Original research

Pan American Journal of Public Health

Importance of local management for delivery of primary health care according to Alma-Ata principles*

Luceime Olivia Nunes,[1] *Elen Rose Lodeiro Castanheira,*[1] *Adriano Dias,*[1] *Thais Fernanda Tortorelli Zarili,*[1] *Patrícia Rodrigues Sanine,*[1] *Carolina Siqueira Mendonça,*[1] *José Fernando Casquel Monti,*[2] *Josiane Fernandes Lozigia Carrapato,*[1] *Nádia Placideli,*[1] *and Maria Ines Battistella Nemes*[3]

Suggested citation (original manuscript) Nunes LO, Castanheira ERL, Dias A, Zarili TFT, Sanine RR, Mendonça CS, et al. Importância do gerenciamento local para uma atenção primária à saúde nos moldes de Alma-Ata. Rev Panam Salud Publica. 2018;42:e175. https://doi.org/10.26633/RPSP.2018.175

ABSTRACT

Objective. *To describe the characteristics of the management process in primary health care units as well as the profile of managers, and to discuss the implications of these elements in implementing the principles of the Unified Health System in Brazil in accordance with the principles of the Alma-Ata Declaration.*

Method. *This descriptive, cross-sectional study used data collected with QualiAB, a self-administered, web-based tool for quality assessment of primary care services. QualiAB was voluntarily answered by 157 unit managers from 41 municipalities in the state of São Paulo from October to December 2014.*

Results. *Of 157 units, 67 (42.7%) were family health care units and 58 (36.9%) were "traditional" units; 95 (60.5%) were located in urban peripheries. At the time of the study, eight units (5.0%) did not have a manager and eight (5.0%) were managed by the city health secretary. Almost 80% of the managers were nurses and performed multiple tasks in addition to management. Multidisciplinary support (technical supervision as a means of continuing education) was available in 75 units (47.7%); 60 (38.2%) did not have any kind of multidisciplinary support. Participation in evaluative processes was mentioned in 130 units (82.8%). The main results of evaluations were: planning and reprogramming of activities with the engagement of the multiprofessional team in 40 units (25.5%); and definition of an annual activity plan in 38 (24.2%). Twenty-nine units (17.8%) did not have access to the results of evaluations.*

Conclusion. *The study supports the importance of work process management and the need to (re)invest in training and upgrading of local management skills as a strategy to produce primary health care that is capable of promoting health as a right and a necessary condition of citizenship.*

Keywords Health management; health services administration; primary health care; Brazil.

* Official English translation from the original Portuguese manuscript made by the Pan American Health Organization. In case of discrepancy, the original version (Portuguese) shall prevail.

[1] Julio de Mesquita Filho State University of Sao Paulo, Botucatu School of Medicine, Botucatu (SP) Brazil. Send correspondence to Luceime Olivia Nunes, olivia@fmb.unesp.br

[2] São Carlos Federal University (UFSCar), Biological and Health Sciences Center, São Carlos (SP), Brazil.

[3] University of São Paulo (USP) School of Medicine, São Paulo (SP), Brazil.

The Global Conference on Primary Health Care (PHC) held in Alma-Ata in 1978 defined PHC as key to the implementation of a health system that promotes social development and health as a right (1). The Alma-Ata recommendations, together with studies demonstrating the greater effectiveness and efficiency of systems based on robust PHC (2), influenced the Brazilian health system, leading it to prioritize greater investment in PHC, especially through the creation of the Unified Health System (SUS) in the 1990s. With the advent of the SUS, PHC (or "basic care," as it is known in Brazilian policy) became the main point of entry to the system, responsible for the delivery of comprehensive care and linkage with health care networks (3–5). Implementation of PHC activities became the responsibility of municipal managers, employing democratic and participatory management and health practices through teamwork, in compliance with the National Primary Care Policy (PNAB) (3–5).

Focusing on the organizational dimension so that PHC can play the role assigned to it by the SUS, managers of primary care units (or "basic health units", known by the Portuguese acronym UBS) must be able to coordinate the team to align the work process with the objectives and purposes established for this level of care. The manager's role is therefore to take the health project defined in public policy and develop strategies in conjunction with the local team and community that translate principles into action – that is, that translate policy principles into concrete practices in the health services (6–9).

According to Weirich et al. (10), the UBS are the setting in which health problems can be identified, addressed, or referred to other levels of care, under the immediate responsibility and coordination of the manager, in order to maintain good referral and back-referral with health care networks. There is evidence, however, that weak managerial capacity limits access to the health services, concentrates efforts in traditional or outdated administrative principles, and hinders data processing (8, 9) and activity planning, resulting in user dissatisfaction, interpersonal conflicts, and an excessive workload (10–12).

