ORIGINAL ARTICLE

Evaluation of the performance of a management contract between a health social organization and the mayor of a city in the interior of São Paulo

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ABSTRACT

Introduction: The Social Health Organization is a non-profit entity that is in an expansion stage and there is a clear divergence of opinions regarding its effectiveness and compliance with the goals designated by the management contract proposed by public institutions. **Objective:** To evaluate if the goals established by the management contract between the City of Catanduva / SP and the Psychiatric Hospital Spiritist Mahatma Gandhi (OSS) are met. **Methods** : It is an observational, descriptive and cross-sectional study. Data collection was carried out based on the 2019 Catanduva Health Observatory Report, establishing a comparative relationship with the goals proposed in the current Management Contract. The following variables were analyzed: number of medical consultations, number of nursing consultations and medical resolvability index in Family Health Units. **Results:** Regarding medical resolution, the average rate of referrals made during 2019 in all FHUs was lower than the reference value established in the contract, suggesting a high rate of resolution of these services. In addition, medical and nursing production in the Family Health Units in the municipality of Catanduva is mostly above that provided for in the management contract, representing compliance with the values established by the contractor. **Conclusion**: The targets assigned to the OSS in the contract were met by the health units in accordance with the values agreed by the City Hall.

Keywords: Health management, Health services management, Contracts.

INTRODUCTION

Primary health care (PHC) is defined by the Ministry of Health (MS)[1] as individual or collective actions, developed at the first level of care in service systems, aimed at health promotion, disease prevention, treatment and rehabilitation. It is designated as the gateway to solving the basic health system, as it constitutes the first level of care within the SUS. Its main purpose is to meet the most prevalent needs in society. Starfield[2] points out that accessibility, the geographic location of the service, the hours and days of operation, as well as the process of using the services by the population, are essential elements for primary care to be considered the initial stage of entry into the system of health.

This primary care is focused on offering services for the prevention of morbidity and general medical support for the community in which it is inserted. This first contact gives the physician the role of *gatekeeper* , who performs initial patient care and filters them to complex or specialized levels of health care[3]. This primary system, implemented in a structured way, allows the development of the integration of health promotion centers, as well as a wide range of actions that have a positive impact on population indicators. Primary health care represents, therefore, a great social advance in the sense of guaranteeing the right to health, which is defended and postulated by the Brazilian Federal Constitution of 1988, since it corroborates the needy and underprivileged population to have access to health services. necessary and vital health services, whether in terms of prevention or promotion of disease treatment[4].

Social Health Organizations (OSS) are non-profit private sector institutions that work in formal partnership with the state and collaborate, in a complementary way, for the consolidation of SUS as provided for in its organic law

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nº 8.080/1990[5,6]. Federal Law 9,637/1998[7] was the legal framework for the structuring of autonomous OSS, defined as "private, non-profit legal entities whose activities are directed at teaching, scientific research, technological development, protection and preservation environment, culture and health".

These organizations were conceived in the context of the Master Plan for the Reform of the State Apparatus, prepared by the Ministry of Administration and State Reform in 1995. The central idea was to define the objectives and guidelines of public administration in Brazil, migrating from a bureaucratic, centered on the control of processes, towards a management model that prioritizes the achievement of results. In this model, the state reduces its role as an executor and direct provider of services, preserving and expanding its role as a planner, regulator and collector of results[8]. In the management model in partnership with OSS, the results achieved are supervised and evaluated by a specific committee, which verifies compliance with the goals stipulated in the management contract. The public institution plans the service to be performed, defines the production and quality goals, guarantees the budgetary resources for the cost of the services and collects the results previously defined in the contract.

In 1998, the Government of the State of São Paulo sanctioned a specific law for the qualification of Social Organizations (846/98) with activities aimed at health and culture, based on federal law 9,637. State law specifies that only non-profit organizations can qualify as OS and that a health service administered by an OSS must provide services exclusively to the SUS[8].

