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Interdependence between government levels in Brazilian health policy: the implementation of Emergency Care Units in the State of Rio de Janeiro, Brazil

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Abstract *This article addresses policymaking related to Emergency Care Units (ECU) in the State of Rio de Janeiro between 2007 and 2013, duly identifying the relationships between the various levels of government in this process. It prioritized the context of policy formulation, the factors that motivated the inclusion and maintenance of ECUs on the state agenda and the process of how the policy was implemented in the state. The study was based on the literature that defines the agenda and implementation of public policies and on contributions from historic institutionalism. The research involved analysis of documents, secondary data, and 51 interviews with people in positions of authority in state and municipal governments. The priority given to ECUs in the government agenda was the result of a confluence of historical, structural, political and institutional factors, as well as the current context. The results of this study indicate the existence of interdependence between levels of government, however federal coordination problems have prejudiced the integration of the various components of emergency health care in the state.*

Key words *Federalism, Health policy, State government, Emergency medical services, Unified Health System*

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Introduction

The term *federalism* refers to a group of institutions that enable political authority and the exercise of the power of the state to be shared between multiple geographical centers[1]. In these cases, the production of public policies tends to be more complex[2,3], calling for negotiations between governments that are endowed with different sources of legitimacy, visions and plans.

Studies show that the issue of federalism has been a crucial element in the history of health policy in Brazil[4,5,6]. However, since the Constitution of 1988, other challenges have imposed themselves on operation by the state in the area of health. The Unified Health System (*Sistema Único de Saúde,* or SUS), which is a national institution to serve the entire population, was implemented in a new federal context[7], characterized by democratization, renewed concentration of political and fiscal resources in the federal Executive[8,9], sharing of governmental functions, and stimulus to decentralization in shaping public political systems[10].

Since the 1990s, mechanisms of inducement and coordination were developed in health policy, that enabled states and municipalities to adhere to national guidelines[1,12], and the strengthening of federal regulation[13]. The strategies adopted also favored the configuration of decision-making arenas, formalization of intergovernmental accords, and dissemination of the rules at the national and state level[14,15,16].

In this context, the federal structure and the relations between instances of government are fundamental variables for understanding specific health policies, particularly those of which implementation was decentralized. The objective of this article is to analyze the policy related to the Emergency Care Units (*Unidades de Pronto Atendimento*), or UPA, in the state of Rio de Janeiro (RJ), from 2007 to 2013, identifying the intergovernmental relations.

Three arguments justify the study. The first is the high degree of importance given to UPA in the period under analysis. UPA have expanded significantly in the country as a whole in recent years, and are now part of Brazil's national Emergency Healthcare Policy[17].

The second one is the strengthening of the states in development of their own policies, coordination of nationally-induced strategies, and the regionalization of health in the years 2000–2010[18]. In this context, the spotlight that was shone upon the national Emergency Healthcare Policy was an opportunity for some states to assume a protagonist stance in the organization of networks or in direct provision of emergency health services.

The third argument relates to the choice of the state of Rio de Janeiro for the study of this subject. This state has a high degree of urbanization and metropolitan agglomeration, associated with inequalities, and difficulties for region-wide integration[19]. Also, it has a history of transformations in the legal and administrative status of the city of Rio[20]: the city was the capital of the nation (from 1889 to 1960), and capital of the state of Guanabara (1960 to 1975), before becoming the capital of the state of Rio de Janeiro (1975 to date). This history explains why there is a high concentration of federal services in the city of Rio. The merger of the state of Guanabara with the former state of Rio de Janeiro in 1975 in fact resulted in exacerbation of some federally-related conflicts[21].

These factors resulted in the configuration of a health system with, among others, the following characteristics: Importance of public hospitals (including emergency hospitals), which were concentrated in the state capital city of Rio; multiplicity of command, and difficulties in integration between federal, state and municipal services; and strong dependence of the municipalities, particularly in the outlying northern suburbs of the city of Rio (the *Baixada Fluminense*), on the services of the capital city itself. In spite of the significant number of hospitals, the state has regional inequalities in the distribution and use of hospital beds[22].

The policy that has been selected in this study expresses the particularities of the health system of Rio de Janeiro state. Also, its federal relationships were an essential element in shaping of the Emergency Healthcare Network in the state, due to the need for integration of services that were managed by different spheres of government. It is worth highlighting the fact that Rio de Janeiro state was the pioneer in putting the UPA in place (starting in 2007) and, in 2013, had the largest number of these units in the country.

The research was oriented by the following questions: What is the context of the formulation of this policy? What factors motivated the inclusion of UPA in the government health agenda in the state, and what factors kept it there? What was the history of implementation of UPA in Rio de Janeiro state? How were intergovernmental relations established, and what conditional effects did they have on these processes?

