Sixteen years of primary health care monitoring in a large metropolis in the Americas*

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ABSTRACT

The present article describes the institutional integration of primary health care (PHC) performance monitoring in a metropolis in the Americas where seven million people use the public health care system. Based on the São Paulo City Health Department Monitoring Panel, developed 16 years ago, a PHC Management Panel was developed, providing information on the behavior of a set of selected indicators at this level of care over time. The Management Panel was incorporated into the process of restructuring governance. This involved management and technical staff at various levels, who were trained in a co-management method with support from the Pan American Health Organization/World Health Organization (PAHO/WHO). The experience with the Management Panel was also useful to increase the effectiveness with which the information provided by the Monitoring Panel was communicated, supporting the implementation of changes in the organizational model to consolidate the PHC attributes of access, longitudinality, comprehensiveness, and coordination of care. The robustness of the historical data series and the involvement of the implementers of this initiative helped to increase trust in the information generated. The monitoring method captured changes over time and alerted stakeholders to the differences among city regions. Monitoring is a strategy that enables the swift and timely use of secondary data, and was essential to meet the challenges identified in this health care system.

Keywords   Public policy; health evaluation; primary health care; health status indicators; Brazil.

Evaluating the performance of health policies has become an expected part of the complex activity of health service management, given the need for greater effectiveness and efficiency. Monitoring and evaluation activities have gained prominence as practices for guiding current activities and have become important management tools for the improvement of public policy (1–4).

Since the Declaration of Alma-Ata, the "health for all by the year 2000" initiative and many others have fueled political and social mobilizations and contributed to the development of concepts expressed in different models for expanding the coverage and organization of the primary health care (PHC) network (5). However, in the city of São Paulo, Brazil, where seven million people each year use the primary care network of the Unified Health System (*Sistema Único de Saúde*, SUS) (6, 7), this process went through a series of iterations that moved it alternately closer to and farther from the underlying precepts of these movements, experimenting with

different models of health service organization in clearly identifiable periods.

In the early 1980s, the first expansion involved a model based on programmatic health activities, with epidemiological risk analysis serving as the basis for health service organization. This was a centralized model in which PHC was considered part of a hierarchical network of services, organized by levels of complexity (8). In the early 1990s, precisely when the SUS initiative began to be implemented across Brazil, the City of São Paulo disregarded the SUS guidelines and created its own network of PHC services, adopting a model known as the Health Care Plan (*Plano de Atendimento à Saúde*, PAS) in which private medical cooperatives focused heavily on medical specialties and access was not universal (9).

In the early 2000s, the City of São Paulo renewed its commitment to the principles of universal access, and the local government took over the management of all units in the PHC network. In some of these units, care was based on the Family Health Strategy (*Estratégia Saúde da Família*) model, which added physicians and community health workers (ACS) to the teams (10). In the second half of the decade, an emergency care model, known as Ambulatory Medical Care (*Assistência Médica Ambulatorial*), was introduced to increase access. This model, however, did not allow for longitudinality in patient care, since many of these units shared physical space with teams from the existing PHC network, thereby competing with the model already in place (11).

In 2011, spurred by technical and financial incentives from the Ministry of Health and following the guidelines of SUS's National Primary Care Policy (*Política Nacional de Atenção Básica*, PNAB) (12), local governments in Brazil began to endorse and resume activities under the Family Health Strategy, guided by the PHC attributes spelled out in the World Health Report of the World Health Organization (WHO) (13). The pillars of the PNAB are open and patient-friendly access that considers users' needs, multi-professional organization of the work process, a geographical and community framework for population coverage, and efforts to make PHC the center of a health service delivery network in which care is coordinated (12). This model came to influence the reorganization of PHC in the

City of São Paulo, whose network at the time included 453 "basic care units" (*unidades básicas de saúde*, UBSs), with 4.4 million people served by family health teams; 98 ambulatory care units; nearly nine million consultations with a physician in primary care per year; and more than 20 million prescriptions issued by the SUS municipal network (6, 7). This reorganization occurred in the context of profound inequality, with social determinants of health impacting the population's access to services and the types of illness that affected people, resulting in different situations in different areas of the city (14).

