

The role of the Family Health Program in the organization of primary care in municipal health systems

O papel do Programa Saúde da Família na organização da atenção primária em sistemas municipais de saúde

Maria Guadalupe Medina ¹
Zulmira Maria de Araújo Hartz ^{2,3,4}

Abstract

The contribution of primary care to population health and health systems organization has been well documented, but some authors have highlighted that in Third World countries it has gained more ground in discourse than in facts and practices, with different possible configurations. The objectives of the current study were to evaluate and correlate organizational and local contextual characteristics to the degree of implementation of primary care in two municipalities (counties) in the State of Bahia State, Brazil, that had adopted the Family Health Program (FHP) as the system's central thrust. The research was based on two case studies with interwoven levels of analysis, using as the point of departure the underlying goal-image of primary care in the definition of criteria and standards for degree of implementation. The total scores for Municipalities A and B were 66 and 81, respectively (maximum total score = 100), while differences were observed between the urban and rural teams. The political and institutional contexts helped explain differences in the degree of implementation of primary care, but regardless of the municipal context, the study showed the emergence of organizational innovations closely related to the FHP.

Primary Health Care; Family Health Program; Health Systems

Introduction

The contribution of primary care to the health of populations and organization of health systems has been well documented in the international scientific literature ^{1,2}. A health system organized with primary care as the basis theoretically improves the possibilities for performance by the health services network: first, because unlike specialized care, primary care plays an integrative role; second, because it is more accessible; third, because patient management becomes more appropriate for the types of complaints users present in their first contact with health services; and fourth, because it organizes and rationalizes the use of resources (both basic and specialized) by targeting the promotion, maintenance, and improvement of health.

Some studies have further highlighted that the organizational characteristics, type of professional (family physician, general practitioner, or pediatrician), and type of service in which the care is provided have an impact on the outcomes ^{3,4}.

In Third World countries, primary care has gained more ground in health discourse than in facts and practices ⁵, since its actual implementation falls short of the original goal-image proposed at Alma Ata. In Latin America, various authors have called attention to different possible configurations in primary care and the risk of implementing "primitive health care", or simplified medicine with low case-resolving capacity

¹ Instituto de Saúde Coletiva, Universidade Federal da Bahia, Salvador, Brasil.

² Grupo de Estudos de Avaliação em Saúde, Instituto Materno Infantil Professor Fernando Figueira, Recife, Brasil.

³ Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz, Rio de Janeiro, Brasil.

⁴ Groupe de Recherche Interdisciplinaire en Santé, Université de Montréal, Montréal, Canada.

Correspondence

M. G. Medina
Instituto de Saúde Coletiva,
Universidade Federal
da Bahia.
Rua Basílio da Gama s/n,
Salvador, BA
40110-040, Brasil.
medina@ufba.br

for excluded groups, thus maintaining or reinforcing health inequalities^{5,6,7}.

In Brazil, managers and training institutions that target the organization of primary care practices have implemented some proposals at the health macro and micro-policy levels. An outstanding example is the Family Health Program (FHP), adopted as a national policy and considered a strategy for reorganization of primary care for establishing comprehensive care⁸.

Although the official documents explicitly describe the program's underlying principles and guidelines, and despite growing scientific output seeking to analyze its effects, there are still few studies on the organizational modality actually adopted for primary care in the municipalities (counties) that have implemented it. This issue is relevant, since one cannot take for granted that implementation will actually convert the country's conventional health care model.

The current study seeks to help fill this gap, discussing organizational characteristics and the municipal context and evaluating the degree of implementation of primary care in two municipalities that adopted the FHP as the central thrust of the municipal health system.

Methodology

Study design

This was an evaluative study of the implementation analysis type – component 1 – according to the classification proposed by Contandriopoulos et al.⁹ and Denis & Champagne¹⁰. Two case studies were developed with interwoven analytical levels¹¹ in selected municipalities. The first was considered a successful experience in terms of the decentralization process in the Unified National Health System (SUS) in the State of Bahia, as well as in relation to FHP implementation at the State and national levels. The second aimed to increase the study's external validity and robustness, seeking a municipality with similar characteristics to the first. In each municipality, teams were selected in the urban and rural areas for in-depth investigation based on interviews with key informants and the following criteria: existence of a complete minimum FHP team in activity for at least a year and a successful track record in terms of FHP implementation.

Demarcation of the research objects used the context as an analytical category, besides constructing a theoretical and logical model¹² based on a social action theory capable of critically dissecting the “change” in the health system's organizational processes. Three elements are central

to this model: the understanding of health as a field of social action, an explanatory theory for health system regulation, and power as a key category for analyzing relations between the actors^{13,14,15,16}.

To evaluate the degree of implementation, a goal-image of primary care was elaborated on the basis of the typology proposed by Lamarche et al.¹⁷, the concept of health surveillance proposed by Paim¹⁸ and Teixeira et al.¹⁹, and the FHP guidelines and norms^{8,20}. This goal-image included two dimensions: teamwork and a community population-based approach, the latter with the sub-dimensions of territorialization, organization of health actions, and establishment of a link between the health service and the population. Table 1 lists the criteria used to evaluate the implementation of each dimension and sub-dimension.

