Integrality, conditions of service delivery and work process of Family Health Teams in Belo Horizonte

Integralidade, condições de oferta de serviços e processo de trabalho de Equipes de Saúde da Família em Belo Horizonte

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ABSTRACT The aim was to analyze the relation between integrality interventions and conditions of service delivery, in addition to the work process of Family Health Teams, in health centers in a district of the city of Belo Horizonte (MG). It is a cross-sectional study with self-administered questionnaire. Descriptive and comparative analyses were carried out through Pearson's chi-square, using p=0.05 value to verify the statistical significance. Both service delivery conditions and the work process showed association with the accomplishment of integrality interventions, and planning proved to be the most important tool for the accomplishment of such activities.

KEYWORDS Integrality in health. Family Health Strategy. Health promotion. Primary Health Care. Working conditions.

RESUMO *Busca-se analisar a relação entre ações de integralidade e as condições de oferta dos serviços, além do processo de trabalho das Equipes de Saúde da Família, em centros de saúde de um distrito de Belo Horizonte (MG). É um estudo transversal com questionário autoaplicável. Ao todo, 538 profissionais participaram do estudo. Foram realizadas análises descritivas e comparativas, por meio do qui-quadrado de Pearson, e de um valor -p=0,05 para verificação da significância estatística. Tanto as condições de oferta dos serviços quanto o processo de trabalho se mostraram associados à realização de ações de integralidade, sendo que o planejamento se mostrou a ferramenta mais importante para a realização de tais atividades.*

PALAVRAS-CHAVE *Integralidade em saúde. Estratégia Saúde da Família. Promoção da saúde. Atenção Primária à Saúde. Condições de trabalho.*

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DOI: 10.1590/0103-1104201611114

Introduction

Family health is the Primary Health Care (PHC) strategy chosen in Brazil for the reorientation of the national model named Unified Health System (Sistema Único de Saúde – SUS) (BRASIL, 2012). International literature considers that a strong PHC increases the country's capability to achieve high quality health care, in association with good cost-benefit relation (KRINGOS *ET AL.*, 2013). The Family Health Strategy (FHS), currently present in over 90% of the country's municipalities (HARZHEIM, 2011), was implemented in 1994 initially aiming at the small municipalities. Since the end of the 1990s, the strategy abandoned its initial statute to become a structuring strategy for the municipal health systems, aiming at the reorientation of PHC (GIOVANELLA; MENDONÇA, 2008). Its intervention is on the realm of health practices carried out in the territory, in so far as it establishes bonds of commitment and co-responsibility between the FHS team and a specific set of circa 3,000 to 4,500 people in a given area. Each team, composed of one physician, one professional nurse, two nurse auxiliaries, and six community health workers, take the responsibility for the integral health care of the population linked to it, by means of health promotion, prevention, recovery and rehabilitation of diseases and disorders, as well as for interventions on risk factors experienced in that community.

According to the National Policy for Primary Care (Política Nacional de Atenção Básica – PNAB) (BRASIL, 2012, P. 19), in its 2012 review, the aim of Primary Care (Atenção Básica) is to

> develop integral care that impacts on health conditions and autonomy of people, and on determinants and conditionings of communities' health,

by means of a set of "practices of care and management". Such practices, hereby named integrality interventions, were the investigation target of the research.

Integrality is understood as health care that congregates treatment and rehabilitation as well as prevention and promotion interventions, in the various levels of complexity; it is one of the fundamental principles of SUS (DOMINGOS *ET AL.*, 2016). Mattos (2009) considers that this principle is the least developed of the sanitary reform. If the aim of PHC is to provide qualified primary care that would respond to 85% to 90% of the populations' health problems, the outcome is not always positive. On the one hand, it is not rare to find FHS teams operating as emergency units, overloaded by the spontaneous demand from the region, and on the other hand, teams that advocate that the work should only be for prevention/promotion, not taking the responsibility for the patient's care and practicing a referral clinic (HARZHEIM, 2011). The balance proposed by integral care between promotional and curative interventions is a crucial requisite for the success of PHC. Despite a certain discursive consensus on the importance of promotion, it does not automatically occur in the daily practice of the Primary Health Units (PHUs).

