PRIMARY HEALTH CARE MANAGEMENT IN BRAZIL

TCU FEDERAL COURT OF ACCOUNTS

ATRICON

Instituto Rui Barbosa
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COORDINATED AUDIT

EXECUTIVE SUMMARY

Health

Federative Republic of Brazil
Federal Court of Accounts

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Health

Brasília, 2015

Gestão da atenção básica à saúde no Brasil : auditoria coordenada / [Coordenação] Tribunal de Contas da União; Tribunal de Contas do Estado do Acre ...[et al.]. – Brasília : TCU, Secretaria de Controle Externo da Saúde, 2015.

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O presente trabalho tem por objetivo divulgar os principais resultados da auditoria operacional realizada sob a coordenação do Tribunal de Contas da União e outros 29 Tribunais de Contas dos Estados e dos Municípios. A auditoria decorreu de acordo de cooperação celebrado com articulação institucional do Tribunal de Contas da União (TCU), da Associação dos Membros dos Tribunais de Contas do Brasil (Atricon) e do Instituto Rui Barbosa (IRB).

1. Saúde pública - Brasil. 2. Acesso à saúde - Brasil. 3. Sistema Único de Saúde (SUS). 4. Gestão pública Brasil. 5. Auditoria operacional. I. Brasil. Tribunal de Contas da União. II Associação dos Membros dos Tribunais de Contas do Brasil (Atricon). III. Instituto Rui Barbosa (IRB). IV. Série.

Ficha catalográfica elaborada pela Biblioteca Ministro Ruben Rosa

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- Minas Gerais State Court of Accounts
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- Paraíba State Court of Accounts
- Paraná State Court of Accounts
- Pernambuco State Court of Accounts
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- Rio de Janeiro State Court of Accounts
- Rio Grande do Norte State Court of Accounts
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- Rondônia State Court of Accounts
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- São Paulo State Court of Accounts
- Tocantins State Court of Accounts
- Municipal Court of Accounts of the State of Ceará
- Municipal Court of Accounts of the State of Goiás
- Municipal Court of Accounts of the State of Pará
- Municipal Court of Accounts of the City of Rio de Janeiro
- Municipal Court of Accounts of the City of São Paulo


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FOREWORD

With a population of over 200 million people, Brazil has as one of its most difficult and complex missions to ensure universal, equal and free access to health care services, a right enshrined in the Federal Constitution itself. In this regard, the implementation of such public policy is faced with many challenges, as in the case of decentralization of actions, funding sources, the human resources required, and the management of the available financial resources.

Primary health care is the main point of entry into, and the communication hub for the entire health care network; and it should be the preferred contact of the users of the Unified Health System (SUS). At this level of care, the main needs of the population are identified, and that has a bearing on the planning and management of the other tiers.

Therefore, this issue is of vital importance to the Brazilian society if we take into account the considerable figures it involves, as regards the quantity of Primary Health Care Units (UBS) meant to provide care, the cities that are covered, the percentage of covered population, and the budgeted amounts made available. According to academic studies, primary health care providing solutions to most of the problems of the users is an essential condition for viability – including financial viability – of public health care systems.

In such a context, it is fundamental the agents in charge of managing this area of such great importance be aware they need to act as dutifully and properly as possible, so that user demands will be met as timely and efficiently as wished.

The Federal Court of Accounts conducted in a coordinated manner with other 29 state and municipal courts of accounts a Performance Audit, whose object was the assessment of the quality of primary health care services provided within SUS. Such auditing encompassed fieldwork – in a spontaneous manner – in 23 states and 317 cities, whose results were added with an electronic survey replied by 14 State Health Departments, 2,577 Municipal Health Departments and 175 Regional Health Management Offices.

The audit stemmed from a cooperation agreement entered into through the institutional articulation between the Federal Court of Accounts (TCU), the

Association of Members of Courts of Accounts of Brazil (Atricon) and the Rui Barbosa Institute (IRB).

The Executive Summary presented herein is aimed to disclose the main results from the audit that was carried out; and constitutes a strategic tool for improving the management of those services, as it offers an excellent diagnosis of the infrastructure, access, delivery of services, and the problem-solving capacity of primary health care.