PHC management is summarily dealt with in PNAB publications in 2006 (13) and 2011 (3), which state that it is the responsibility of city health secretariats and the Federal District to organize, execute, and manage primary care services and activities (13, p. 12; 3, p. 32). The 2017 National Primary Care Policy (14) restates the need for local management, recommending that a professional be assigned this role and defining some of his or her functions. Unlike the proposals in the reform adopted by the São Paulo state Health Secretariat in the 1970s (15, 16), under which the management role was exercised exclusively by physicians specializing in public health, the recommended manager today should "preferably" be more senior, not be a member of UBS teams, and have experience in primary care. (14).

Ideally, the UBS manager should be responsible for the planning, coordination, management, and control of the activities of the team and for ensuring that its members have the necessary technical, administrative, and psychosocial knowledge and skills; for coordinating the work of the team; and for giving access to users in participatory planning (6–9). Thus, the manager is a key actor, responsible for coordinating the work of the team and aligning activities with PNAB principles and guidelines. Notwithstanding, the literature on the subject points to an almost complete lack of technical management in PHC in the SUS, due either to the absence of a professional with this responsibility or the failure to define the role (17–19). Managers' time today is absorbed by activities that are more administrative in nature, along with direct care, with little left over for technical coordination of the team (8–10, 18, 20).

Furthermore, the decentralization of management to the municipalities and the policies to incentivize implementation of the Family Health Strategy as a priority organizational model have increased the number of services and redefined the rules for managing work in the UBS (9, 21). These measures have facilitated implementation of the ethical and regulatory guidelines of the SUS, reflected in the principles of universality, equity, and comprehensiveness (3–5), and have redefined the role of UBS managers.

Against this complex backdrop, the purpose of this article is to describe the role of managers in PHC units in terms of coordinating the work and municipal management and to discuss its implications for the implementation of PHC services based on the guidelines and principles of the SUS and the recommendations of Alma-Ata for the delivery of care.

MATERIALS AND METHODS

This descriptive, quantitative, cross-sectional study used data on management obtained through QualiAB, a self-administered, web-based tool for quality assessment of primary care services (22) and the records of UBS managers. QualiAB, which was completed voluntarily, was administered from October to December 2014 in five health regions in the state of São Paulo. These health regions cover 68 municipalities with a combined population of 1,624,623 (23) and 303 UBS (24). A total of 157 UBS in 41 (63.1%) municipalities of different sizes participated, with small municipalities (<25 000 inhabitants) predominating (23).

QualiAB is a structured, self-administered, web-based survey used to evaluate the organizational quality of PHC services. Developed in 2007 (22.25) and updated in 2014 and 2016 (www.abasica.fmb.unesp.br), the results of this tool have been analyzed from different angles (26, 27). The 2014 version consisted of 126 multiple-choice questions that generated care and management indicators. This study analyzed 31 questions about management that covered aspects more directly related to local management and others more dependent on municipal management, considering that the interface between them affects the quality of the care provided.

The steps involved in participation in the study were: voluntary enrolment of the municipality by the city health secretary; registration of the unit by the local team; and the creation of a user name and password to respond to the questionnaire, with a guarantee of confidentiality and the recommendation that the responses be determined jointly with the team. The entire process was conducted online, with city secretaries and local managers signing a voluntary informed consent form. The study was approved by the Research Ethics Committee of the Botucatu School of Medicine – UNESP (opinion 1.314.674).

RESULTS

General characteristics of the services

Of the 157 participating units, 136 (86.6%) were directly linked to municipal management and 17 (10.8%) provided services through management contracts with civil society organizations/foundations. The following types of organizational arrangements were observed: 67 (42.7%) family health units; 58 (36.9%) "traditional" UBS with teams consisting of physicians from different specialties and no community health workers; 29 (18.5%) "traditional" UBS with a community health workers' program or the presence of family health teams; and three (1.9%) "traditional" UBS or family health units that were part of emergency medical services.

The units' hours of operation were: in 114 (72.6%), every morning and afternoon; in 12 (7.6%), every morning, afternoon, and night; and in 31 (19.4%), in only one of those periods. As to their geographical location, 95 (60.5%) were located in the urban periphery, 49 (31.2%) in the heart of the city, and 13 (8.3%) in rural areas.

Profile of managers or individuals responsible for unit coordination

At the time the questionnaire was administered, eight (5.0%) units did not have a manager and eight (5.0%) were managed by the city health secretary. The local managers' profile is described in Table 1. As the table indicates, almost 80% of the managers were nurses with multiple duties, as described in Table 2. In fact, none of the nurses with management responsibilities indicated that their work was devoted exclusively to this activity.

Interface between municipal and local management

Relations between unit and municipal managers consisted mainly of meetings to handle problems as they arose (68 units, 43.3%) or periodic technical supervision meetings or visits (63 units, 40.1%). Eight units (4.9%) did not have formal mechanisms connecting them with the municipal level. Of these, two were managed by the city health secretary.