Literature confirms that the association between integrality and PHC is a central issue in collective health research (BAPTISTA; FAUSTO; CUNHA, 2009). However, Norman and Tesser (2015) point out that despite much discussion about prevention/promotion and care in the organization of services, there is scarce production regarding the operationalization of these interventions in routine care at FHS.

Regarding the advancement of the sanitary reform, it is important to understand how the work processes and the conditions of service delivery in PHUs are related to the integrality interventions carried out by FHS. The aim of this article is to analyze the relation between the integrality interventions and the services delivery and work process in the Family Health Strategy Teams (Equipes da Estratégia Saúde da Família – EqSFs) in 20 PHUs of a sanitary district in the municipality of Belo Horizonte (MG), Brazil.

Methods

A transversal study was carried out with data collection between April and December 2014. Questionnaires were individually answered by each professional working in the 88 EqSFs of the 20 PHUs of the chosen district. In this district there is a universe of 752 posts authorized for the composition of teams. From this amount, 703 posts are actually occupied, according to data provided by the municipal administration.

There was an attempt to submit the questionnaires to all professionals of the EqSFs, using the exclusion criteria for those who had been working at the unit for less than three months, considering that they would have scarce knowledge on the unit's routine. The tool was designed to meet the objectives of the research and was divided in four sections: 1) worker's characterization; 2) daily work at the Primary Health Unit; 3) work management; and 4) work in the territory.

For this study, a number of variables were selected and divided into the following categories of analysis: Integrality in Health Interventions Developed by FHS (20 variables); Conditions of Service Delivery (3 variables); and Work Processes (3 variables). It is worthy to highlight that among the variables in category Conditions of Service Delivery there are: risk classification of the territory where the PHUs are, provided by the municipality of Belo Horizonte (MG); Primary Health Unit that possesses differentiated delivery (Program of Education from Health Work – Programa de Educação pelo Trabalho para a Saúde – PET-Saúde, medical residency); and the relation between the number of EqSFs and population. Category Work Processes includes: assessment of teamwork in meetings; assessment of interventions accomplished on the population; and planning. The variable 'planning' was designed from four questions: 'How often do you participate in meetings?'; 'How often are issues on planning interventions in the unit discussed in meetings?'; 'How often are issues on planning interventions outside the unit discussed in meetings?'; and 'How far does the autonomy of your team go to plan interventions on the territory?'. Regarding the first three questions, scores were attributed: 2 points for answers 'always'; 1 point for answers "often' or 'at times'; and 0 (zero) for negative answers ('never' or seldom'). The last question was scored with 1 (yes) or 0 (no). The sum of points could vary between 0 and 7. In this score model, variable 'planning' was divided in: 'Satisfactory Planning' for score (decreasing) between 7 and 5 points; 'Some Planning' for score between 4 and 2 points; and 'Little Planning' for score between 1 and 0.

Descriptive analyses were carried out (frequency distribution and measures of central tendency and dispersion) as well as comparative analyses (univariate analyses using Pearson's chi-square and Fischer's exact test when appropriate). Value $p \leq 0.05$ was considered to verify statistical significance. For each variable, using confidence interval of 95%, odds ratios (OR) were found. Data was stored and analyzed using the program Statistical Package for Social Sciences (SPSS), 19.0 version.

The project was submitted to and approved by the Ethics Committee of the Pontifical Catholic University of Minas Gerais (Pontifícia Universidade Católica de Minas Gerais de Minas Gerais), with the approval of the Municipal Secretariat of Health (Secretaria Municipal de Saúde) of the Municipality of Belo Horizonte, state of Minas Gerais (MG), in compliance with the ethical regulations for research involving human subjects (Certificate of Application for Ethics Review 14928213.9.0000.5137).

