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PATIENT PARTICIPATION IN SERVICE IMPROVEMENT OF PRIMARY CARE SERVICES: A CASE STUDY OF THE CITY OF FLORIANOPOLIS

PARTICIPAÇÃO DE PACIENTES NA MELHORIA DE SERVIÇOS DA ATENÇÃO PRIMÁRIA À SAÚDE: UM ESTUDO DE CASO DA CIDADE DE FLORIANÓPOLIS

PARTICIPACIÓN DEL PACIENTE EN LA MEJORA DE LOS SERVICIOS DE ATENCIÓN PRIMARIA DE LA SALUD: UN ESTUDIO DE CASO DE LA CIUDAD DE FLORIANÓPOLIS

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ABSTRACT

Healthcare services from western economies use patient and public participation to promote quality improvement. In Brazil, community participation is a guideline for the public healthcare system. However, community participation is little developed and few efforts are made to improve it. Through a case study, we described and analyze the service improvement process used in the Brazilian Public Health System, named SUS. The focus was on primary care units of Florianopolis and on the community involvement in this process. Semi-structured interviews with healthcare professionals, and community representatives were conducted. Results show that improvements are made in local improvements or in an annual planning process, and the community participation in them is low. The annual planning process has deficiencies in its methodology and conduction. The adoption of co-creative methods can improve community participation in SUS and strengthen its participation policy. These methods can also help better structure improvement processes.

Keywords: Service improvement, patient participation, co-design.

RESUMO

Serviços de saúde de economias ocidentais têm promovido a participação de pacientes e do público na melhoria da qualidade de serviços. No Brasil, a participação da comunidade é uma diretriz para o sistema público de saúde. Porém, a participação da comunidade é pouco desenvolvida e poucos esforços são feitos para sua melhoria. Por meio de um estudo de caso, o processo de melhoria utilizado nos centros de atenção primária do SUS de Florianópolis e o envolvimento da comunidade neste processo foi descrito e analisado. Foram conduzidas entrevistas semi-estruturadas com profissionais de saúde e representantes da comunidade. Resultados demostraram que as melhorias ocorrem em ações locais ou pelo planejamento anual, e a participação da comunidade neles é pequena. O processo de planejamento anual apresenta deficiências em sua metodologia e condução. A adoção de métodos cocriativos pode melhorar a participação da comunidade no SUS e fortalecer sua política de participação. Esses métodos também podem auxiliar na melhoria de estruturação de processos de melhoria.

Palavras-chave: Melhoria de serviço, participação dos pacientes, codesign.

RESUMEN

Los servicios de salud de las economías occidentales utilizan la participación pública y del paciente para promover la mejora de la calidad. En Brasil, la participación comunitaria es una guía para el sistema público de salud. Sin embargo, la participación comunitaria está poco desarrollada y se hacen pocos esfuerzos para mejorarla. A través de un estudio de caso, describimos y analizamos el proceso de mejora del servicio utilizado en las unidades de atención primaria del SUS de Florianópolis y la participación de la comunidad en este proceso. Se realizaron entrevistas semiestructuradas con profesionales de la salud y representantes de la comunidad. Los resultados muestran que se realizan mejoras en las mejoras locales o en un proceso de planificación anual, y la participación de la comunidad en ellas es baja. El proceso de planificación anual tiene deficiencias en su metodología y conducción. La adopción de métodos co-creativos puede mejorar la participación comunitaria en el SUS y fortalecer su política de participación. Estos métodos también pueden ayudar a mejorar la estructuración de los procesos de mejora.

Palabras-clave: Mejora del servicio, participación del paciente, codiseño.

INTRODUCTION

To face the current challenges of public administration, countries are bringing the community to participate in governance in hopes that it leads to better and more responsive public services (SKIDMORE; BOUND; LOWNSBROUGH, 2006). In healthcare services, this initiative is also present in quality improvement (RENEDO et al., 2015). There is increasing recognition that high-

quality health services are organized around and responsive to the needs of the people who use it. For this purpose, patients and the public must be involved in decisions about their own care and the way that services are delivered (COULTER; ELLINS, 2006). In this sense, Western economies have created policies aiming to develop stronger patient and public participation/involvement in the organization and delivery of health care (OCLOO; MATTHEWS, 2016).

