

Changes offered by the National Program for Improving Access and Quality of Primary Care

Mudanças ofertadas pelo Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica

Rúbia Mara Maia Feitosa

Universidade Potiguar. Escola da Saúde. Departamento de Enfermagem. Mossoró, RN, Brazil.
E-mail: rubinhafeitosa@hotmail.com

Ayson Ayron Paulino

Universidade Potiguar. Escola da Saúde. Departamento de Enfermagem. Mossoró, RN, Brazil.
E-mail: ayslonayron@hotmail.com

José Oscar de Souza Lima Júnior

Universidade Potiguar. Escola da Saúde. Departamento de Enfermagem. Mossoró, RN, Brazil.

Kallyane Kelly Duarte de Oliveira

Universidade Potiguar. Escola da Saúde. Departamento de Enfermagem. Mossoró, RN, Brazil.
E-mail: kk20102010@hotmail.com

Rodrigo Jacob Moreira de Freitas

Universidade Potiguar. Escola da Saúde. Departamento de Enfermagem. Mossoró, RN, Brazil.
Universidade Estadual do Ceará. Programa de Pós-Graduação em Cuidados Clínicos em Enfermagem e Saúde. Fortaleza, CE, Brazil.
E-mail: rodrigojmf@gmail.com

Wanderley Fernandes da Silva

Universidade Estadual do Rio Grande do Norte. Departamento de Enfermagem. Mossoró, RN, Brazil.
Universidade Potiguar. Escola da Saúde. Enfermagem. Mossoró, RN, Brazil.
E-mail: cacowfs@hotmail.com

Abstract

Objective: to analyze the changes that the National Program for Improving Access and Quality of Primary Care has imparted to the primary health care services. The survey was conducted in 2014 in the city of Grossos, state of Rio Grande do Norte, Brazil. **Method:** the study scenario was the Family Health Strategies (FHS), which have joined the National Program for Improving Access and Quality of Primary Care. We interviewed 10 health professionals, with secondary and higher levels of education, and four managers responsible for the program's coordination. Data were analyzed using content analysis. **Results:** three main changes were identified: work organization; material resources and infrastructure of the FHS; and records organization. **Conclusion:** the program enabled the production of changes and induces not only physical reforms in the units, but also the evaluation and monitoring of ongoing performance in primary health care.

Keywords: Health Professionals; Primary Care; Health Evaluation.

Correspondence

Rúbia Mara Maia Feitosa
Rua João da Escóssia, S/N, Nova Betânea. Mossoró, RN, Brasil. CEP 59600-000

Resumo

Objetivo: analisar as mudanças que o Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica tem provocado nos serviços da atenção básica em saúde. A pesquisa foi realizada em 2014 em Grossos/RN. **Método:** o cenário de estudo foram as Estratégias de Saúde da Família (ESF) que aderiram ao Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção. Foram entrevistados 10 profissionais de saúde, de nível médio e superior, e quatro gestores responsáveis pela coordenação do programa. Os dados foram analisados pela técnica de análise de conteúdo. **Resultados:** foram apontadas três principais mudanças: organização do trabalho; recursos materiais e infraestrutura da ESF; organização dos registros. **Conclusão:** o programa possibilitou a construção de mudanças e induz não só as reformas físicas nas unidades como também a avaliação e o monitoramento de desempenho permanente da atenção básica.

Palavras-chave: Profissionais de Saúde; Atenção Básica; Avaliação em Saúde.

Introduction

In recent decades, there has been concern about the implementation of strategies aimed at the qualification of the health care model. In this process, Primary Health Care (PHC) has stood out, particularly regarding equity and universal access. The dissemination of this strategy and the investments in the sector have brought new questions for reflection; among them, we have the organization and the quality of access to health services (Fausto; Fonseca, 2013).

The PHC is considered strategic for reorganizing the health care model, enabling a change in the clinical care practice of professionals, because it seeks to identify community health needs that can be met by the service itself. Thus, this represents the first level of health care (Oliveira; Pereira, 2013).