Results

The total amount of 538 professionals responded the questionnaire. Losses varied

from 16% to 30%, being lower among professionals holding a university degree. Although 30% of the technical nurses did not take part in the research, it is considered that it was a representative sample, because 76.5% of workers of all professional categories participated.

The analysis of the total number of professionals shows that: the majority is composed of women (89.7%), average age 42 years old (pattern deviation=9.7), varying between 22 and 67 years of age; work at the PHUs for over 6 years (46.6%). When analyzing the amount of years of work specifically of physicians it drops to less than one year (48.4%). Professionals holding a university degree (physicians and nurses) have also been working there for less than one year (33.1%), whereas 58% have been there from one to three years, and 21.3% for over six years. The PHUs where those professionals work are situated in areas classified as medium/low risk (69.1%), according to the municipality of Belo Horizonte (PBH-MG), and they attend an average of 33 users per day; 41.3% of those PHUs have a registry of between 2,800 and 3,400 people attended per EqSF. Regarding differentiated delivery at the units (medical residency and PET-Saúde), 60.8% provide these activities.

Regarding work performed by the professionals *(table 1)* it is observed that listening to the user is what happens most frequently during the reception (97.6%), followed by referral (86.2%). Most users (87.3%) have their demands attended during reception.

Concerning consultation with physicians and nurses, it is observed that the activities occurring with higher frequency are providing guidance in general (99.3%) and guidance on how to use medicaments (84.7%), followed by medical history of user's health treatment (87%). External referral occurs with lower frequency (24.4%). On table 1 there is more information on referral to prevention/promotion activities.

Table 1. Work characteristics of the 538 health professionals, in Belo Horizonte (MG). Brazil, 2015

Variables	n	%
When does reception happen at the unit?		
During entire opening time	279	53,3
At hours defined by the team	184	35,2
Varies according to the team	60	11,5
Which professionals participate in the reception?		
Nurses	495	92,2
Nurse auxiliaries	517	96,3
Physicians	193	36
Community Health Agents	76	14,2
What is the average amount of time spent in each reception?		
Maximum 5 minutes	64	17
More than 5 minutes	313	83
What happens during reception?		
Listening to user's need	525	97,6
User referral	463	86,2
Providing information/guidance	448	83,3
Risk classification	255	47,4

Table 1. (cont.)

Delivery of examination results	188	34,9
How many patients have their demands met at reception?		
Few or none	24	6
Half	28	6,7
Most	365	87,3
What happens during examination (only physicians and nurses: n=138)?		
Guidance	137	99,3
Medical history of user's health treatment	120	87
Medical history of user's other health practices	93	67,4
Prescription of medicaments	94	69,6
Guidance on how to use the medicaments	116	84,7
Prescription of diet/food guidance	82	60,3
Prescription of physical activity	81	59,6
Other guidance on life habits	102	74,5
Listening to the user on resistance to prescriptions	87	64,4
Internal referral – medical support , mental health, Nasf	56	41,5
External referral – specializations, hospitalization, Emergency Unit (UPA), Social Assistance Reference Center (Cras)	37	27,4
Group activities with users at the unit	31	23
Referral to prevention/promotion activities	94	68,6
Prevention/promotion activities to which users are referred:		
Leisure activities	75	54
Community activities	70	50,4
Walking	95	68,3
Lian Gong	120	87
Town academy	114	82
Health groups	77	55,4
Nasf	113	81,3
How long after referral does the user get access to urgency/emergency services?		
Same day	124	97,6
More than 1 day	5	2,4
Has the heath professional received permanent education in the last 12 months?		
Yes	333	62,8
No	197	37,2
Tools used by ESF for territory analysis:		
Family register	406	83,2
Health at the Territory Project	66	13,5
Health at School Program	234	48
Vulnerability index	200	41
Epidemiological data	252	51,6
Professional reports	371	76
Territory characteristics	137	28,1

Source: Authors' elaboration.

