REME • Rev Min Enferm. 2025;29:e-1572
DOI: 10.35699/2316-9389.2025.51577

RESEARCH

STRATEGIES OF MUNICIPAL MANAGERS REGARDING THE FINANCING OF PRIMARY HEALTHCARE

ESTRATÉGIAS DOS GESTORES MUNICIPAIS FRENTE AO FINANCIAMENTO DA ATENÇÃO PRIMÁRIA À SAÚDE

ESTRATEGIAS DE LOS GESTORES MUNICIPALES PARA EL FINANCIAMIENTO DE LA ATENCIÓN PRIMARIA DE SALUD

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Funding: Fundação de Amparo a Pesquisa e Inovação do Estado de Santa Catarina - FAPESC.

Submitted on: 11/03/2024
Approved on: 27/02/2025

Responsible Editors:
Kênia Lara da Silva
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ABSTRACT

Objective: to understand the strategies of municipal primary healthcare managers for meeting the performance indicators of the Previne Brasil program. **Method**: this is a qualitative Convergent Care research study, grounded in the principles of the National Primary Care Policy. The study involved management teams from the primary healthcare sector of municipalities within a health macro-region of Santa Catarina, Brazil. Data were collected through workshops, one conducted in each Health Region of the studied macro-region, between October and November 2022. Thematic analysis guided the data interpretation. **Results**: the study included 75 participants, comprising Health Secretaries and designated members of management teams, representing 46 (58.9%) municipalities of the macro-region. This study highlights the main strategies used by the participants, which were linked to the work processes carried out by family health teams. These strategies were systematized into three subcategories: the first being continuous monitoring, evaluation, and updating. The second, organization and management of workflows and routines. Finally, bonding and shared responsibility in health care. The macro-region observed an average Final Synthetic Indicator score of 8.0, with variations between 4.8 and 10.0. **Conclusion**: the study emphasized the strategies that led to advancements in performance indicators, aiming to establish effective work processes, overcome emerging challenges, ensure adequate funding, and strengthen primary healthcare. It also points to the need for greater managerial action in improving infrastructure, human resources, and integrated support, going beyond merely demanding productivity to strengthen healthcare..

Keywords: Primary Health Care; Brazil; National Health Strategies; Health Care Financing; Health Management; Family Health; Unified Health System.

RESUMO

Objetivo: *conhecer as estratégias dos gestores municipais da atenção primária à saúde para o atendimento dos indicadores de desempenho Previne Brasil. Método: trata-se de pesquisa qualitativa Convergente Assistencial, fundamentada nos pressupostos da Política Nacional de Atenção Básica. Contou com a participação de equipes gestoras da atenção primária de municípios de uma Macrorregião de saúde de Santa Catarina, Brasil. Os dados foram coletados em oficinas, realizadas uma em cada Região de Saúde da Macrorregião estudada, entre outubro e novembro de 2022. Análise temática guiou a análise dos dados.* ***Resultados****: participaram do estudo 75 gestores entre secretários de Saúde e integrantes de equipes gestoras designados, representantes de 46 (58,9%) municípios da Macrorregião. Este estudo evidencia as principais estratégias utilizadas pelos participantes da pesquisa, as quais remeteram ao processo de trabalho desenvolvido pelas equipes de saúde da família. Essas foram sistematizadas em três subcategorias, sendo a primeira o monitoramento, a avaliação e a atualização permanentes. A segunda, organização e gestão de fluxos e rotinas. E por fim, o vínculo e corresponsabilidade no cuidado em saúde. A Macrorregião observou média de Indicador Sintético Final 8,0, com variação entre 4,8 e 10,0.* ***Conclusão****: o estudo destacou as estratégias que permitiram os avanços nos indicadores de desempenho, as quais objetivavam estabelecer processos de trabalho eficazes, superar desafios emergentes, garantir financiamento adequado e fortalecer a atenção primária. Aponta, ainda, a necessidade de maior atuação da gestão na qualificação de infraestrutura, recursos humanos e suporte integrado, indo além da cobrança de produtividade para fortalecer a saúde.*

Palavras-chave*: Atenção Primária à Saúde; Brasil; Estratégias de Saúde Nacionais; Financiamento da Assistência à Saúde; Gestão em Saúde; Saúde da Família; Sistema Único de Saúde..*