The study begins with an identification of the approach, the reference frame of analysis, and the methods employed in the research. This is

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followed by the description of the results of the study, in a structure that accords with the literature, emphasizing the context of formulation of the proposal, the inclusion and maintenance of UPA in the health agenda of RJ state, and the history of their implementation in the state. Finally, in the conclusions, the influences of intergovernmental relations on the process of production of the policy, and the repercussions of those influences for the configuration of the system of emergency healthcare in the state of Rio de Janeiro, are highlighted.

Method

The study has a basic point of reference an analysis of public policies, and actions proposed and enacted by the state, highlighting the reasons and the *modus operandi* of the various governments[23]. An attempt was made to identify the context of formulation of the proposal, the factors that operated in the inclusion, and permanence, of UPA in the state agenda[24], and the players, the strategies and reconfigurations of the policy during its implementation[25].

In this study, the term 'state health agenda' has been adapted from Kingdon[24], and refers to the group of subjects that mobilized the attention of the state government agents that were involved with policy for the sector (the Governor, the state Health Secretary, and the state officials). Still using the same author as a starting points, the 'Multiple Streams' model of policymaking was employed to explain the dynamics of the UPA in the governmental agenda.

The study was also anchored on the contributions of historic institutionalism[26], mainly political-institutional factors conditioning the positions taken and choices made by the agents of government. These include: Brazil's federal structure; the flow of politics over time; and the legacy situations, and the organization of management and provision of health services in the state of Rio.

This is an empirical study, of a qualitative nature, bringing together various sources of information, with emphasis on the period 2007 to 2013. Methods involved analysis of official documents, semi-structured interviews with state and municipal elected officials and managers, and systematization of the secondary data provided by the health departments.

Those interviewed held positions of senior management, coordination or supervision in the health departments and units – including: Health Secretary, Basic Healthcare Coordinator, Coordinator of the Emergency Care Network (*Rede de Atenção às Urgências*, or 'RAU'), and Coordinators of Regulation, Hospitals or UPA. An effort was made to select municipalities that expressed a diversified profile of UPA in Rio de Janeiro state in terms of location, date of inauguration and method of management. As well as the managers, other players were selected who brought together important information about emergency services in the state.

A total of 51 semi-structured interviews were held with: the Secretary, and seven members of senior management, of the central unit of the state Health Department; six Secretaries and 16 members of central unit senior management in municipal health departments; 19 directors of UPA (10 in the city of Rio de Janeiro, four in the metropolitan region of Rio, and five in regions of the interior of the state); one former federal-level manager; and one member of the municipal legislature of the city of Rio de Janeiro.

The interviews, held over the period from November 2012 through January 2013, were recorded and transcribed. Procedures of subject breakdown and distribution were adopted in the analysis of the documents and of the interviews, with a view to identifying recurring elements, and common and diverging views among those interviewed.

The following separation of subject areas was adopted for understanding of the continuities and changes in the process of implementation of the UPA in the state: the political coalition in government that sustained the proposal; the dynamics of the intergovernmental relationship in the process of implementation; the directionality (conduct, purpose and design) and the institutionality (rules, incentives and organizational aspects) of the policy, and the number and location (municipality, and region) of the UPA that were put in place.

The research project was approved by the Research Ethics Committee, in accordance with the legal and ethical principles of Resolution 196/96 of the National Health Council (*Conselho Nacional de Saúde*). All those interviewed signed an Informed Consent form.

Results and discussion

Context and the state health agenda

The priority given to emergency care, and the inclusion of the UPA in the health agenda of Rio

de Janeiro state as from 2007, is related to factors of a historical-structural and political-institutional nature, which were expressed in the implementation of the SUS, in the first half of the 1990s.

The existence in Rio de Janeiro city of a significant number of public services under management of different spheres of government, associated with the exuberant presence of the private sector, and the regional inequalities, created limits to decentralization and organization of healthcare in the state. Intergovernmental conflicts and crises were a feature of the process of municipalization of health units.

At the start of the 1990s, the services linked to the municipality of Rio de Janeiro comprised unequally distributed health centers, maternity hospitals and large-scale emergency hospitals. In response to the directive for decentralization, there were transfers of management of federal services to the state sphere (federal hospitals), and to the municipal sphere (federal hospitals and Medical Health Posts – *Postos de Assistência Médica*, or PAM, which provided emergency care).

Transfer of the PAM to the municipality was gradually put in place during the 1990s. Some units were closed or converted into health centers. The first wave of decentralization of federal hospitals to the state (in 1991) was not successful, resulting in their return to the federal sphere in 1994. This negative experience resulted in resistance by the hospitals to later movements of decentralization or subordination to the directives of the municipal government.