Table 2 shows the results of univariate analysis between variables related to Conditions of Services Delivery and Integrality Interventions. It is observed that the variable 'risk classification' appears as important to four integrality interventions; and variable 'relation between nr. of EqSF and population' appears as significant to three integrality intervention.

No integrality intervention showed relation with the three variables selected to represent the conditions of service delivery at the PHUs. At most, there was relation with two of those variables, as 'differentiated delivery' seems to have more importance in accomplishing integrality interventions, while 'risk classification' seems to be least important.

Table 2. Association between integrality interventions and conditions of health services delivery –univariate analysis, Belo Horizonte (MG). Brazil, 2015

Variables related to integrality	Variables related to conditions of services delivery (n=538)									
	Risk classification (%)			Differentiated delivery (%)			Relation between nr. of ESF and population (%)			
	High	Medium	Value p	Yes	No	Value p	2400-2800	2800-3400	> 3400	Value p
Provide information during reception:			0,548			**0,015**				0,211
Yes	161 (97)	364 (97,8)		262 (80)	186 (88,2)		106 (78,5)	190 (85,6)	152 (84)	
No	5 (3)	8 (2,2)		65 (20)	25 (11,8)		29 (21,5)	32 (14,4)	29 (16)	
Referral to promotion/ prevention/ activities during consultation:			**0,006**			0,448				0,191
Yes	22 (52,4)	72 (75,8)		61 (71)	33 (64,7)		19 (57,6)	44 (75,9)	31 (67,4)	
No	20 (47,6)	23 (24,2)		25 (29)	18 (35,3)		14 (42,4)	14 (24,1)	15 (32,6)	
Prescription of physical activities during consultation:			0,083			**0,024**				0,281
Yes	21 (48,8)	60 (64,5)		58 (66,7)	23 (46,9)		20 (58,8)	38 (66,7)	23 (51)	
No	22 (51,2)	33 (35,5)		29 (33,3)	26 (53,1)		14 (41,2)	19 (33,3)	22 (49)	
Guidance on life habits during consultation:			0,203			**0,003**				**0,025**
Yes	29 (67,4)	73 (77,7)		72 (82,8)	30 (60)		24 (70,6)	49 (86)	29 (63)	
No	14 (32,6)	21 (22,3)		15 (17,2)	20 (40)		10 (29,4)	8 (14)	17 (37)	
Referral to group activities during consultation:			**0,037**			0,676				0,125
Yes	5 (12,2)	26 (27,7)		19 (21,8)	12 (25)		4 (11,8)	17 (30,4)	10 (22,2)	
No	36 (87,8)	68 (72,3)		68 (78,2)	36 (75)		30 (88,2)	39 (69,6)	35 (77,8)	

Table 2. (cont.)

Invitation for activities at Basic Health Unit during home visit:			0,608			**0,039**			**0,015**
Yes	100 (64,5)	236 (66,9)		197 (62,7)	139 (71,6)		70 (55,6)	149 (69,6)	117 (69,6)	
No	55 (35,5)	117 (33,1)		117 (37,3)	55 (28,4)		56 (44,4)	65 (30,4)	51 (30,4)	

Fonte: Elaboração própria.

Table 3 shows the results of univariate analysis between variables selected to represent the work process in PHUs and integrality interventions. Differently from variables related to the conditions of service delivery, the three variables related to the work process were more significant to integrality interventions. The variables 'assessment of teamwork in meetings' and 'assessment of interventions on the population' appear as important to five integrality interventions, and only three were integrality interventions in common. The variable 'planning' was the most significant to the selected integrality interventions, having been related to eight of them. In this sense, it is observed that planning seems to be the most important tool for the accomplishment of integrality interventions.