Data sources and analysis

- Characterization of the political/institutional context and health system organization: Secondary data were used from the Brazilian national demographic and health information system databases (Information Technology Department of the Unified National Health System. <http://www.datasus.gov.br>), and a search was performed for technical documents in the municipalities related to the health system management and organization processes; semi-structured interviews were held with representatives of the four principal groups of health system actors (users, managers, health professionals, and private providers), and the work routine was observed in the primary care coordinating teams.
- Evaluation of the degree of implementation of primary care actions: Semi-structured interviews were held with the professionals (physicians, nurses, dentists, and community health workers), and the work routine was observed in the four selected family health teams and a local health council.

Data were collected from March to November 2005, after informed consent was obtained in writing from all the interviewees.

To characterize the municipal cases, a descriptive analysis of the secondary data and document analysis were performed. Analysis of the political/institutional context adopted the ideological classification in partisan blocs, according to Melo²¹.

To characterize the primary care implementation modality, the criteria were scored such that the higher the score, the greater the integrity of the implementation in the observed dimension. The scoring followed a scale in each criterion, so

Table 1

Dimensions, criteria, and scoring system used to analyze the implementation of primary care.

Criteria	Score
DIMENSION: Community-based population approach	
Sub-dimension: territorialization	
Definition of target population	0 – non-existent. 2 – exists, but does not meet FHP criteria for population adjacency and size. 4 – exists, and meets FHP criteria for population adjacency and size.
Enrollment of families	0 – non-existent. 2 – incomplete or outdated. 4 – exists and is updated.
Mapping of area	0 – non-existent. 2 – incomplete or outdated. 4 – exists and is updated.
Mapping logic	0 – no mapping exists. 2 – exists, but is disordered (non-contiguous areas, large distortions). 4 – exists, ordered, but does not consider micro-areas at risk. 8 – exists, ordered, and considers micro-areas at risk.
Sub-dimension: organization of health actions	
Health situation analysis performed and updated	0 – never performed. 2 – performed more than a year ago, and never updated. 4 – team systematically analyzes the health situation in its area.
Logic of the health situation analysis	0 – never performed. 1 – included limited participation by some health professionals. 2 – included participation by most of the team's professionals. 4 – included participation by most of the team's professionals plus community representatives.
Problem focus	0 – non-existent. 2 – team organizes its activities based on problems identified in the health situation analysis in its area. 4 – team organizes its activities based on problems identified in the health situation analysis in its area, developing initiatives to seek solutions when they extend beyond their sphere of intervention.
Use of risk-based focus	0 – no. 2 – team identifies groups with greatest vulnerability and proposes specific interventions according to program guidelines (FHP, national programs). 4 – team identifies groups with greatest vulnerability and proposes specific interventions based on analysis of local health situation.
Linkage between individual and collective approaches	0 – no. 2 – sometimes, in some activities or circumstances. 4 – always or nearly always (through implementation of proposals, actions, and use of tools – e.g.: family health record – linking individual and collective).
Establishment of partnerships with other institutions	0 – non-existent. 2 – partnerships exist, but weak and sporadic. (Team is capable of mapping the existing institutions in the area and conducting occasional activities linked with some institutions – e.g.: vaccination of schoolchildren). 4 – partnerships exist systematically for specific activities (e.g.: oral health activities with daycare centers and schools). 8 – partnerships exist and are linked to the local management and planning process. (Team develops work linked to institutions in the area, based on the joint discussion and prioritization of problems – e.g.: risk factor prevention program for hypertension or drug use with community associations).

(continues)

Table 1 (continued)

Criteria	Score
Sub-dimension: establishment of team-population linkage	
Knowledge of population and territory	0 – health professionals unable to describe the population and territory. 2 – only the CHW can describe the population and territory. 3 – CHW and nursing staff can describe the population and territory. 4 – health professionals from the core team (physician, nurse, nurse technician, CHW, and dentist, when present) can describe the population and territory.
Understanding the family context	0 - no. 2 – health professionals familiar with user's living conditions, family dynamics, and social network (capable of describing the patient's family and housing and work conditions). 4 – health professionals know the user's living conditions, family dynamics, and social network and take them into consideration in the intervention (analyzes the patient's problem in light of his/her family and work context; discusses the treatment plan in light of these considerations; implements another type of intervention to approach the patient's problem – e.g., linkage to social support network, etc.).
Understanding community context	0 - no. 2 – health professionals know the cultural background of the community in which the user lives (capable of describing the community where the patient lives). 4 – health professionals know the cultural background of the community in which the user lives and consider it in the intervention (professional or team analyzes the patient's problem in light of his/her place in the community; discusses the treatment plan in light of these considerations; implements another type of intervention to approach the patient's problem – e.g.: community actions).
Operationalization of the accountability principle	0 – non-existent. 2 – team feels accountable for the users of services and develops mechanism to follow up users at home. 4 – team feels accountable for users of services and develops mechanisms to follow up users at home and elsewhere. 8 – the above items, plus team feels accountable for the community and seeks concrete forms of community involvement.
Population's participation in local health unit planning and management	0 – no. 2 – limited; representatives or community invited sporadically to specific activities. 4 – community invited frequently, but no formal representation in the health unit (or non-functional when it does exist). 8 – existence of active Local Council.