RESUMEN

Objetivo: *conocer las estrategias de los gestores municipales de la atención primaria de salud para el cumplimiento de los indicadores de desempeño Previne Brasil.* ***Método***: *se trata de una investigación cualitativa Convergente Asistencial, fundamentada en los principios de la Política Nacional de Atención Básica. Contó con la participación de equipos gestores de la atención primaria de municipios de una Macrorregión de salud de Santa Catarina, Brasil. Los datos se recolectaron en talleres, realizados uno en cada Región de Salud de la Macrorregión estudiada, entre octubre y noviembre de 2022. El análisis temático guió el análisis de los datos.* ***Resultados***: *participaron en el estudio 75 gestores, entre secretarios de salud e integrantes de equipos gestores designados, representantes de 46 (58,9%) municipios de la Macrorregión. Este estudio evidencia las principales estrategias utilizadas por los participantes de la investigación, que remitieron al proceso de trabajo desarrollado por los equipos de salud de la familia. Estas se sistematizaron en tres subcategorías: la primera es el monitoreo, la evaluación y la actualización permanentes;*

How to cite this article:

Hoffmann AY, Tombini LHT, Geremia DS, Madureira VSF. Strategies of municipal managers regarding the financing of primary healthcare. REME - Rev Min Enferm [Internet]. 2025 [cited ___ ___ ___];29:e-1572. Available from: https://doi.org/10.35699/2316-9389.2025.51577

la segunda, organización y gestión de flujos y rutinas; y por último, el vínculo y corresponsabilidad en el cuidado de la salud. La Macrorregión observó un promedio de Indicador Sintético Final de 8,0, con una variación entre 4,8 y 10,0. ***Conclusión****: el estudio destacó las estrategias que permitieron los avances en los indicadores de desempeño. Apuntaron a establecer procesos de trabajo eficaces, superar desafíos emergentes, garantizar un financiamiento adecuado y fortalecer la atención primaria. Aún señala la necesidad de una mayor actuación de la gestión en la cualificación de infraestructura, recursos humanos y soporte integrado, yendo más allá de la demanda de productividad para fortalecer la salud.*

Palabras clave: *Atención Primaria de Salud; Brasil; Estrategias de Salud Nacionales; Financiación de la Atención de la Salud; Gestión em Salud; Salud de la Familia; Sistema Único de Salud..*

INTRODUCTION

The consolidation of the public policy of the Unified Health System (SUS) and the strengthening of Primary Health Care (PHC) result from ensuring stable and sufficient financial resources. Since 1988, however, this has not been fully achieved in Brazil, despite numerous political and technical disputes regarding financial resources. The financing of SUS is tripartite and based on federal resource transfers, constituting an important revenue source for states and municipalities, with the goal of fulfilling a redistributive role and contributing to the reduction of regional inequalities[1]. With Primary Health Care (PHC) defined as the preferred entry point into the healthcare service network, adequate funding is essential to ensure access to healthcare and maintain the flow of services.

At the municipal level, the Municipal Health Secretary and their management team are responsible for appropriating, recombining, and reallocating these resources to meet the health demands and needs of the population[2]. However, it is within the work processes of healthcare teams and their direct interaction with users that results materialize, demonstrating the importance of effective management for the functioning of the Unified Health System (SUS).

Although financing models emphasize strengthening PHC, and despite municipalities having increased health spending in recent years, this level of the healthcare network received only 16.4% of health investments, while the largest share (52.8%) was allocated to curative care[3]. In parallel, municipal hospitalization expenses grew by 85% during the analyzed period (2010-2014), indicating that PHC can and must be reoriented and improved[3] to reverse the logic of SUS financing.

Amid numerous debates about the PHC financing model, in 2019, Ordinance No. 2,979 established the Previne Brasil Program (PBP), proposing resource transfers based on weighted capitation criteria, incentives for strategic actions, population-based financial incentives, and performance-based payments[4].

Performance-based payment utilizes the Final Synthetic Indicator (FSI), calculated from seven indicators encompassing strategic healthcare actions for pregnant women, women, children, and those related to chronic diseases[4].

These indicators were selected to meet criteria of availability, simplicity, granularity, periodicity, low acquisition cost, adaptability, stability, traceability, and data representativeness, respecting clinical and epidemiological relevance[5].

In implementing the PBP, the work processes of Family Health Teams (FHTs) emerge as a crucial resource for achieving positive results in health performance targets. Thus, by applying the foundational principles of PHC (access, longitudinality, comprehensiveness, coordination, and family- and community-oriented care) within FHTs, the teams focus on providing healthcare to users and families, with these indicators becoming part of their routine[6]. Achieving performance targets requires not only internal organization but also technical and financial support from municipal management, highlighting the strategic role of municipal coordinations in monitoring and supporting teams. In this sense, these coordinations assume the strategic function of tracking and monitoring outcomes, as well as providing technical and financial support for the development of work and benefits to the population[6].