Table 3. Association between integrality interventions and work process in health services –univariate analysis, Belo Horizonte (MG). Brazil, 2015

Variables related to integrality	**Variables related to Work Process in services (n=538)**								
	Assessment of teamwork in meetings%			Assessment of interventions on the population%			Planning%*			
	Always	Little /Never	Value p	Yes	No	Value p	1	2	3	Value p
Provide information at reception:			**0,008**		0,917					0,258
Yes	81,7	92,4		84,1	84,6		81,2	82	879,3	
No	18,3	7,6		15,9	15,4		18,8	18	12,7	
Prescription of diet/ consultation:			**0,003**			0,213				0,210
Yes	61,1	33,3		61,8	50		54,1	55,1	70	
No	33,9	66,7		38,2	50		45,9	44,9	30	
Internal referral to consultation:			0,984			0,718				**0,004**
Yes	41,4	41,7		41,3	45,5		31,4	30	60	
No	58,6	58,3		58,7	54,5		68,6	70	40	
External referral to consultation:			0,771			0,546				**0,028**
Yes	27,9	25		27,3	28,6		17,1	21,6	40,8	

Table 3. (cont.)

No	72,1	75	72,7	71,4	82,9	78,4	59,2	
Invitation for activities at UBS, during home visit:		0,294		**0,001**				**0**
Yes	65,4	71	69	45,8	51,4	74,7	73,5	
No	34,6	29	31	54,2	46,6	25,3	26,5	
Assessment of health condition, during home visit:		0,455		0,744				**0**
Yes	72,3	76	73	70,8	56,4	79,3	80,5	
No	27,7	24	27	29,2	43,6	20,7	19,5	
Does ESF use family register?		**0,014**		**0**				**0**
Yes	85,3	74,7	85,9	61,5	74	86,3	90	
No	14,7	25,3	14,1	38,5	26	13,7	10	
Does ESF use vulnerability index?		**0,001**		**0,031**				**0**
Yes	45,4	27,4	43,4	25,6	33,1	35,1	56,3	
No	54,6	72,6	56,6	74,7	66,9	64,9	43,7	
Does ESF use professional reports?		0,855		0,113				**0,001**
Yes	77	79,9	77,8	66,7	65,7	81,5	85,5	
No	23	22,1	22,2	33,3	34,3	18,5	18,5	
Are there group activities outside Basic Health Unit?		0,776		**0**				**0,024**
Yes	77,4	76	79	21	68,2	79,6	78,8	
No	22,6	24	42	58	31,8	20,4	21,2	

Source: Authors' elaboration.

*Planning: 1=little; 2=some, 3=satisfactory.

Tables 4 and *5* describe the estimation of the measure of association – Odds Ratio (OR) – for each variable that appeared associated to integrality interventions. For the conditions of service delivery *(table 4)*, it is observed that the PHUs that have differentiated delivery have less chances to provide information during reception (OR=0.54) and to invite to activities at PHU during home visit (OR=0.67), when compared to the units that do not have differentiated delivery. However, they have twice as many chances to prescribe physical activities during the consultation (OR=2.26) and three times more chances to provide guidance on life habits during the consultation (OR=3.2). The analysis of risk classification shows that PHUs with high risk classification have less chance to refer the users to prevention/promotion activities during the consultation (OR=0.35) when compared to PHUs with medium/low classification risk.

Regarding the relation between the number of EqSFs and population, a

dose-response gradient is observed: the higher the number of users per team, the lower the chance to accomplish integrality interventions. But one cannot state that there has been a significant difference, since the confidence interval of the OR estimation contains the number 1, indicating that at some point the groups are equal. Probably the difference observed for value -p(<0.05) is due to the sample size.

