

Implementation of promotion and prevention activities in decentralized health systems: comparative case studies from Chile and Brazil

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SUMMARY

The policies for restructuring health systems in Latin America during the 1990s have included an emphasis on changing in the model of health care delivery to one that incorporates prevention and promotion activities. At the same time, health systems have been decentralized in their management, allowing room for greater variation in local interpretation and implementation of policy directives. Despite rhetoric and policy debate, there is no documentation or evaluation of actual experiences of prevention and promotion within decentralized health systems in Latin America. This paper explores the ways in which the national structure of a health system influences the implementation of activities for prevention and promotion through a comparison of the experiences in four local health systems in each of Brazil and Chile. These experiences in Brazil and Chile are presented by key themes of national health system structure, local health system structure, partnership and intersectorality, human

resources and introducing a family health approach. Five clear factors emerge as operating at the national level that influence prevention and promotion activities in local health systems: vertical (Chile) versus horizontal (Brazil) structure of health system; greater awareness of prevention and promotion issues in Chile; greater urban bias in Chile compared with Brazil; strategies to attract human resources to primary care and rural areas; importance of local capacity building especially in rural areas. This account of case study experiences in Brazil and Chile provides a series of examples of arrangements and strategies that can facilitate implementation and usefully highlights a number of issues that policy-makers and health system managers need explicitly to consider. As such, the paper hopes to provoke debate about the structures and strategies for supporting the implementation of prevention and promotion programmes in Latin America and further health systems research in this field.

Key words: prevention; promotion; decentralization; Latin America

INTRODUCTION

The launch of the Ottawa Charter in 1986 (WHO, 1986) coincided with a period of major political change in many countries of Latin America as they moved towards civilian government following decades of military dictatorships. Within this democratization, the role of the public service sectors have also been reviewed and reformed.

Alongside policies to restructure the organization, financing and accountability of national health systems have come policies to shift the vision or model of the health care to be provided. This has taken the form of a renewed commitment to a focus on prevention along the lines of Alma Ata (WHO, 1978) together with new discussions about

the incorporation of health promotion (see for example, Brazilian Constitution, 1988; Minsal, 1988a; Minsal, 1988b). The need for a new vision of health care provision is particularly marked in Latin America where countries display an epidemiological polarization in which high levels of infectious disease persist accompanied by high levels of chronic, lifestyle diseases (PAHO, 2002). Moreover, the common assumption that this polarization tends to follow a poor–rich division is incorrect; the poor, it appears, suffer the highest levels of both disease types (Stephens *et al.*, 1994). The importance of reorienting health care provision in Latin America is also strongly supported by the Pan-American Health Organization as evidenced by series of statements and publications during the 1990s (PAHO, 1992; PAHO, 1997; PAHO, 1998; PAHO, 2002; Paim 1994; Mendes 1996). The interest of Latin American countries in reorienting health care is reflected in Mexico's hosting the 5th Global Conference on Health Promotion in 2000.

Nonetheless, despite recognition of a need for change, commitment of PAHO and national governments and involvement of Latin American policy-makers in international and national debates, 'Changing a paradigm was never meant to be easy' (Kickbusch, 2001: 1). Movements for change need to be located within the broader context of neo-liberal reforms that have been implemented across the region (Lloyd Sherlock, 2000), which at times have brought new challenges to the health sector as levels of inequalities and poverty rise (Raczynski, 1994). At a regional level, the international finance institutions advocating market reforms, such as the World Bank and the Inter-American Development Bank, have replaced the PAHO as the central actors in health policy-making processes with an increased momentum in the globalization of health policy (Deacon *et al.*, 1997; Abel and Lloyd Sherlock, 2000). Within Chile and Brazil themselves, the marketization of health care has increased inequalities in the health sector (Almeida *et al.*, 2000; Barrientos, 2000; Collins *et al.*, 2000; Gideon, 2001), health professionals are under increased stress within the public sector (Minsal, 1996) and many low-income households have access only to poor quality public services. Under such circumstances, where neo-liberal reforms directly contribute to declining public health systems and reinforced the dominance of bio-medical health care models, skepticism is inevitable about

governments' apparent commitment to shifting primary health care towards more holistic approaches. Although this paper is focused on the public sector, it is important to note that both countries have extensive private sectors with little (financial) incentive to provide preventative services rather than curative or health promotion activities.