In this context, it was only in December 1998 that the municipality of Rio de Janeiro was qualified for Full Management of the Municipal System (*Gestão Plena do Sistema Municipal*, or GPSM), after a long period of conflicts with the Health Department of Rio de Janeiro state[27], which did not want to transfer management of the federal funds to the municipal level.

Among the political factors that arise from the current context from time to time, the following can be highlighted: The exacerbation of tensions between the federal government and Rio de Janeiro city in the first half of the 2000's; the 'health crisis' in the municipality of Rio de Janeiro in 2005, which was heralded by overload of the emergency systems, the precarious nature of the municipal service, and the city government's difficulties in managing the health actions and services; and, as from 2007, the party-political alignment between the federal and state government, involving the Workers' Party (*Partido dos Trabalhadores*, PT) and the Brazilian Democratic Movement Party (*Partido do Movimento Democrático Brasileiro*, PMDB).

The period 2001–2004 – identified with the second administration of Mayor Cesar Maia in Rio de Janeiro city – saw exacerbation of the political conflicts with the federal government in health. An example was the low level of adhesion by the municipality to federal programs, such as the 'Family Health Strategy' (*Estratégia Saúde da Família*), and the Emergency Mobile Service (*Serviço de Atendimento Móvel de Urgência*, SAMU).

In 2005, in the third administration of Cesar Maia, faced with the allegation of a 'state of public calamity' in the SUS' hospitals, the federal government requisitioned assets, services and employees relating of four federal hospitals that had been transferred to the municipality in 1999, and two major municipal emergency hospitals[28]. Further, it proposed a series of administrative and financial measures for maintaining health services in Rio de Janeiro city.

The municipality filed an appeal to the Federal Supreme Court, which ruled in favor of: the former federal hospitals remaining under management of the Health Ministry; restitution of two municipal hospitals to the city; and prohibition on the use of municipal employees in the federal units without the due counterpart in funds.

This episode took place in a context of a national political crisis. In this situation, the federal government began a series of negotiations to restructure its support base, including assumption of the post of Health Minister by Saraiva Felipe (a congressman of the PMDB Party), replacing then minister Humberto Costa (of the PT Party).

Thus, this episode resulted in political coalition between the PT and the PMDB, which was later expressed in the 2006 presidential and state elections. Further, two important health managers involved in the process of requisition – Sérgio Côrtes, Director of the National Trauma and Orthopedic Care Institution, and José Gomes Temporão, Director of the National Cancer Institute – came to occupy the posts of Health Secretary of Rio de Janeiro state, and Health Minister, respectively, as from 2007.

The problems that had emerged worked in favor of incorporation of proposals for improvement of health service in the platforms of candidates for the governorship of the state in 2006. One of the highlight proposals of the then candidate Sergio Cabral (PMDB Party), was to open primary healthcare posts working 24 hours a day, to help absorb the demand for emergency care, and to reduce the backlog and queues at hospitals.

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The Sergio Cabral administration began in 2007, in a situation of political alignment with the federal government (PT Party), and strong opposition to the municipal government of Cesar Maia (linked at that time to the PFL – Liberal Front Party). This political context was decisive in the formulation of the proposal for the UPA, in that the government of the state of Rio de Janeiro took upon itself the responsibility for provision of emergency services.

In this scenario, the Health Secretary of Rio de Janeiro state saw implementation of the UPA as an alternative to the proposal for '24-hour health centers', in view of the low governability of the state in relation to primary care, the management of which was decentralized to the municipalities. The UPA would meet the expectations of the governor, without the need for support from the prefectures. They would also enable the state to respond in a more direct manner to the difficulties faced by the health system. Further, the proposal to build UPA was aligned with the nationwide healthy policy at that time in effect[29], especially in view of the Health Secretary's deep qualification and long professional experience in management and practice of emergency care.

Other factors favoring the formulation of the proposal were: the existence of technical solutions – modular structures using containers – that made it possible to install them rapidly and to provide services in areas of high traffic and population that provided easy access; the accumulation of institutional practice provided by prior experiences of the state Health Department and Fire Department.

In May 2007 the first UPA was put in place in the Maré, a district on the periphery of the municipality of Rio with low social and economic levels and a high incidence of violence.

Figure 1 shows application of the Kingdon model streams24 to analysis of the entry of UPA into the state health agenda in 2007. In the 'problems' stream, the highlights are the difficulties of the local populations' access to public health services; the 2005 crisis in the city's health system; and the limits on integration of the services of the three spheres of government. For the 'solutions' stream, one identifies the attractiveness to the state of the proposal of the UPA. In the 'politics' stream, highlights were the repercussions of the health crisis in Rio de Janeiro city in 2005; the changes of government in 2007, with the political alignment between the state and federal governments; and the profiles of the state Health Secretary and the national Health Minister. The confluence of these three flows, in 2007, created a 'window of opportunity' for UPA to enter the state's health agenda.