The contracting of Social Health Organizations (OSS) aims to specify the work program that must be implemented by the organization's management, stipulating deadlines and execution goals, whether quantitative or qualitative[9]. In addition, the management contract presents performance evaluation criteria, which are approached through quality and productivity indicators. The main items of a management contract are: Work Program and Goals; Payment System; Personnel Expenses System; Inventory and Valuation of Movable Assets; and Usage Permission Term[10]. This contract is carried out with the consent of both parties, aiming at the execution of the proposed activities with the required effectiveness and efficiency. In this way, the execution of the proposed goals is done by the OSS and the supervision of the services by the government, through the control of the result.

The contract consists of its design and specification. The design refers to the general objective, the duties and rights of the OSS, while the contract specification concerns the description of the goals and planning that must be carried out by the organization, the monthly contracted volume, quality indicators and the schedule for transferring resources. financial. In this operating system, the OSS receives incentives associated with the transfer of financial resources and there is monitoring of the performance in the execution of the services that were destined for the contract. OSS performance refers to the service provider's ability to carry out activities in accordance with the contract's specifications, ie, the contractor's performance is evaluated according to the performance of the contract[11].

In short, in the management contract, incentive mechanisms are established and the goals and plans that must be implemented in accordance with the required effectiveness are defined. The monitoring and evaluation of the OSS aims to determine if the third sector is fulfilling the duties proposed by the contractualization , that is, if the service offered is in line with the contract specifications. Possible variations in the performance of the OSS may directly reflect the application of incentives. Transparency of resources is necessary so that society can monitor the management of public services[12].

Thus, the New Public Management established in health aims to make management more flexible due to the transfer of execution responsibility to the institution signing the contract, thus establishing an indirect administration in which the state function is based only on the collection of the achievement of goals and inspection. of the production performed. This context makes the OSS to be understood as an autarchy since it corresponds to an independent service, established by law, with a legal nature, patrimony and exclu-

sive revenue to perform actions characteristic of Public Administration[13,14].

The use of the management contract as an instrument has the purpose of generating cultural changes that make the State and the social interest entities dependent or linked to it build and maintain high levels of 1. effectiveness: achieving the social effects desired by the population, in addition to providing services of community importance that meet their needs in terms of size, quality and cost; 2. Efficacy: politically and institutionally agree with an effective planning and with the conscientious realization of its accomplishment; 3. Efficiency : using community possessions and resources sparingly, carefully and carefully[13].

Also, according to the prescriptions of the Ministry of Federal Administration and State Reform (MARE)[15] , the OSSs have the status of private law and have a much greater administrative autonomy than that possible in the face of a direct administration of the State. These conditions, in addition to indicating flexibility, also explain the enormous adherence to the OSS model by state and municipal health managers across the country[16]. In addition, the use of professional incentives has been adopted as a component of the management strategy constituted by the set of stimuli, financial or not, aimed at adjusting and optimizing the components of the production process in health services, which is extremely complex and must have the interests and needs of users as its main objective[17].

Therefore, the present study aims to analyze the results obtained from the contracting of an OSS with the municipality of Catanduva, more specifically in the management of Health Units, in order to find out if there is adequate effectiveness and compliance with the plans assigned to primary care. The goals verified in the contract and in the municipal document that demonstrates the production were: number of medical and nursing consultations, in addition to the rate of referrals made by doctors.

METHODS

It is a descriptive and cross-sectional study. It was analyzed whether the goals proposed by the management contract between the Municipality of Catanduva and the Spiritual Psychiatric Hospital Mahatma Ghandi (OSS) were met in 2019. This year was chosen because it is the most current period of data under study.

Data collection was carried out from the 2019 Catanduva Health Observatory Report, a document that contains information about the services provided by the Basic Health Units and Family Health Units, which are managed by the analyzed OSS, the Psychiatric Hospital Spiritualist Mahatma Ghandi , in the period described. Based on these data, the variables were analyzed: number of medical consultations, number of nursing consultations and rate of medical referral in the USF.

The collected data were stored in a *Microsoft Office Excel spreadsheet*. The results were expressed in number, percentage and mean.

The present study was submitted to the Research Ethics Committee of UNIFIPA and approved under protocol number 4,333,977.