The form of health promotion model advocated is likely to reflect the wider political context. Models can be broadly categorized as either lifestyle (individual) approaches that focus on individual behavioural change or structural approaches that focus on environmental factors (Bunton and MacDonald, 1992). Lifestyle approaches are more associated with curative models of care as they are concerned with the identification and subsequent reduction of behavioural risk factors associated with morbidity and/or premature death. In the current era of neo-liberalism it is not clear how far policy-makers are able to move beyond individual approaches.

This paper aims to explore how rhetoric translates into reality. It is at the implementation stage where negotiation and compromise around public policy really takes place and determines the outcomes of policy (Elmore, 1997; Lipsky, 1997). Within the current context of health systems that are decentralized, the room for manoeuvre and reinterpretation of national policy directives is even greater (Atkinson, 1995). The processes by which policy intentions are transformed into practice have long been recognized as complex and influenced by a multitude of factors both within the health system and from outside it (Pressman and Wildavsky, 1973; Lipsky, 1980; Atkinson *et al.*, 2000). This paper focuses on influences from the national scale structure of a health system on the implementation of activities for prevention and promotion through an empirical exploration and comparison of the systems of Brazil and Chile based on four local health systems case studies in each country.

A COMPARATIVE CASE STUDY RESEARCH DESIGN

In order to identify the influence of national scale structures and actions on local scale activities, a comparative case study research design is used. Eight local health systems (called *municípios*), four from each country, were purposively selected to provide an urban and a rural pair in

which one local health system was relatively advanced and one relatively basic in implementing prevention and promotion activities. The case study site selection, presented in Table 1, was made in close consultation with regional health managers, a consideration of existing secondary data on health outputs and socio-economic characteristics as well as a preference for sites where the national research institutes already had existing contacts to thus facilitate access. Data collection at all scales in the health system, local, regional and national, was based on formal documents of policy strategies and on in-depth interviews with health personnel at all scales in the system as well as with personnel in related sectors and in the user population at the local case study scale. In this paper, we present a discussion of the differences between the operations of the two national health systems and the ways in which this can

influence the local scale. A summary of the activities found in each case study site is in Tables 2–5. The discussion is structured by key themes of national health system structure, local health system structure, partnership and intersectorality, human resources and introducing the family health approach. The paper concludes with a summary of the key issues for consideration by policy-makers and national health system managers.

PREVENTION AND PROMOTION IN CHILE AND BRAZIL

The Chilean health system has been more successful in getting discussion of prevention and promotion onto local health policy and planning agenda and where implementation has been successful there are a number of innovative and exciting developments. Local health staff in Chile are explicitly aware of the need for prevention and promotion and define priority health issues to be addressed. Brazil remains more conservative in the provision of health care with a greater focus on treating individuals once a problem has been identified. In Brazil, health professionals rarely talk about health promotion as such.

The activities undertaken (Tables 2–5) demonstrate the variation between local health systems in the extent to which they have adopted

Table 1: Study site selection

| Region | Brazil | Chile |
|--------|---------------------|--------------------------------|
| Urban | São Paulo State | Región Metropolitana, Santiago |
| Active | Diadema | La Pintana |
| Basic | São José dos Campos | Pudahuel |
| Rural | Ceará State | Región VI |
| Active | Pedra Branca | Perallilo |
| Basic | Tauá | Paredones |

Table 2: Prevention and promotion activities in rural Brazil

| Pedra Branca | Tauá |
|--|---|
| Health sector: service based activities Vaccination, ANC Videos on education at health facilities | Vaccination, ANC |
| Health sector: community-based activities CHWs, seven family health teams, basic health posts—general health education, focus on MCH/adolescent health Environmental monitoring; chlorine tablets distribution | CHWs, family health teams, but only one functioning Radio programmes, school campaigns on environmental health (State/MoH initiatives) |
| Intersectoral activities Sanitation kits distributed for health sector by social workers Dental health programme in schools Health programmes on local radio station | Campaigns on dental health in schools |
| Other agencies' activities Prefecture Sanitation and water infrastructure projects; awareness through radio External Touring theatre group addressing health promotion issues | FNS (parastatal organization) Epidemiological surveillance/monitoring |