Patient and Public involvement refer to the ways that individuals can participate in decisions about the development, planning, and provision of health services (COULTER; ELLINS, 2006). Participation or involvement, in this context, are activities that are done 'with' or 'by' patients or members of the public. The participation process seeks a partnership between patients, the public and health professionals (OCLOO; MATTHEWS, 2016). Participation can occur at multiple levels, such as consultation, involvement to partnership or collaboration (COULTER; ELLINS, 2006; OCLOO; MATTHEWS, 2016). According to Coulter and Ellins (2006), the consultation level of involvement works with patient/public feedback. The involvement level refers to working directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered. Lastly, in the collaboration level, there is a partnership with the public in each aspect of the decision - development of alternatives and defining solutions (COULTER; ELLINS, 2006).

In Brazil, community (public) participation in healthcare services is stated in the constitution as one of the guidelines for the public healthcare system, the *Sistema Único de Saúde* (SUS) (BRAZIL, 2012). This guideline assures community oversight over SUS, which may participate in the identification of problems and solutions, as well as inspecting and evaluating public healthcare services and activities undertaken in this sector (PAIM, 2015). Community participation takes place on Health Councils, collegiate bodies composed of the government, service providers, health professionals, and users' representatives, which formulate strategy and guarantee the execution of health policies, including economic and financial aspects (BRAZIL, 1990). However, health councils face barriers such as not exercising their deliberative character in most cities and states, and in many cases, they are fragile in the effectiveness and efficiency of their actions (BRAZIL, 2009).

There is little discussion on community participation in SUS service planning and delivery, and few efforts made to promote it. As seen in the literature, active patient involvement (involvement and collaboration levels), improve service quality and, in the Brazilian case, could aid health councils and community oversite fulfilling their designed roles. To explore this issue, in this article, we will describe and analyze the service improvement process used in SUS primary care units of Florianopolis city and the patient/community participation in this process. Analyzing this process, we will identify the level of patient/community involvement in it and the positive and negative points of the process. Knowing how this process is conducted and patients are involved is an important step to improve it.

THEORETICAL REFERENCE - Patient participation in healthcare service design and improvement

In the service design and improvement context the higher levels of user (patient) participation, as described introduction, have a strong relation to what is called co-creation or co-design. Co-design enables users to participate in the development process. Users have a vital role in service design and delivery because they work with the design team and service providers in creating solutions. Co-design goes beyond a formal consultation in which designers give users the opportunity to express their opinions in a limited number of alternatives. It is a more creative and interactive process that challenges the opinions of the involved sides and combines the expertise in new ways (COTTAM; LEADBEATER; DESIGN COUNCIL, 2004). The combination of different perspectives helps to understand the needs of users and service providers, and in turn, develops successful services. Co-design brings benefits that reflect in higher quality, more adequate and more satisfying services, being more user-focused (STEEN; MANSCHOT; DE KONING, 2011).

There are many reports on the use of co-design and related approaches in service delivery improvement (BATE; ROBERT, 2007b; BORGSTROM; BARCLAY, 2017; BOWEN et al., 2013; DONETTO et al., 2015; LIN et al., 2011; SALGADO et al., 2017). The co-design adopted in some models used in healthcare services aims to bring users and other stakeholders into the service creation process, changing the power relations so that all own the process (BATE; ROBERT, 2006; DONETTO et al., 2015). When patients and staff get actively involved in the development process, those involved have difficulty in leaving the job unfinished, facilitating project continuity and implementation, as people will support what they help create (BATE; ROBERT, 2007b). Patients who become involved in the process feel valued and their self-esteem is improved (COAD et al., 2008).

The use of co-design and patient participation in healthcare has shown improvements in service development by assuring the services represent the needs of users (patients, carers). With their involvement, deductions concerning the users' positioning and needs are reduced, and there is improved communication between the stakeholders (FALLON et al., 2008; WOO et al., 2011). Co-design methods used in healthcare, such as Experience-Based Co-Design (EBCD), have been shown to be efficient in constructing collaborations between users and service providers, and useful in identifying areas for improvement with a focus on lived service experiences (BOWEN et al., 2013).