As part of the effort to tackle these challenges, in the period 2013-2016, the São Paulo City Health Department introduced two priority strategies for strengthening PHC: the Strategic Management and Monitoring Plan of the São Paulo City Health Department (SMS-SP) and a cooperation agreement with the Pan American Health Organization (PAHO)–Brazil (15). The strategies were divided into four activities: 1) the development of a program for investing in infrastructure for the UBSs; 2) participation in and implementation of the *Mais Médicos* program (PMM) (16) geared to the UBSs with the greatest difficulty obtaining physicians; 3) reorganization of work processes in ambulatory care units, integrating UBS teams and endowing them with the following attributes: UBS as the first contact for access to the SUS, longitudinality, comprehensiveness, community-based territorialization of coverage, and coordination of care, as indicated in the city guidelines, which were widely discussed in community participation forums and online public consultations (17); and 4) the development, in partnership with PAHO, of a continuing education process for nearly 300 health professionals from the city network and management agencies, in which educational and training institutions were involved (18, 19).

This effort provided an opportunity to make available all the knowledge acquired since 2001 through the development of a monitoring instrument to support decision-making, the SMS-SP's Monitoring Panel (20, 21). This panel employs a suitable monitoring methodology, using the most recent period available as the focus of its analysis. It is accessible on the network to managers and technical staff through an application

that facilitates user interface and automated reports.

During this same period (2013-2016), the SMS-SP Management Committee was created, coordinated by the city's health authority. The committee was responsible for primary, intermediate, and high-complexity care, regulation, urgent and emergency care, health surveillance, and the respective managers of the city's six health regions, subdivided into 26 local supervision districts. Meetings were held weekly, sometimes in person and sometimes by video conference to reduce the travel time of the respective health region managers. The committee reviewed the PHC Management Panel monthly, facilitating the dissemination, discussion, and analysis of results. This initiative was premised on the need for more effective communication of the results of the activities and more content and better conditions to support decision-making by managers and technical staff at the different levels of the city health system, all of which was essential for reducing the inequalities observed.

The purpose of this article is to present the experience with the institutionalization of monitoring as a strategy to support the proposed PHC strengthening activities in the City of São Paulo in 2016 through the development and use of the PHC Management Panel.

MATERIALS AND METHODS

The PHC Management Panel can be defined as a data set referring to selected indicators analyzed throughout the established period in order to monitor strategic areas. Development of this PHC Management Panel involved training a working group under the Epidemiology and Information Coordination Office (CEInfo), with representatives from the Primary Care Coordination Office, the technical areas that interfaced with primary care, and advisory services. This group conducted a critical review of every action involved in the selection of indicators summarizing the different aspects to be monitored, considering the criteria of validity, timeliness, availability, disaggregation, and governance – all of them important for monitoring (22) – and giving special priority to the use of secondary data from the different areas and other relevant information systems. A total of 21 indicators were chosen, based on the aspects selected (medical,

dental, and nursing consultations, scheduling, human resources, patient advocacy, and supplies) (15) (Figure 1).

The period for the historical series was also defined (2012-2016), along with the units of measurement for the selected indicators (ratios, average annual numbers, and percentages). For the indicator analysis, the statistical methodology of the SMS-SP's Monitoring Panel application was used: the performance of each indicator in the past seven months in relation to the historical series and the trend in the past 48 months. This methodology made it possible to capture and signal poor performance in the monitored indicators and issue forecasts, using the simple Holt-Winters additive method (hwA) or the centered moving average method, and indicated trends and seasonality after statistical significance testing. Indicator performance was also analyzed through statistical control of the process, to effectively identify abrupt changes in the processes analyzed. The Monitoring Panel has been continually updated and improved, most recently with PAHO support in the contracting of specific consulting services (23). Annual and monthly data, together with indicator performance and trends, are presented in a single table to facilitate understanding of the analysis that will be performed (15) (Figure 2).