Table 3: Prevention and promotion activities in urban Brazil

| São José Dos Campos | Diadema |
|--|---|
| Health sector: service based activities Vaccination, ANC, smear tests Hypertension and diabetes programme Projeto Casulo—focus on high risk pregnancies and infants | Vaccination, ANC, smear tests Hypertension and diabetes programme Health lectures (patchy attendance) |
| Health sector: community based activities Centre for elderly Campaigns for vaccination, cervical cancer | Activities for elderly Community based campaigns for vaccination, environmental health, BP AIDS awareness and condoms at carnival Chase up defaulters for vaccination Family health and CHW programme |
| Intersectoral activities Sabesp (water provider) leaflets on cleaning tanks; Limited education and chlorine provision for water home treatment in remote areas; Independent water quality monitoring Dental care: school children focus, some programmes for babies | Water and drainage distribution and pricing under municipal control allows progressive charges and schemes to facilitate payment by poorest Chlorine distribution for home-treatment Independent water quality monitoring Dental care: school children focus, some programmes for babies Litter clearance, recycling in community |

Table 4: Prevention and promotion activities in rural Chile

| Peralillo | Paredones |
|--|--|
| Health sector: service based activities Adult health check—ESPA as obligatory programme Info leaflets on various health issues Dental care for school children 6–9 years Workshops for women's health—seen increase in uptake of cervical screening Incorporate promotion education into daily work | Adult health check—ESPA as obligatory programme Info leaflets on various health issues Dental care for school children 6–9 years Programme against obesity Visual info re different programmes |
| Health sector: community based activities Hypertension and risks, healthy eating and lectures re doing blood pressure Prevention of domestic violence—ad hoc lectures with little effect | CHWs including programme for seniors Health kiosk in square |
| Intersectoral activities Education sector: Programme on prevention of alcohol and drugs, involve health and police departments | |
| Other agencies' activities Intendencia Rancagua: Prevention of STDs and HIV via theatre | |

prevention and promotion activities. While none of the urban sites is weak, the rural sites are both rather weak in Chile and one so in Brazil. In Chile, the obstacle to action is not awareness of the problem but lack of local capacities of various kinds to put ideas into action. In Brazil, lack of awareness is at times an issue but local capacities for action are potentially greater compared with Chile.

NATIONAL HEALTH SYSTEM STRUCTURES

The major difference between the two national health systems of Chile and Brazil concerns the organizational structure, hierarchical and vertical in Chile, equal and horizontal in Brazil. Directives and resources from the Ministry of Health in Chile constitute compulsory activities

Table 5: Prevention and promotion activities in urban Chile

| La Pintana | Pudahuel |
|--|---|
| Health sector: service based activities Adult health check-ESPA: 30% coverage Niño Sano project—age-related risks Adolescent health Cardiovascular for at risks re self-care Dental health Mental health | Adult health check-ESPA: 10% coverage Prevention of prostate cancer Dental health education Geographic information system |
| Health sector: community based activities ESPA in markets, limited resources Abuse/neglect of child-adolescent expectant and mothers via home visits Dental health prevention—pre-school age CHW activities Workshops on drugs, HIV/AIDS | ESPA in workplaces, neighbourhoods Prevention of alcoholism and drug addiction with NGOs and clubs Lectures at nurseries and clubs for elderly CHW activities Workshops on healthy lifestyles |
| Intersectoral activities Healthy schools (healthy comuna project) Project Mírame: with education sector (Admire me: to be a healthy adult in the 2000s) lifestyle training | Dental health in schools Support to self-help NGO (<i>hipertensas liberadas</i>) Environment sector very active, CHWs in schools link environment and health |
| Other agencies' activities | Social sector: family health education on respiratory infections for seniors and pre-school children at neighbourhood centres; projects for elderly re activity and care Environment sector: many activities |