TABLE 1. Characteristics of managers in 157 primary care units in 41 municipalities in central-west São Paulo, Brazil, 2014

Characteristic	No.	%
Sex		
Female	141	89.8
Male	16	10.2
Professional in charge of unit management		
Nurse	124	79.0
Other	17	10.8
Municipal health secretary	8	5.1
Social worker	6	3.9
Physician	1	0.6
Unit has no manager	1	0.6
Education of managers who answered "Other"		
Nursing technician	6	35.2
Nursing assistant	4	23.5
Nutritionist	2	11.8
Administrator	1	5.9
Lawyer	1	5.9
Pharmacist	1	5.9
Accountant	1	5.9
Dental assistant	1	5.9
Time working in health (years)		
<1	7	4.4
1 to 3	33	21.0
4 to 7	47	30.0
8 to 15	47	30.0
>15	23	14.6
Time in current unit (years)		
<1	55	35.0
1 to 3	54	34.4
4 to 7	26	16.6
8 to 15	19	12.1
>15	3	1.9
Employment relationship		
Public employee under Consolidation of Labor Laws (CLT)	58	36.9
Statutory civil servant	40	25.5
CLT contract	36	22.9
Commissioned position	19	12.1
Temporary contract issued by public administration and governed by special legislation	2	1.3
Temporary service contract	2	1.3
Hours per week devoted to management		
40	140	89.2
30	13	8.3
20	1	0.6
Other	3	1.9

[a] Results obtained through the QualiAB tool (www.abasica.fmb.unesp.br).

Infrastructure and basic inputs

With regard to physical structure and equipment, 107 units (68.2%) reported a good state of repair, 106 (67.5%) reported a structure with adequate ventilation and lighting, 149 (94.9%) reported having bathrooms for users, 149 (94.9%) had a waiting room, 115 (73.2%) had sufficient chairs, 110 (70.1%) had a bathroom in the gynecologist's office, 106 (67.5%) had enough consultation rooms, 141 (89.8%) had a gynecological examination table, 123 (78.3%) had a refrigerator exclusively for vaccines, 67 (42.7%) had a crash cart, and 50 (31.8%) had a defibrillator.

Of the total services, 38 (24.2%) did not dispense medications; 20 (12.7%)

mentioned an occasional lack of hypertension and diabetes medications, 27 (16.6%) did not dispense these medications, and 96 (61.1%) had all the legally required medications. In addition, 151 (96.2%) units dispensed male condoms, 127 (80.9%) dispensed oral contraceptives, and two (1.3%) did not dispense contraceptives.

Among the services that offered vaccination, 105 (66.9%) provided BCG and 91 (58.0%) provided 23-valent pneumococcal vaccine; 25 (22.3%) services did not offer vaccination (22.3%).

The tests performed in the units were: hemoglucotests (HGT) in 154 (98.1%), urine pregnancy tests in 131 (83.4%), rapid HIV tests in 74 (47.1%), rapid syphilis tests in 72 (45.9%), hepatitis B tests in 35 (22.3%), hepatitis C tests in 37 (23.6%), electrocardiograms (ECG) in 8 (51.0%), and the collection of clinical laboratory tests in 102 (65.0%).

TABLE 2. Duties of the nurse who served as manager in 124 primary care units in 40 municipalities in central-west São Paulo, Brazil, 2014[a]

Activities	No.	%
Reception, assessment, and referral of "extra" cases (walk-ins)	98	79.0
Recording of care in the register	97	78.2
Counseling for pregnant women, hypertensives/diabetics, etc.	95	76.6
Counseling on proper use of medications	95	76.6
Nurse consultation for walk-ins	94	75.8
Supervision of patient reception by the nursing assistant/technician	92	74.2
Management of the unit	90	72.6
House call	88	71.0
Epidemiological reporting	87	70.2
Participation in meetings of the multidisciplinary team	87	70.2
Sexually transmitted infections/AIDS counseling	86	69.4
Supervision of the team of nurses/community health workers	85	68.5
Scheduled follow-up consultation	84	67.7
Harvesting of tissue for biopsy	81	65.3
Coordination of the meetings of multidisciplinary team	74	59.7
Continuing education activities for the team	74	59.7
Educational/care groups	73	58.9
Urgent/emergency care	72	58.1
Evaluation of no-shows	66	53.2
Prescription of drugs for conditions with an established protocol	37	29.8
Participation in the unit health committee	29	23.4
Other	2	1.6

[a] Results obtained through QualiAB tool (www.abasica.fmb.unesp.br).

TABLE 3. Technical and social support network for 157 UBS in 41 municipalities in central-west São Paulo, Brazil, 2014[a]

Municipal or regional support services	No.	%
Social Welfare Referral Center (CRAS)	136	92.5
Psychosocial Health Center (KAPS)	101	68.7
Specialized clinics	75	51.0
Workers' Health Referral Centers (CEREST)	75	51.0
Specialized Social Welfare Referral Center (CREAS)	69	46.9
Outpatient clinic for medical specialties	62	42.2
Women's health services	55	37.4
Geriatric health services	43	29.3
Multidisciplinary teams	40	27.2
Pediatric health services	37	25.2
Family Health Support Centers (NASF)	35	23.8
Faith-based community action	24	16.3
Nongovernmental organizations	22	15.0
Other	11	7.5
No access to support services	3	2.0

[a] Results obtained through QualiAB tool (www.abasica.fmb.unesp.br).