The Brazilian Courts of Accounts which took part in such a significant endeavor hope the conclusions of this work will offer citizens, experts, public administrators and other professional from the field a nationwide view on the issue, and help both government and society to reach proper solutions to the betterment of health public policies, thus benefiting Brazilian society.

Aroldo Cedraz
President
Federal Court of Accounts - Brazil

Valdecir Fernandes Pascoal
President
Association of Members of Courts of Accounts of Brazil

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President
Rui Barbosa Institute

CONTENTS

01
OVERVIEW

1.1 COORDINATED AUDIT

Primary health care was the subject of this coordinated performance audit conducted by the Federal Court of Accounts (TCU) and by 29 Courts of Accounts (TC), signatories to the Technical Cooperation Agreement entered into on March 25, 2014.

A coordinated audit is one in which each audit institution carries out – based on joint planning – independent audits and reports, and in the end they prepare a consolidated report based on the main audit findings.

The agreement was made through an institutional articulation of the Association of Members of Courts of Accounts of Brazil (Atricon), Rui Barbosa Institute (IRB), and also the TCU; and it is pursuant to the Statement of Vitória/ES, drafted during the 27th Conference of Courts of Accounts of Brazil, on June 12, 2013. Among other things, the Statement established the commitment to ensuring technical and institutional support for the performance of coordinated audits on issues of relevant national interest and which impact society.

Coordinated audits have provided citizens, experts and concerned professionals with a nationwide view on issues of relevant social interest, based on rigorously selected aspects. Furthermore, the fact the courts of accounts have jointly carried out those assignments has enabled the respective technical teams an opportunity to exchange experiences, spread knowledge and build capacities, thus developing the oversight methodology.

This executive summary consolidates the main findings from each court of account participating in this performance audit. The term "findings" refers to the situations encountered by the auditor during fieldwork which will be used to answer the audit questions. The work was jointly undertaken by the TCU; the state courts of accounts (TCE), except for the Courts of Accounts of the states of Alagoas, Maranhão and Sergipe; and the municipal courts of accounts (TCM), except for the Municipal Court of Accounts of the State of Bahia .

1. Overview

1.2 OBJECT

Primary health care is characterized by an array of health actions, both at individual and collective levels, which encompass health promotion and protection, prevention of hazards, diagnosis, treatment, rehabilitation, reduction of harms and maintenance of health with the aim to develop an all-around health care which produce an effect on the health situation and autonomy of people and on the conditioning and determining factors of the health of communities, according to the National Policy on Primary Health Care (PNAB), established by the Directive GM/MS 2,488, of 10/21/2011, of the Ministry of Health.

In Brazil, it is the main entryway into the Unified Health System (SUS), and care delivery takes place at the Primary Health Care Units (UBS), facilities which must be set up close to where people live, work, study, and live.

The importance of placing priority on actions for health prevention and on specific care approaches intrinsic to primary health care stems from the fast-paced demographic transition experienced in Brazil, which led to considerable impacts on the health of the population. Such change is seen, for example, in the increasing incidence of non-communicable diseases (NCDs), and in the emergence of new ways of falling ill and dying (urban violence, emerging and reemerging infectious diseases), which bears upon SUS management.

According to the 2012-2015 National Health Plan, in the year of 2007, the NCDs accounted for about 67% of all deaths registered in Brazil. Cardiovascular diseases were the main cause: 29% of all declared deaths, followed by cancer (15%), respiratory diseases (5.6%) and diabetes (4.6%).

In such a context, studies indicate that primary health care working properly may provide quality solution to most health-related problems of the population (STARFIELD, 1994; PNAB, 2011; CONASS, 2011; SOUZA, 2014).