FIGURE 1. Indicators of the PHC Management Panel, City of São Paulo, Brazil, 2016[a]

1	Complaints to the Ombudsman's office
2	Requests for services to the Ombudsman's office
3	Primary care consultations with a physician (emergency and non-emergency)
4	Primary care consultations with a physician–non-emergency
5	Emergency consultations with a physician in primary care clinic
6	Emergency consultations with a specialist (hospitals; 24-h outpatient, urgent care, and rescue services)
7	First dental consultation
8	Consultation with a nurse
9	Hospitalizations for conditions sensitive to primary care
10	Consultations offered in primary care (scheduling)
11	Consultations scheduled in primary care
12	Average wait in primary care(days)
13	Patients lost to primary care
14	No-shows in primary care
15	7 or more prenatal consultations for childrenborn in SUS hospitals
16	Physicians currently in PHC units
17	Physicians contracted for PHC units
18	Shortages in 0–10% of units (drugs and hospital medical supplies)
	Shortages in 11–30% of units (drugs and hospital medical supplies)
	Shortages in over 30% of units (drugs and hospital medical supplies)
19	Requests to Ombudsman's office
20	IDM-% existing-% hrs contracted/expected -% hrs worked/contracted
21	Requests from PHC for consultation with a specialist

[a]Reproduced from (15), with authorization.

FIGURE 2. Summary of annual and monthly data, performance, and trends, obtained through the Monitoring Panel of the City Health Department (external series), City of São Paulo, Brazil, November 2016[a]

CITY OF SÃO PAULO	2012	2013	2014	2015	Aug 2016	Sep 2016	Oct 2016	Performance	Trend
	Consultations per inhabitant				No.				
Consultations with a physician in primary care (emergency and non-emergency)	1.46	1.46	1.31	1.21	1,455,706	1,348,126	...		⬆
Consultations with a physician in PHC (non-emergency)	0.67	0.66	0.67	0.67	890,963	814,435	...	Good, 7 pts above	⬇
Emergency consultations with a physician in PHC clinic	0.79	0.79	0.64	0.54	564,743	533,691	...	Stable	
Emergency consultations with a specialist	0.49	0.50	0.48	0.46	450,363	448,909	...		
First dental consultation	0.06	0.05	0.04	0.04	42,901	39,041	...	Stable	
Consultation with a nurse	0.25	0.25	0.27	0.30	342,967	321,815	...	Good, 7 pts above	⬆
Hospitalizations for conditions sensitive to primary care (CSPC)	0.46	0.47	0.46	0.44	4,665	4,313	...		
	Monthly Average				No.			Performance	Trend
Consultations offered in primary care (scheduled)	734,625	760,806	766,160	729,332	983,947	872,683	798,082	Good, 7 pts above	⬆
Consultations scheduled in primary care	635,801	679,685	705,300	718,922	1,044,038	940,166	862,132	Excellent, 7 pts above	⬆
Average wait in primary care (days)	34	32	29	25	14	14	14	Good, 7 pts below	⬇
	Weekly Average				Weeks 45, 46, and 47			Performance	Trend
Complaints to Ombudsman'soffice	...	...	...	176	194	221	177		⬆
Requests for services to Ombudsman's office	...	...	...	299	348	378	278		
Supply requests to Ombudsman's office	...	...	...	71	515	663	554	Alert, 7 pts above	⬆
	Percentage							Performance	Trend
Patients lost to primary care	26.6	20.2	17.1	12.8	14.0	13.4	13.5	Good, 7 pts below	⬇
No-shows in primary care	31.1	30.2	29.0	27.9	27.3	27.8	28.7	Good	⬇
Requests by PHC for consultations with a specialist	24.5	22.3	21.1	19.7	14.4	15.6	15.1	Good, 7 pts below	⬇
Prenatal consultations for children born in SUS hospitals	67.8	69.1	68.8	70.4	76.5	...	...	Improvement	⬆

[a]Reproduced from (15), with authorization.

For monthly presentation of the PHC Management Panel in the SMS-SP's Management Committee, slides showing the selected indicators were made available to all participants beforehand. This facilitated extensive decentralized discussion among managers at the different levels of the system through teleconferencing.

Although the PHC Management Panel contained several indicators, the authors of this study opted to discuss only one of them: "number of primary care consultations with a physician, except for emergency consultations," since this indicator represented access as well as the desired change in the health care model. The authors also opted to present the indicator for the City of São Paulo and for the regional health coordination offices in two different periods, corresponding to the first and last discussion of the Management Committee (22 February 2016 and 28 November 2016, respectively), even though they are not fully equivalent (which would be ideal in a comparative study). The object of this option was to provide a clearer picture of the changes that had occurred in each aspect during the year of monitoring (2016).