METHOD

We conducted a case study in the primary care system of Florianopolis, Brazil, as recommended by Yin (2001) in questions of exploratory nature. We conducted interviews with members of distinctive levels acting in the process studied, such as the planning department of the Municipal Health Secretariat, health districts, and Health Center coordinators, as well as users' representative bodies, such as the Municipal Health Council (MHC) and Local Health Council (LHC).

To invite members of the planning sectors, health districts, and MHC to participate, we sent an e-mail presenting the research and requested an indication of a sector member to participate. We then scheduled the interviews. For Health Center coordinators we defined two Health Centers in each health district (eight in total), one high capacity and one low capacity. The Municipal Health Secretariat research department suggested the Health Centers for participation. For the Local Health Councils, we invited the coordinators of the referent council for the chosen Health Centers.

Data collection was primarily based on semi-structured interviews, they were conducted from March to August 2017. We protected the identity of all participants by replacing their names with an alphanumeric identifier in the research documentation. The interviews were audio-recorded to aid data treatment and analysis. The interview schedules explored processes, methods, and tools used in service improvement; the people involved; patient/community participation – moments of participation, how they are involved; and challenges faced in this context. A primary care physician and an administrative technician, both currently working in Health Centers in Florianopolis, reviewed the interview schedules. In addition to the interviews, we used other complementary sources of information, such as observation, and documents available from the Municipal Health Secretariat or provided by the participants. Research procedures are in agreement with Resolution 466/2012/CNS/MS and were approved by the (University name – hidden for blind review) Ethics Committee on Human Research (CAAE Number: hidden for blind review).

For the analysis of the interview data, we used the content analysis method based on Bardin (2011) and Guerra (2006). In this process, we first transcribed the interviews; then read the content fully and highlighted illustrative sentences that demonstrated facts. Based on this reading, we constructed a synopsis, a speech synthesis; then we conducted categorical and thematic descriptive analysis; finally, we undertook the interpretative analysis, conceiving new concepts and advancing potentially explanatory theoretical propositions, as suggested by Guerra (2006).

RESULTS ANALYSIS AND DISCUSSION

In this study 19 people were interviewed, 5 members of managerial sectors (4 health districts and planning), 7 Health Center coordinators (of the 8 invited, one chose not to participate), 7 members of health councils, one from a Municipal Health Council and 6 from Local Health Councils (of the 8 invited, 2 chose not to participate). The employees of the Municipal Health Secretariat, on average, had worked 11.83 years for SUS, and 2.96 years on average in their current position. User representatives had participated in the council 5.5 years on average. Table 1 present these data.

Table 1: Interviewees' profile.

SUS employees				
ID	**Occupation**	**Position**	**Time on SUS (y)**	**Time on the position (y)**
S01	Dentist	Health Center coordinator	4	3,5
S02	Nurse	Health Center coordinator	11	4
S03	Doctor	Health Center coordinator	29	1
S04	Nurse	Health Center coordinator	15	1
S05	Dentist	Health Center coordinator	12	3
S06	Nurse	Health Center coordinator	5	3
S07	Nurse	Health Center coordinator	17	6
S08	Nurse	Planning Adviser	10	6
S09	Nurse	Health district supporter	10	3
S10	Dentist	Health district coordinator	9	4
S11	Nurse	Health district coordinator	7	0,25
S12	Dentist	Health district coordinator	13	0,83
		Average	11,83	2,96
Health Council members				
ID		**Council**	**Age**	**Time as a member**
C01		Local Health Council	63	3
C02		Local Health Council	54	1,5
C03		Local Health Council	68	6
C04		Local Health Council	58	5
C05		Local Health Council	51	2
C06		Local Health Council	66	13
C07		Municipal Health Council	41	8
		Average	57,29	5,50

Source: Elaborated by the authors.