Grounded on principles established by the Conference of Alma-Ata, held by the World Health Organization (WHO), primary health care constitutes an answer for keeping the sustainability of universal health care systems, seeking to reorganize health care services centered on the physician and on the hospital (doctor/hospital centered methods) to a tiered care model where

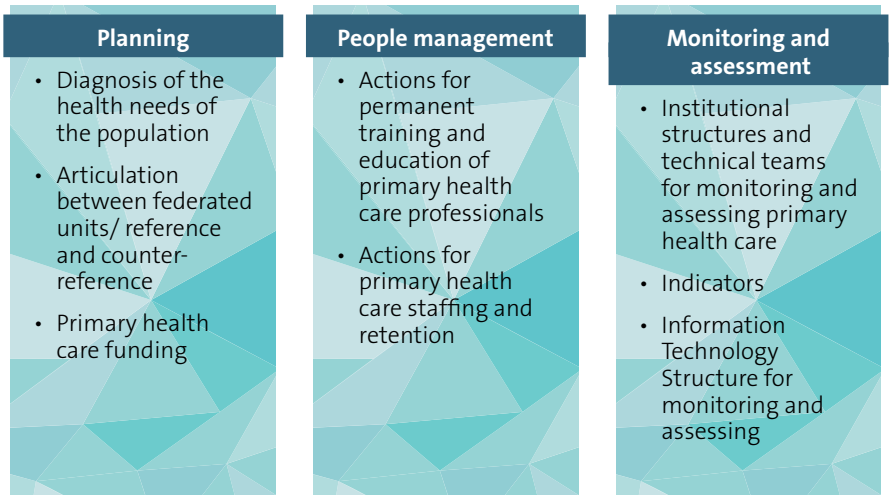
primary health care is the first contact, the point of entry into the health care system, which moves further on to medium and high levels of complexity.

Thus, primary health care must be the ordering factor of the primary health care network, as it identifies the health needs, which has a bearing on the planning and management of the other health care tiers, and it also must be the coordinating element of health care, since it must follow up on the users so as to keep up the health of the communities.

The strengthening of primary health care also entails the benefit of enhancing problem-solving capacity, understood as the final solution to the problems brought by the community to the health care system, with user satisfaction; to improve health care equity; and to provide adequate cost-effectiveness. Besides that, planning health actions must take local peculiarities into account.

The object of this audit was to assess, in a joint and coordinated manner, aspects related to the delivery of services, access, infrastructure and problem-solving capacity of primary health care to citizen-users. More specifically, to define that scope, we sought to assess whether primary health care management (at the federal, state and municipal levels) provides quality when delivering services. Therefore, it was considered that quality derives – among other variables – from managerial actions (management processes) implemented for primary health care.

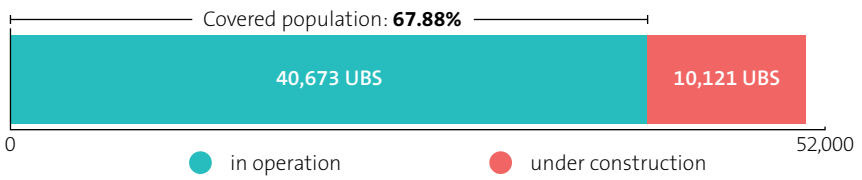
This way, the audit questions were developed around three big subjects: planning, people management, and monitoring and assessment.



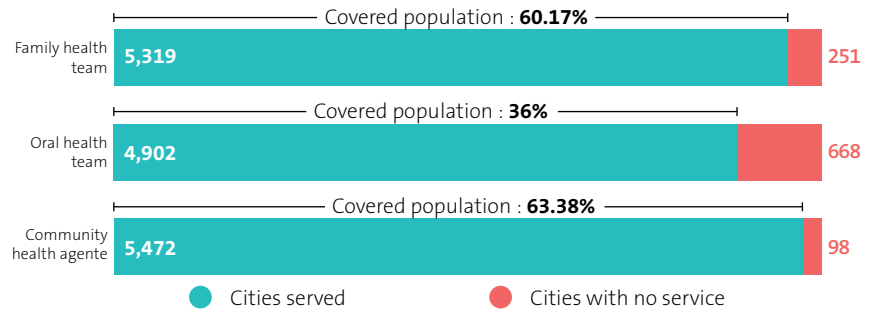
1.3 THE IMPORTANCE OF PRIMARY HEALTH CARE

Besides the fact that primary health care working properly can solve most health problems of the population, the relevance of the issue can be seen by looking at the significant figures concerning this level of health care.