The following procedures were included in the "number of primary care consultations with a physician, except for emergency consultations" indicator, with the respective code from the SUS Standardized Table of Procedures (SIG-TAP) (available at http://sigtap.data-): consultation with a patient cured of tuberculosis (treatment) (0301010013), consultation with identification of new tuberculosis cases (0301010021), consultation with a physician in primary care (0301010064), consultation for monitoring growth and development (0301010080), consultation for clinical assessment of a smoker (0301010099), prenatal consultation (0301010110), post-partum consultation (0301010129), home primary care consultation/treatment (0301010137), consultation to order/provide a uterine diaphragm (0301040010), and consultation to obtain an order for/ provision and insertion of an IUD (0301040028).

The UBS teams were expected to continue care for people who had previously been seen under the emergency care model. To illustrate the change that occurred, the evolution of the selected indicator between 2015 and 2016 (before and after implementation of the various PHC strengthening initiatives) is presented through analysis of performance and trends, comparing the two respective points in time.

The experience presented here is an initiative to improve management, using secondary data and indicators traditionally used in health. Hence, there was no need to submit this project for the approval of the SMS-SP Research Ethics Committee.

RESULTS

Figure 3 shows the performance of the indicator "number of consultations with a physician in primary care, except for emergency consultations" in the City of São Paulo throughout the period analyzed, as well as the months that produced the results presented in Table 1. In the period analyzed (January 2012 to December 2015) no significant upward or downward performance trend had been verified prior to implementation of the programmed PHC restructuring activities (Figure 3).

Figure 3B, for the period October 2012 to September 2016, shows a gradual monthly increase in the number of consultations, representing a significant upward trend for the period as a whole. The performance at this stage of monitoring (information up to September 2016) was "good," at seven points above the mean, with the months from March to September 2016 contributing to this result. In addition to these seven months with values above the mean in the period analyzed, four months (March, June, July, and September 2016) had values between 1 and 2 standard deviations (SD), and one month (August 2016) had a value between 2 and 3 SD, calculated based on the mean.

Table 1 shows that the percentage variation in the "number of consultations with a physician in primary care, except for emergency consultations" indicator had increased in both the City of São Paulo and the regional coordination offices, with values ranging from 14.2% to 17.4%. In the historical series analyzed, the trend observed in two coordination offices (East and South) at the start of monitoring (22 February 2016) was significant; in the first of these, it was downward, and in the second, upward. This initial situation had changed by the final monitoring (28 November 2016), when the trend was upward for five of the six coordination offices analyzed, and for the city as well.