Access and composition of the care network

The average wait time from referral to consultation with a specialist in the specialized services was one to three months, with longer waits in the following specialties: ophthalmology, otorhinolaryngology, orthopedics, gastroenterology, cardiology, neurology, psychiatry, and physical therapy. Table 3 shows the municipal or regional support network for the PHC services.

Investments in continuing education – technical supervision and training opportunities

Technical supervision as a form of continuing education was conducted in 26 (16.6%) units by the Family Health Support Centers and in 49 units (31.2%), by an external multidisciplinary team; 60 (38.2%) units did not receive any type of technical supervision. The professionals who participated the most in the training and continuing education activities were nurses, in 147 units (93.6%), followed by physicians in 110 (70.1%), nursing assistants/technicians in 97 (61.8%), and administrative personnel in 50 (31.8%). The topics covered most often in the training were: sexually transmitted infections (STI) and AIDS, in 113 (72.0%); women's health in 99 (63.1%); and the reception and care of walk-ins in 85 (54.1%).

Local management and coordination of the work

Concerning the frequency of team meetings in the year prior to completion of the questionnaire, 60 units (38.2%) indicated weekly meetings and 39 (24.8%) monthly. A total of 23 units (14.6%) reported the absence of regular meetings or any meetings at all. The main topics addressed in the team meetings in the last year had been: unit routines in 141 (89.8%), the organization of the work in 135 (86.0%), reports in 128 (81.5%), activity planning in 127 (80.9%), upgrading of technical skills in 103 (65.6%), and case discussions in 95 (60.5%).

Table 4 lists the main obstacles to good UBS performance mentioned by the respondents, resulting in problems coordinating the work.

Planning and evaluation

Unit coverage areas were defined at the central level by the Municipal Health Secretariat (SMS), based on administrative criteria in 76 units (48.4%) and a participatory process in 47 (29.9%), taking the local situation and access into account. The coverage area of 22 units (14.0%) was not defined. Table 5 lists the information systems used and the data routinely recorded in some manner.

In the three years prior to completion of the questionnaire, 111 (70.7%) services had conducted studies on the local situation using program data (prenatal care and care for children, people with hypertension, and people with diabetes). In 33 units (21.0%), no type of survey had been conducted.

A total of 130 (82.8%) services indicated participation in one or more evaluations, namely: 76 (48.4%) in the National Program for Improving Primary Care Access and Quality (PMAQ), 62 (39.5%) in evaluations conducted by the MSS, 45 (28.7%) in evaluations conducted by the QualiAB system, 31 (19.7%) in evaluations conducted by the unit itself, and seven (4.3%) in other evaluations.

The main activities stemming from the evaluation processes included: the planning and reprogramming of activities with the multidisciplinary team in 40 units (25.5%) and the preparation of an annual unit activity plan in 38 (24.2%). A total of 29 units (17.8%) had not been given access to the results of the evaluations. As for changes made as a result of the evaluations, 82 units (52.2%) described changes in the management and organization of care and 21 (13.4%) had not made any changes.

Of the services studied, 72 (45.9%) did not have a local unit health committee. In units with a local committee, the main issues addressed at the meetings in the past year had been: in 61 (71.8%), problems related to care; in 44 (51.8%), the planning of community education activities and the diagnosis and prioritization of problems in the territory; in 27 (31.8%), municipal health conferences. Six units (7.0%) had not held a meeting in the past year.

TABLE 4. Principal obstacles to improving the quality of health care mentioned by 157 UBS located in 41 municipalities in central-west São Paulo, Brazil, 2014[a]

Obstacles	No.	%
Lack of counter-referral from the specialized services	78	53.8
Lack of human resources	72	49.7
Excess demand	70	48.3
Inadequate physical space	68	46.9
Inappropriate" user behavior	67	46.2
Low pay of professionals	65	44.8
Lack of a personnel policy in the secretariat/prefecture	55	37.9
Lack of back-referral from the specialized services	50	34.5
Lack of community mobilization	44	30.3
Need for computerized data system	43	29.7
Lack of linkage/interaction with urgent care/emergency services	32	22.1
Changes in local policy guidelines, due to changes in prefects/secretaries	30	20.7
Failure to keep to the medical schedule	29	20.0
Lack of training for the technical nursing and/or oral health team	27	18.6
Lack of commitment by physicians	21	14.5
Lack of teamwork	20	13.8
Lack of adequate training for the university team	16	11.0
Lack of drugs	14	9.7
Lack of commitment by the technical nursing and/or oral health team	12	8.3
Lack of commitment by university professionals	8	5.5
Other	5	3.4
There are no major obstacles to overcome	13	8.3

[a] Results obtained through the QualiAB tool (www.abasica.fmb.unesp.br).