Number of UBS in Brazil x Population Covered



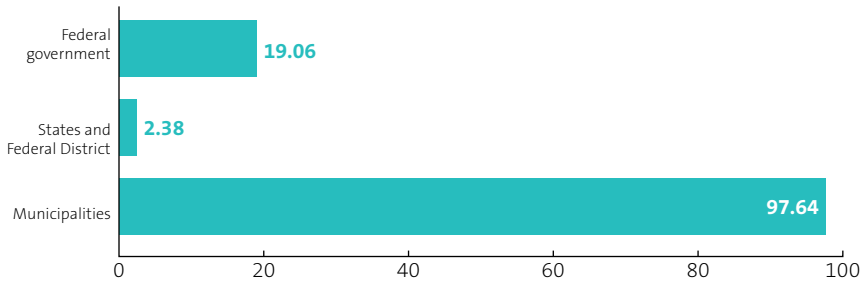
Covered population and cities served by primary health care professionals



Source: Strategic Management Support Office of the Ministry of Health - data from March, 2015
http://189.28.128.178/sage/

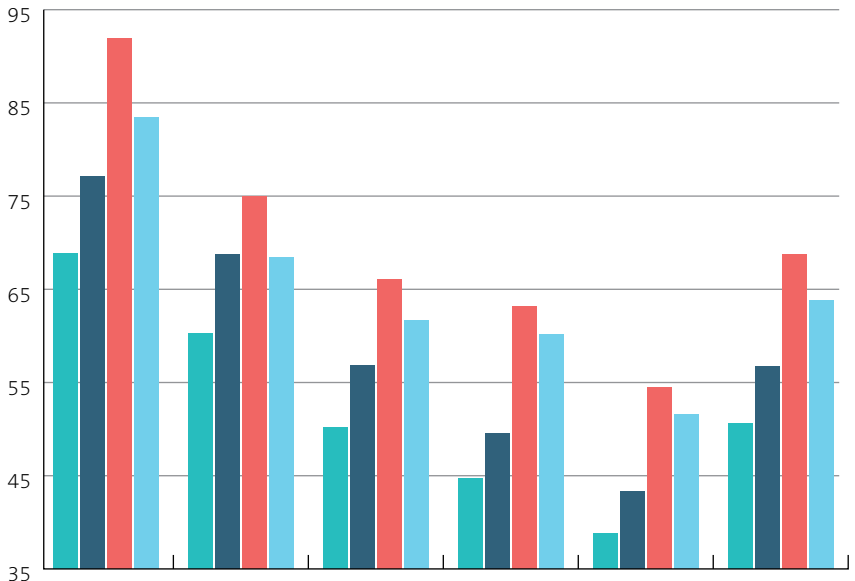
Primary health care budget

Committted expenditure (BRL billion) in 2014, to Primary Health Care sub-function



Source: SIOPS – data from 06/26/2015
http://www.tesouro.fazenda.gov.br/documents/10180/352657/RROdez2014+%28Corre%C3%A7%C3%A3o+2%29.pdf/3c9ae8f9-193a-40b8-9b00-75c03509f9a4,
http://siops.datasus.gov.br/rel_subfuncaoUF.php
http://siops.datasus.gov.br/rel_subfuncao.php

Federal transfers *per capita*, fund by fund, from the FNS (National Health Fund), in the grant funding block for primary health care, between 2010 and 2013



	Northeast	North	Midwest	South	Southeast	National
2010	68.80	60.27	50.15	44.74	38.77	50.61
2011	77.15	68.73	56.80	49.56	43.31	56.74
2012	91.96	74.98	66.01	63.12	54.50	68.73
2013	83.46	68.46	61.69	60.17	51.58	63.84

Source: SUS Computing Departament (http://tabnet.datasus.gov.br/cgi/deftohtm.exe?ibge/cnv/poptuf.def)
Remark: Amounts in BRL$ - status as of 11/13/2014

1.4 AUDIT METHODOLOGY

International standards for performance auditing from the International Organization of Supreme Audit Institutions (Intosai) were adopted to undertake this work, and also procedures defined in the Working Plan annexed to the Technical Cooperation Agreement mentioned above.