As to the performance analysis, which considers the results of the last seven months, only the coordination offices in the East and North provided their results, with poor performance in the East (seven points below the mean) and "good" performance in the North. In this analysis, the final monitoring also showed positive results in five regional coordination offices and the city of São Paulo.
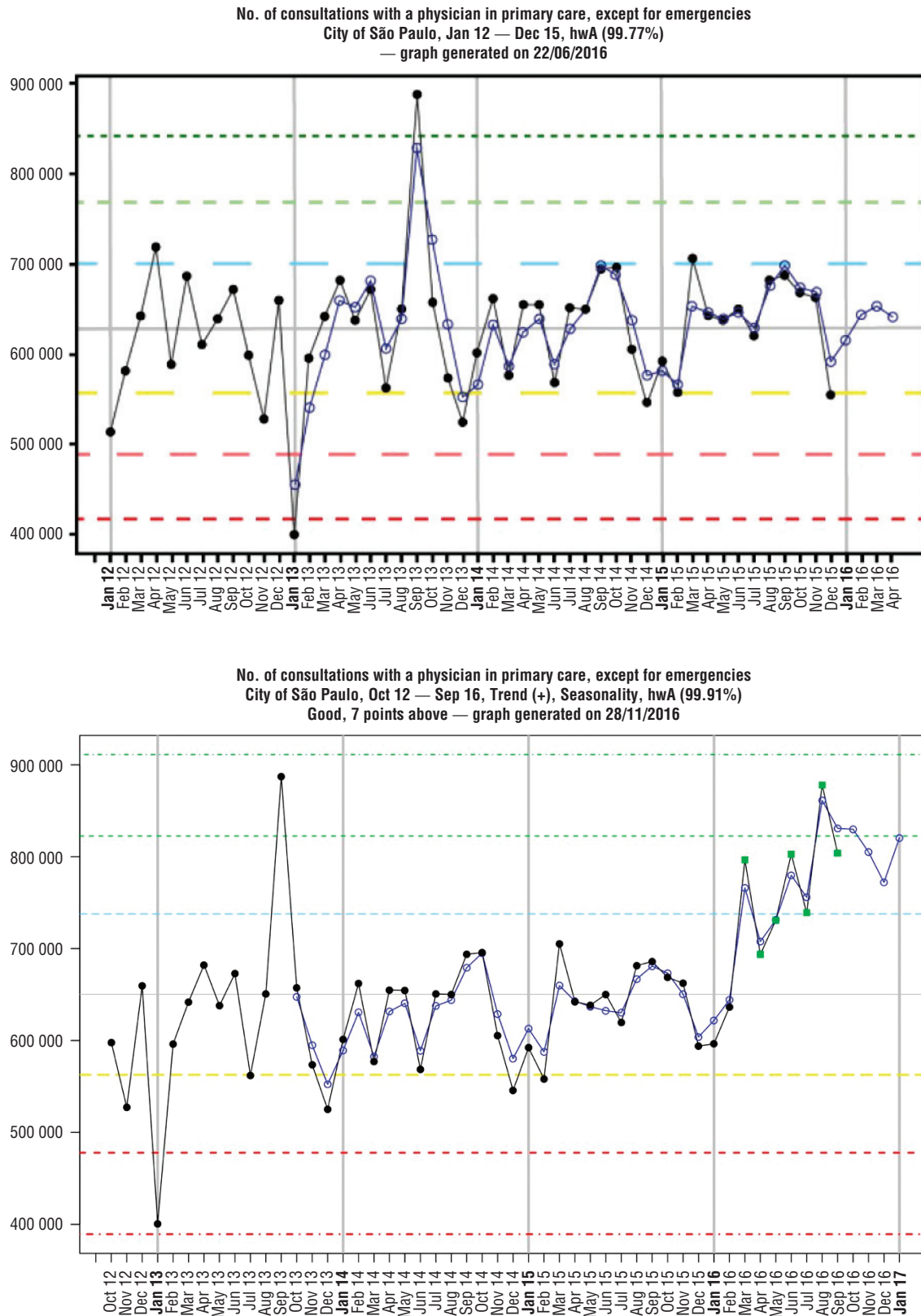
DISCUSSION

Health service management entails the challenge of coordinating individual, corporate, and collective interests that are not always convergent. This requires knowledge of the multiple contexts of the areas in which the services operate, creating the conditions for an appropriate response to their different needs. Thus, the development of monitoring and evaluation instruments and their use by teams at the different levels of the health system support decision-making in the SUS (24).

Moreover, expanding health service delivery as a national policy has demanded greater skills and flexibility on the part of managers and health professionals to find solutions more suited to this context, which requires a more critical and thoughtful approach to their practices. It should be underscored, however, that implementation of systematized monitoring and evaluation initiatives does not in itself ensure that decisions in health management will be based on the knowledge generated by these processes (23).

The experience presented here is unique, since it allowed for the systematic monitoring of preselected indicators and activities considered as priorities by management, thus capturing the trends of 2016, which is unconventional. This exercise contributed to the implementation of a policy to reorganize the PHC model in a network that is extremely complex due to its size (large metropolis), the history of changes in the organization of PHC, and the profound inequalities in access to and effectiveness of the network.

One of the factors contributing to the acceptance of the PHC Management Panel (i.e., the data set on the indicators selected for the period of analysis) was

FIGURE 3. Number of consultations with a physician in primary care, except for emergencies, in two selected periods, City of São Paulo, Brazil

No. of consultations with a physician in primary care, except for emergencies
City of São Paulo, Jan 12 — Dec 15, hwA (99.77%)
— graph generated on 22/06/2016

No. of consultations with a physician in primary care, except for emergencies
City of São Paulo, Oct 12 — Sep 16, Trend (+), Seasonality, hwA (99.91%)
Good, 7 points above — graph generated on 28/11/2016

Source: SIA-SUS/SMS-SP Monitoring Panel.