Interview data presents two main themes: service improvement processes and user participation in them. We divided these themes into categories and those into sub-categories. These categories represent methods used, improving processes and process phases on the first theme, and the community participation on councils and on service improvement processes in the second. On the following topics, we present the processes used described in the interviews and community involvement in it. We also evaluate the processes based on service design literature.

Service improvement process

Service improvements in primary care usually occur in Health Centers. These improvements may be to service provision or the work process. Improvements happen based on local actions or through annual planning. Annual planning occurs in all centers and the Municipal Health Secretariat planning sector guides it. The definition of the methods used in these processes varies depending on the Health Center and sectors. Table 2 show these categories of the improvement process theme.

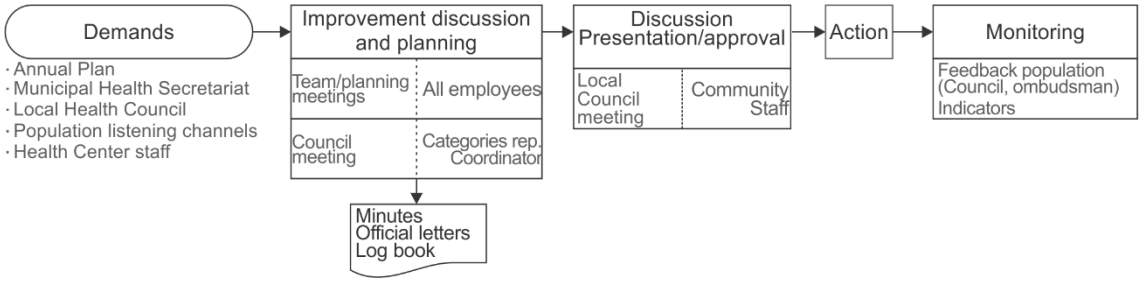
Table 2: Service improvement categories

Categories	Sector	Sub-category	N°(interviewees)
Local improvement	Health Centers	Staff meetings	4 (S01, S02, S05, S07)
		Local Health Council	3 (S01, S02, S06)
		Management board	3 (S03, S04, S05)
		Planning meetings	4 (S04, S05, S06, S07)
		Suggestion box	2 (S01, S06)
		Municipal policy	1 (S02)
Annual planning	Health Center	Mentioned as a used method	3 (S04, S05, S07)
		Improvement support	2 (S03, S07)
		Issues with evaluation instrument	1 (S07)
	Planning Health Districts	Process description	1 (S08, secretariat files)
		institutionalized process	3 (S08, S10, S12)
		Issues with evaluation instrument	1 (S11)
Method used in processes	Health Centers	Do not use a method	2 (S01, S02)
		Secretariat/annual planning	3 (S04, S05, S07)
		Other tools	4 (S03, S04, S05, S06)
	Planning Health Districts	PDCA/strategic planning	3 (S08, S09, S10)
		Policies	2 (S09, S10, S11, S12)
		Supporters' work	2 (S10, S11)
		Several points of initiation	1 (S12)

Source: Elaborated by the authors.

According to the interviews, local improvement discussions frequently takes place in staff meetings. These improvements tend to originate from demand that may come from the users through several channels. Such demands are discussed in staff, management council (formed by representatives of all professional areas), or planning meetings, in which changes are planned to improve the issue at hand. In reference to LHC participation, in one Health Center, the LHC takes part in planning (S01), and in other three, they participate by validating proposed plans or informing on the changes that will be made (S01, S02, S06). In all Health Centers, the resulting documentation of the process comprises meeting minutes; other documents are mentioned but not with the same importance and frequency—official letters (S01), papers (S02), a logbook (S03), and an intervention matrix (S04, S07). **Erro! Fonte de referência não encontrada.** illustrates the process based on the interview narratives.