The process of implementation

The process of implementation of the UPA in Rio de Janeiro state began in 2007, expanding significantly until December 2012, when there were 61 UPA functioning in the state, of which 50% were located in Rio de Janeiro city (Chart 1).

Our research indicates that the process of implementation of the policy could be divided into four principal phases, which are illustrated systematically in Table 1. This separation into different periods does not mean there was any organized or linear process of implementation. There were superimpositions between the periods, which helped in identification of the dynamics of the implementation in specific contexts.

The first phase, in 2007–2008, expresses the factors that influenced the inclusion of UPA in the state's agenda, especially the coalition that was formed between the parties of the President of the Republic (PT) and the Governor of the state (PMDB), at both the national and state level, there being significant conflicts with the municipality of Rio de Janeiro city, which was governed by an opposition party (PFL). On the one hand, the proposal acquired a political shape and profile, and became centered on the capital city and its northern neighboring region (the *Baixada Fluminense*), in the context of the dispute between the parties in the state. On the other hand, one sees the influence of the coalition (PT-PMDB) at the national level in the formulation of a strategy of inducement to establishment of UPA in the country.

Creation of regulations governing the national policy for emergency healthcare began in 1998[29]. Thus, when the UPA were implemented in Rio de Janeiro state, there was already a group of federal directives/guidelines dealing with the subject. However, the use of the term 'UPA' to refer to fixed pre-hospital units appears for the first time in a federal rule issued almost two years after the opening of the first UPA in Rio de Janeiro state. It is also evident that the Rio de Janeiro state Health Department was the principal party responsible for the investments and running costs of the units in that period.

From a technical point of view, the proposal was based on the need to reduce the overload of the emergency hospitals, thus altering their demand profile. Urgent clinical cases would be served by the UPA, and those that were more complex by the hospitals. In choosing locations,

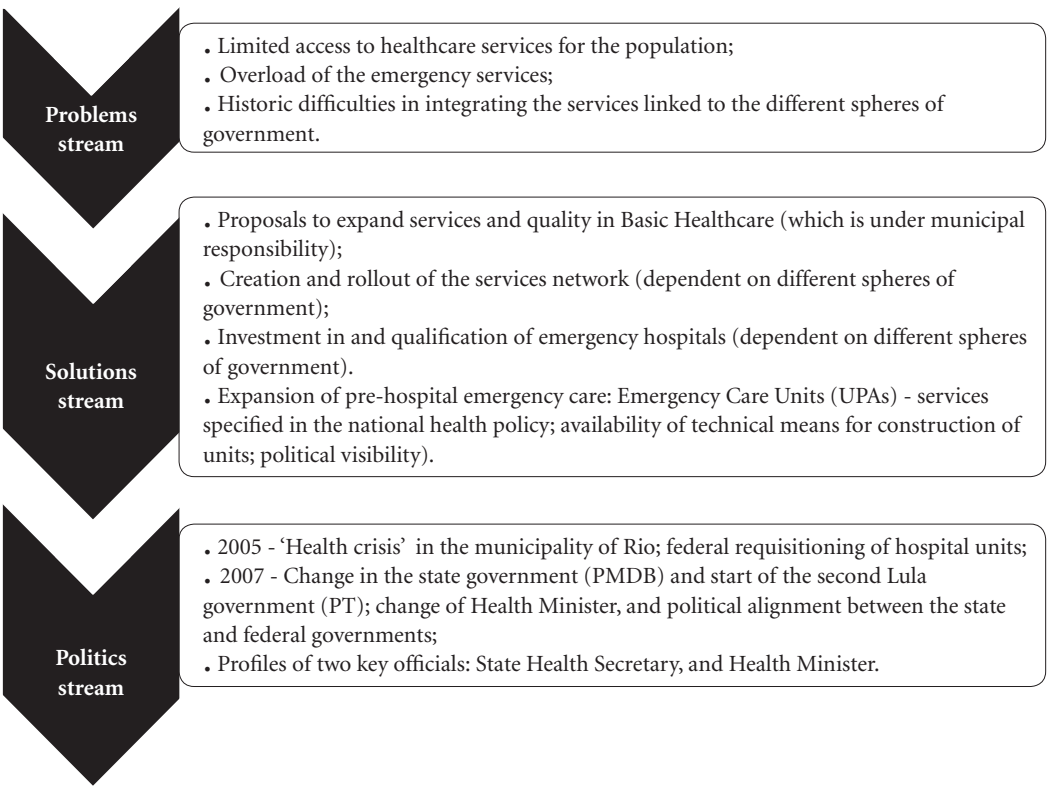
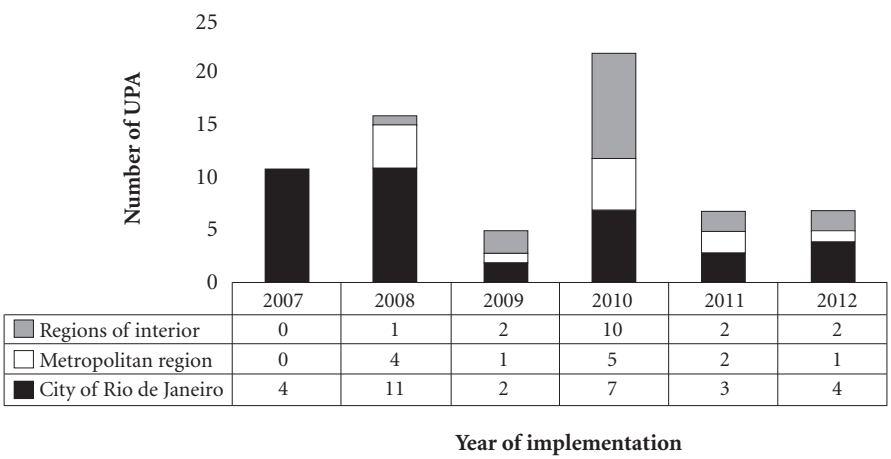