TABLE 1. Percentage variation and performance and trend analysis for the indicator "number of consultations with a physician in primary care, except for emergencies" for the City of São Paulo and Regional Health Coordination Offices, February–November 2016[a]

Coordination Office	No. consultations		Variation %	Performance		Trend	
	2015	2016		22 Feb 2016	28 Nov 2016	22 Feb 2016	28 Nov 2016
CENTER	155 379	177 443	14.2	—	Good	—	↑
EAST	1 746 318	2 031 980	16.4	7 points below	Good, 7 points above	↓	—
NORTH	1 555 245	1 793 001	15.3	Good	Good, 7 points above	—	↑
WEST	444 092	521 381	17.4	—	Improvement	—	↑
SOUTHEAST	1 467 441	1 696 852	15.6	—	Good, 7 points above	—	↑
SOUTH	2 428 052	2 834 883	16.8	—	Improvement, 7 points above	↑	↑
City of São Paulo	7 796 527	9 055 540	16.1	—	Good, 7 points above	—	↑

Source: SIA-SUS/SMS-SP Monitoring Panel.
[a] Summary of the results for the last seven points of the series analyzed. Unsatisfactory performances are rated as: ATTENTION, ALERT, or CRITICAL. Satisfactory performances, based on monthly data are rated as GOOD, IMPROVEMENT, or EXCELLENT. In addition to considering the sequence of monthly data by bands, three performances that unexpectedly improved are: 1) score of 7 points above or below the mean; 2) 7-point upward or downward sequence and 3) recent reversal of a trend.

the confidence in the source of the data: the SMS-SP's Monitoring Panel. This instrument contains almost 16 years of experience collected through a continuous participatory development and improvement process involving managers and technical staff from the central and regional levels of the SMS-SP, which has improved the process of joint, decentralized analysis. Another aspect to consider is that, even though the SMS Monitoring Panel had been available since 2009, indicator monitoring was improved through the use of the SMS-SP's Management Committee as a body for monthly dissemination and discussion of the PHC Management Panel (25)—something that had not been done systematically or jointly in the coordination offices. It should also be noted that the reorganized governance structures—both the Management Committee, which brings together senior officials and managers from the decentralized system, or an institutional support network responsible for the UBS – are initiatives based on a method for group co-management that presupposes stakeholder engagement in the management and implementation of policies and organizations. The SMS-SP Monitoring Panel, the PHC Management Panel, and the new governance structures were therefore created as instruments for the implementation of organizational policies (26).

The participation of senior and decentralized management in the discussions on the results had the potential to boost confidence in the information and improve the teams' ability to use these tools to make the changes in question. Participation as a mechanism for understanding the reality of the activities is an important factor for the improvement of practices to obtain better results.

Use of the information is a challenge for health systems management, and monitoring permits the timely and expeditious organization, classification, and dissemination of secondary data from the different SUS information systems. Based on secondary data from the SUS Information Systems (SIASUS), it is possible to describe the production of ambulatory services only three months after the month of interest. Using the SMS-SP application, 95% of data can be analyzed in the month of interest, facilitating the capture of temporal changes, which is essential for addressing the problems identified.

The practice of using information for decision-making is still incipient and it has helped promote discussion on the various issues involved in management priorities. This experience aroused interest among stakeholders and increased the critical use of health information. It also facilitated capacity building and encouraged support for course correction, leading to achievement of the desired results.

The opportunity to understand the process involved in developing the information facilitated more objective and effective decisions on the action to be taken, boosting confidence in the information produced, which legitimized the process within the SMS-SP. Furthermore, technical cooperation from PAHO-Brazil facilitated the movement toward change in the PHC network and helped ensure its quality, while seeking to implement the guidelines established in the PNAB (12) and PMM (14). As a result, institutional support and supervision strategies were quickly developed; technical staff and managers from the city health network were trained to exercise these roles; institutional arrangements were established; and guidance was provided for developing new information technology tools to monitor and orient the strategies (7).

The priority strategies for strengthening PHC are aligned with the health reforms recommended in the WHO *World Health Report 2008. Primary Health Care (Now More than Ever)* (13). These reforms are aimed at reorganizing health services around people's needs, replacing both authoritarian management and laissez-faire disengagement with leadership that is based on the inclusive, participatory negotiations required by today's complex health systems.