Table 4. Estimation of measure of association between integrality interventions and conditions of health services delivery – univariate analysis, Belo Horizonte (MG). Brazil, 2015

Variables related to integrality	Variables related to conditions of service delivery (n=538)						
	Risk classification (high)		Differentiated delivery		Relation between nr. of ESF and population		
	OR	CI 95%	OR	CI 95%	OR [CI 95%] 2400-2800	OR [CI 95%] 2800-3400	OR [CI 95%] >3400
Provide information at reception:			0,54	[0,33-0,89]			
Referral to promotion/prevention activities during consultation:	0,35	[0,16-0,76]					
Prescription of physical activities during consultation:			2,26	[1,10-4,63]			
Guidance on life habits during consultation:			3,20	[1,45-7,07]	1	2,55 [0,89-7,29]*	0,71 [0,27-1,84]*
Invitation for activities at Basic Health Units during home visit:			0,67	[0,45-0,98]	1	1,83 [1,16-2,89]	1,83 [1,13-2,97]

Source: Authors' elaboration.

*Despite value p <0.05, confidence intervals (CI 95%) do not show to be significant.

Table 5 describes the estimation of the measure of association (OR) for each variable related to work process that appears associated to integrality interventions. 'Planning' was the variable mostly associated to integrality interventions, being important to eight of them. For most integrality interventions, the more planning there is, higher are the chances that the PHU will accomplish them. PHU that has satisfactory planning has three times more chances to accomplish internal (OR=3.27) and external (OR=3.33) referrals, and to make the assessment of health condition during home visit (OR=3.19), when compared to the PHU with little planning. The variable 'assessment of interventions on population' has appeared as important to five integrality interventions; the PHUs that have this practice have five times more chances, e.g., to accomplish group activities outside the PHU, when compared to PHUs that do not make the assessment of interventions on the population.

Variable 'assessment of teamwork in meetings' also appeared as important to five integrality interventions, and the PHUs with teams that have the practice of making such assessments have less chances to provide information during reception (OR=0.37). On the other hand, they have three times more chances to provide the prescription of a diet during the consultation (OR=3.89) and almost twice as many chances to make use, as tools for the analysis of the territory, of

the family register (OR=1.96) and the vulnerability index (OR=2.61), when compared to the PHU whose professionals do not make teamwork assessment in meetings.

Table 5. Estimation of OR between integrality interventions and work process in health services –univariate analysis, Belo Horizonte (MG). Brazil, 2015

Variables related to integrality	Variables related to work process in services (n=538)						
	Assessment of teamwork in meetings		Assessment of interventions on population		Planning		
	OR	CI 95%	OR	CI 95%	OR [CI 95%] Little	OR [CI 95%] Some	OR [CI 95%] Much
Provide information at reception:	0,37	[0,17-0,79]					
Prescription of diet during consultation:	3,89	[1,53-9,91]					
Internal referral during consultation:					1	0,93 [0,37-2,40]*	3,27 [1,32-8,14]
External referral during consultation:					1	1,33 [0,44-4,01]*	3,33 [1,17-9,50]
Invitation for activities at Basic Health Units during home visit:			2,62	[1,44-4,80]	1	2,79 [1,78-4,38]	2,63 [1,66-4,17]
Assessment of health condition, during home visit:					1	2,96 [1,85-4,74]	3,19 [1,94-5,24]
ESF uses family register for territory analysis:	1,96	[1,14-3,39]	3,81	[1,89-7,67]	1	2,22 [1,27-3,88]	3,19 [1,69-6,02]
ESF uses vulnerability index for territory analysis:	2,61	[1,58-4,30]	2,22	[1,06-4,68]	1	1,09 [0,69-1,71]*	2,60 [1,65-4,09]
ESF uses professional reports for territory analysis:					1	2,31 [1,40-3,82]	2,29 [1,37-3,86]
Conducting group activities outside Basic Health Unit:			5,20	[2,83-9,55]	1	1,82 [1,12-2,98]	1,73 [1,05-2,87]

Source: Authors' elaboration.

* Despite value p <0.05, confidence intervals (CI 95%) do not show to be significant.