However, the PHC cannot be considered the only entry door, since people's needs manifest in different ways and need to be accepted, and not understood as mandatory entryways, which would bureaucratize and paralyze the relationship between the people and the system. Therefore, all parts of the system need to be responsible for the results and the lives of the people. Thus, primary care is considered a coordinator of the Health Care Network (Oliveira; Pereira, 2013).

In Brazil, the term "primary care" (PC) was adopted to serve as a counterpoint to the approach taken by many countries and international organizations, such as the World Bank, which refers to primary care as a set of health activities of low complexity dedicated to low-income populations, seeking to minimize the feeling of social and economic exclusion (CONASS, 2011).

Brazil, according to the political-ideological precepts of PC, has the objective of rescuing the universalistic character of the Alma-Ata Declaration (DECLARAÇÃO, 1978), focusing on the role of reorganizing the care model. In this perspective, the organization of PC health services, through the Family Health Strategies (FHS), prioritizes actions geared towards promoting, protecting and recovering health (Fausto; Fonseca, 2013).

In expansion throughout the whole national territory, the FHS is defined by a set of actions

and services that go beyond medical care, in fact structured based on the recognition of the needs of the population, seized from the establishment of links between service users and health professionals in permanent contact with the territory. These principles and guidelines underline the National Primary Care Policy (PNAB) (Brasil, 2011b), established in 2011 (Cunha et al., 2013).

With two decades since its creation, the significant increase in the FHS coverage is directly implicated in the increase to health care access and the improved health indicators of the population. However, there are still many problems that need to be addressed, particularly those linked to access, resolve rate and quality of care (Fausto; Fonseca, 2013).

As part of the recent Ministry of Health guidelines for PC, the National Program for Improving Access and Quality of Primary Care (PMAQ-AB) was created. The Program, established by the Ordinance No. 1.654 GM/MS, of July 19, 2011 (Brasil, 2011a), aims to encourage managers and the Brazilian Unified Health System (SUS) teams to improve the standard of care quality offered to users of the SUS in the FHS, through a process of self-assessment, improvements development and external certification (Brasil, 2012).

The PMAQ-AB was the product of an important process of negotiation and agreement of all three spheres of SUS management to enable a program design that would allow increased access and improved quality of PC throughout the Brazilian territory. The PMAQ-AB is the main change inducer strategy in the operating conditions and modes of PC, pursuing permanent and progressive expansion of the access and the quality of management practices, care and participation of the population in health care services (Pinto; Souza; Florêncio, 2012).

To achieve these objectives, the PMAQ-AB promoted a profound change in the funding of PC, linking an important part of the funds transfer to the implementation of “standards” that would indicate access expansion to services, improved working conditions and the quality of attention, as well as an investment in professional development. With the creation of the “Quality Component” of the Primary Care Goal (PAB) variable, the cities were then allowed the possibility to double the staff re-

sources received, should they achieve an excellent performance in what PMAQ-AB considers its object of contractualization and evaluation - the excellent “standards” of reference (Brasil, 2012a).

Given the above, we pose the question: what changes the PMAQ-AB has provided for health services? What perceptions and records do health professionals have about these changes?

Thus, this study has the objective of analyzing what changes the PMAQ-AB has provoked in the primary health services of the city of Grossos (RN). The research poses a set of specific questions to the team professionals and the local managers about their perception of the changes incited by the PMAQ-AB. As important as access to the services, has been the construction of strategies for improving the quality of the health care being provided.

Methods

This is a qualitative and descriptive study. The research was conducted in the city of Grossos, located in the western region of the state of Rio Grande do Norte, Brazil, 324 km from the city of Natal, occupying an area of 139 square kilometers, home to 9,886 inhabitants, according to the Brazilian Institute of Geography and Statistics (IBGE, 2014).

The city of Grossos has one small hospital and, regarding PC, the city counts with four FHS, two in urban areas and two in rural areas.

The study’s research scenario included two FHS from the city of Grossos, one located in the countryside. Only the two FHS selected to compose this research went through the implementation process, being in 2014 on evaluation for the PMAQ-AB.