Figure 1: Health Center improvement processes

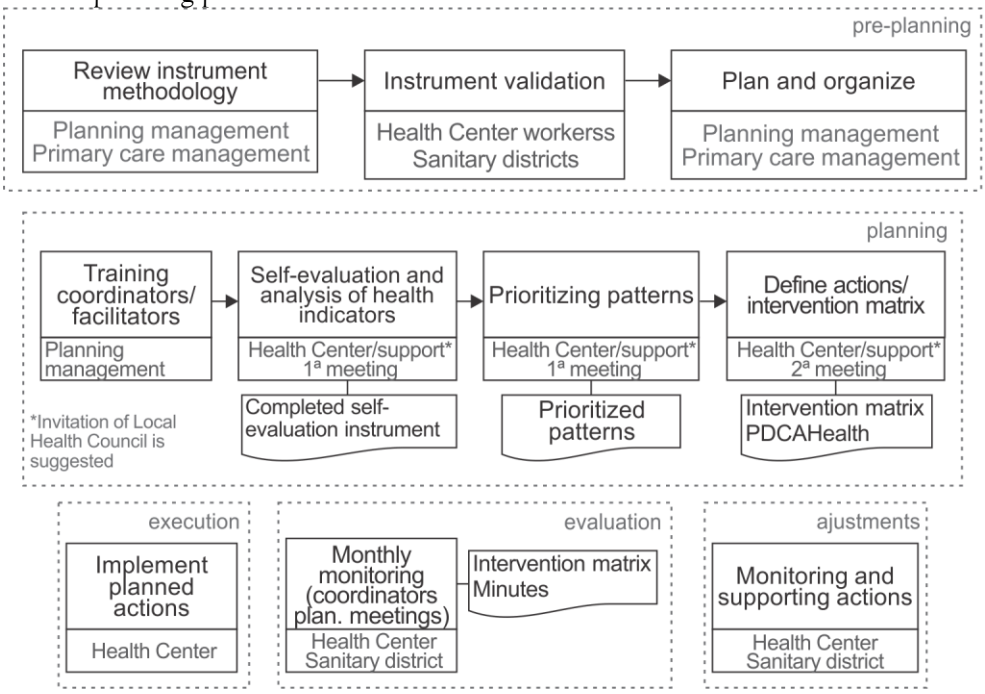


Source: Elaborated by the authors.

The Annual Plan process proposed by the planning sector of the Municipal Health Secretariat is divided into four phases: planning, execution, evaluation, and adjustments (FLORIANOPOLIS, 2017). According to S08 the process begins in the second semester of the preceding year with the revision of the methodology and used instruments, and planning the process implementation. Health districts and health centers professionals validate the instruments used during the process. At the beginning of the year, Health Centers coordinators and one facilitator from each center are summoned to a capacity-building where the annual planning process is explained step by step. After this, it is suggested that in the next Health Centers' meetings, the Health Center team does a self-evaluation using

an instrument provided, and prioritize what will be worked on that year. In the following meeting, based on the prioritized issues, the teams propose actions, evaluate costs, plan an execution schedule and indicate a leader for each action. To aid this process, the planning sector developed a system called *"PDCA Saúde"* (PDCA Health, in reference to the Plan, Do, Check, Act method), in this system Health Centers coordinators register the activities made and the action plan (S08). Through the system, health districts and primary care directorate can monitor the process (S08). **Erro! Fonte de referência não encontrada.** illustrates this process.

Figure 2: Annual planning process



Source: Elaborated by the authors based on interviews and documents provided by the planning sector (FLORIANOPOLIS, 2017).

The annual planning is an institutionalized process, which is considered beneficial for some interviewees as it provides a designated moment for service improvement and health centers can reflect and self-evaluate their conditions (S03, S08, S10, S12). For the self-evaluation, Health Centers use an instrument created by the Municipal Health Secretariat; this instrument is aligned with the municipal primary health care service portfolio, aiming to identify Health Center teams' strengths and weaknesses, so the team can gain a full understanding of the situation (FLORIANOPOLIS, 2017). In this step, the staff evaluates if established patterns are executed totally, partially, or not at all in the Health Center (S08). As the self-evaluation instrument has predefined points of evaluation/improvement, two interviewees (S07, S11) see it as problematic, as they may not reflect the real needs of the Health Center.

When we asked the health professionals if they followed a method for these processes, and if so which, two Health Center coordinators responded that they did not use a method, three cited the annual planning process, and four indicated the use of tools and other processes. One of the coordinators stated she used her professional experience and SUS guidelines to make improvements at the Health Center (S03). Another coordinator reported the use of the Strengths, Weaknesses, Opportunities, and Threats (SWOT) matrix (S04), and one of the Health Centers prioritizes weekly demands through a vote among the staff members (S05). One of the coordinators also reported using the Health Center data to solve its problems (S06).