Discussion

This research has found statistically significant associations between integrality interventions and conditions of service delivery, and between work processes involving the variables assessment and planning, with highlight on the latter.

The research data confirm the strong tendency to the feminization of the work force at PHC, with 89.7% of respondents to the questionnaire being women, which is confirmed in various researches (ELLERY; PONTES; LOIOLA, 2013; SEIDL et al., 2014).

The journal 'Saúde em Debate' (Health on Debate) has published in 2014 an issue dedicated to the analysis of data from the National Program for Access and Quality Improvement in Primary Care (Programa Nacional de Melhoria do Acesso e da

Qualidade da Atenção Básica – PMAQ-AB), whose information has guided this research. The articles published in the journal analyzed data from 2012, covering the national territory and producing descriptive analyses that are related in several aspects to the data presented here.

Regarding the time span working at the EqSFs, the data extracted from the PMAQ-AB 2012 indicate that in municipalities with more than 500,000 inhabitants, among professionals with university degree, 21.1% have less than one year and 27.3% have more than six years in the job (SEIDL *ET AL.*, 2014); the national average is considerably above that found in the district researched, which is peripheral in relation to the Central-Southern region of the municipality. Difficulty retaining physicians, which is confirmed by the strong presence of professionals of the Program More Doctors (Programa Mais Médicos) temporarily composing the teams, stresses the dimension of the problem. As integrality presupposes the continuity of care, having difficulty retaining professionals in this region may hinder the effectiveness of the assistance (SEIDL *ET AL.*, 2014).

The difficulty with the retention of physicians in the district is to be highlighted; according to information of the district management, it was the one with the highest need of physicians from the Program More Doctors. Considering that ten physicians were excluded from the sample due to having been for less than three months at the unit, the percentage of physicians with less than one year raises to 61.8%. Several studies point out that among the crucial factors contributing to this situation are the inadequate working conditions (MAGNANO; PIERANTONI, 2015). Ney and Rodrigues (2012, P. 1305) highlight that among health professionals, physicians have more job offers in the private sector and this contributes to the turnover at SUS. They also point out that the system lacks on offering a medical career and providing a 'perspective for the future', thus hindering the retention of physicians. From the point of view of integral care, this turnover hampers the bond and continuity of work with the population involved.

Regarding the conditions of service delivery and integrality, it is necessary to highlight the excessive number of population involved, in Brazil, when compared to other countries (TESSER; NORMAN, 2014). While the country presents a limit of 4,500 users per EqSF, other countries with less vulnerable population have quite lower limits: Spain with 2,500; United Kingdom with 2,000; and Portugal with 1,500 (GIOVANELLA *ET AL.*, 2008). It is evident that a reduction on the size of the population involved could result in improvements on integral care, as indicated on table 3.

The article by Cruz *et al.* (2014) sought to characterize the use of management tools for planning and self-assessment by the EqSFs, drawing on data from PMAQ-AB. The authors understand that planning and self-assessment are strategic management tools for the quality improvement of health care. They observe that the institutionalization of assessment has been contributing to the incorporation of a 'reflective and pedagogical practice' in support to management and to changes in the institutional culture.

The results shown in the above mentioned article indicate that the frequency of answers concerning activities planning is lower in municipalities with up to 50,000 inhabitants, and higher in those with more than 100,000 inhabitants. Yet in the construct self-assessment its occurrence was mentioned by over 80% of the EqSFs, except for the Central-Western region.

The comparative analysis in the present research indicated a strong relation between management tools and integral care practices, with a stress on the variable 'planning', in the large municipality under study. Literature highlights the importance of understanding the relation between working in a team and the interaction between the team's members (PEDUZZI, 2001; PEDUZZI *ET AL.*,

2011), emphasizing the role of communication, which is a competence still neglected in health education (ELLERY; PONTES; LOYOLA, 2013). Thus, team meetings are crucial to guarantee the persistence of participative and engaged management from the members of the EqSFs. This study has found this relation between assessment and planning tools and integral care, with a stress on planning. It has also found the institutionalization of meetings between the EqSFs, as well as between the EqSFs and the Nucleus of Support to Family Health (Núcleo de Apoio à Saúde da Família – Nasf) and the mental health teams, with a monthly frequency for the meetings between teams.