TABLE 5. Information systems and data routinely recorded in 157 UBS in 41 municipalities in central-west São Paulo, Brazil, 2014[a]

Information systems	No.	%
Automated Prenatal Care System (SIS Prenatal)	103	70.1
Reportable Disease Information System (SINAN)	96	65.3
Primary Care Information System (SIAB)	82	55.8
Municipal information system	71	48.6
Primary Care Health Information System (e-SUS/SISAB)	67	45.6
Information System for the Registration and Support of Hypertensives and Diabetics (SIS HIPERDIA)	48	32.7
Other information systems	31	21.1
Local information management	5	3.4
Does not support any information system	8	5.4
Data routinely recorded		
Number of procedures	146	99.3
Consultations with a physician	141	95.9
Consultations with a nurse	136	92.5
Number of patients seen	133	90.5
Number of Pap smears performed	127	87.8
Number of "extra" cases (walk-ins)	121	82.3
Number of house calls	121	82.3
Dental consultations	120	81.6
Consultations per age group	113	76.9
Number of vaccines administered	110	74.8
Number of groups created	90	61.2
Consultations per multidisciplinary team	59	40.1
No-shows	59	40.1
First visit of the year (per patient)	37	25.2
Other	10	6.8
No data register.	1	0.7

[a] Results obtained through the QualiAB tool (www.abasica.fmb.unesp.br).

User complaints could be lodged: directly with management in 122 (77.7%) units; through a suggestion/complaints box or register in 86 (54.8%); through the SMS ombudsman system in 85 (54.1%); directly with the central level in 50 (31.8%); and with the municipal board of health in 43 (27.4%). Only three (1.9%) units stated that they did not have a channel for lodging complaints.

Organization of care flow

Care-flow management prioritized issues connected with the organization of scheduling strategies, care for walk-ins, and measures to facilitate health surveillance activities.

Consultations in the services were scheduled as follows: with a specific appointment time for each patient in 60 units (38.2%); for all patients at the start of the shift in 57 units (36.6%); and for groups of patients per hour in 31 units (19.7%). Nine units (5.7%) did not schedule consultations, because they only served walk-ins.

Four of the services (2.5%) did not accept walk-ins. In the 153 units that served this group, patient flow in 72 (47.1%) was handled through triage performed by a physician or nurse; in 45 (29.4%), the reception desk directed the flow and determined whether or not to refer the patient for care; in 32 (20.9%), the referral was made by a nursing assistant or technician, with supervision, based on risk and/or vulnerability criteria; and in 3 (2.0%), by a physician or nurse, based on a risk stratification protocol.

Concerning health surveillance support measures, test results were evaluated in 89 units (56.7%) when the service received them; in 45 (28.7%), when the patient came in for care; in 18 (11.5%), when the results arrived, but only those considered a priority (mammograms, prenatal tests, emergency tests, etc.); and in five (3.2%), on the day of the appointment, even if the patient failed to appear.

Follow-up for no-shows to support health surveillance was conducted for: pregnant women in 122 (77.7%) units; vaccination in 119 (75.8%); abnormal test results in 116 (73.9%); tuberculosis or Hansen's disease in 111 (70.7%); at-risk newborns in 97 (61.8%); newborns in 87 (55.4%); postpartum/puerperium check-ups and adults with chronic conditions (hypertension and diabetes) at risk for complications in 82 (52.2%). Nine (5.7%) units did not follow up on no-shows.

DISCUSSION

A number of Alma-Ata proposals – for example, matters related to the decentralization of management, planning, evaluation, financing, and technology use – remain a challenge for many national health systems (28). In operational terms, the Declaration noted the need to determine who would be responsible for coordinating the work and solving administrative, technical, and social problems related to the activities in each service, underscoring the importance of training administrators and planners at all levels of the system (1).

In this article, we see that most UBS managers had been trained as nurses. Other studies also reported a predominance of female nurse-managers (8, 17–20, 29–31). Although nursing is one of the few health careers whose training includes administrative content, some studies (30, 32) find this content inadequate to prepare these professionals for the complexity of managing PHC services. Added to the lack of specific training for this purpose is the fact that the multiple duties of the nurse-manager compromise the effectiveness of the work in management (9, 11, 33).

Training for PHC management has taken a back seat in recent decades. The deficiencies most noted not only in Brazil but in Latin America and Central America underscore the need to broaden the training of managers in areas connected with administration, epidemiology, and operational methodologies. (19, 34).

With regard to problems in local management, the obstacles noted are concentrated in areas outside unit governance, such as the lack of human resources and physical space, "inappropriate" user behavior in terms of following rules, and service constraints that hinder access. Mentioned less often were issues more internal to the organization of the work, such as the difficulty working as part of a team or the lack of training or commitment among different professionals (9).