(continues)

as to assess what were considered the most relevant aspects. Integrity of implementation, expressed in the goal-image, corresponds to a total score of 100.

Criteria were scored for each team based on the analysis of the consistency of the information provided by the various interviewees, comparing it to the other evidence (triangulation).

The municipality and health team were considered the analytical units in the case studies. Thus, besides assigning the score by team, a score was assigned to the municipality, obtained from

the mean score for the two respective teams, analyzing each criterion singly, the observed sub-dimensions and dimensions, and the overall score.

Qualitative data from the interviews were processed with NVIVO (version 2.0, QRS International Pty, Doncaster, Australia).

Table 1 (continued)

Criteria	Score
DIMENSION: teamwork	
Circulation of information is satisfactory for the core team professionals	0 – no. 2 – partially (information circulates, but with problems). 4 – yes.
Existence of spaces for case discussion and activities	0 – no. 2 – sporadically. 4 – regularly.
Existence of shared decision-making spaces	0 – no. 2 – yes, including some professionals from the core team. 4 – yes, including all professionals from the core team.
Satisfactory sharing of responsibilities among team's professionals	0 – no. 2 – partially (to some professionals). 4 – yes.
Balance of power relations among team members	0 – concentration of power in physician's hands. 4 – some power sharing, but biased in favor of physician. 8 – power shared by the team.

FHP: Family Health Program; CHW: community health workers.

Results

Analysis of secondary data and documents corroborated the municipalities' similarity in relation to socio-demographic and economic characteristics, but showed differences in the political context and organization of the health system (Table 2).

Although in both cases the mayors and municipal health secretaries belong to the same leftwing political party and there was no break in administrative continuity in the last two administrations, when analyzing the stability and ideological coherence of the political alliances in the last three elections and the support from the city council, Municipality B showed a more favorable political scenario. In relation to organization of the health system, the two municipalities differed as to administrative continuity in the Municipal Health Secretariat, per capita health expenditures, and proportion of expenditure on primary care.

Primary care activities were conducted by both traditional primary care units and FHP units, with a coverage rate of 49% (Municipality A) and 63% (Municipality B) for this program in 2004, and an important increase in 2000-2004. In both municipalities, the mean number of families per FHP team was far higher than recommended by the Ministry of Health. Some 36% and 5% of the

family health teams lacked a physician, respectively, in Municipalities A and B.

The organization of activities in the primary care and traditional health units differed in the two municipalities in relation to management and health care practices. The differences cited by interviewees related to: health workers' wages (higher in the FHP), territorialization and user enrollment (well-established in the FHP areas), work organization (greater autonomy, joint definition and integration of work activities in multi-professional teams in FHP areas). In Municipality B, interviewees emphasized the presence of a link between health professionals and family health teams. In Municipality A, there were contradictions between the interviewees in their responses. While some emphasized that this link was an important aspect, according to others there were no differences in the link between professionals and the FHP team, comparing the two organizational models.

Important differences between the municipalities were identified in the organization of primary care, in relation to: definition of priority areas for FHP implementation, linkage between traditional primary care units and family health teams, and supervisory processes in the health units.

Although in both municipalities the key informants mentioned – as a criterion for defin-

Table 2

Socio-demographic, political, and health system organizational characteristics and primary care coverage in the case municipalities.

Criteria/Indicators (approximate values)	Municipality A	Municipality B
Socio-demographic (2000)		
Urbanization rate (%)	85	85
Population < 29 years (%)	60	60
Human Development Index	0.8	0.8
Persons living with capita income less than one-half the minimum wage (%)	44	42
Functional illiteracy rate in population > 25 years (%)	35	44
Households without running water (%)	15	21
Households not connected to sewage system (%)	68	65
Households without garbage collection (%)	25	17
Political (2000 and 2004)		
Administrative continuity (Mayor)	Yes	Yes
Stable political party alliances	No	Yes
Ideological identity in alliances	No	Yes
City council members belonging to party front that elected current mayor (%)	27.3	50.0
Health system organization		
Administrative continuity in Municipal Health Secretariat	4 Secretaries in 5 years	2 Secretaries in 5 years
Qualified for fully autonomous management of the municipal system (Ruling NOB-SUS 01/1996)	Yes	Yes
Per capita health expenditure (2003; R\$)	100	165
Municipal treasury expenditures on health (2004; in thousands of R\$; %)	17	16
Primary health care expenditure (2004; %)	60	33
Primary care coverage (2004)		
FHP coverage	49	63
Primary medical consultations per inhabitant	0.7	0.9
Live births in women with ≥ 4 prenatal visits (%)	0.8	0.8

NOB-SUS: Basic Operational Norm of the Unified National Health System (rules on local management autonomy over transferred Federal health funds); FHP: Family Health Program.

Sources: IBGE, UNDP, DATASUS, TSE (National Electoral Court), and interviews.

ing areas for FHP team implementation – the existence of “social risk” (worse social and health indicators and lack of health services), the selection of priority areas differed in technical aspects (problems with the territorial distribution of community health workers and underestimation of the population size, among others, in municipality A) and political issues (in Municipality B only, the areas were defined by the Municipal Health Council).