The present results show that attention to unscheduled demand—which until then had been absorbed by the emergency medical services—form part of the work of multidisciplinary teams, ensuring continuous care in primary care services. Monitoring "initial care in emergency medical and dental services" was a particular challenge. The goal was to reduce the "rigidity" of location-based coverage in order to handle unscheduled demand, comply with the program agenda, and increase access by the population.

The authors consider that the experience presented on the construction and implementation of the PHC Management Panel was a successful strategy for transforming the health system, since it combined the availability of relevant information with the creation of conditions for regular monitoring and evaluation. As a result, the stakeholders indicated

their support for training, learning, discussion, and reflection. This process therefore helped improve the health conditions of the population. Through this initiative, evaluations were conducted, joint strategies developed, and potential

deviations from the established objective corrected, constituting significant support for decision-making bodies to improve SUS performance.

Conflicts of interest. None declared.

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RESUMEN

Dieciséis años de monitoreo en salud en la atención primaria en una gran metrópolis de las Américas

El presente artículo describe el proceso de integración institucional del monitoreo de la atención primaria de salud (APS) en una metrópolis de las Américas donde 7 millones de personas utilizan el sistema público de salud. A partir del desarrollo y elempleo, desde hace 16 años, del Panel de Monitoreo de la Secretaría Municipal de Salud de São Paulo, se desarrolló un Panel de Gestión de la APS que brinda información sobre el comportamiento de un conjunto de indicadores seleccionados en este nivel de atención a lo largo del tiempo. El Panel de Gestión se incorporó al proceso de reorganización de la gobernanza, involucrando a los líderes y técnicos de diversos niveles, que recibieron capacitación en un método de cogestión con el apoyo de la Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS). La experiencia con el Panel de Gestión también fue útil para aumentar la efectividad con la que se comunicó la información proporcionada por el Panel de Monitoreo, apoyando la implementación de los cambios en el modelo organizacional para consolar los atributos de acceso, longitudinalidad, integralidad y coordinación de cuidados en la APS. La robustez de la serie de datos históricos y el compromiso del equipo que implementó esta iniciativa contribuyeron a aumentar la confianza de los equipos en la información generada. El método de monitoreo captó los cambios durante el período analizado y guió a los profesionales involucrados respecto de las diferencias entre las regiones de la ciudad. El monitoreo como estrategia permite el uso rápido y oportuno de datos secundarios, lo cual es esencial para enfrentar los problemas identificados.

Palabras clave   Política pública; evaluación en salud; indicadores de salud; atención primaria de salud; Brasil.

RESUMO

Dezesseis anos de monitoramento em saúde na atenção primária em uma grande metrópole das Américas

O presente artigo relata a institucionalização do monitoramento de indicadores sobre o desempenho da atenção primária à saúde (APS) em uma grande metrópole das Américas, com 7 milhões de usuários no sistema público de saúde. A partir da experiência de desenvolvimento e uso, há 16 anos, do Painel de Monitoramento da Secretaria Municipal de Saúde de São Paulo, foi desenvolvido o Painel de Gestão da Atenção Básica, fornecendo um conjunto de indicadores selecionados sobre o comportamento desse nível de atenção ao longo do tempo. O Painel de Gestão foi incorporado à reorganização da governança, envolvendo dirigentes e técnicos dos diversos níveis, capacitados com um método de cogestão de organizações, com apoio da Organização Pan-Americana da Saúde/Organização Mundial da Saúde (OPAS/OMS). A experiência de uso desse Painel de Gestão aumentou também a efetividade nacomunicação das informações do Painel de Monitoramento, apoiando a implementação de mudanças no modelo de organização para consolidar os atributos de acesso, longitudinalidade, integralidade e coordenação do cuidado na APS. A robustez da série histórica dos dados e o envolvimento dos implementadores dessa iniciativa fortaleceram a confiança das equipes na utilização das informações geradas. A metodologia de monitoramento captou mudanças no período em análise, orientando os envolvidos quanto às diferenças entre regiões intramunicipais. O monitoramento é prática que possibilita a utilização ágil e oportuna de dados secundários, fundamental para o enfrentamento dos problemas evidenciados.

Palavras-chave   Políticas públicas; avaliação em saúde; atenção primária à saúde; indicadores de saúde; Brasil.