The study subjects were 14 health professionals involved in health care as the ones responsible for the coordination of the municipal PMAQ-AB. We used the following criteria of inclusion: health team professionals linked to the FHS surveyed, who play assistance or managerial roles and already have ties to it during the period of the PMAQ-AB implementation. Exclusion criteria considered were: professionals who were traveling or away from Grossos at the time of the survey and who had not the physical and/or mental conditions to participate.

To recruit participants, the researchers visited the FHSs, after the project was approved by the Ethics Committee. These occurred during different shifts, morning and afternoon, to deliver everyone an invitation letter to participate in the study.

The invitation letter is a document to clarify beforehand the research objectives, methodology, risks and benefits. The guests resolved their doubts with the researchers when they received the document and, at this stage, those who agreed to participate in the study scheduled, with the researchers, the day and time for their individual interviews. We sought to prioritize a schedule that did not get in the way of the rules and routines of the health unit.

We had six questions. The interview had the objective of identifying the professionals' understanding regarding the PMAQ-AB and the changes they pointed out on the organizational, managerial and health care panorama after the PMAQ-AB was implemented by the FHS team. The questions were also geared towards the financial incentives granted by the PMAQ-AB and implications of this funding for the care provided to users, as well as the changes that these health professionals still believe are necessary, after experiencing the PMAQ-AB, to improve access and the quality of care offered by PC.

For didactic purposes, the researchers started interviewing managers who acted as coordinators of the PC and the PMAQ-AB; subsequently, they interviewed health professionals working in the FHS. Data were analyzed using content analysis, subsidized by Bardin (2006).

The research was based on the ethical aspects of the Resolution No. 466/12, approved by the National Health Council of the Ministry of Health in December 2012, which deals with guidelines and standards for research involving human subjects (Brasil, 2012b).

The research subjects were identified by acronyms. Regarding the health professionals, they were identified by the abbreviation "PS". At the end of this acronym, we added the letter "S", designating their higher (superior) level, or the letter "M", informing their secondary (medium) level. Professionals working in the management of the PMAQ-AB were identified by the letters "PG", signifying "professional managers" in Brazilian Portuguese. Below are the

categories obtained from analyzing the speeches of the participants.

The study was submitted to the Ethics Committee of the Potiguar University, Campus Natal (CEP/UNP), and was approved under the opinion number 859.810 and the CAAE: 35823314.0.0000.5296.

Results and discussion

Understanding of the health professionals and managers regarding PMAQ-AB

At first, when asked about their understanding on the PMAQ-AB, all participants seemed to understand the program and, succinctly, pointed out some of the objectives and/or guidelines of the PMAQ-AB, regardless of their training level or position.

Well, the PMAQ is the National Program for Improving Access and Quality of Primary Care. In my understanding, it has brought financial support and it seeks a greater cooperation between professionals, community health workers, nurses, seeking an adjustment of improvements in the quality of service in primary care. (PSS1)

It is a program that aims to improve the care and quality for patients, as well as improving access to primary care. (PSS3)

The speeches by PSS1 and PSS3 reinforce one of the main objectives of the PMAQ-AB, which calls for better quality of PC, with guarantees of a quality standard. Another main objective of the PMAQ-AB, as a way to induce the expansion of access, is also explicit in the understanding of the professionals in the speech PSM1: "The Program has come to encourage those who provide services to the population and brings improvements to every day users, so that they have easier access and are the main beneficiaries".

In turn, one of the managers, PG1, mentions that the program "makes primary care more efficient for it expands the use of it as the entryway to health services". When considering PMAQ-AB as a strategy that synthesizes both the PC's assertion effort as a warm and resolute entryway, it creates specific

conditions for it to coordinate the continuity of priority lines of care in health care networks (Pint; Souza; Florêncio, 2012).