In Municipality B, unlike Municipality A, there was a link between the traditional and family health units, consisting of: definition of a territorial reference between the family health units and the traditional units; support from the traditional units for the family health units in pediatrics and gynecology, with patient appointment quotas in these areas for the teams; supply of medical appointments with a general practitioner in cases

of temporary absence of a physician in the family health units.

Although both municipalities had professionals in charge of coordinating primary care, there were differences in both the level of organization of management practices and the permeability to teams' participation in the primary care management decision-making processes.

Municipality B clearly defined the responsibilities for members of the coordinating team, with a general coordinator, regular weekly work meetings, systematic scheduling with standardization of routine supervision of primary care teams (traditional and family health), use of management support tools, and regular meetings with the urban and rural teams.

Implementation of primary care

As for implementation of primary care activities in the teams analyzed in depth, the total scores for Municipalities A and B were, respectively, 66 and 81, out of a maximum of 100 (Figures 1 and 2; Table 3).

Although the overall score for Municipality B was higher than for Municipality A, the scores were identical in the sub-dimensions “territorialization” and “teamwork”. The rural teams covered considerably larger areas than the urban teams; importantly, the rural team in Municipality B was located 45 kilometers from the municipal seat.

In all the teams, the areas were adequately mapped, and the family rosters were systematically updated. Definition of the target population was consistent with FHP guidelines in the rural team in Municipality A and in the urban team in Municipality B.

Division of the territory into micro-areas preferentially followed natural geographic criteria, and there was no mention of risk criteria in

mapping micro-areas. Some community health workers in both municipalities reported the existence of different living conditions within a single micro-area.

In Municipality B only, the teams had conducted an analysis of the health situation with the population’s participation at least a year previously, and were seeking to adjust the scheduling of activities in the unit, based on the problems they had identified. We observed that the university-level health professionals were very familiar with the epidemiological data from their respective areas and with handling of monthly reports from the Primary Care Information System (SIAB), suggesting a different grasp of social and health problems, that is, based not only on their experience in treating the population, but also on the use of management tools. For example, the analysis of the health situation in the urban team’s area indicated the need for backup in mental health, since the survey identified numerous families with psychosocial problems and drug abuse among adolescents. The team select-

Figure 1

Evaluation of implementation of primary care in Municipality A.