that have to be carried out. The Ministry organizes its core activities around a number of programmes to different age or sex groups: child, adolescents, women, adults and elderly. The programmes set policy, strategies and targets across the country. Within this structure, the national health system of Chile has explicitly championed the need for health promotion. A promotion unit was established within the Ministry of Health in 1997 with representatives at all levels in the system. The first Congress for health promotion was held in Santiago in August 1999, and a formal policy document produced (Minsal, 1999a; Minsal, 1999b). The Ministry's health promotion unit has identified sixteen priority health issues, potential causal factors and strategies for action. The health promotion unit has funding for specific activities addressing these priorities, which is distributed through the Regional level of management, the 'Servicio de Salud' down to the local health system. Each local health system names a local contact person for promotion, identifies its own priorities and action plans to submit to the Servicio, which then distributes funding according to its evaluation of the plans. However, unlike other Ministry programmes, the availability of funding is not automatic. The rural *municipios* are particularly

dependent on the central Ministry resources, but the Servicio in our study region distributed its limited funds for promotion to less than half of those within its region. The Servicio also has no free human resource capacity to support local health systems in developing their plans. Thus, only those with experience in writing good project proposals and probably experience in health promotion are likely to win funding.

The Brazilian national health system looks on first impression to be similar. The central Ministry of Health provides funding to local health systems for activities within the same range of age and sex defined programmes: child, adolescent, women, adult and seniors. There are also funds for specific activities such as hypertension and diabetes similarly to Chile. The difference is that the health system's legal structure is horizontal in that the three levels of the system, federal (national), regional (state) and local (*município*) are all equal; the federal level cannot dictate to the local level what health activities to carry out beyond the basic legal framework. Thus, the available funds of the Ministry act as an incentive for local health systems to adopt certain types of health activities rather than this being a directive. In Brazil, the urban *municípios* have their own sources of

funding and thus the financial incentives of Federal programmes are less influential. In contrast, the rural *municipios* are almost entirely dependent on federal funds and are much more in tune with what funding possibilities are available from the Ministry.

The advantages and disadvantages of the vertical or horizontal structures are mixed. The advantage in Chile is the great awareness now of health promotion as an issue. Similarly, the regional *Servicio* plays an important role in the Chilean rural areas in ensuring some activities are carried out. The rural local health systems in Chile largely carry out activities that are directives from the national and regional levels. Without these, very little would be done. The advantage of this is seen in rural Brazil where local health systems without hierarchical controls can potentially end up providing extremely weak services for their populations. On the other hand, a vertical structure does not support local initiatives. In a system that is decentralized in order better to respond to local needs, the Chilean system that provides support mostly for promotion activities that correspond to the national and regional identified priorities expressly conflicts with a policy for local responsiveness. The Brazilian system in this respect explicitly works to strengthen local capacity to identify, plan and implement activities that respond to local needs; its success in doing so in part depends on adequate structures of accountability not only upwards but also locally to the *municipio's* population. A second disadvantage to the vertical structure is the danger that prevention and promotion programmes (but particularly promotion) are seen as an additional, separate set of activities to be funded through the vertical system rather than viewed as a significant component of a re-orientation in health care provision in general. This separate, vertical programme view of prevention and promotion is evident in attitudes of health staff in Paredones and Pudahuel. Peralillo has a better vision of trying to re-organize existing practice of the local health system to accommodate prevention and promotion while La Pintana has received resource inputs specifically to restructure the provision of health care. Although the Brazilian *municipios* show less explicit awareness of health promotion and fewer activities currently, the horizontal structure means that what activities are initiated are integrated into a culture of practice within the local health system.

LOCAL HEALTH SYSTEM STRUCTURES

A decentralized health system allows for flexibility in the way the local health system is structured. The eight local health system case studies show four different structures.

In rural Chile, the local health system largely depends on the regional *Servicio*. However, in Peralillo, the social worker has found space to initiate some few local activities and health centre staff have re-organized their daily routines to include promotion inputs.