Given the scenario of federal co-financing linked to meeting PBP performance indicators and the varying realities observed in achieving results among the municipalities of the studied macro-region, the central issue of this study lies in understanding how strategies adopted by municipal managers influence the achievement of PBP performance indicators. Understanding these strategies is crucial to overcoming challenges related to meeting targets and strengthening PHC, especially in a context of limited resources and growing demands.

Thus, the research question guiding this study is: What are the strategies adopted by municipal PHC managers to meet the performance indicators of the PBP? The general objective of this study is to understand the strategies of municipal PHC managers in relation to the performance indicators of the PBP, contributing to the improvement of management practices and the consolidation of a financing model that promotes greater equity and effectiveness within the SUS.

MÉTODO

This work is part of the broader project "Primary Health Care Management in the Face of Previne Brasil:

Seeking Strategies for the Greater West Macro-Region of Santa Catarina," developed by the Federal University of Southern Border (Universidade Federal da Fronteira Sul - UFFS) in partnership with the Santa Catarina Research Support Foundation (Fundo de Amparo à Pesquisa de Santa Catarina - FAPESC), which also funded the project.

This is a qualitative research study classified as Convergent Care Research, a methodology that integrates and articulates management, care, teaching, and research actions within the context of practices experienced in the SUS[7].

The study setting was the Greater West Health Macro--Region (MRGO) of Santa Catarina, comprising three Health Regions (HRs) headquartered in the municipalities of Chapecó, Xanxerê, and São Miguel do Oeste, collectively encompassing 78 municipalities with an estimated population of 809,008 inhabitants for the year 2021[8].

All municipal PHC managers who participated in the monthly meetings organized by the Regional Health Management (GERSA) in each HR were invited and included in the study. In this study, managers were defined as professionals who are part of the management team and were designated to participate in the meetings. The exclusion criterion was holding a position on the management team for less than six months or lacking formal designation to represent the municipality at the meetings. There were no participant dropouts, refusals, or withdrawals during the research due to the high level of interest from the management teams in the topic addressed.

No pilot study or pre-testing of the script was conducted for data collection. Data collection involved the presence of participants and the research team, composed of undergraduate students and professors experienced in developing workshops as a research strategy. Three workshops were conducted, one in each HR of the MRGO (Chapecó/SC, Xanxerê/SC, and São Miguel do Oeste/SC). The workshops took place between October and November 2022, in person, during meetings organized by the GERSAs. Management teams were invited and informed via email that the meeting agenda would include an invitation to participate in the research.

Initially, the research proposal was presented to the participants, followed by the reading and signing of the Free and Informed Consent Form (TCLE). Subsequently, each workshop, lasting approximately three hours, was conducted by the research team and consisted of two phases.

The first phase of data collection occurred through debates facilitated by the research team. An initial detailed presentation was delivered by a professor specializing in the subject, addressing the financing criteria of the PBP and the performance indicators, which were the focus of this study. The seven performance indicators explored in the discussion were: 1 – Proportion of pregnant women with at least six prenatal visits, with the first occurring by the 12th week of pregnancy; 2 – Proportion of pregnant women who underwent syphilis and HIV testing; 3 – Proportion of pregnant women who received dental care; 4 – Proportion of women with cervical cancer screening performed in PHC; 5 – Proportion of one-year-old children vaccinated in PHC against diphtheria, tetanus, pertussis, hepatitis B, infections caused by Haemophilus influenzae type b, and inactivated polio; 6 – Proportion of people with hypertension who had consultations and blood pressure measured in the last semester; and 7 – Proportion of people with diabetes who had consultations and glycated hemoglobin requested in the last semester[5].

During this stage, management teams were encouraged to express their questions, which were discussed among participants and clarified by the research team. This fostered enriching discussions on the topic, focusing on the real challenges faced by municipalities and the shared construction of knowledge. Following this, the workshop continued in an interactive dialogue format, presenting the achievements of the municipalities in each health region during the second quarter (Q2) of 2022 for each Previne Brasil performance indicator. Considering the diagnosis of municipal data and the difficulties reported by participants, the moderator asked: "What strategies have municipalities used to achieve the goals set for the Previne Brasil performance indicators and increase resources in PHC?"

In this second phase, characterized as data collection, the management teams shared their local experiences, encompassing municipalities with both better and worse indicators. This exchange of experiences allowed for a broader understanding of the strategies adopted by each municipality within the health region to meet the criteria for securing financial resources.

The discussions and debates generated were audio--recorded, while summaries of statements and non-verbal data were documented in field notes by members of the research team. After transcribing the recordings and organizing participants' statements, the data were validated by different members of the research team and GERSA managers present at the workshops.