To address management barriers, integration between managers and municipal administrators is essential and should not be confined simply to when problems arise. It should be based on the knowledge and commitment of the stakeholders involved to implementing PHC activities in a manner consistent with the principles of comprehensiveness, universality, and equity. Maintenance of the necessary structure and inputs, along with management's relative independence in coordinating the work of the team, should be the reflection of a mission to promote health as a right, as proposed by the SUS (3, 5, 9, 31). Unit management must be tailored to the specific characteristics of each region without abandoning this mission or ignoring the role of coordinating the planning and organization of work processes (8, 9). Management exercised directly by the municipal health secretaries has proven inadequate, since these are political appointees whose position requires no training in this field but does require macroinstitutional action (8, 31).

Only 29.9% of the services employed participatory planning to define their coverage area. Decentralization (3), with professional and community participation, provides managers with knowledge about the situation of the area in which the unit is located and enables them to plan activities to meet the health needs of the population, improving the response capacity of the service. Regarding the organization of the care flow, a high number of services continued scheduling all users at the start of each service period, replicating a traditional practice that lengthens the wait time for each user and anticipates a high proportion of no-shows in order to tend to walk-ins, who tend to be given priority.

Access to walk-in care should be guaranteed, but without ignoring or giving a back seat to the periodic monitoring of people with chronic conditions or at certain stages of life, among them infants and the elderly (17). The UBS are the main point of entry to the SUS and are responsible for receiving patients, connecting them with care, and facilitating longitudinal care (2). The question is how to guarantee that care on demand is part, and not a simplification, of comprehensive care. The predominance of immediate service tends to replicate care for the complaint of the moment, supplanting measures for longitudinal follow-up and jeopardizing the comprehensiveness of the care.

In this study, the limitations of voluntary participation and self-administered instruments should be recognized, given the variable rigor and commitment of participants, in addition to the inability to generalize the findings. Nevertheless, this study highlights the importance of managing work to create PHC that adheres to the guidelines issued in the Declaration of Alma-Ata and reaffirmed internationally and in Brazil.

In the current context, (re)investment in the training of managers is a necessary strategy for developing work processes consistent with the principles of comprehensive PHC capable of responding to health needs. It is the responsibility of local managers, with technical and political support from municipal managers, to connect resources with needs, in conjunction with the team and with user participation, to ensure performance that promotes health as a right and a condition of citizenship.

Acknowledgements. This article is part of the project "Primary Care: updating and validation of the QualiAB tool for the national level," funded by CNPq (File No. 485848/2012-0) and a product of the LON master's program.

Conflicts of interest. None declared.

Disclaimer. Authors hold sole responsibility for the views expressed in the manuscript, which may not necessarily reflect the opinion or policy of the RPSP/PAJPH or the Pan American Health Organization.