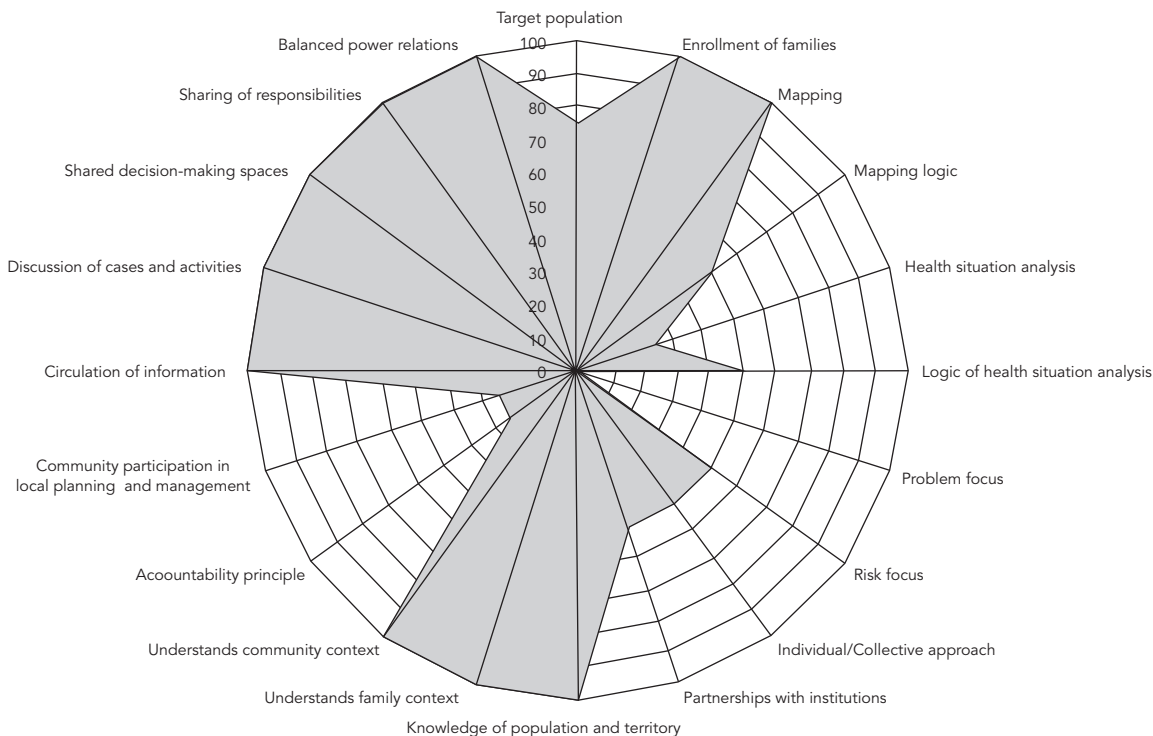
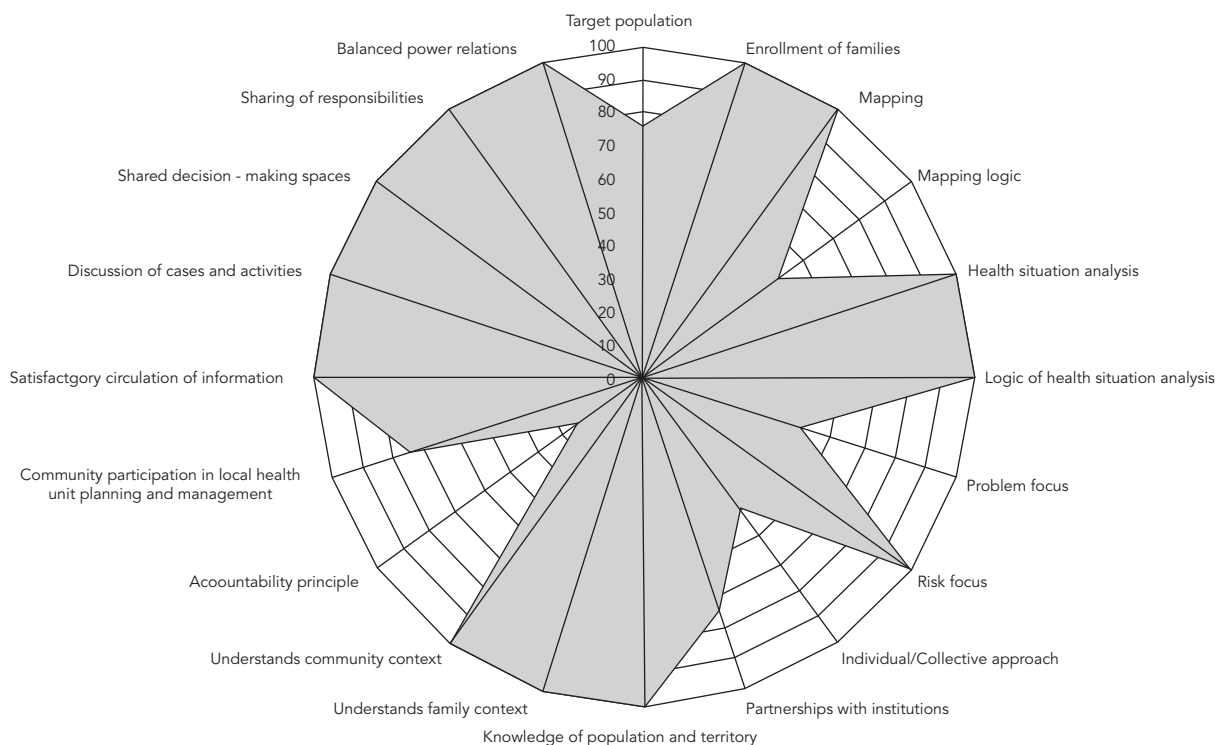


Figure 2

Evaluation of implementation of primary care in Municipality B.



ed families at risk in each micro-area and began to offer them “special care”.

In Municipality A, although the teams received the “introductory training” for conducting a diagnosis of the health situation, they did not incorporate this activity as a practice.

In this municipality, the university-level health professionals, especially the physician, devoted most or nearly all of their working hours to treating the spontaneous demand, with the appointments having been scheduled through the distribution of numbered slips on a first come-first served basis on four days of the week, for the next day in the rural unit and on two days of the week for the other days at the urban unit. In a planning meeting, the rural team decided to establish treatment shifts by micro-area, further stipulating that each family would only have the right to one appointment.

Importantly, the family health teams had complete autonomy in defining their work routine and organizing the supply of care. The man-

agement team in the municipality only required that one weekly time slot be dedicated to a team meeting and that the meeting be coordinated by the nurse, since they felt that the physicians did not adequately meet their management roles, in addition to complaining administrative tasks.

Both municipalities established specific treatment time slots for special groups (patients with hypertension and diabetes, pregnant women, and children), while in Municipality B there was a more even balance in the team activities between treatment of spontaneous demand and the specially scheduled programs.

Unlike Municipality A, in Municipality B the units had implemented a system for receiving users for treatment of the spontaneous demand through a “daily listening” process (7:00-8:00 AM), for all users that showed up at the unit. In the rural unit, this reception process was only used at the headquarters; in the different treatment sites in the rural hamlets, the community health worker prioritized the patients ahead of

Table 3

Evaluation of implementation of primary care in the selected teams.