Subsequently, the data were explored through thematic analysis, which initially involved pre-analysis, followed by a floating reading of the material, (re)formulation of hypotheses and objectives based on the collected

material, determination of registration units in phrases, context units, excerpts, and categorization and coding that guided the analysis[9].

During the exploration of the material, the coding of statements was operationalized, previously developed through the classification and aggregation of text excerpts corresponding to the proposed categories[9]. Finally, an interpretation of the categorized data was conducted according to the theoretical framework and grounding of the National Primary Health Care Policy[9,10].

The thematic analysis, performed with the data collected during the workshops, involved multiple readings in search of patterns of meaning among the themes and strategies presented by the participants. This research sought reflexivity regarding the various ways PHC managers have acted in response to Previne Brasil, as observed during the workshops. Furthermore, the strategies used and their actual influence on achieving performance indicator goals were examined.

To ensure quality and guarantee the necessary methodological rigor for qualitative research, criteria of credibility, dependability, confirmability, recurring patterns, and saturation were utilized[11]. The recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ) were used to guide the study.

This study was conducted in accordance with Resolution No. 466, of December 12, 2012, from the National Health Council, which approves guidelines and regulatory norms for research involving human beings. The present study was approved by the Research Ethics Committee (CEP), under opinion number 5,433,164, on June 29, 2022. All participants were assigned pseudonyms based on enumeration criteria according to the statements made throughout the workshops. The collected data were stored in a location with exclusive access for the researchers and will be destroyed after the pre-established period of five years.

RESULTS

Seventy-five managerial professionals participated in the study, including municipal health secretaries or designated members of PHC management teams, representing 46 (58.9%) municipalities in the MRGO. Of these, 84% were female, 71% had higher education in nursing, and 77% held management roles in PHC and/or the municipal FHS (Figure 1).

The results obtained by the municipalities in the macro-region under study showed, for the second quarter of 2022, positive ISF averages, with an average of 8.0, ranging between 4.8 and 10.0. In the same evaluated period, the specific averages for each indicator showed results of 9.4, 8.2, and 8.4 for indicators related to prenatal care: six consultations, syphilis and HIV testing, and oral health, respectively.

For the immunization indicator, the macro-region achieved an average of 8.8. The performance of the cytological exam recorded an average of 7.5, while attention to chronic diseases such as hypertension and diabetes registered averages of 5.4 and 4.1, respectively.

During the workshops, challenges and difficulties were identified from the perspective of the management teams regarding the achievement of indicators and targets. Among the most frequently cited were the high demand faced by services and professional overload, lack of communication between the Ministry of Health's information and registration systems (eSUS and Cad-SUS), and issues related to proprietary systems used by municipalities, which, for example, do not accept records of consultations not performed by a physician.

Additionally, adjustments related to permanence and inclusion in the denominator of transient conditions such as gestational diabetes were flagged as concerns by the teams. Statements emerged about the impossibility of correcting erroneously registered data, considering that errors may occur during the work process of the teams. Moreover, there are also situations related to user co-responsibility, such as moving cities; if a pregnant woman does not update her registration at a new primary healthcare unit (PHU) or arrives in a municipality at an advanced stage of pregnancy, her indicators could likely be affected.

From the contributions, a macrocategory emerged titled "Strategies related to the work process developed by FHTs to advance performance indicators." It was observed that the analysis and establishment of these strategies by the management teams were based on identifying needs for adaptations to the work process already carried out by the teams. These adaptations were gradually incorporated into routines, aiming to improve performance regarding established indicators. These management strategies demonstrate alignment and proximity to the practice of the teams.

Monitoring and situational analysis of PBP performance indicator targets in the researched municipalities are conducted through monitoring the results achieved by each FHT. The strategies include regular analysis of indicators using computerized tools, facilitating data-driven decision-making and enabling continuous adjustment of care practices, promoting a cycle of ongoing improvement in services offered to the population.

Figure 1 – Characterization of participants by sex, education, and role, according to health region, Santa Catarina, Brazil, 2023

	FAR WEST HR N (%)	WEST HR N (%)	RS XANXERÊ N (%)	TOTAL N(%)
Gender				
Male	03 (13)	02 (10)	07 (22)	12 (16)
Female	20 (87)	18 (90)	25 (88)	63 (84)
Training				
Nurses	18 (78)	15 (75)	20 (62)	53 (71)
Other health profession	04 (18)	03 (15)	07 (22)	14 (19)
Other knowledge area	01 (04)	02 (10)	05 (16)	08 (10)
Function				
PHC management team	20 (87)	17 (85)	30 (94)	67 (89)
Municipal manager (municipal health secretary)	03 (13)	03 (20)	02 (06)	08 (11)
Total of participants	**23 (100)**	**20 (100)**	**32 (100)**	**75 (100)**

Source: Prepared by the authors, 2023.