The speeches allow us to see the importance of health care professionals understanding what the PMAQ-AB proposes, thus giving them the tools to build, through collective work in health, strategies that conform to the health needs of the community. This creates the possibility of institutionalizing, within each professional work processes, a culture of improvement and monitoring the quality of health care practices in PC.

Changes offered by the PMAQ-AB from health professionals and managers point of view

This category refers to the main changes, identified by health professionals and managers, in the FHSs, after the implementation of the PMAQ-AB. Three main changes were identified: work organization; material resources and infrastructure of the FHS; and organization of records. The speeches of PNS₃ and PNS₄ synthesize the professional view of the changes linked to the work organization.

Well, after the implementation of the PMAQ, we saw many changes, especially in the organization area. After this implementation, the family health strategy is much more organized and, with that, we end up with better care services, more humane, a care service where we can give priority to the patient. (PNS₄)

Well, the main change is the more dedicated participation of the staff in organizing things. (PNS₆)

The PMAQ-AB involves a range of management commitments, such as the structuring and strengthening of PC, and the organization of the work process is one of the elements evaluated in the third phase of the program, known as the external evaluation. The professionals and users perspective evaluate: access; the implantation of devices such as the reception, shared calendar, care management tools and collegial management of the work process;

as well as evaluating, quality standards linked to priority health care lines (Brasil, 2012a).

Regarding material resources and the infrastructure of the Family Health Strategies (FHS), mentions were made:

Since we joined the PMAQ, some changes occurred to structures, air conditioning, for example, there wasn't any in my office, and other materials that were acquired after the adhesion to the PMAQ and that, in some way, ended up improving our work. (PNS₉)

We got more materials. We have more comfort. But there were also other changes, beyond the physical structure, which did improve care. (PNM₁₀)

The PMAQ-AB enables the tools of changes, induces and stimulates not only physical renovations, but also the evaluation and ongoing monitoring of PC's performance. However, we consider that inadequate physical space, the lack of professional equipment and the precariousness of labor relationships influence the quality of care offered to the population (Fontenelle, 2012).

The speeches of other health care professionals point out, also, this perspective:

With the implementation of the PMAQ, we also got as a contribution, money to the city, which brought improvement to the structure of the working environment, improvement of the materials we need to care for the population, the procedures, all that. (PNS₁₁)

In Brazil, there are serious difficulties linked to these FHS infrastructure conditions: inadequate physical spaces, deficit of materials, incomplete teams, fragmentation of care and health services. These factors have affected the access and the quality of the care provided, which led the Ministry of Health to create the PMAQ-AB (Souza et al., 2013), as explained by the speech of one of the managers regarding the contribution of the PMAQ-AB: "It brought improvements due to more adequate equip-

ment, which often were found to be insufficient, so now we have better equipment and more of them” (PGAB3).

The other managers who work directly in the coordination and implementation of the PMAQ-AB in the city of Grossos/RN, address the changes as only being effective through the articulation and the involvement of professionals and managers, providing the necessary tools for improved access and PC quality: “Management is more concerned with providing the necessary tools to enable improved access and a quality standard required and driven by the interest of obtaining a good assessment” (PGAB4).

We could note, throughout the interviews, that both health professionals working in the FHS, as well as the city managers pointed to “standard quality” as an immediate result for the improvement of PC’s service to be effective. Speaking of changes is to achieve the quality standard stipulated by the program. Therefore, this parameter is used to measure the changes and the contributions of the implementation of the PMAQ-AB for the quality of care and the access to health services. We see this in the speech of one of the managers: “when we reach the standard, we see the result easily, the encouragement for teams to work following quality standards prescribed and defined by AMAQ” (PGAB2).

The AMAQ-AB (Self-Assessment for Improving Access and Quality of Primary Care) is a self-assessment tool, used as a base document for the second phase of the program. The AMAQ-AB has as one of its guidelines the reflection of quality standards that have incremental character in themselves, whose suitability of the situation analyzed occurs through a numeric scale. Thus, we can declare that the speech by PGAB2 complies with what the AMAQ-AB suggests on the work following quality standards (Brasil, 2012a).