REFERENCES

1. Organização Mundial de Saúde (OMS), Fundo das Nações Unidas para Infância (UNICEF). Conferência internacional sobre cuidados primários de saúde, Alma-Ata-URSS, 6–12 de setembro de 1978: relatório final. Brasília: OMS-UNICEF; 1979. Disponível em: http://apps.who.int/iris/bitstream/handle/10665/39228/9241800011_por.pdf;jsessionid=-7556C7A7DB6CE5C150FE9B6089C479C1?sequence=5 Acessado em 2 de outubro de 2017.
2. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457–502.
3. Brasil, Ministério da Saúde, Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica. Brasília: Ministério da Saúde; 2012. Disponível em: http://189.28.128.100/dab/docs/publicacoes/geral/pnab.pdf Acessado em 15 de agosto de 2017.
4. Mendes EV. As redes de atenção à saúde. 2a ed. Brasília: Organização Pan-Americana da Saúde; 2011.
5. Brasil, Ministério da Saúde. Portaria 399/2006. Diário Oficial da União. 2006;22 fev. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2006/prt0399_22_02_2006.html Acessado em 11 de agosto de 2017.
6. Castanheira ERL. A gerência na prática programática. Em: Schraiber LB, Nemes MIB, Mendes-Gonçalves RB, organizadores. Saúde do adulto: programas e ações na unidade básica. 2a ed. São Paulo: Hucitec; 2000. Pp. 222–33.
7. Peduzzi M, Carvalho BG, Mandú ENT, Souza GC, Silva JAM. Trabalho em equipe na perspectiva da gerência de serviços de saúde: instrumentos para a construção da prática interprofissional. Physis. 2011;21(2):629–46.
8. Fernandes JC, Cordeiro BC. O gerenciamento de Unidades Básicas de Saúde no olhar dos enfermeiros gerentes. Rev Enferm UFPE on line. 2018;12(1):194–202.
9. Bazzo-Romagnolli AP, Gimenez-Carvalho B, Almeida-Nunes EFP. Gestão de unidade básica de saúde em municípios de pequeno porte: instrumentos utilizados, facilidades e dificuldades relacionadas. Rev Gerenc Polit Salud (Colombia). 2014;13(27):168–80.
10. Weirich CF, Munari DB, Mishima SM, Bezerra ALQ. O trabalho gerencial do enfermeiro na rede básica de saúde. Texto Contexto – Enferm. 2009;18(2):249–57.
11. Andre AM, Ciampone MHT, Santelle O. Tendência de gerenciamento de unidades de saúde e de pessoas. Rev Saude Publica. 2013;47(1):158–63.
12. Passos JP, Ciosak SI. A concepção dos enfermeiros no processo gerencial em unidade básica de saúde. Rev Esc Enferm USP. 2006;40(4):464–8.
13. Brasil, Ministério da Saúde, Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica. Brasília: Ministério da Saúde; 2006. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_atencao_basica_2006.pdf Acessado em 11 de agosto de 2016.
14. Brasil, Ministério da Saúde. Portaria 2 436/2017. Diário Oficial da União. 2017;21 set. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html Acessado em 14 de outubro de 2016.
15. Marsiglia RMG. Comentário: curso de saúde pública em um semestre. Rev Saude Publica. 2006;40(5):778–9.
16. Mota A, Schraiber LB. Atenção primária no sistema de saúde: debates paulistas numa perspectiva histórica. Saude Soc. 2011;20(4):837–52.
17. Bloise MS. Os gerentes de unidades básicas de saúde do município do Rio de Janeiro: perfil, vivências e desafios [dissertação]. Rio de Janeiro: Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz; 2015.
18. Ohira RHF, Cordoni Junior L, Nunes EFPA. Análise das práticas gerenciais na Atenção Primária à Saúde nos municípios de pequeno porte do norte do Paraná, Brasil. Cienc Saude Colet. 2014;19(11):4439–48.
19. Alves M, Penna CMM, Brito MJM. Perfil dos gerentes de unidades básicas de saúde. Rev Bras Enferm. 2004;57(4):441–6.
20. Falcão SMR, Sousa MNA. Gerenciamento da Atenção Primária à Saúde: estudos nas unidades básicas. Rev Enferm UFPE on line. 2011;5(6):1510–7.
21. Fertonani HP, de Pires DE, Biff D, Scherer MD. The health care model: concepts and challenges for primary health care in Brazil. Cienc Saude Colet. 2015;20(6):1869–78.
22. Castanheira ERL, Nemes MIB, Almeida MAS, Puttini RF, Soares ID, Patrício KP, et al. QualiAB: desenvolvimento e validação de uma metodologia de avaliação de serviços de atenção básica. Saude Soc. 2011;20(4):935–47.
23. Instituto Brasileiro de Geografia e Estatística (IBGE). Análise da disponibilidade domiciliar de alimentos e do estado nutricional no Brasil. Rio de Janeiro: IBGE; Cidades. Disponível em: http://www.cidades.ibge.gov.br/xtras/uf.php?lang=&coduf=35&search=sao-paulo Acessado em 11 de agosto de 2016.
24. Cadastro Nacional de Estabelecimentos de Saúde (CNES). Brasília: CNES. Disponível em: http://www.cnes.datasus.gov.br Acessado em dezembro de 2014.
25. Castanheira ERL, Nemes MIB, Zarili TFT, Sanine PR, Corrente JE. Avaliação de serviços de atenção básica em municípios de pequeno e médio porte no estado de São Paulo: resultados da primeira aplicação do instrumento QualiAB. Saude Debate. 2014;38(103):679–91.
26. Sanine PR, Zarili TF, Nunes LO, Dias A, Castanheira ER. Do preconizado à prática: oito anos de desafios para a saúde da criança em serviços de atenção primária no interior de São Paulo, Brasil. Cad Saude Publica. 2018;34(6): e00094417.
27. Placideli N, Castanheira ERL. Atenção à saúde da pessoa idosa e ao envelhecimento em uma rede de serviços de atenção primária. Kairós Gerontol. 2017;20(2):247–69.
28. World Health Organization (WHO). The world health report 2008. Primary health care, now more than ever. Genebra: WHO; 2008. Disponível em: http://www.who.int/whr/2008/en/ Acessado em 1 de dezembro de 2016.

29. Carvalho BG, Peduzzi M, Nunes EFPA, Leite FS, Silva JAM. Gerência de unidade básica de saúde em municípios de diferentes portes: perfil e instrumentos gerenciais utilizados. Rev Esc Enferm USP. 2014;48(5):907–14.
30. Coatto A, Traldi MC. Competências gerenciais do enfermeiro na atenção primária. Saude Colet. 2011;8(52):180–6.
31. Nunes EFPA, Carvalho BG, Nicoletto SCS, Cordoni Junior L. Trabalho gerencial em Unidades Básicas de Saúde de municípios de pequeno porte no Paraná, Brasil. Interface (Botucatu). 2016;20(58): 573–84.
32. Aarestrup C, Tavares CMM. A formação do enfermeiro e a gestão do sistema de saúde. Rev Eletrônica de Enferm. 2008;10(1):228–34.
33. Feliciano KVO, Kovacs MH, Sarinho SW. Superposição de atribuições e autonomia técnica entre enfermeiras da estratégia saúde da família. Rev Saude Publica. 2010;44(3):520–7.
34. Motta PR. Manual sobre tendencias contemporáneas en la gestión de la salud. (Manual operativo 1.1 v). Washington: OPS; 1996.