From this macrocategory, three subcategories were defined: 1 – permanent monitoring, evaluation, and updating; 2 – organization and management of workflows and routines in PHC; and 3 – bonding and co-responsibility in healthcare.

Permanent Monitoring, Evaluation, and Updating

This category of strategies addresses the discussion of monitoring tools, updating user data, integrating systems, and training teams. Parallel tracking of performance indicators by each team was frequently mentioned by participants as a strategy to monitor their own results, identify inconsistencies, and develop feasible strategies and improvements.

Aspects related to monitoring, evaluation, and updating of health data were highlighted as fundamental in this process. Moreover, tools such as reports and spreadsheets were pointed out as central to improving mastery and knowledge of the population's health status and service performance.

> *Regarding the indicators, in the last quarter, we didn't meet the diabetes-related targets, but I have everything noted down—I would have reached 85% in my count. We downloaded that list showing all the patients who self-reported as diabetic or hypertensive, and those who had a diagnosis* (P1).

> *We have a data spreadsheet, which is managed by the doctor on our team. We have everything registered there* (from the consultations) (P5).

> *We have* (in the municipality) *our own system. I generate a report with their names, indicating whether they had the test done three years ago* (cytological exam) (P33).

> *I always instruct them* (the CHWs) *to maintain a list of all women within this age group* (for cytological collection). *They keep track, maintaining lists from 2015, 2016, noting if they did it that year or privately* (P70).

In addition to monitoring the health situation, managers also emphasized the importance of updating user data. It was observed that the persistence of death records in the reports used for calculating indicators (denominator) often compromised the results achieved by the teams, considering the need for general actions in municipalities to train the teams.

This scenario highlighted the lack of integration between the Ministry of Health's information and registration systems. To ensure that the available reports are more accurate and useful, it is essential to guarantee the continuous updating of user data. During the discussions, managers shared strategies and solutions they found to overcome this challenge.

> *In our municipality, we are trying to update the individual and citizen registration every 180 days, very precisely, otherwise the file won't go through, and it causes inconsistencies* (P1).

> *But there is a way to remove* (the deaths). *We need to deactivate them in the National Health Card* (SUS Card) *because the information doesn't cross-reference* […] *you deactivate it in e-SUS, but the systems don't communicate, so it remains active in the National Health Card and still counts in the indicator* (denominator). […] *You need administrator access; otherwise, it won't work.* [...] *Each unit is handling the deactivation of its own death records* (P3).

> *The CHWs extracted* (the data) *one by one from RANG* (a proprietary system), *and we updated it. People who lived on other streets or in different cities were removed from e-SUS* (P60).

Registration updates are not limited to users and their families but also extend to data about professionals working in primary health care (PHC). For consultations to be counted in performance indicators, they must be conducted by the reference professional, meaning they need to be registered with the user's linked team. Thus, the importance of updating professional registrations within the teams is reinforced. These updates must be performed both in the National Register of Health Establishments (*Cadastro Nacional de Estabelecimentos de Saúde* - CNES) and in the National Team Identifier (*Identificador Nacional de Equip*e - INE). However, challenges related to linking medical specialties to services and teams were noted, as these professionals often have a limited number of hours and sometimes serve multiple locations within the same municipality.

> (The specialist professionals) *need to be linked to the INE of the team* (P3).

> *You need to check if the professional is registered in the CNES of the team and in the correct INE of the team. Sometimes, in one unit, you have two teams, so if she* (the specialist) *sees pregnant women from both, she needs to be registered in both* (P10).

> *In* (Municipality Y), *there's an obstetrician-gynecologist and four FHS teams; she allocated some hours to each team* [...] (P11).

> *There are two things to consider here because all this data goes for validation. So, if a professional is in the wrong CNES or has any other incorrect information, that information won't reach e-SUS* (P55).

In this context, periodic review of information systems, updated registration of users, and the correct linking of this data to health teams and specialties were highlighted by managers as fundamental strategies. These processes allow not only the identification and correction of inconsistencies in records but also align the information with performance indicators and the health demands of the population.