Besides all this, the AMAQ-AB proposes self-assessment as a triggering process for reflection and collective creation of change; enrich it with monitoring; and supporting the collective through continued education and institutional support, to bestow practical consequence to what has been named as a problem in the self-assessment process. Lastly, recognizing this effort in the external evalu-

ation may explain, in large part, their differences in use (Pinto; Souza; Florêncio, 2012).

Another change and contribution offered by the implementation of the city’s PMAQ-AB were the organization of records, which ended up being pointed by health professionals and managers as an improvement to the care offered by the FHS, ending with satisfactory response for the demand of service by users and, consequently, shorter waiting time, as shown by the speech of a health professional: “the chart, in my opinion, was the most improved, before it was kind of messy and now the organization is much easier, since it is through family charts” (PNM4).

Another professional specifies how these records helped to improve the care of users in the programs offered by the Family Health Strategy (FHS), providing a basis for the collection of information and data.

Now we have a separate hyper-day book, another separate book for diabetes, a book on prenatal on obesity... so when we need any information, anything about our PSF, we have, we know where to go and use it directly to decide which actions to take. (PNS12)

One of the fundamental requirements of the PMAQ-AB is the use of medical family charts as a work tool, ensuring the recording of information and allowing, swiftly, access to the measures taken by the family health team. These serve to generate information that can guide the planning of health actions by the professionals. It is, therefore, a crucial element to better care for the family, gathering the necessary information for its members to receive a continuity of health care. It is also an indicator of the quality of care offered, as well as a tool to assess the need for continued education, a key element in the event of an audit or legal and ethical conflicts (Pereira et al., 2008).

The organization of records can also be perceived by health care professionals as an element that strongly influences the service and a shorter waiting time, as addressed by the following professionals: “[...] the waiting lines are shorter because, with the

charts, all recorded, and standardized the right way, our care service is better and faster”. (PNS6). Another professional defended that:

The issue of care before was pretty much just on free demand and today we make scheduled visits, the patient no longer needs to come early, waking up at dawn to get a password. Consultations are scheduled by health workers, along with the staff, easing access to those who are really in need. (PNS14)

This better response to demand is closely linked to the PMAQ-AB and the new PNAB stand for, not forgetting, of course, the need to maintain actions of reception and the organization of the free demands (Pinto; Souza; Florêncio, 2012).

Financial incentives

The fifth question of the survey concerns the financial incentive for professionals working in teams that participate in the PMAQ-AB. Both professionals and for managers were asked if the extra financial incentive that the PMAQ-AB assigns to health care professionals due to their performance changed in some way their degree of satisfaction, reflecting on the way they work and the care they provide to the users.

The answers, at this point, were heterogeneous. Some of the professionals believe that the financial incentive serves as a way of valuing the professionals and drives them to work harder, while the others see the financial incentive as not interfering the way work is performed, or the care provided to the users.

For me, nothing has changed. [...] It is always good to have a penny more, but, for me, nothing has changed, I'm caring for the people the same way I did when I wasn't part of the PMAQ. It's like I said, the only improvement we see is that everything gets better organized, so perhaps today's care service is better than it was before, precisely because of this, the organization, and not because I'm getting this financial incentive. (PNS13)

There are various ways to recognize and reward to encourage people to maintain an excellent performance or to improve performance that is below average. Invariably, the first incentive that comes to mind are the financial rewards; however, people are motivated by different needs, and the most basic ones are home and food. Thus, we understand that not all people have the same needs and this means that not all people are motivated by the same incentives (Fochesatto, 2002).

This position of the PNS2 is contrary to most of the other professionals interviewed, who understand the added incentive as a means of valuing the professionals and pushing for better care.

Through the incentive, the staff will feel more financially encouraged to seek and better care due to the remuneration it will mean to the professional staff. With this, we expect to have an even bigger improvement in the care provided to our users. (PNM3)

For the management, this financial incentive also acts a motivator for better professional practices: “it is perceptible to us as managers, that the financial appreciation contributes towards encouraging a more effective and committed performance” (PGAB2).