Manuscript received (original Portuguese version) on 14 January 2018. Revised version accepted for publication on 9 August 2108.

RESUMEN

Importancia de la gestión local para una atención primaria de salud según las propuestas de Alma-Ata

Objetivo. Describir las características de la gestión de las unidades de atención primaria de salud y el perfil de los gerentes, y analizar las implicaciones de esos elementos en la puesta en práctica de los principios del Sistema Único de Salud de Brasil de forma coherente con las propuestas de Alma-Ata.

Métodos. Estudio descriptivo, transversal, con datos recolectados a través del cuestionario de Evaluación de la Calidad de Servicios de Atención Básica (QualiAB), un instrumento autoadministrado a través de Internet. En total 157 gerentes de Unidades Básicas de Salud de 41 municipios del estado de São Paulo respondieron voluntariamente el QualiAB entre octubre y diciembre de 2014.

Resultados. De las 157 unidades, 67 (42,7%) eran unidades salud de la familia y 58 (36,9%) eran unidades básicas de salud de organización "tradicional"; 95 (60,5%) estan ubicadas en una región urbana periférica. En el momento del estudio, ocho (5,0%) unidades no poseían gerente y ocho (5,0%) eran gestionadas por secretarios municipales de salud. Casi el 80% de los gerentes eran enfermeros y desempeñaban múltiples funciones además de la gerencia. En 75 (47,7%) unidades se disponía de apoyo multidisciplinario (supervisión técnica como forma de educación permanente); 60 (38,2%) unidades no contaban con ningún tipo de apoyo multidisciplinario. La participación en procesos de evaluación fue referida por 130 (82,8%) servicios. Las principales modificaciones inducidas por las evaluaciones fueron la planificación y reprogramación de las actividades con participación del equipo multiprofesional en 40 unidades (25,5%) y la definición de un plan anual de actividades en 38 (24,2%). No tuvieron acceso a los resultados de las evaluaciones 29 unidades (17,8%).

Conclusión. El estudio subraya la importancia de la gestión del trabajo y la necesidad de reinvertir en la formación y valorización de la gestión local como estrategia para hacer efectiva una atención primaria de salud capaz de promover la salud como derecho y condición de ciudadanía.

Palabras clave Gestión en salud; administración de los servicios de salud; atención primaria de salud; Brasil.

Importância do gerenciamento local para uma atenção primária à saúde nos moldes de Alma-Ata

RESUMO

Objetivo. Descrever as características da gerência das unidades de atenção primária à saúde e o perfil dos gerentes e discutir as implicações desses elementos para a efetivação dos pressupostos do Sistema Único de Saúde no Brasil de forma coerente com as proposições de Alma-Ata.

Métodos. Estudo descritivo, transversal, com dados colhidos pelo questionário de Avaliação da Qualidade de Serviços de Atenção Básica (QualiAB), um instrumento autoaplicado via web. O QualiAB foi respondido voluntariamente por 157 gerentes de unidades básicas de saúde de 41 municípios do estado de São Paulo entre outubro e dezembro de 2014.

Resultados. Das 157 unidades, 67 (42,7%) eram unidades de saúde da família e 58 (36,9%) eram unidades básicas de saúde de organização "tradicional"; 95 (60,5%) se localizavam em região urbana periférica. No momento do estudo, oito (5,0%) unidades não possuíam gerente e oito (5,0%) eram gerenciadas por secretários municipais de saúde. Quase 80% dos gerentes eram enfermeiros e desempenhavam múltiplas funções além da gerência. O matriciamento (supervisão técnica como forma de educação permanente) era feito em 75 (47,7%) unidades; 60 (38,2%) unidades não contavam com nenhum tipo de matriciamento. A participação em processos avaliativos foi referida por 130 (82,8%) serviços. Os principais desdobramentos induzidos por avaliações foram planejamento e reprogramação das atividades com participação da equipe multiprofissional em 40 unidades (25,5%) e definição de um plano anual de atividades em 38 (24,2%). Não tiveram acesso aos resultados das avaliações 29 unidades (17,8%).

Conclusão. O estudo recoloca a importância da gestão do trabalho e a necessidade de (re) investir na formação e valorização do gerenciamento local como estratégia para efetivar uma atenção primária à saúde capaz de promover a saúde como direito e condição de cidadania.

Palavras-chave Gestão em saúde; administração de serviços de saúde; atenção primária à saúde; Brasil.