RESULTS

Medical Referral Fee

The management contract in force for the year 2019, signed between the Municipality of Catanduva / SP and the Mahatma Ghandi Psychiatric Hospital (OSS), determines resolution values for basic health care. The resolution of 80% of the medical consultations performed is determined, and if there is a need for other levels of care, there must be referral to the appropriate level of care. Therefore, only 20% of the total assistance provided by primary care should be referred to other sectors. Tables 1 and 2, extracted from the Health Observatory Report, portray the percentage of referrals made by the USF in the city of Catanduva.

Table 1

Rate of medical referral by health facilities, from January to June 2019.

Health Units	Goal - Month	JAN RATE	FEB RATE	MAR RATE	APR RATE	MAY RATE	JUN RATE
Napoleão Pellicano USF (Alpino)	5 to 20%	16	10	24	7	6	8
Milton Maguollo USF (Bom Pastor)		15	18	36	16	10	12
Sergio da Costa Peres USF (Del Rey)		13	9	9	6	9	6
Jose Rocha USF (Gavioli team I)		11	10	14	8	10	11
Jose Rocha USF (Gavioli team II)		12	19	22	14	10	7
Jose Ramiro Madeira USF (Euclides)		17	22	17	10	11	17
Alcione Nasorri USF (Solo team I)		12	12	21	20	17	14
Alcione Nasorri USF (Solo team II)		18	17	13	15	19	15
Alcione Nasorri USF (Solo team III)		22	12	22	19	19	13
Armindo Mastrocola USF (Santa Rosa)		14	17	21	9	10	14
Athos Procópio de Oliveira USF (Imperial)		8	10	13	11	7	7
Carlos Roberto Surian USF (Nova Catanduva team I)		6	7	14	15	18	6
Carlos Roberto Surian USF (Nova Catanduva team II)		19	18	18	5	8	6
Carlos Eduardo Bauab USF (Theodoro)		18	21	26	14	6	12
Geraldo Mendonça Uchoa USF (Lunardelli)		8	6	12	8	23	12
Joao Miguel Calil USF (Santo Antonio)		10	11	23	13	11	15
Jose Pio Nogueira de Sá USF (Gabriel Hernandes)		11	10	19	9	7	9
Michel Curi USF (Nosso Teto team I)		11	6	12	7	9	15
Michel Curi USF (Nosso Teto team II)		17	15	20	14	9	14
Olavo Barros USF (Monte Líbano)		9	14	16	9	9	14
Sergio Banhos USF (Pachá)		13	17	19	12	18	13
Gesabel Clemente Marques de la Haba USF (Pedro Nechar)		17	10	12	7	9	10
Isabel Ettruri USF (Flamingo team I)		15	11	13	8	11	11
Isabel Ettruri USF (Flamingo team II)		9	12	20	7	7	9

Source: Annual Report of the Health Observatory of Catanduva (2019) – Health Department of Catanduva.

Table 2

Physician referral rate, by health units, from July to December 2019.

Health Units	Goal - Month	JUL RATE	AUG RATE	SEP RATE	OCT RATE	NOV RATE	DEC RATE
Napoleão Pellicano USF (Alpino)		10	10	10	8	6	5
Milton Maguollo USF (Bom Pastor)		19	19	12	18	16	14
Sergio da Costa Peres USF (Del Rey)		6	11	9	6	9	5
Jose Rocha USF (Gavioli team I)		10	9	8	9	8	6
Jose Rocha USF (Gavioli team II)		21	16	10	10	1	7
Jose Ramiro Madeira USF (Euclides)		12	12	15	15	11	11
Alcione Nasorri USF (Solo team I)		11	16	10	11	14	11
Alcione Nasorri USF (Solo team II)		10	17	8	8	11	8
Alcione Nasorri USF (Solo team III)		14	17	15	25	13	6
Armindo Mastrocola USF (Santa Rosa)		7	10	12	9	8	5
Athos Procópio de Oliveira USF (Imperial)		7	15	10	10	11	8
Carlos Roberto Surian USF (Nova Catanduva team I)		6	6	10	8	8	6
Carlos Roberto Surian USF (Nova Catanduva team II)	5 to 20%	6	5	8	9	9	11
Carlos Eduardo Bauab USF (Theodoro)		10	9	13	11	12	8
Geraldo Mendonça Uchoa USF (Lunardelli)		11	16	18	11	9	11
Joao Miguel Calil USF (Santo Antonio)		13	12	13	9	9	9
Jose Pio Nogueira de Sá USF (Gabriel Hernandes)		9	9	9	9	10	10
Michel Curi USF (Nosso Teto team I)		17	23	8	13	10	9
Michel Curi USF (Nosso Teto team II)		17	12	9	13	7	7
Olavo Barros USF (Monte Líbano)		10	11	11	9	11	9
Sergio Banhos USF (Pachá)		16	15	18	9	9	9
Gesabel Clemente Marques de la Haba USF (Pedro Nechar)		8	8	8	5	11	4
Isabel Ettruri USF (Flamingo team I)		9	10	12	10	7	12
Isabel Ettruri USF (Flamingo team II)		10	14	13	11	7	7