The PMAQ-AB's financial incentive not only stimulates the municipal managements that can significantly expand the resource received by the health funds, but also the teams, since the PMAQ-AB itself encourages the adoption of logics of reward and remuneration according to results and performance. In other words, part of this larger financial resource will necessarily become better compensation for the teams, which in turn would mean changes in the work process, stimulating harder and better quality work (Pinto, 2012).

However, the speeches made by the professionals highlight that the work posture changes are not linked only to the extra financial support. PNS5 says that “we can't tell. So I'll do the PMAQ-AB just because of the extra financial inducement. You know what I mean?”. Another element that strongly motivates workers are the dimensions of the PMAQ-AB which ensure better work conditions, standards

that are known as “workers’ appreciation” in the program.

Several quality standards point to an adequate ambience in the primary health units (UBS) regarding the assurance of infrastructure, facilities, equipment and those supplies necessary to the work process of the teams. They are, therefore, integral elements of evaluating the program, which are municipal management governance and that interest the teams for strongly influencing the conditions and the quality of the work being developed.

Conclusion

Research shows the main changes identified by health professionals and managers surrounding the PMAQ-AB. Although significant, professionals involved need to be aware that changes should be continuous, able to meet the population’s health needs, which are always dynamic.

The PMAQ-AB, according to the awareness of health professionals, can contribute to the construction of collective spaces for discussion and reflection regarding health planning, locally, using monitoring and performance indicators.

The quality of services rendered in health care becomes an ever more pressing concern among professionals and their managers. Currently, it is not enough to provide only the bare minimum for health service to work; there are numerous requirements surrounding these services, whether these requirements arise from managers, professionals, or users.

The methodological use of a mechanism of self-evaluation and external evaluation as a way to identify the weaknesses and possible improvements to health services has positively contributed to the search for health care quality provided to the users. Through constant evaluations and strong support to health centers, it is possible to see change and meet goals, which have been increasingly demanded.

References

BARDIN, L. *Análise de conteúdo*. Tradução L. de A. Rego e A. Pinheiro. Lisboa: Edições 70, 2006.

BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. *Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ): manual instrutivo*. Brasília, DF, p. 62, 2012a. Disponível em: <<http://dab.saude.gov.br/portaldab/biblioteca.php?conteudo=publicacoes/pmaq>>. Acesso em: 25 nov. 2013.

BRASIL. Ministério da Saúde. *Portaria nº 1.645, de 2 de outubro de 2015*. Dispõe sobre o Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB). Brasília, DF, 2 out. 2011a. Disponível em: <http://bvsmms.saude.gov.br/bvs/saudelegis/gm/2015/prt1645_01_10_2015.html>. Acesso em: 8 ago. 2016.

BRASIL. Ministério da Saúde. *Portaria nº 2.488, de 21 de outubro de 2011*. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). Brasília, DF, 21 out. 2011b. Disponível em: <http://bvsmms.saude.gov.br/bvs/saudelegis/gm/2011/prt2488_21_10_2011.html>. Acesso em: 8 ago. 2016.

BRASIL. Ministério da Saúde. *Resolução nº 466, de 12 de dezembro de 2012*. Estabelece as Diretrizes e Normas Regulamentadoras de Pesquisas envolvendo Seres Humanos. Brasília, DF, 12 dez. 2012b. Disponível em: <http://bvsmms.saude.gov.br/bvs/saudelegis/cns/2013/reso466_12_12_2012.html>. Acesso em: 8 ago. 2016.

CONASS - CONSELHO NACIONAL DE SECRETÁRIOS DE SAÚDE. *Atenção primária e promoção da saúde*. Brasília, DF: CONASS, 2011.

CUNHA, G. T. et al. *Programa Nacional de Melhoria ao Acesso e a Qualidade da Atenção Básica: um estudo qualitativo*. In: CONGRESSO BRASILEIRO DE POLÍTICA, PLANEJAMENTO E GESTÃO EM SAÚDE, 2., 2013, Belo Horizonte. *Anais...* Belo Horizonte: Unicamp, 2013. Disponível em: <<http://www.politicaemsaude.com.br/anais/trabalhos/publicacoes/235.pdf>>. Acesso em: 15 dez. 2014.