Health district interviewees do not mention the improvements are guided by policies, which determine certain qualities or characteristics services should have (S09, S10, S11, S12). To support the implementation of such policies Health Centers count with the assistance of district supporters (S10,

S11). One of the health districts' interviewees also mentioned the possibility of service improvements coming from health professionals or user suggestions (S12). These answers, however, do not reflect a method.

The planning management sector reported that annual planning always follows the Plan, Do, Check, Act method (PDCA): *"They understand the PDCA, so much so that the name of the monitoring system is PDCA Health (…) I'm sure they already know what planning is using PDCA"* (S08). However, the other interviewees did not mention PDCA as a method; in general, they reported the process as being instructed by the planning sector, city policies, and other tools. One of the Health Center coordinators reports on the use of PDCA Health as a system, but queried the relation to a method he/she does not recognizes as a method: *"(…) the method is established by the Municipal Health Secretariat–would that be PDCA? PDCA is the operational system"* (S07).

User participation in service improvement

Community participation in SUS primary care services happens in different channels and with different levels of participation. Table 3 shows how user participation occurs in service improvement and in health councils.

Table 3: Categories of user participation in service improvement

Categories	Sector	Sub-category	N°(interviewees)
Councils/patient participation	Health Centers	On Local Health Council	7 (S01, S02, S03, S04, S05, S06, S07)
		Low participation	6 (S01, S02, S03, S04, S05, S07)
		Residents' association	2 (S06, S07)
		Users input initiate improvement (LHC, suggestion box, others)	6 (S01, S03, S04, S05, S06, S07))
		Do not participate	1 (S02)
	Planning Health districts	Induced through self-evaluation	2 (S08, S11)
		On Local Health Councils	4 (S09, S10, S11, S12)
		Lack of participation culture	2 (S09, S10)
		Summon council in case of urgency	1 (S10)
		Changes informed in councils	1 (S11)
		Population channels of input	1 (S12)
		Lack of data analysis and systematization	1 (S12)
	Local Health Council	Participates without interfering/partnership	1 (C01)
		Discussion in meetings	3 (C02, C04, C06)
		Does not participate	1 (C03)
		Has an interest in participating	1 (C03)
		Participates more or less	1 (C05)
	M. Health Council	Participates	1 (C07)
Community participation in Health councils	Local Health Council	Users' low participation	6 (C01, C02, C03, C04, C05, C06)
		Re-education to participate	1 (C01)
		Lack of awareness	1 (C02)
		Low advertising of councils	1 (C02)
		Community active only when lack of RH/medicines	2 (C04, C06)
		Difficulty of replacing councilors	2 (C04, C06)
	M. Health Council	Society does not know the council exists	1 (C07)

Source: Elaborated by the authors.

Health councils are directly related to SUS's guidelines for community participation. All of the Health Center coordinators mentioned the participation guideline occurs through LHC. The same was

noted with the health district representatives. Two Health Centers also reported working with residents' associations (S06, S07). One of the health districts also uses other channels of population input as a means of community participation; however, it lacks data systematization (S12). The planning sector seeks to induce the creation and involvement of LHC in the changes made in the Health Centers through the self-evaluation instrument (S08).

Health Center coordinators highlighted the scant participation of the population in councils and lack of awareness of the importance of their participation. According to S02, people usually go to the LHC to resolve their own problems with health services, and not to collaborate with the council's social role or act in service planning/improvement. Two district representatives also mentioned the shortage of community participation in Health Councils. Indeed, one of them pointed to the non-existent culture of participation in the country: *"I neither go as an individual to participate nor as a member of an institution to speak up and consider what is deliberated on in a participation forum"* (S09). Although council participation is foreseen, one of the interviewees stated that it is difficult in practice for the LHC to act in the planning of all Health Centers; the councils are usually called in to address urgent situations (S10).