Source: Annual Report of the Health Observatory of Catanduva (2019) – Health Department of Catanduva.

The Health Observatory Report, which portrays the execution of the Management Contract, informs that during the months of January to June 2019 the rate of referrals in primary health care presented values above the proposed target in nine Family Health Units , corresponding to 50% of the total USF in the municipality of Catanduva. Based on the referential value of referrals (5 to 20%), the following FHUs had values that did not agree with the referral target in at least one month of the semester: FHU Napoleão Pellicano, FHU Milton Maguollo (Bom Pastor), FHU Jose Rocha (Gavioli team II), USF Jose Ramiro Madeira (Euclides), USF Alcione Nasorri (Solo team I), USF Alcione Nasorri (Solo team III), USF Armindo Mastrocola (Santa Rosa), USF Carlos Eduardo Bauab (Theodoro), USF Michel Curi (Our Teto team II), USF Isabel Ettruri (Flamingo team II). Of these, approximately 77.8% (n=7) had referral values above 20% in just one month of the semester.

In relation to the second half of 2019, the rate of referrals from primary health care presented values above the proposed target in three Family Health Units, representing 16.6% of the total FHU in the municipality of Catanduva. The following USF are mentioned: USF Michel Curi (Our Teto team I), USF Alcione Nasorri (Solo team III) and USF Jose Rocha (Gavioli team II). In total, all presented referral values above the proposed target in just one month of the final semester.

Based on the average rate of referrals made during 2019, all USFs showed values below 20%: USF Napoleão Pellicano (10%), USF

Milton Maguollo (17%), USF Sergio da Costa Peres (8%), USF Jose Rocha (Gavioli Team I) (10%), USF Jose Rocha (Gavioli Team II) (12%), USF Jose Ramiro Madeira (14%), USF Alcione Nasorri (Solo Team I) (14%), USF Alcione Nasorri (Solo team II) (13%), USF Alcione Nasorri (Solo team III) (16%), USF Armindo Mastrocola (11%), USF Athos Procópio de Oliveira (10%), USF Carlos Roberto Surian (Nova Catanduva team I) (9%), USF Carlos Roberto Surian (New Catanduva team II) (10%), USF Carlos Eduardo Bauab (13%), USF Geraldo Mendonça Uchoa (12%), USF Joao Miguel Calil (12%) , USF Jose Pio Nogueira de Sá (10%), USF Michel Curi (Our Teto team I) (12%), USF Michel Curi (Our Teto team II) (13%), USF Olavo Barros (11%), USF Sergio Baths (14%), USF Gesabel Clemente Marques de la Haba (9%), USF Isabel Ettruri (Flamingo team I) (11%) and USF Isabel Ettruri (Flamingo team II) (10%).

Medical production

The 2019 management contract provides for a monthly production of 400 medical appointments for each medical team at the Family Health Units. Of this total, 85% of the expected production is set as a target. Table 3 shows the percentage of services performed by each USF team in comparison with the expected amount during the period from January to June 2019, while Table 4 shows the same profile but during the period from July to December of the same year.

Table 3

Expected medical production and the production rate performed in relation to the goal in the USF in the period from January to June 2019.