Although both La Pintana in urban Chile and the Brazilian *municipios* are subject and answerable to the local government, this has taken two different forms. The urban Brazilian *municipio* of São José dos Campos has created a distance between the health system and local politics by portraying health care provision as a technical issue, allowing some autonomy from local government and continuity in health policy across governments of different political orientations. In contrast, the urban *municipios* of Diadema, Brazil and La Pintana, Chile, see the activities of their local health systems located within wider government concerns of poverty, violence and other social issues. In this respect the two health systems have a much closer involvement politically with their local governments; however, a close relationship to the local government is not always indicated as an advantage. A close political relationship to the local government exists also in the rural Brazilian *municipios*. The political upheavals and lack of continuity in Tauá is echoed in the health system with a high turnover of senior management staff, a lack of continuity and little policy direction in contrast with Pedra Branca where the opposite has been the case.

Finally, Pudahuel has established an independent municipal development corporation in which all sectors are equal members. This administrative structure provides greater flexibility for sectors to seek independent resources and establish partnerships with other entities, particularly in the private sector. Nonetheless, the health sector in Pudahuel has not been very active in this compared with the environmental sector indicating that the corporation structure alone is not enough for such partnerships to emerge. The corporation structure does facilitate intersectoral actions; the health system in Pudahuel is brought into some of the innovative activities of the environment sector.

There is further decentralization within some municípios such that health centres and their catchment territories have some autonomy in their own management. In Pudahuel, Pedra Branca and the two urban Brazilian municípios, territories and health centres have local health committees with members from the population that define their own strategies and actions within the framework of the município goals. The Chilean urban município of La Pintana has a pilot family health centre (El Roble), which has greater than normal autonomy. However, the special character of El Roble as a pilot with inputs of external resources means that the success of this experience is not automatically relevant for all municípios. Indeed, the two urban Brazilian municípios have pulled back from a more extensive decentralization finding this created a system that was too fragmented.

PARTNERSHIPS AND INTERSECTORALITY

Those municípios considered more successful in initiating prevention and promotion activities have effected this often in collaboration with other partners including other local sectors and particularly with the education sector. Both countries and many of the municípios have a longer-term strategy of targeting the next generation rather than trying to tackle established behaviours, attitudes and habits amongst adults. Both countries have good rates of primary education and so schools present a captive target population. Provision of dental health care through schools is a common approach and is exceptionally successful in São José dos Campos with coverage rates above WHO targets. Intersectoral collaborations have often started with personal contacts facilitating project success, but for longer-term sustainability, these relationships need to be institutionalized. More formal working relationships are found in Pedra Branca in rural Brazil compared with its partner study site, Tauá, in both urban Brazilian municípios and in La Pintana in urban Chile. Pudahuel has a strong intersectoral collaboration between the environment sector and the education sector, which involves the health sector but not as the initiator. Intersectoral activities, therefore, are favoured by a combination of formal local government support and informal personal contacts.

Contracts can be made with the regional scale authorities. Peralillo, rural Chile, has a contract with the regional government to provide health promotion through a touring theatre group. Ceará state similarly has various project resources that local governments can contract into with the state government for sanitation, water and other infrastructure impacting on health. La Pintana, urban Chile, has a formal agreement with the higher education sector enabling the município to improve its human resources, open the health centre El Roble, access other pilot schemes such as the innovative project *Mírame* (WHO, 1997) and access additional resources for new programmes such as involving University psychologists in developing a mental health programme. Pudahuel, in contrast, has had great success in attracting project resources from the private sector particularly into environmental projects.

It is clear that the ability to exploit opportunities for partnership are far greater in urban than in rural municípios. First, the partners outside of the immediate public sector are more likely to be based in the urban region and secondly, the urban municípios with a larger cadre of personnel are more likely to have local capacity for developing proposals to such partners. Rural areas need specific support from the regions to develop their capacity in this respect.