Efficient integration between information systems and detailed recording of services provided by each team were emphasized as essential aspects to strengthen management and optimize results in the municipalities of the West Macro-region of Santa Catarina. The implementation of these strategies contributes to increasing data accuracy, promoting more reliable analysis and more assertive actions in the planning and execution of health activities

Organization and Management of Workflows and Routines in PHC

This category of strategies addresses discussions on routines and workflows, integrated care, active case finding, and adaptation to local demands. During the workshop, participants engaged in intense debates about organizing and establishing workflows that ensure user care and the achievement of performance indicators. The importance of teams in recognizing the potential and challenges of the territory, service, and assisted population became evident, allowing each unit to define its methods of outreach and goal achievement.

Establishing routines for professionals, fostering teamwork, and adopting care protocols for priority groups stand out as strategies to broaden the reach of program goals. By organizing workflows and making them more fluid, achieving indicators becomes easier, creating a constant and organic routine of pursuing results in a sustained manner.

> *When she* (the pregnant woman) *arrives, she goes through the nursing consultation, tests are requested, and follow-ups are conducted with the doctor and the nurse* (P5).

> [For pregnant women] *the first consultation is with the nurse. So, the first rapid test is already done* […] *they* (nurses) *always check the health card and make the necessary records registros* (P27).

> *When entering the consultation data into the system, the entire process is completed, and blood pressure is recorded immediately to avoid forgetting* […] *we established this evaluation* (for

hypertensive and/or diabetic users) *every four months instead of every six to minimize risks* (P24).

On the day the pregnant woman comes, she has appointments scheduled with the doctor and also sees the dentist […] *she moves from one professional to another, completing the circuit. Dental care is usually provided before the medical consultation because otherwise, she might leave* (P30).

We started scheduling consultations (for hypertensive and/or diabetic patients). *Medical consultations include not only an assessment of the chronic condition but also a general evaluation. I'm organizing it by CHW; I'll take one per month, and everyone in their micro-area will renew their registration, with a new consultation every six months* (P76).

Bonding and Shared Responsibility in Health Care

This category of strategies addresses discussions on user engagement, team empowerment, and intersectoral actions. The efforts reported by managers in the discussed categories, combined with bonding and accountability of teams toward the territory and enrolled population, were identified as key factors for progress in achieving program goals. This bond not only strengthens the relationship between professionals and users but also enhances the teams' ability to plan and execute interventions more aligned with community needs.

I know almost all the diabetics at the unit (P7).

We need to strengthen the bond with the CHWs […] *we realized that we can enhance outreach with the CHWs* (P24).

The Previne Brasil program doesn't just hold the team accountable; it also holds the population accountable (P54).

We are aware of our responsibility as well as the patient's responsibility (P55).

We are working on raising awareness among the CHWs for active case finding […] *it's important to understand that, beyond numbers, we need to provide care* (to specific groups) (P58).

We also have pregnant women who receive follow-up care privately, and we maintain contact with them. Through the active case finding by the CHWs […], *the first point of contact will be the primary health care unit. So, it's important that we establish a bond with her [the pregnant woman] and stay informed about how the pregnancy is progressing* (P65).

Every month, the CHWs invite and remind people (for cytological exams), *even reaching out via personal WhatsApp messages* (P54).

The bond with users was highlighted as one of the main tools to enhance the quality of the teams' work. By deeply understanding the population and the territory, health teams can identify specificities and priorities that guide the selection of more effective strategies tailored to the local context. This territorial knowledge thus emerges as an essential pillar for building effective and sustainable health actions.

However, managers also emphasized the importance of shared responsibility of users regarding their own health and the functioning of the service network. This engagement is crucial not only for health promotion but also for establishing a healthy balance between the supply and demand for services. User accountability strengthens the bond with the teams, creating a virtuous cycle that fosters more collaborative and effective interactions among all actors involved in health care.

This perspective underscores the need for an integrated approach where both professionals and users share responsibilities, contributing to the consolidation of a more efficient, accessible, and equitable health network. It is worth highlighting that bonding with users, especially through the work of CHWs, can improve adherence and continuous patient follow-up, ensuring active case finding and care for priority groups. In this sense, it is important to raise awareness and hold users accountable for their own health as active participants in the care process.

Finally, the following are considered positive aspects: the adoption and combination of strategies such as systematic monitoring and evaluation; efficient organization of workflows and the care network, including the use of care and management protocols; the development of active case finding; regularization of CNES and INE for teams; continuous registration updates; and user awareness. This is a feasible and low-cost path to ensure compliance with the performance indicators of the Previne Brasil program. Such strategies are reflected in the strong indicators of the region and serve as a model for other health regions.

DISCUSSION

A Primary Health Care (PHC) is grounded in the accountability of services and teams for organizing the network and coordinating care for users, families, and communities, without disregarding the political leadership of municipal management teams. In this sense, efforts are being made to guide workflows that prioritize

equity, comprehensiveness, and shared responsibility between teams and users, ensuring effective health production within territories[10].