Health Center coordinators reported that the community participates in improvement and service planning processes. Health Center coordinators reported that the users' inputs (complaints, suggestions) originate service improvements (S01, S03, S04, S05, S06, S07); and before LHC meetings all users inputs, logged in several channels, are discussed, and that provides a direction for the improvements in the Health Center (S03). On the other hand, one of the interviewees stated that this participation does not happen (S02); however, this center checks the information concerning users' complaints on the system and uses this to make changes to the service, which other health centers coordinators saw as participation.

Regarding the views of the users on participation, here represented by the MHC and LHCs, four councilors indicated participation in service planning and improvement: One stated they take part but do not want to interfere in the process; they work in partnership with the Health Center team (C01). The other three said participation occurs during the LHC meetings (C02, C04, C06), as also pointed out by the Health Center coordinators. One of the councilors (C03) said the LHC does not participate in Health Center service planning, but they and the center coordinator would like to. According to C07, the MHC participates in the city health planning, but that was not the case a few years back. C07 highlighted that they currently participate by raising problems; however, they would like to be part of the city's health services proposal creation and are trying to progress to this.

Although the MHC participates in city health planning, the councilor interviewed affirmed that current participation is insufficient; the council is seeking to build participatory management. In the case of the LHC, one of the interviewees pointed out that participation has its fragilities, such as being too isolated from the MHC and from health management (C03). Other councilors reported council participation in the form of making suggestions (C01, C06). C01 also commented on listening to the problems of staff and trying to advocate in their favor with the coordinator. C05 said that it was unclear whether current participation was sufficient or not, but the LHC boost the meeting of demands.

Councilors also reported insufficient user participation in MHC and LHC, as well as a lack of awareness of the importance of participation and the council. The MHC representative (C07) highlighted an issue with user participation, namely that most parts of society do not know that the councils exist. Interviewee C02 also mentioned the need to improve the exposure of the councils so that people will participate. Related to awareness, one of the interviewees declared that he is trying to re-educate the community members to participate and support the council (C01). One councilor pointed to the lack of interest of society and passivity in accepting the existing situation, even if people's rights are not being addressed, and that this passivity is reflected in council participation (C06).

Two councilors (C04, C06) explained that active community participation occurs when the Health Centers present problems, such as insufficient human resources (general healthcare professionals), or medicines. However, usually, when the problem is resolved, community participation returns to a low level. Low community participation also hinders the replacement of councilors: C04

said that the current team had been in place for the last five years and that they needed more people to become involved to enable existing councilors to retire.

Discussion

In this study, we found positive and negative aspects of the improvement process used in SUS primary care services of the city of Florianopolis. The main positive aspects are the annual planning process that has a defined method and is institutionalized; there is some community participation though the Health Councils, and all staff members' classes are represented and are part of the improvement process. On the negative side, the improvement processes, in general, need more method detailing, staff training; and there are limited patient and community involvement in the process, especially on the creation of solutions for improvement. We will discuss further these issues as follows.

Service improvements, in the case studied, happen in the Health Centers by two processes: local improvements or annual planning. Local improvements reflect the needs of the local community. These service improvements do not follow an official, defined, or structured model. Moreover, in this process, the interviewees did not describe how the team generated the solutions proposed. This improvement scenario is recurrent in healthcare services. The service development or improvement processes in healthcare do not fully explore what is commonly recommended to project phases in design methods; for instance, the generation phase is not about generating a wide range of options, but rather detailed plans for implementation (JUN; MORRISON; CLARKSON, 2014).

The annual planning process is well defined and institutionalized and is protected by the Municipal Health Secretariat, and it is seen by the professionals as a benefit to the services. Still, the annual planning process has fragilities. The self-evaluation instrument obliges Health Centers to work on pre-defined points. These points, however, may not reflect the real need of employees and users. This issue can be related to the fact that, in most healthcare services, the approaches used in improvement or design processes are not favorable to the exploration of needs and problems through stakeholder involvement (JUN; MORRISON; CLARKSON, 2014). The use of service design approaches that promote patient involvement can help address this issue as they are effective in building collaborations between service users and providers (BOWEN et al., 2013; JUN; MORRISON; CLARKSON, 2014), and allows to discover stakeholders unattended needs (HAN et al., 2018).