Dimensions, sub-dimensions, and criteria	Municipality A		Municipality B		Score Maximum
	Rural team	Urban team	Rural team	Urban team	
Community population approach	40	44	52	62	76
Territorialization	16	14	14	16	20
Definition of target population	4	2	2	4	4
Enrollment of families	4	4	4	4	4
Mapping of area	4	4	4	4	4
Mapping logic	4	4	4	4	8
Organization of health activities	8	14	20	24	28
Health situation analysis performed and updated	0	2	4	4	4
Logic of health situation analysis	0	4	4	4	4
Problem-based focus	0	0	2	2	4
Use of risk focus	2	2	4	4	4
Linkage between individual and collective approaches	2	2	2	2	4
Establishment of partnerships with other institutions in the area	4	4	4	8	8
Establishment of health team-population linkage	16	16	18	22	28
Knowledge of population and territory	4	4	4	4	4
Understanding of family context	4	4	4	4	4
Understanding of community context	4	4	4	4	4
Operationalization of accountability principle	2	2	2	2	8
Population's participation in local health unit planning and management	2	2	4	8	8
Teamwork	24	24	24	24	24
Satisfactory circulation of information to core team professionals	4	4	4	4	4
Existence of spaces for discussion of cases and activities	4	4	4	4	4
Existence of shared decision-making spaces	4	4	4	4	4
Satisfactory sharing of responsibilities among team members	4	4	4	4	4
Balance of power relations among actors	8	8	8	8	8
Overall score	64	68	76	86	100

time for consultation, without a daily reception process.

In both municipalities, community health workers mainly conducted health promotion and prevention activities through home visits and educational groups. Participation by other health professionals in these activities differed between the two municipalities, with greater involvement by university-level professionals in Municipality B.

All the teams used family health records containing information on the household's living conditions, but they did not include any record of the family's psychosocial profile or dynamics. The health professionals clearly valued the family health record as a tool that facilitated the link between the individual and collective approaches and allowed an expanded intervention with individual care as the point of departure in relation to both the individual-group dyad and the treatment-prevention dyad, especially in

the case of diseases and groups that are prioritized nationwide by the FHP. The interviewees further mentioned that the supply according to programmed groups in specific shifts facilitated the link between the individual and collective approaches by fostering reflection on a given problem or specific group, by focusing individual care for similar clinical cases.

The team professionals were able to name and describe the main activities of the institutions present in their respective work areas. However, the establishment of partnerships was limited to the scheduling and holding of preventive activities in daycare centers and schools. Only the urban unit in Municipality B conducted more systematic and lasting work with neighborhood associations in the area. They showed a grasp of the territory and the families' living conditions, as expressed by their ability to describe the place, discuss the population's socio-economic profile, and identify patients by name

and place of residence. This was true not only for the technical staff, but also for the university-level health professionals.

The link (in the form of interpersonal relations) between the health service and the population was perceived by interviewees as an advantage over the care provided by the traditional primary health clinics. All the users interviewed in the two municipalities reported a high degree of satisfaction with the FHP professionals. The users felt respected, showing trust in the team's work, and the team also reported feeling welcomed by the population.

The community health workers proved to be the principal mediators in the relationship between the health service and the population, with an important role in circulating information: they advised the population on scheduling activities, setting specialized appointments, delivering test results, communicating problems reported by the population, requesting appointments, and providing systematic information on users and families; 94% of the users interviewed could name the community health workers in their respective areas.

The health professionals reported feeling responsible for the population in their respective areas and accompanied the users' at home, in addition to conducting home visits to obtain information from family members whenever a patient was hospitalized. However, there was no exchange between the health units, and all the information about hospitalized patients came from the families (through home visits by the community health workers) and/or from the users themselves when they returned for follow-up by the health teams.

As for systematic, regular participation by the local population in planning and managing health activities, only the urban team in Municipality B reported the presence of an organized and active Local Health Council.

The teams received the maximum score on the "teamwork" item, but the municipalities showed differences in the division of labor among team members.

In Municipality A, the physicians were in charge of individual care in managing diseases and injuries, as their main activity. Nurses were responsible for management and supervision (especially for the community health workers), provided individual preventive care, and organized the educational group activities, in which they occasionally participated. This technical division of labor had two reasons: the physicians opted for some specific programs, and the nurses lacked training in hypertension and diabetes.

Municipality B showed greater sharing of administrative tasks among the team members (even technical-level personnel), as well as administration of the units (among the university-level professionals), with no clear definition of a coordinator. In relation to health care practices per se, unlike Municipality A, the technical division of labor did not establish a rigid division between preventive and curative activities, so that physicians, nurses, and dentists were directly involved in the health promotion and prevention activities within the unit's territory.

Discussion

Implementation analysis studies the changes that occur after an institution decides to introduce an intervention. A key concern is the distinction between fixed (robust) effects and variable (context-dependent) effects of this intervention, as well as the implications of contextual differences for the variability in the implementation of its components.

This study corroborated the assumption that the FHP is a highly complex intervention and that its implementation is heavily determined by the context. In addition, the different municipal contexts explained the differences in implementation of primary care, but they did not produce uniform effects on its different dimensions and sub-dimensions.

It was interesting to observe that (at first glance) the political and institutional contexts appeared very similar in the two municipalities. However, a more in-depth analysis revealed differences in the intra-institutional arrangements, internal power configurations, and continuity of health policies in the municipalities. This had implications for the organization of activities within the family health teams and primary care within the municipal health system in terms of: competencies, organizational modality, and the team's work process in providing primary care, in the relationship between the coordinating team and the primary care teams, the relationship between the traditional primary care units and the FHP teams, and the role of the Health Councils, among other issues.