Health Units	Expected Prodution	Goal - Month	JAN %	FEB %	MAR %	APR %	MAY %	JUN %
Napoleão Pellicano USF (Alpino)	400 for team	85%	149	124	122	163	175	162
Milton Maguollo USF (Bom Pastor)			122	127	11	141	115	118
Sergio da Costa Peres USF (Del Rey)			116	110	95	124	117	96
Jose Rocha USF (Gavioli team I)			119	111	104	120	122	102
Jose Rocha USF (Gavioli team II)			118	103	90	110	114	82
Jose Ramiro Madeira USF (Euclides)			114	92	86	113	109	95
Alcione Nasorri USF (Solo team I)			100	102	86	106	113	85
Alcione Nasorri USF (Solo team II)			101	106	93	117	115	95
Alcione Nasorri USF (Solo team III)			113	98	89	113	113	91
Armindo Mastrocola USF (Santa Rosa)			146	127	114	128	138	113
Athos Procópio de Oliveira USF (Imperial)			125	111	105	119	118	100
Carlos Roberto Surian USF (Nova Catanduva team I)			120	107	98	116	131	101
Carlos Roberto Surian USF (Nova Catanduva team II)			119	114	99	111	139	98
Carlos Eduardo Bauab USF (Theodoro)			106	99	92	108	110	90
Geraldo Mendonça Uchoa USF (Lunardelli)			113	142	135	155	130	116
Joao Miguel Calil USF (Santo Antonio)			130	130	110	130	129	69
Jose Pio Nogueira de Sá USF (Gabriel Hernandes)			122	105	103	114	133	102
Michel Curi USF (Nosso Teto team I)			109	99	91	115	107	91
Michel Curi USF (Nosso Teto team II)			114	106	97	107	106	94
Olavo Barros USF (Monte Líbano)			109	97	93	109	111	99
Sergio Banhos USF (Pachá)			112	96	88	95	95	83
Gesabel Clemente Marques de la Haba USF (Pedro Nechar)			99	93	88	95	93	86
Isabel Ettruri USF (Flamingo team I)			121	118	102	104	122	101
Isabel Ettruri USF (Flamingo team II)			99	89	89	92	92	87

Source: Annual Report of the Health Observatory of Catanduva (2019) – Health Department of Catanduva.

Table 4

Expected medical production and production carried out at USF from July to December 2019

Health Units	Expected Prodution	Goal - Month	JUL %	AUG %	SEP %	OCT %	NOV %	DEC %
Napoleão Pellicano USF (Alpino)	400 for team	85%	171	179	179	181	180	157
Milton Maguollo USF (Bom Pastor)			131	117	129	160	110	82
Sergio da Costa Peres USF (Del Rey)			124	117	108	91	104	93
Jose Rocha USF (Gavioli team I)			125	122	119	122	110	91
Jose Rocha USF (Gavioli team II)			97	115	97	108	110	86
Jose Ramiro Madeira USF (Euclides)			118	107	108	117	104	90
Alcione Nasorri USF (Solo team I)			107	110	115	115	105	85
Alcione Nasorri USF (Solo team II)			107	104	119	131	114	93
Alcione Nasorri USF (Solo team III)			101	108	124	109	113	95
Armindo Mastrocola USF (Santa Rosa)			150	135	136	145	141	104
Athos Procópio de Oliveira USF (Imperial)			113	108	116	123	88	69
Carlos Roberto Surian USF (Nova Catanduva team I)			130	129	95	130	121	91
Carlos Roberto Surian USF (Nova Catanduva team II)			116	143	109	123	120	83
Carlos Eduardo Bauab USF (Theodoro)			104	107	113	105	87	81
Geraldo Mendonça Uchoa USF (Lunardelli)			158	140	125	138	134	104
Joao Miguel Calil USF (Santo Antonio)			111	125	116	119	128	109
Jose Pio Nogueira de Sá USF (Gabriel Hernandes)			109	118	113	107	91	67
Michel Curi USF (Nosso Teto team I)			100	93	118	92	89	81
Michel Curi USF (Nosso Teto team II)			97	94	110	102	80	88
Olavo Barros USF (Monte Líbano)			112	105	100	113	110	96
Sergio Banhos USF (Pachá)			105	97	103	97	116	74
Gesabel Clemente Marques de la Haba USF (Pedro Nechar)			100	97	110	90	90	87
Isabel Ettruri USF (Flamingo team I)			108	123	126	143	100	99
Isabel Ettruri USF (Flamingo team II)			84	101	80	73	73	88

Source: Annual Report of the Health Observatory of Catanduva (2019) – Health Department of Catanduva.