Medina *et al.* (2014) sought to describe the promotion and prevention interventions of the EqSFs captured in the PMAQ-AB. According to those authors, Noncommunicable Diseases (NCDs) represent 70% of the morbidity in Brazil. However, a small number of studies assess the effectiveness of promotion interventions in PHC. Those interventions require a commitment that continues over time. The authors consider it important to focus on interventions aiming at changes in the collective lifestyle, directed to environments like schools and the communities. Activities at schools are mentioned in that research by 75% of the EqSFs (MEDINA *ET AL.*, 2014). Even so, the results show a low institutionalization of promotion interventions in FHS. It is known that health promotion is a highly controversial theme in public health in Brazil (FERREIRA NETO *ET AL.*, 2013) and that the understanding of managers is still very much centered on preventive interventions directed to changes in lifestyle (FRACOLLI; GOMES; GRYSCHEK, 2014); thus, this area requires greater advancements. This research has focused on health promotion in the scope of the interventions of the EqSFs, associating them with integrality, which is a central principle of SUS. Working conditions as well as work processes, consolidated in the assessment and planning tools, appear as variables with significant correlation with integral care interventions in PHC.

Conclusion

The external assessment of PMAQ-AB, unlike the present study, searched documents that would prove such activities and verified a disparity between answers and documentary evidence (CRUZ *ET AL.*, 2014). This research used only the answers to the questionnaires, with no search of documents to prove the activities, which is a limitation of this study.

In short, integral care interventions have a double association, with the conditions of service delivery and with the management of work processes of the EqSFs, in the PHC. Therefore, advancements in this direction should involve both the improvement of the conditions of service delivery, with the required investment, and permanent education of teams, aiming at the use of management tools. In Brazil there is still a long way to go when comparing with countries where there is funding for health services with an effectively universal scope, like England (DUNCAM *ET AL.*, 2015).

In the district under study, there is a highlight concerning the difficulty to retain physicians in the EqSFs, associated to the precariousness of working conditions. This is an aspect of no secondary character, and it must be handled aiming to strengthen integral care in FHS. In parallel to this, it is important to progressively reduce the number of families per EqSF; in Brazil, the amount of EqSFs is twice as big as in European countries, and it must be reminded that besides having less poor populations, those countries have basic sanitation issues far better resolved. Thus, the problem of retention of physicians will not be solved separately, without general improvement of working conditions in PHC.

On the other hand, there was a confirmation

of the relation between work processes and integral care interventions (CRUZ *ET AL.*, 2014). In this aspect, planning has been revealed as an essential tool for the qualification of work in primary care and it should be stimulated through strategies of continuing education, institutional support, and the increase of the attention to risks focusing on spontaneous demand, which restricts the necessary amount of time for team meetings to overcome the model 'transfer of cases'. In conclusion, both working conditions and work processes are factors that may either favor or hinder integrality interventions in PHC.

Colaborators

The authors João Leite Ferreira Neto and Graziella Lage Oliveira have substantially contributed to the design, planning, analysis and interpretation of data; drafting and critical review of contents; and approval of final version of manuscript. Natália de Oliveira Viana and Luiz Guilherme Mafle Ferreira Duarte have substantially contributed to the analysis and interpretation of data; critical review of contents; and approval of final version of manuscript.

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Received for publication: June, 2016
Final version: October, 2016
Conflict of interests: non-existent
Financial support: Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq), process 470509/2013-9 and Fundação de Amparo à Pesquisa de Minas Gerais (Fapemig), process CHE – PPM-00244-13