Meanwhile, even in distinct contexts, organizational innovations clearly emerged that were closely related to the intervention's nature, i.e., the FHP's operational guidelines. Thus, the FHP is potentially an inductor of changes, especially in relation to the object (territory/population, with a new approach to health problems in the individual/collective dimension) and the team's work process, reshaping the power rela-

tions among the team members and establishing new relations between the teams and the population (linkage and accountability).

There were also differences in the degree of implementation of actions related to the urban/rural context, with better performance by the urban teams in both municipalities. Thus, even where there was a favorable political and institutional context and integrated teamwork, the distance, size of the territory, and population dispersal were limiting factors for the team's work and social oversight by the local health council, thereby constraining the possibilities for organizational innovation. This finding reinforces the idea that the FHP is failing to positively favor the rural population. This is especially important since one of the underlying principles of the program is the notion of territory as a space for intervention. It thus becomes necessary to rethink the program's guidelines, analyzing and operationalizing the concept of territory more consistently in relation to its underlying concepts.

The implementation of territorially structured primary care highlights a set of issues and challenges that are not always obvious at first glance, and which the case analysis unveils. First, it appears that regardless of contextual factors, FHP implementation was able to promote the incorporation of technical procedures related to territorialization. However, the mapping logic still fails to meet the more radical goal of organizational innovation, to the extent that it overlooks the concept of risk as central to understanding this process. This can be observed in the absence of thematic maps, the heterogeneity sometimes present within micro-areas, and the lack of critical analysis of the concept of territory in the daily work routine. However, it is important to emphasize how strongly the actors valued the concept itself, based on its possibilities for establishing a link between the FHP team and users in this process.

In fact, the opportunities for interface between the FHP team and the local population, in the daily relations and diversity of spaces where they occur in the territory (which multiples or unfolds as territory/home, territory/school/ territory/unit, territory/street), tend to help strengthen ties and establish exchanges between the health professionals and users. Thus, the health team's understanding of the socio-cultural and family context and the establishment of a link with users appear to be directly related to the territorially structured primary care model. A study in Petrópolis, Rio de Janeiro State, comparing the organization of care between traditional primary care units and family health units, showed a stronger link with users in the latter²².

The overall score observed in each municipality was probably higher than would have been measured on the basis of mean values obtained from all the existing primary care units, since the study focused on successful cases. This could be considered a limitation to the study. Still, given that the intention was to evaluate an intervention that aims to reorganize primary care, the findings were important in the sense of highlighting the direction, limits, and potentialities of changes in the implementation of a new health care organizational model in a primarily dynamic reality. In Municipality B, there was probably greater homogeneity among the teams than in Municipality A, given the high degree of standardization in primary care actions and the constancy and regularity of local supervisory processes. Thus, it is worrisome that the scores fell short of the goal-image.

The gap between the teams and municipalities and the goal-image in the sub-dimension "establishment of linkage" was due to the score for the criteria "operationalization of the accountability principle" and "population's participation in the local health unit's planning and management". Municipality B showed greater openness to the population's participation in the discussion of problems and priority setting. However, despite the population's perception of accountability, all the teams displayed insufficient operationalization of this principle, showing that the sought-after shared responsibility for health care between users and professionals is still a utopia. Some factors may be limiting this operationalization in practice, including: lack of more solid management tools for communication between the units; lack of a culture of coordination in the primary care network; and lack of a user-centered model to test the limits of this accountability.

The two municipalities showed very different performance on the sub-dimension "organization of primary care actions". In the first, although there were changes in practice as compared to the complaint-approach model or so-called "primitive basic care", the supply of actions is based on a logic that has little basis in health surveillance.

In Municipality A, the organization of the actions led to a model focused on what we call "organization of the demand", that is, adjustment to and training for a predefined supply. In this case, the issue is not to submit the supply of services to an analysis of health needs, to target the problems and shape the organization of services, the linkage of preventive and curative action exclusively as a function of such needs. Primarily, a rationalizing logic is applied to the service so as to optimize the health professionals' workload.

The logic is to organize the demand by offering programs. The demand becomes limited by the organizational constraints in the health service. The system's center is not the users, the population, or their health or health services needs, but the needs of the health services themselves, expressed by the health professionals.

The findings raise the need to debate some issues related to the health teams' work process and object.

A first issue involves the polarity between autonomy and standardization. While in Municipality B there were mechanisms aimed at standardizing and supervising the teams' work processes, in Municipality A the professionals had greater autonomy to manage and organize the actions in this sphere, although conditioned by the Program's guidelines, administrative norms from the Municipal Health Secretariat, and more general bureaucratic processes.

The autonomy assigned to health professionals in managing their work processes has been identified as an important initiative to allow the emergence of more creative processes, with solutions that are more adequate for the local realities. However, the study showed that if this is not subject to the logic of user-centered care, the risk is that the teams adopt (as norms) the kinds of approaches and procedures that contradict the very basic principles of the Brazilian health reform. Municipality A was illustrative in this sense, demonstrating the implementation of health care norms in the units that created veritable barriers to services, hindering access by users, or establishing prioritization criteria (like setting a limit of one appointment per family or one day of care per micro-area) that could potentially increase the existing health inequalities.