Figure 1. Emergency Care Units (UPAs) in the health agenda of Rio de Janeiro state from 2007: The problems, solutions and politics streams.

Source: Compilation by this project, based on primary and secondary sources.



	2007	2008	2009	2010	2011	2012
Regions of interior	0	1	2	10	2	2
Metropolitan region	0	4	1	5	2	1
City of Rio de Janeiro	4	11	2	7	3	4

Graphic 1. Number of Emergency Care Units (UPAs) put in place in each year, by geographical location – Rio de Janeiro, Brazil, 2007 to 2012.

Sources: Health Departments of Rio de Janeiro state and city of Rio de Janeiro.

Chart 1. Periods of the process of implementation of the Emergency Care Units in Rio de Janeiro state - Brazil, 2007 to 2013.

Aspect	2007-2008 Introduction, and expansion in metropolitan area	2009-2010 Expansion in the interior, transfer to municipalities, regionalization initiatives	2011-2012 Support from federal government; initiatives to constitute the Emergency Care Network (RAU)	2013* Transition, with stabilization and reorientation of the management model
Political coalition	PT and PMDB Parties, at federal and state level. Federal: Presidency / Health Ministry (Lula / Administration José Temporão); State: Rio state government, and state Health Dept. (Sergio Cabral / Administration Sérgio Côrtes).	PT and PMDB Parties: federal, state and municipal levels. Federal: Presidency / Health Ministry (Lula / Administration José Temporão); State: Rio state government, and state Health Dept. (Sergio Cabral / Administration Sérgio Côrtes); City: prefecture of Rio / Municipal Health Service (Eduardo Paes / Hans Domann).	PT and PMDB Parties: federal, state and municipal levels. Federal: Presidency / Health Ministry (Dilma / Administration Padilha); Rio state government, and state Health Dept. (Sergio Cabral / Administration Sérgio Côrtes); City: prefecture of Rio / Municipal Health Service (Eduardo Paes / Hans Domann).	PT and PMDB Parties: federal/state/municipal. Presidency / Health Ministry (Dilma / Administration Padilha); Rio state government, and state Health Dept. (Sergio Cabral / Administration Sérgio Côrtes); City: prefecture of Rio / Municipal Health Service (Eduardo Paes / Hans Domann).
Dynamics of inter-governmental relations	Political conflicts between state government and city of Rio (Administration: Cesar Maia).	Relations of cooperation between federal, state and city governments. Cooperation and conflicts between state and municipal governments (in metropolitan region and in regions of the interior).	Relations of cooperation between federal, state and city governments. Cooperation and conflicts between state and municipal governments (in metropolitan region and in regions of the interior).	Relations of cooperation between federal, state and city governments. Important political-party changes in some prefectures of the Baixada Fluminense region (result of 2012 elections).
Directionality	Predominance of the state executive in conduct of the policy in the state. Policy basically directed to the city of Rio and the Baixada Fluminense, aiming to make good areas with 'absence of care', and reduce demand on emergency services, with the state taking over management of the UPAs.	Greater balance between the federal and state executives in conduct of the policy in the state. State/city partnership in the conduct of policy in the municipality of Rio. Expansion of implantation of UPAs in the regions of the interior of the state, with municipalization and efforts for regionalization. Implementation of UPAs under the initiative of the municipality in the city of Rio.	Greater balance between the federal and state executives in conduct of the policy in the state. State/city partnership with stronger activity of the Municipal Health Service in conduct of the policy in the municipality of Rio. Strengthening of implementation in the metropolitan region and support for the constitution of the RAUs in the health regions	Greater balance between the federal, state and municipal executives in conduct of the policy in the state. State-city partnership, with: predominance of the Municipal Health Service in the conduct of the policy in the municipality of Rio de Janeiro; influence of municipal policy over the state policy; and stagnation of the process of implementation of the UPAs.