These data for the year 2019 reveal that the monthly medical production in the Family Health Units of the municipality of Catanduva is, for the most part, above 85% of the 400 appointments provided for in the management contract. This pattern is not seen, however, in the following months of the units: USF João Miguel Calil - Santo Antônio (June); USF Sergio Banhos – Pachá (June); USF Milton Maguollo - Good Shepherd (December); USF Athos Procópio de Oliveira - Imperial (December); USF Carlos Roberto Surian - Nova Catanduva team II (December); USF Carlos Eduardo Bauab - Theodoro Rosa Filho (December); USF Jose Pio Nogueira de Sá - Gabriel Hernandes (December); USF Michel Curi - Our Teto team I (December) ; USF Michel Curi - Our Teto Team II (November); USF Sergio Banhos – Pachá (December); USF Isabel Ettruri - Flamingo Team II (July, September, October and November.

Production of nurses

It is foreseen in the 2019 management contract that the production of consultations carried out by nurses at the Health Units is at least 85% of the 192 appointments provided by the city hall. Tables 5 and 6 show the target for each unit followed by this monthly production performed.

Table 5

Production of consultations carried out by nurses from basic health units in the municipality of Catanduva, from January to June 2019.

Health Units	Expected Prodution	Goal - Month	JAN %	FEB %	MAR %	APRI %	MAY %	JUN %
Napoleão Pellicano USF (Alpino)			100	107	99	159	191	152
Milton Maguollo USF (Bom Pastor)			115	110	107	133	111	119
Sergio da Costa Peres USF (Del Rey)			65	86	86	82	100	71
Jose Rocha USF (Gavioli team I)			111	102	85	113	120	95
Jose Rocha USF (Gavioli team II)			105	112	91	107	107	89
Jose Ramiro Madeira USF (Euclides)			119	90	107	113	102	101
Alcione Nasorri USF (Solo team I)			94	100	111	103	121	104
Alcione Nasorri USF (Solo team II)			110	210	109	114	134	106
Alcione Nasorri USF (Solo team III)			100	103	114	106	117	104
Armindo Mastrocola USF (Santa Rosa)			126	119	111	97	130	110
Athos Procópio de Oliveira USF (Imperial)			103	106	101	117	105	105
Carlos Roberto Surian USF (Nova Catanduva team I)			110	120	129	162	164	133
Carlos Roberto Surian USF (Nova Catanduva team II)	192	100%	107	108	114	140	143	116
Carlos Eduardo Bauab USF (Theodoro)			105	92	120	144	107	101
Geraldo Mendonça Uchoa USF (Lunardelli)			113	85	69	128	128	88
Joao Miguel Calil USF (Santo Antonio)			110	95	97	112	106	60
Jose Pio Nogueira de Sá USF (Gabriel Hernandes)			108	106	106	105	131	115
Michel Curi USF (Nosso Teto team I)			25	97	71	109	110	91
Michel Curi USF (Nosso Teto team II)			122	90	87	132	103	96
Olavo Barros USF (Monte Líbano)			104	106	96	105	101	100
Sergio Banhos USF (Pachá)			113	93	121	102	117	104
Gesabel Clemente Marques de la Haba USF (Pedro Nechar)			88	85	94	104	110	95
Isabel Ettruri USF (Flamingo team I)			130	97	104	112	139	96
Isabel Ettruri USF (Flamingo team II)			121	51	108	132	143	106

Source: Annual Report of the Health Observatory of Catanduva (2019) – Health Department of Catanduva.

Table 6

Production of consultations carried out by nurses from primary health care units in the city of Catanduva, from July to December 2019.