To achieve this, the actions and strategies at this level of the care network require managers and teams with knowledge and competencies in clinical care, process management, team and user education, and the policies governing established relationships. The strategies adopted by management teams demonstrated, in this study, a greater focus on improving team workflows than on implementing new policy and administrative actions at the macro-municipal level. These strategies have yielded positive results, as evidenced by the strong average performance of the FHS, which reached a score of 8.0.

However, the variation observed among indicators and municipalities highlights the need for collaborative approaches and more effective dialogue among managers to collectively advance population health across the macro-region. What emerges from both this research and current literature is the lack of studies presenting managers' experiences and proposing ways to address regional specificities in achieving goals and, above all, improving service quality.

Despite the positive outcomes achieved by most municipalities in meeting performance indicators, challenges in fully achieving targets remain evident, particularly regarding chronic disease care and coverage of cytological exams. Among the main obstacles are certain populations not seeking PHC services, low user adherence to preventive follow-ups, and service organization and orientation often misaligned with user needs, undermining the achievement of expected results.

This scenario calls for careful attention to positive directions in goal attainment, but especially in ensuring effective care for this population. In this regard, adopting strategies that strengthen the bond between FHTs and users, promote educational actions and shared responsibility with the community, and guide team workflows to meet the needs of the assisted population becomes crucial to improving these indicators and ensuring the effectiveness of health policy.

From participants' statements, it is clear that the focus is on what FHTs need and must produce in terms of results, but few practices or strategies are mentioned by management teams to support this achievement. While the work of the teams and their challenges are acknowledged, little is said about management's role in improving spaces, infrastructure (physical and technological), and human resource availability, as if strategies solely relied on demanding productivity from teams.

In this study, continuous monitoring, evaluation, and updating of registries and records emerged as means to understand and manage the enrolled population, aiming to meet these indicators and, consequently, secure greater funding for PHC. Based on these efforts, defining workflows and routines for addressing identified needs, as well as establishing bonds and accountability between teams and users, were used as strategies to make progress toward indicators set by the PBP.

Establishing mechanisms for self-assessment, control, and systematic monitoring of results achieved through PHC actions is a shared responsibility across all levels of government[10]. In organizing their work, health teams use electronic and/or manual tools to monitor actions and outcomes.

In this study, control and monitoring conducted by professionals through reports enabled the identification of inconsistencies and errors, which in turn allowed these factors to be investigated, corrected, and improved. This strategy demonstrates that the team's knowledge of the enrolled population and territory complements the mechanisms technology provides for workflow processes.

User registration in PHC reduces treatment gaps and improves the management of chronic diseases and screening actions[12]. Furthermore, registry updates enable qualified and unique records, control duplicates, and incorporate information such as phone numbers and addresses, facilitating interventions through technologies like social media. These actions foster the realization of PHC attributes, such as first contact, longitudinality, and care coordination[13,14].

Similarly, user registration, correct team recording in the SISAB, use of electronic health records with proper qualification of PEC, and inclusion of reliable and measurable clinical variables characterize the largest set of demographic and clinical health data in the world[13,15], which can be implemented through adherence to the e-SUS-AB health information digitalization strategy. Since its introduction in 2013, the e-SUS strategy has been implemented in Brazil and continues to progress with each analyzed period[15], providing teams with the potential to advance in the quality of health information and care.

In the pursuit of better health outcomes, it is also important to highlight that the existence of workflows and protocols grants greater autonomy to professionals, with particular emphasis on nurses. These resources bring with them accountability and closer engagement with the user's health/illness situation and are essential for meeting performance indicators.

In addition to aiding decision-making, the adoption of protocols contributes to user safety by ensuring uniformity in practices and guiding workflows, serving as a tool to be explored in the processes and routines of PHC work[12,16,17].

Still within the scope of meeting performance indicators, active case finding emerges as a primary strategy in PHC routines. When routinely implemented by teams, active case finding significantly differs from the results achieved by locations that do not incorporate it into their workflows, particularly regarding vaccination[18].

Active case finding strengthens the comprehensiveness of PHC with the aim of bringing the population closer to health actions and services. Moreover, it is an action that can be carried out by all team members, with the CHW playing a leading role due to their strong bond and close relationship with the community, as well as their facilitative role in communication, linkage, and integration of services within the community[19,20].