HUMAN RESOURCES

Human resources are limited in all municípios. The greater degree of decentralization in Brazil has given value and career status to working in primary care at the municipal level, at least in the urban regions; attracting health professionals to work in rural areas remains difficult. Chile has difficulties attracting physicians to work in primary care in both urban and rural regions. La Pintana gets round the problem through partnership with the University; Pudahuel gets round the problem by hiring foreign physicians, mainly from Cuba. The rural municípios have no means to exploit either of these strategies and function with a high turnover of staff. In rural Brazil, the incentives offered through the Ministry's family health programme could attract senior and experienced management staff to rural municípios. However, the morale of staff is also critical in innovating new activities. Staff left the family health programme of Tauá because their salaries were not paid on time.

In Pudahuel, staff feel overworked, undervalued and blame the organization of the health system. The pilot experience in La Pintana has created staff commitment, support for one another and a good working atmosphere through a flexible matrix structure of management involving teamwork, team responsibilities and self-evaluation. This may be an interesting model for other *municipios* to explore.

INTRODUCING THE FAMILY HEALTH APPROACH

Both countries recognize a need to change the model of basic primary health care delivery and are promoting a model of family health medicine but with different approaches to implementation.

The Chilean government established around thirty-five pilot health centres, including El Roble in La Pintana, to implement a new family health model of primary health care. The Universities support this strategy through specialization courses in family health medicine. El Roble is a teaching centre for practical experience and is run by the first generation of graduates from the specialization course. The Brazilian Ministry of Health provides incentives for *municipios* to implement a family health approach through the provision of financial support for family health teams (the PSF programme). The teams work in underserved areas or as mobile teams in the *municipio*. Specialized training in family health is entering University curricula but subsequent to the Ministry initiative rather than as a precursor.

Thus, Chile has an approach whereby showcase health centres pioneer the way and other *municipios* may choose to follow in a snowball effect. However, other *municipios* may wait for the Ministry to provide funds; the case of Pudahuel is instructive. Although expressing an intention to implement a family health approach, staff reported that there were no funds for this, implicitly viewing this as a parallel programme rather than an integrated one. In contrast, Brazil has a blanket approach in which the Ministry encourages a family health approach through the availability of good salaries and other perks. The local health systems themselves decide whether to adopt the programme and how to implement the approach in their *municipio*. In Brazil, this programme has been particularly attractive to rural local health systems where the problem of providing good accessible care for a dispersed population is a

major challenge. Although rural *municipios* in Chile have the same challenge, the University link and Ministry piloted project has an urban base and urban interest. The Brazil approach thus might have value for the Chilean context.

CONCLUSIONS

The decentralized health systems of Brazil and Chile do show great variation in the extent and ways that prevention and promotion activities are implemented. Five factors are seen as operating at the national level influencing this.

- Vertical (Chile) versus horizontal (Brazil) structure of health system.
- Greater awareness of prevention and promotion issues in Chile.
- Greater urban bias in Chile compared with Brazil.
- Strategies to attract human resources to primary care and rural *municipios*.
- Importance of local capacity building especially in rural *municipios*

Other issues that emerge as important factors in both national systems are:

- Organization of the local health system within a decentralized structure.
- Matrix management and teamwork within health centres.
- Ambivalence about the value of decentralization within the *municipio*.
- Snowball versus blanket approach to introducing family health approach.
- Importance of links to education sector—targeting the next generation.

Clearly different constellations of strategies work successfully together and there is no simple blueprint for an optimal health system structure or set of incentives. The paper hopes to provoke debate about the structures and strategies for supporting the implementation of prevention and promotion programmes in Latin America and further health systems research in this field.

Whilst any national health system has its own particularities, the health challenges of Brazil and Chile, the strategies of introducing prevention and promotion into mainstream health care and indications of what works and the role of contextual factors have relevance for other Latin

American countries. Equally relevant are the broader questions as to whether these early moves towards health promotion can thrive in the climate of neo-liberal reforms of health sector marketization or can advocate structural changes needed for sustainable, population-oriented health promotion. Nevertheless, the empirical findings here do present a series of examples of arrangements and strategies that can facilitate implementation and usefully highlight a number of issues that policy-makers and health system managers need explicitly to consider.

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