it continues

Chart 1. continuation

Aspect	2007-2008 Introduction, and expansion in metropolitan area	2009-2010 Expansion in the interior, transfer to municipalities, regionalization initiatives	2011-2012 Support from federal government; initiatives to constitute the Emergency Care Network (RAU)	2013* Transition, with stabilization and reorientation of the management model
Institutionality	Creation of SESDEC (2007). Rules and incentives predominantly coming from the state.	Rules and incentives coming from state and federal government. Transfer to municipalities, and strategies to articulate the process of regionalization (start of implementation of the Regional Management Committees – CGRs – in 2009). Creation of the Municipal Health and Civil Defense Department in the city of Rio. Adoption of the Social Organizations (SO) model in the UPAs, under management of municipality in Rio de Janeiro city.	Rules and incentives coming from state and federal government (Emergency Care Network – RAU). Separation of SESDEC (2011) and creation of the RAU Coordination Unit (2012). Fiotec removed from the process of hiring of staff (2012). Adoption of the SO model in the UPAs under management of the municipality in Rio de Janeiro city. Creation of Regional Emergency Centers in the municipality of Rio.	Rules and incentives coming from state and federal government (RAU). Start of implementation of the SO model in the UPAs under management of the state.
Number of UPAs created in the period, by location	City of Rio: 15 Metropolitan region: 4 Regions of the interior: 1 Total: 20	City of Rio: 9 Metropolitan region: 6 Regions of the interior: 12 Total: 27	City of Rio: 7 Metropolitan region: 4 Regions of the interior: 3 Total: 14	*City of Rio: 0 Metropolitan region: 0 Regions of the interior: 0 Total: 0

* Situation in January 2013.
Source: Compilation by this project, based on primary and secondary sources.

priority was given to areas with 'absence of care', close to hospitals and high-traffic access routes, aiming to widen the population's access to health services.

However, at that time, disputes caused difficulties for the formulation of an integrated policy for emergency care that would be able to incorporate the various levels and types of services managed by the different spheres of government. The priority given to areas in which care had been lacking resulted in the UPA receiving a demand that had been repressed, whether for social-economic reasons or because of the scarcity of services, and this resulted in challenges for management and organization of healthcare.

On the institutional aspects, there were two significant initiatives at the beginning of 2007: (i) The creation of the Rio de Janeiro State Health and Civil Defense Department (SESDEC); and (ii) the presence of the fire department in the management and provision of services, justified by their experience and by the possibility of hiring their staff on a fixed basis. An important proportion of the doctors and nurses of the state UPA were members of the fire department; and a public competition was held in 2010 for the placement of these staff in the UPA.

In 2007–2008 a total of 20 UPA were put in place – 15 in the city of Rio, four in the *Baixada Fluminense* (one in Belfort Roxo, two in Duque de Caxias and 1 in Nova Iguaçu), and 1 in the city of Barra Mansa, all under the Direct Administration of Rio de Janeiro State.

The second period, 2009–2010, was that of the political party coalition formed with the election of Eduardo Paes (PMDB Party) as Mayor of Rio de Janeiro city. From that point on, the political agreement reached between the three spheres

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of government had repercussions for the organization of emergency healthcare in the state.

A highlight of this was that, during part of the campaign period and during the transition period, assembly of the Eduardo Paes administration's proposal for healthcare had the support of the technical and political players linked to the state Health Department. The alliance that was agreed upon between the state and the municipality led to initiatives by the state and partnerships in conducting the emergency healthcare policy in the city. The organizational structure of the municipal health department reproduced the unification between health and civil defense already adopted by the state.

Another important feature of health policy adopted by the Eduardo Paes administration, since its earliest days, was the expansion of primary care through 'Family Clinics', which were an adaptation of the 'Family Health Strategy' to the municipal context. The strategy of the municipality was to build a significant number of units, overhaul the previous health centers to provide space for Family Health teams, contract Social Organizations (SOs) to manage the Family Clinics, recruit health staff through the SOs, and design 'portfolios of services' of basic care, including procedures for support in diagnosis and medication.