The fact that all the teams received the maximum score on the "teamwork" dimension might actually express the presence of innovations in the primary care work process in family health teams in relation to the division of responsibilities and power. However, one needs to consider the limits of the research instrument for revealing nuances in the technical and social division of labor, and which were not incorporated. Silva²³, studying the linkage of actions and integration among members of a family health team, in a context similar to that of our study, showed similar findings in relation to internal communication, the existence of spaces for case discussion, and sharing of decisions.

A nuance in this division relates to the sharing of tasks between physicians and nurses, implemented differently in the two municipalities. One can hypothesize that in Municipality A, the clear preventive/curative distinction in the divi-

sion of labor reproduces the hegemonic training of health professionals, which fragments the understanding of the object and the health interventions. That is, while medical training prepares the professional to understand the pathophysiological processes involving the disease from the perspective of intervening with a curative individual approach, nurse training places much greater emphasis on preventive and management activities. Thus, the division of labor adapts to the professional qualifications without creating uncomfortable situations during the work. In Municipality B, the division of tasks did not reproduce the preventive-curative model, and the sharing of responsibilities between physicians and nurses was more balanced, suggesting the emergence of re-arrangements that point to deeper changes in the team's work.

Importantly, although we observed greater sharing of power by the members of family health teams as compared to the traditional physician-centered model, this sharing was not uniform among all the health team members.

In Municipality A, there was primarily a shift in administrative power in favor of the teams' nursing professionals, since they played management roles in the health unit. Although the nurses admitted to a work overload resulting from the accumulation of management and patient care responsibilities, they did not express dissatisfaction with this division of labor. On the contrary, the status of unit coordinator symbolized the recognition of professional competence that is generally diluted and undervalued in other organizational processes in the primary care circuit. In short, the administrative power led to symbolic power for the teams' nursing professionals. Importantly, the extra workload was not valued economically (i.e., remunerated). On the contrary, the physicians' standard wages remained higher than those of nurses. In addition, in clinical case management, the physicians detained the ultimate decision-making power over the therapeutic approach, thus preserving their technical and symbolic power in the health team.

Further in relation to power distribution in the team, it was interesting to observe the creation of spaces for listening and democratization, based on team meetings. The existence of these spaces reflects greater valuing of technical-level health workers (assistants and community health workers), who clearly occupy a subordinate hierarchical position, but nevertheless gain a greater voice in the collective body and see themselves (and are seen) as protagonists in the health unit's organizational process.

The coexistence of traditional primary care units and family health units in the two munici-

palties, as in other municipalities of the same size elsewhere in Brazil, was expected in this study. However, it was surprising to observe the existence of two distinct logics or rationalities for the organization of primary care, with some level of complementariness, and with no apparent negative influence of the other primary care units on the FHP strategies.

Municipality B showed territorialized organization and establishment of rules for referral between FHP and other primary care units. Municipality A had established a disordered logic for referral and counter-referral, especially due to the high percentage of teams without physicians. This may even explain the similarity between the two organizational models as perceived by some

interviewees in this municipality (the perception that “nothing works right” or that nothing goes according to expectations).

Given the findings, it is important to debate whether the FHP is actually being implemented as a model to replace the organization of primary care, or to what extent it promotes new institutional arrangements, based on its insertion in a given organizational logic. In any case, it is important for new studies to verify whether the coexistence of the two modalities tends to gain stability, especially in large cities, and to what extent such coexistence draws the real implementation of primary care closer to or farther from the goal-image of the Brazilian health reform.

Resumo

A contribuição da atenção primária à saúde das populações e na organização de sistemas de saúde é bem documentada, mas alguns autores têm destacado que, em países do Terceiro Mundo, ela ganhou mais força no espaço do discurso do que sobre fatos e práticas, com diferentes possibilidades de configuração. Este trabalho teve por objetivos avaliar e relacionar características organizacionais e do contexto municipal ao grau de implantação da atenção primária, em dois municípios da Bahia, Brasil, que adotaram o Programa Saúde da Família (PSF) como eixo estruturante do sistema. A pesquisa se realizou por meio de dois estudos de caso com níveis de análise imbricados, partindo de uma imagem-objetivo

da atenção primária que orientou a construção de critérios e padrões do grau de implantação. Os escores totais dos municípios A e B foram, respectivamente, 66 e 81 (pontuação máxima de 100), observando-se igualmente diferenças entre equipes urbanas e rurais. Os contextos político-institucionais foram explicativos de diferenças no grau de implantação da atenção primária, mas, também, independente do contexto municipal, evidenciou-se a emergência de inovações organizacionais intimamente relacionadas ao PSF

Atenção Primária à Saúde; Programa Saúde da Família; Sistemas de Saúde

Contributors

M. G. Medina contributed with the formulation of the research question, literature review, study conceptualization and design, processing, analysis, and interpretation of the findings, and writing of the article. Z. M. A. Hartz contributed with the supervision of the study in all its stages and with the revision of the article.

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