monitoring the activities provided, which make it difficult to evaluate the performance of the services contracted.

From this point of view, the successes and failures of the partnerships of the State with the third sector depend on the capacity of the state at the various phases of organization of those partnerships. Factors required will include: a high level working group; clarity of objectives; analysis of alternatives – use of partnerships would have to show advantages in relation to the public option; technical and legal capacity; specification of baselines for evaluation; management of change; clear communication with the professionals and the population; and appropriate monitoring of the processes and control of the results.

Management of the health services is a complex practice, due to the breadth of the field and the need to reconcile individual, corporate and collective interests, which are not always convergent. Systematic analysis of the management models could contribute to improvement of the responses to the needs of the health sector, and expansion of governments' capacity to implement public policies as a strategy of promotion of social justice.

Collaborations

VC Silva worked on the conception, research and the final drafting; VA Hortale, on the critical review and final drafting; and PR Barbosa on the critical review.

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