Health Units	Expected Prodution	Goal - Month	JUL %	AUG %	SEP %	OCT %	NOV %	DEC %
Napoleão Pellicano USF (Alpino)			176	187	177	172	180	166
Milton Maguollo USF (Bom Pastor)			117	125	116	133	173	130
Sergio da Costa Peres USF (Del Rey)			83	80	82	101	97	72
Jose Rocha USF (Gavioli team I)			101	81	111	93	85	91
Jose Rocha USF (Gavioli team II)			101	103	90	91	84	86
Jose Ramiro Madeira USF (Euclides)			117	101	129	126	143	101
Alcione Nasorri USF (Solo team I)			106	103	116	118	100	100
Alcione Nasorri USF (Solo team II)			109	107	105	107	101	100
Alcione Nasorri USF (Solo team III)			107	105	108	107	91	100
Armindo Mastrocola USF (Santa Rosa)			131	113	118	123	121	109
Athos Procópio de Oliveira USF (Imperial)			102	121	100	102	126	100
Carlos Roberto Surian USF (Nova Catanduva team I)			139	103	96	97	110	60
Carlos Roberto Surian USF (Nova Catanduva team II)	192	100%	98	79	85	85	79	70
Carlos Eduardo Bauab USF (Theodoro)			98	104	115	100	71	77
Geraldo Mendonça Uchoa USF (Lunardelli)			85	101	125	126	103	89
Joao Miguel Calil USF (Santo Antonio)			44	103	87	89	90	89
Jose Pio Nogueira de Sá USF (Gabriel Hernandes)			113	114	127	108	133	87
Michel Curi USF (Nosso Teto team I)			96	97	186	135	141	116
Michel Curi USF (Nosso Teto team II)			96	88	79	118	67	100
Olavo Barros USF (Monte Líbano)			104	137	95	109	136	116
Sergio Banhos USF (Pachá)			108	104	104	109	112	108
Gesabel Clemente Marques de la Haba USF (Pedro Nechar)			97	117	101	101	91	100
Isabel Ettruri USF (Flamingo team I)			111	104	101	121	98	76
Isabel Ettruri USF (Flamingo team II)			118	115	96	143	130	80

Source: Annual Report of the Health Observatory of Catanduva (2019) – Health Department of Catanduva.

These data from the year 2019 reveal that the production of nurses in the Family Health Units of the municipality of Catanduva is, for the most part, above that provided for in the Management Agreement. However, this pattern is not seen in some months of 7 of the 18 units, as follows: USF Sérgio da Costa Perez (Del Rey) in the months of January, April, June, July, August, September and December, USF Jose Rocha (Gavioli team II) only in November, USF Carlos Roberto Surian (Nova Catanduva team I) only in December, USF Carlos Roberto Surian (Nova Catanduva team II) in August, November and December, USF Carlos Eduardo Bauab (Theodoro Rosa Filho) in November and December, USF João Miguel Calil (Santo Antonio) only in the month of June, USF Michel Curi (Our Teto team I) in the months of January and March, USF Isabel Ettruri (Flamingo team I) only in the month of December and USF Isabel Ettruri (Flamingo team) II) in the month of February and December.

DISCUSSION

The contracting process , according to previous research, refers to four fundamental steps, among them: the elaboration of goals, the definition of a management plan, the execution of the contract and the follow-up process[18]. The analysis of the goals proposed to the Social Health Organization is valid in the verification of the services,

since it indicates if there is adequate effectiveness and compliance with the plans assigned to primary care.

In this study, we sought to relate, among other variables, the medical resolvability index of primary health care to the social organization management model in force at the time. Among the results found, the average rate of referrals made by primary care during 2019 was less than 20%, demonstrating compliance with the contractual goal.

It is therefore essential to discuss the solvability of primary care, its limits and possibilities, in order to optimize and expand the services offered. According to the Ministry of Health, the power of resoluteness allows the solution of 85% of health problems in the community, avoiding unnecessary hospitalizations and improving the population's quality of life[19]. The agreement on targets needs to be based on the local reality, on the population's needs, on existing resources and on the historical series of indicators. This reality presents numerous structural and socioeconomic difficulties that perpetuate the public health system and constitute obstacles in the resolution of cases, such as: low professional qualification, irregularly available supplies, insufficient funding and failures in the organization of care[20]. In addition, the disorganized flows of reference and counter-reference generate interference in the coordination of care, in longitudinality and, as a consequence, in solvability, since we have fragmented and non-integrated health care networks. What is observed in the current system, especially in small municipalities, is the provision of a fragmented, disjointed and poorly distributed care network[21].