Furthermore, to achieve success and better health outcomes, continuous follow-up of users and families by the entire FHT stands out as a key component of the PHC workflow. In this way, the strengthening of bonds with users and the community is observed, as PHC is responsible for the longitudinal follow-up of users throughout their health/disease process[10]. In this process, it is necessary to build trust so that, over time, the team can delve deeper into the individualized care process for each user[10,21].

Although PHC should be recognized by users as the first point of contact within the healthcare network, this bond may show fragility, especially in aspects such as the therapeutic professional/user relationship, a factor that varies according to individual perception[22].

It is noted that recognition of the territory and enrolled population, as well as the bond established and accountability assumed by the team, must be intrinsic to the workflow developed by FHS teams. From this, it becomes possible to plan specific actions to address issues related to the comprehensive context of local health care.

This study addresses the achievement of goals set for the Previne Brasil performance indicators, which, beyond numbers, represent each team's commitment to its users. In this research, references emerged regarding the recognition and appreciation of the role played by CHWs, a function that remains potentially weakened since the 2017 PNAB makes the hiring of these professionals optional when municipalities adopt basic care teams as their strategy.

The absence of this professional in such teams renders actions like outreach and territorialization unfeasible, potentially compromising the quality of registries, data, bonds, and, consequently, the entire PHC operation. The studied reality observes a predominance of FHT (99.7%) as the strategy adopted by municipalities, highlighting the potential for team workflows and subsequent outcomes and PHC funding.

Data obtained from PHC monitoring strategies and workflow organization indicate practices that can be generalized and applied to teaching, research, and health practice. In the field of education, these strategies can be incorporated as pedagogical models that emphasize the importance of using information systems and proactive professional engagement in PHC management and public health.

In research, surveillance methods and continuous data updates provide a basis for studying the efficiency of health teams and the impact of user bonding on improving health indicators. In practice, the adoption of well-structured workflows and care protocols for priority groups can be replicated in different PHC contexts, expanding the reach of PBP-established goals and promoting more effective, safe, and integrated care.

As limitations of this study, it is noted that contextual and socioeconomic factors that may directly influence municipal performance on evaluated indicators—such as health infrastructure, funding, and local policies—were not explored in depth, limiting the ability to understand more complex dynamics.

Additionally, the predominant participation of the "nurse" professional category may restrict the diversity of perspectives on PHC management and care. However, it is worth noting that the predominant representation of nurses reflects the legitimate role of this professional in coordinating and articulating FHTs in municipalities, which is crucial for PHC care management.

CONCLUSION

This study highlighted both the potential and challenges of the PBP, emphasizing the need for continuous qualification and monitoring of PHC processes, with a focus on team integration and updating information systems. The analyses and discussions conducted reinforced the importance of a well-organized workflow in FHTs and the need for these practices to be constantly adapted to territorial and population realities.

The exchange of experiences among municipalities, promoted in workshops, emerges as a valuable tool for strengthening PHC in an integrated and regionalized manner, serving as an intervention model that assists managers in developing local and focused strategies.

Beyond the debate on the availability of financial resources and the achievement of established goals, the *Previne Brasil* Program presents several critical points that need to be addressed and improved.

The performance indicators refer to health issues that can be resolved within PHC, provided there is continuous improvement in information systems. This is a critical factor for the accurate updating of registries and the monitoring of prenatal, gynecological, pediatric, and chronic condition health indicators, under the coordination of managers, as well as the structuring of professional workflows through established protocols and processes, especially with adequate infrastructure and human resources.

The strategies proposed in the workshops aim to establish effective workflows, overcome emerging challenges, ensure adequate funding, strengthen PHC, and provide the population with services that promote, prevent, and protect health, ensuring continuity, trust, safety, and shared responsibility in user care.

As the main contributions of this study, it is emphasized that the implementation of the cited strategies was crucial for improving indicators, with advancements in areas such as prenatal care and immunization, despite challenges related to chronic diseases. It is worth highlighting the overcoming of barriers to reduce the impacts of high demand, team overload, and limitations in information systems. Finally, the promotion of quality in care is reinforced, focusing on the organization of workflows, the use of care protocols, and the regular monitoring of epidemiological and sociodemographic data, with the adoption of local and regional collective management practices within the SUS to ensure continuous and integrated healthcare for users.

The dedication of the teams in achieving the indicators and the progress made in public health in the Western Macroregion of Santa Catarina is acknowledged, despite the challenges faced. However, there is an evident gap regarding the role of management in improving workspaces, upgrading physical and technological infrastructure, and ensuring adequate human resources.

Often, especially in smaller municipalities, the adopted strategies seem to focus solely on demanding productivity from teams, neglecting the importance of structured and integrated support from management to create more suitable and sustainable conditions for health work.

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