- DECLARAÇÃO de Alma-Ata. In: CONFERÊNCIA INTERNACIONAL SOBRE CUIDADOS PRIMÁRIOS DE SAÚDE, 6-12 set. 1978. Disponível em: <<http://cmdss2011.org/site/wp-content/uploads/2011/07/Declara%C3%A7%C3%A3o-Alma-Ata.pdf>>. Acesso em: 9 ago. 2016.
- FAUSTO, M. C. R.; FONSECA, H. M. S. (Org.). *Rotas da atenção básica no Brasil: experiências do trabalho de campo PMAQ-AB*. Rio de Janeiro: Saberes, 2013.
- FOCHESATTO, S. A. *Os planos de incentivos e recompensas como fatores de motivação: estudos de caso nas duas maiores empresas do ramo metal-mecânico de Caxias do Sul*. Dissertação (Mestrado em Administração) - Universidade Federal do Rio Grande do Sul, Porto Alegre, 2002. Disponível em: <<http://www.lume.ufrgs.br/bitstream/handle/10183/3510/000339322.pdf>>. Acesso em 25 nov. 2014.
- FONTENELLE, F. Mudanças recentes na Política Nacional de Atenção Básica: uma análise crítica. *Revista Brasileira de Medicina da Família e Comunidade*, Florianópolis, v. 7, n. 22, p. 5-9, 2012.
- IBGE - INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA. *Rio Grande do Norte: Grossos*. Brasil: IBGE, 2000. Disponível em: <<http://www.cidades.ibge.gov.br/xtras/perfil.php?lang=&codm un=240440&search=rio-grande-do-norte|grossos>>. Acesso em: 30 dez. 2014.
- OLIVEIRA, M. A. C.; PEREIRA, I. C. Atributos essenciais da Atenção Primária e a Estratégia Saúde da Família. *Revista Brasileira de Enfermagem*, Brasília, DF, v. 66, p. 158-164, 2013. Número especial.
- PEREIRA, A. T. S. et al. O uso do prontuário familiar como indicador de qualidade da atenção nas unidades básicas de saúde. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 24, p. S123-S133, 2008. Suplemento 1. Disponível em: <<http://www.scielo.br/pdf/csp/v24s1/17.pdf>>. Acesso em: 13 nov. 2014.
- PINTO, H. A. Informe técnico institucional: o Programa Nacional de Melhoria do Acesso e da Qualidade e o processo de trabalho das equipes de atenção básica. *Revista Tempus Actas de Saúde Coletiva*, Rio de Janeiro, v. 6, p. 315-318, 2012. Disponível em: <www.tempus.unb.br/index.php/tempus/article/viewFile/1131/1044>. Acesso em: 25 nov. 2014.
- PINTO, H. A.; SOUSA, A.; FLORÊNCIO, A. R. O Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica: reflexões sobre o seu desenho e processo de implantação. *Revista Eletrônica de Comunicação, Informação & Inovação em Saúde*, Rio de Janeiro, v. 6, n. 2, p. 1-20, 2012. Suplemento 2. Disponível em: <<http://www.reciis.icict.fiocruz.br/index.php/reciis/article/view/492/1142>>. Acesso em: 25 nov. 2014.
- SOUZA, M. B. et al. Trabalho em equipe na atenção primária: a experiência de Portugal. *Revista Panamericana de Salud Publica*, Washington, DC, v. 33, n. 3, p. 190-195, 2013. Disponível em:

Authors' contribution

Feitosa, Paulino, and Lima Júnior were responsible for the theoretical design, bibliographical review, and writing and organizing the text. Oliveira, Freitas, and Silva were responsible for proof-reading and final redaction of the text.

Received: 06/30/2015

Resubmitted: 04/20/2016

Approved: 06/03/2016