In addition to this variable, in terms of the number of medical appointments provided for in the contract and that carried out at the USF in 2019, results are generally higher than 85% of the 400 provided, suggesting a high production by the units evaluated. In this regard, it is important to highlight the various benefits that this agreement generates in Primary Health Care, mainly punctuating the fact that these goals guide the services insofar as they ensure the search for results, the allocation of resources in a more efficient way, the increase in of managerial autonomy through decentralization and expansion of the effectiveness and effectiveness of actions[20]. This view is in line with perspectives that emphasize the importance of evaluation which, according to Araújo (2010), is carried out by comparing the goals established and those achieved, allowing the identification of successes and errors for a better adaptation of the reality[22]. From this contractualization scenario, Marty (2009) comes to the conclusion that the management contract represents a great managerial advance for the Municipal Health Department, since it provides transformations, making health professionals more active and directed to reach the agreed indicators and targets[23].

On the other hand, it is necessary not to confuse meeting goals with quality. A survey carried out in the city of Curitiba analyzed, among other central ideas, the achievement of goals and the incentive to develop quality (IDQ). In these items, it was observed that professionals share the idea that the search for the number of agreed procedures has often led to the lack of appreciation of the quality of the services provided. It was also observed that unnecessary procedures were often performed just to reach the expected goal or even exceed it in order to receive incentives, which may explain why many FHUs present production much higher than expected[20]. In this scenario, it is seen that there is an appreciation of quantity over quality in the face of the implementation of goals to be achieved, punctuating a failure in this contractualization process.

Some considerable oscillations are seen between the units, for example the USF Isabel Ettruri (Flamingo team II) and the USF Napoleão Pellicano (Alpino). While the first failed to achieve the goals set in most months of the 2nd semester, the second exceeded the goal by more than 100% in the same period evaluated. These variations are due to multiple factors such as the epidemiological profile of each Health Unit and the socio-economic characteristics that interfere in the greater or lesser search for health services. Another important point to be highlighted is the fact that health professionals often do not participate in the process of agreeing on goals, resulting in a lack of knowledge about the local

reality and an absence of readjustment of this contract in a particular way. Due to these individualities, Lima (1996) argues that the management contract involves the periodic establishment of commitments agreed between the local and central levels with the aim of increasing participation and granting greater autonomy at the local level[24].

In the context of the work of nurses in family health units, a minimum production of 85% of the target proposed by the city hall is proposed. Analyzing the 2019 production, it was found that most of them reached this goal, with the exception of four units. However, their deficit was not very relevant, that is, there was little production to reach the indicated.

According to Marty (2009), there was an intensification of teamwork that stimulated the commitment to achieve goals, making professionals more active[23]. This high performance can be observed in other surveys such as the one carried out in Curitiba, which claims to be due to the implementation of management contracts which stimulated the expansion of commitment, providing improvements in terms of compliance with clinical protocols, the performance of professionals, the work process and management[20]. Thus, this development of the teams includes the nursing team that produces more under a management contract, as shown in the research "Social Health Organizations as a Public/Private Management Form", as well as this advantage has been shown in the current research[25].

CONCLUSION

The public health administration model, exercised in the present study by a Social Health Organization, is a performance reference in the execution of the services designated by the management contract, presenting adequate effectiveness in its activity. It appears that the management goals assigned to the OSS, such as the rate of medical referral, nursing production and medical production were met by the health units according to the reference values agreed by the contracting party. In this sense, when the issue of productivity is evaluated, the goals present in the management contract are considerably favorable to the administration of health units. However, it is necessary that this agreement be polished so that this management acts in accordance with the reality of each region of operation and the valorization of the quality of service prevails.

Despite the great discussion and popularity of the subject, there is a lack of scientific data regarding the effects of Social Health Organizations and their consequences on public health. It is undoubted: the administration carried out by the OSS is gradually growing and has a direct impact on the services offered to society.

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Attributions: study idealization, analysis design, statistical analysis and final review of the manuscript.

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