Another problem faced in the annual planning process is that staff do not have a complete understanding of the PDCA method or see it as a method in which the annual planning is based on. In fact, the annual planning method capacity building only includes one employee and the coordinator of each Health Center. However, for the successful implementation of a method, it is indicated that all the stakeholders involved in the process to be trained on it (BAYLISS et al., 2017; CAMPOS, 1992; ISHIKAWA, 1986). The evaluation and adjustments phases of the process do not present the same level of detail in activities like others and they are only monitored in terms of whether the planned actions are being executed as scheduled. These phases present inconsistencies with the aims described in the literature for them (CAMPOS, 1992; ISHIKAWA, 1986). The evaluation phase (check) should verify the results and compare the results achieved with the goal(s), analyzing if the causative factors are under control and if the effects/results are according to plan. The adjustment phase (act) should trace corrective actions based on the verified results (CAMPOS, 1992; ISHIKAWA, 1986). Not executing these phases correctly, may lead to improvements that do not fully solve the initial problem, needing to work on it again in the future.

Community participation is present in some aspects of the improvement processes. MHC and LHCs, user representatives, participate by raising issues that need to be worked on or approving changes proposed by the health centers. Although users' input can initiate improvements, the participation described in the interviews indicates it is in the lower level of participation, being mainly based on consultations through users' feedbacks (COULTER; ELLINS, 2006; OCLOO; MATTHEWS, 2016). As mentioned in the introduction, using service design methods could aid in achieving higher levels of participation as involvement and partnership/collaboration. In co-design methods, such as

EBCD, the users (patients/community) and the staff work together throughout the whole process, sharing lived experiences, identifying problems, and constructing improvements (BATE; ROBERT, 2007a, 2007b; BOWEN et al., 2013; BOYD et al., 2012; BOYD; MCKERNON; OLD, 2010; DONETTO et al., 2015; NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT, 2010; WOLSTENHOLME et al., 2010).

A problem involved with community participation is the low participation of members of the community in the health councils due to the lack of knowledge of the importance of their participation in the councils or even that they exist, and a week participation culture. Co-design methods face difficulty in recruiting community members to participate in the process and keep them engaged throughout the process (FORBAT et al., 2009; GUSTAVSSON, 2014; IEDEMA et al., 2010; JUN et al., 2018; NIMEGEER et al., 2016; PIPER et al., 2012; TOLLYFIELD, 2014) as is seen here. Considering the motives for the recruiting difficulty, Health Centers staff should increase the promotion of the health centers, their role, and importance to the improvement of service quality. To overcome limited community participation and maintain them engaged, it is suggested to keep them informed on the project progress (improvement implementation) and its results (PIPER et al., 2012), as people will want to see what their participation resulted in.

CONCLUSION

In this article, we demonstrated how SUS's primary care services in the city of Florianopolis are being improved and how the community is involved. Results show that service improvements are made through local (isolated) improvements or through the annual planning process, in both cases community participation is low. Local improvements lack a systemic method, not having a well-defined method increases the likelihood of fragilities in the process and in the service provided. Using a structured method would help to define more effectively service activities, and improve the overall planning and management of services contributing to better use of resources. The annual planning is an institutionalized process with a defined process; however, the process is not detailed enough in important phases, and people involved in the processes are not familiar with the adopted method. That can lead to flawed or incomplete execution of important phases and affect the quality of the resulting solutions.

Even though the Brazilian constitution predicts user participation, participation is low, and there is a narrow view of community participation. Bringing the community to co-design health services can improve service provision quality and user satisfaction. Using Service Design methods, they have co-design as one of its principles, and related co-creative approaches can strengthen community participation in healthcare services, achieving higher levels of participation and provide a structured method to conduct the service improvement process.

This study was conducted in SUS primary care services of Florianopolis; however, the issues identified in this case might be similar in other cities, countries, and levels of services, and the opportunities of improvement may be applicable in them as well. To verify this hypothesis, we suggest conducting more studies in different locations and levels of services.

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