One of the municipal managers who was interviewed believed that care for emergency cases of low complexity should be given by the existing basic units in the city – which would require them to function over an extended period of the day. However, in spite of the significant expansion, the supply of basic care at the beginning of 2013 was still insufficient, and there were few units working over the extended time period in the day.

A second important feature of this government was inauguration of the municipal UPA, based on the same model as the state UPA, starting in 2010. The original target was to put 40 UPA in place in the municipality. In the interviews, the managers in the city of Rio indicated the same reasons as the state government for implementation of the municipal UPA: the need to reduce low-complexity demand in the large emergency hospitals.

From the point of view of organization, the influence of the model adopted by the state was evident, even in the purchase of the same type of physical structure for installation of the units. Three UPA that were originally managed by the state government were transferred to the municipality. However, in the case of the municipality, since the beginning the UPA were inaugurated under the management of an SO. This was a form of administration that had been regulated in 2009, and some of the UPA also took over responsibility for Family Clinics, and subsequently, the Regional Emergency Centers (CER).

From then on, a diversified market of SOs grew up in the municipality, either able to manage one type of service, or to assume different unit profiles. According to those interviewed, the SOs were regulated by the municipality through management contracts, and through monitoring of monthly management reports, which comprised information on the functioning of the UPA, covering the healthcare process and the results achieved. When the staff group was contracted through the SOs, hiring usually followed a simplified selection process (analysis of résumé, and interview), and employees were formally registered in the normal way under the employment laws.

In implementation of the UPA in the other regions of the state, this period represented a new phase, of extension into the interior, stimulus for transfer of management to municipalities, and efforts to articulate this process with implantation of Regional Management Committees (*Colegiados de Gestão Regional*, CGR). It should be pointed out that implementation of the CGRs began in 2009, influenced by various factors, including the federal policies that emphasized the importance of regional negotiation[30].

Although the trend to transfer of management to municipalities was at its strongest in the regions of the interior, there were some cases of units being decentralized and subsequently returned to administration by the state.

As from this moment there was a larger influence by the Health Ministry in the implementation of the UPA in Rio de Janeiro state, through the publication of new Ministerial Orders, and passing through of funds for investment and running costs. Although the state continued to provide a significant proportion of the financing of the UPA, the federal directives stimulated regional negotiation and adhesion to the plan by municipalities, and in fact led to a reorientation of the policy.

In interviews, managers of Rio de Janeiro state reported initiatives to encourage inter-municipal participation and negotiation in the process of implementation of the UPA. One of the highlights was the 'UPA networks' project, which involved rounds of regional negotiation with the municipalities, including health secretaries, and coordinators of hospitals and of primary health-

care. However, according to some municipal managers, the participation of the municipalities in this process was fragile, which favored a view of the UPA as a 'project of the state'.

Other state strategies of support for municipal and regional organization of services were expanded in this period, involving mechanisms of transfer of specifically-allocated funds. Among these, the mechanisms of co-financing of primary healthcare according to redistributive criteria, in place since 2008, and the Program to Support Hospitals in the Interior (PAHI), put in place as from 2010, were important.

In the period 2009–2010, a further 27 UPA were put in place, 12 of them in the interior of the state, 9 in Rio de Janeiro city and 6 in other municipalities of the metropolitan region, thus providing working UPA in the majority of the regions of the state.

In the third period, 2011–2012, the political coalition between the federal, state and municipal governments was maintained, with support from the central government and stimuli to shape the emergency care network, in the context of specific national regulation. Another feature of the period was a more protagonist stance by the city government in conduct of the policy in the city itself.

In 2012, four Regional Emergency Centers (CERs) were inaugurated in the municipality of Rio. These are emergency healthcare units similar to UPA, connected to the major emergency hospitals. The main justification given for opening these centers was to 'relieve the pressure on the emergency services', and offer qualified care for emergency situations of intermediate complexity. This care was able to have the support of the diagnostic, therapeutic and specialty structures of the hospital, and mechanisms for transfer of patients when necessary.

The CERs were also inaugurated under management of the SOs. Some managers admitted that this was the alternative adopted for the hiring of workers, in view of the expansion of the services provided in the emergency departments of hospitals. Another attribution proposed for the CERs was coordination of the flow of emergency care in a given region, but it was recognized that this had not yet been put in place at the beginning of 2013.

As for the institutionality of the policy on the state level, it is noted that as from 2011 the SES-DEC was dismantled, and the participation of firemen in the management and provision of the services in the state UPA was gradually reduced. The SAMU, in turn, came under the command of the Civil Defense Department. Initially, some of the staff worked as employees under assignment to the SES; but, gradually, there was diversification of contracting of doctors and nurses through other types of link.

In this period it was noted that management of the workforce in the UPA was deteriorating. While the selection of firemen had been dependent upon a public competition or transfer of staff to the UPA, that of the other doctors and nurses took place by simplified selection processes. Other types of staff (such as nursing technicians) had various types of employment link, and the diagnostic support services (radiology, laboratory work) and logistics (cleaning) were outsourced.

In the efforts to shape the emergency network, a highlight was the creation of a specific coordination unit under the state's Healthcare Sub-secretariat. The shaping of this structure allowed for directives to be proposed for articulation of components of the network, but also showed the difficulties relating to regulation in the state. Strategies were also adopted for expansion of basic emergency healthcare service, such as implementation of risk classification on reception in the units, and creation of financial incentives.

In 2011–2012 a total of 14 UPA were put in place: 11 in the metropolitan region – 7 in the city itself and 4 in other municipalities – and three in regions of the interior of the state.

The last period we identify is from November 2012 through January 2013 – starting with Eduardo Paes's win in the first round of elections for Mayor of Rio de Janeiro (he began his second period of office in 2013), and the changes in party-political arrangements that resulted in changes to the management teams in the municipal health departments.

There was an inflection point in the process of implementation of UPA in the state, since the management of the state units was being transferred from the Direct Administration to SOs. According to those interviewed, each SO had been selected to manage three or four state UPA, not necessarily in the same region. Some of these SOs, they reported, had prior experience in working in the capital city itself, while others had come from other states.

The adoption of the SOs in the state-controlled UPA suggests that municipal policy influenced the management by the state, which adopted the new model of management after other alternatives for contracting and placing of staff had been exhausted. This transition period was one of tensions and instability, and several state UPA coordinators had not yet defined their own situation in the unit, and indeed did not have

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enough information about the way in which the SO would be selected and the staff team retained.

In the municipality of Rio there was a proposal to continue the expansion of primary healthcare through the Family Clinics. In January 2013 the city had 14 municipal UPA (in addition to the state UPA), and the government team believed that this number would be sufficient for it to meet its emergency care responsibilities. Those interviewed reported the possibility of opening of two more UPA in specific locations, and emphasized the priority for expansion of basic care and of the CERs.

Summing up, at the beginning of 2013 the structure of emergency care in the municipality of Rio included a significant number of services, linked to different spheres of the government: The primary care units (Family Clinics, Health Centers and Health Posts); the mobile pre-hospital component (SAMU); the fixed pre-hospital care component (UPA and CER); and the emergency hospitals. However, even with the significant number of existing services, the majority of those interviewed mentioned problems of overload, quality, capacity to provide solutions, and integration – adversely affecting the structure and functioning of the emergency care network.

Conclusions

Analysis of the process of production of policy related to the UPA in the state of Rio de Janeiro shows strong interdependence between the three governmental levels. Reciprocal conflicts, agreements and influences were a significant part of the context of formulation and implementation of proposal, indicating the existence of various concurrent processes of production of policy.

As a result of several different factors of context, and due to various causes of differing natures, an important intergovernmental coalition was established which sustained, from both the technical and the political point of view, the inclusion of UPA in the state health agenda, and its permanence in that agenda, over the period from 2007 to 2013. However, changes were seen in both its directionality and its institutionality, with changes in the political command.

At the same time, the political shape of the proposal, and the intergovernmental agreements that were established, worked in favor of a rapid and wide dissemination of UPA in the municipality of Rio and the various regions of the state. The state Health Department played an important role in the management and provision of the services during the greater part of the period that was studied. The process of implementation not only resulted in the building of a significant number of new units, but also in changes in the forms of management and functioning of previously existing services (particularly basic and hospital emergency care), and an increased perception of the value of the state government's role in providing emergency care.

However, it should be pointed out that adoption of the regional focus and of the emergency care network came relatively late in the process of implementation of the policy. Thus, the rapid implementation of the UPA did not take place in association with the initiatives to improve the other components of emergency care – those that were dependent on integrated planning and coordinated activity between various spheres of government. Fragmentation and failures of coordination on the institutional plane (both within and between spheres of government), and the disputes between levels of government in the process of management of the policy, tend to prevent integration of the various components of emergency healthcare in the state.

Collaborations

LD Lima and CV Machado were responsible for the conception, collection and analysis of the information and for writing the article. GO'Dwyer, TWF Baptista, CLT Andrade and MT Konder participated in the collection and analysis of the information, preparation of the tables and diagrams, and writing and final revision of the article.

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