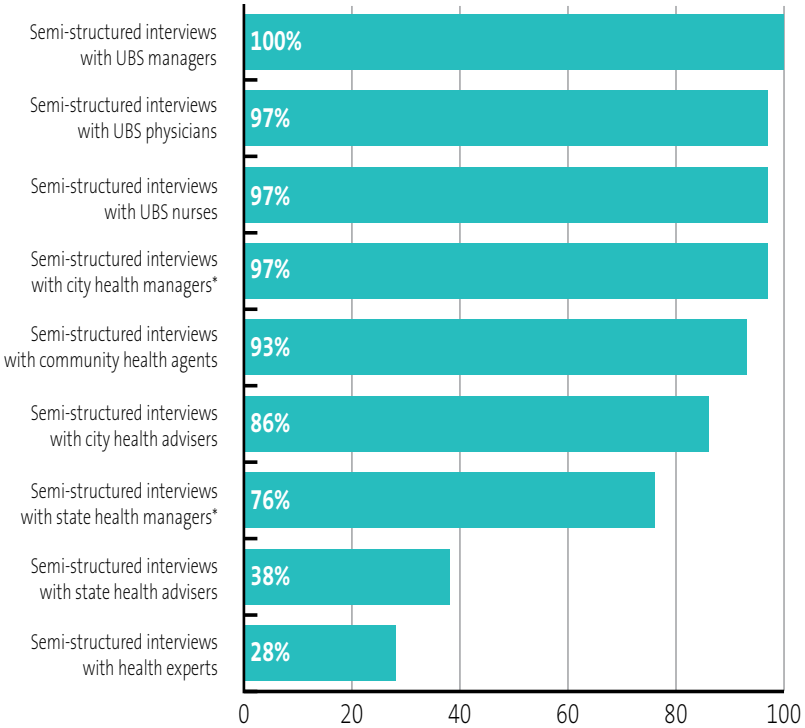
The coordination of the assignment was charged to the Thematic Group on Performance Audit (GAO) from the IRB, which originated within the National Capacity Building on Performance Audit promoted by the Program for Modernization of the External Control System of Brazilian States, Federal District and Cities (Promoex).

The teams from the Courts of Accounts participated in two face-to-face workshops (one during the planning of the assignment, to develop the planning matrix and audit procedures; and another one during the phase of discussion and harmonization of audit findings), videoconferencing, and virtual discussion, and were supported by monitors and the supervision of members from the GAO.

The assignments were executed on the themes of planning, people management, and monitoring and assessment, in consonance with the developed planning matrix; and each participating court of accounts was allowed freedom to expand their investigations – according to their operational capacity – to other themes related to the audit object.

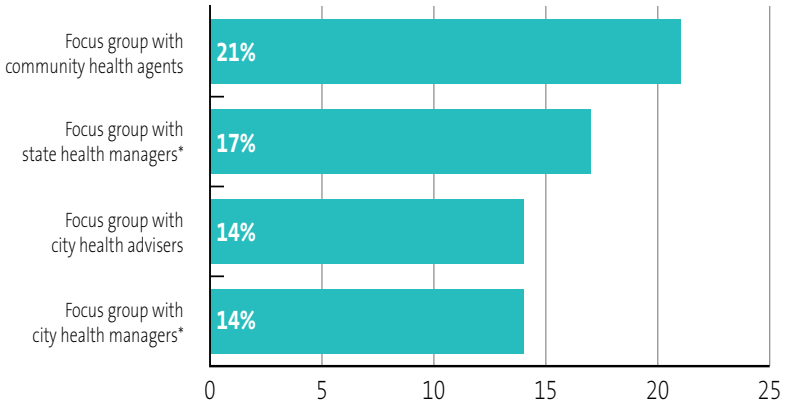
The audit teams from the participating courts of accounts made use of a variety of tools for data collection, such as, for example: electronic questionnaires, semi-structures interviews, requests of information, direct observation, and information system queries. We can see on the following charts the percentage of participating courts using each tool.

Tools for data collection – Quantity of teams that used interviews



Remark: * Both health department directors and primary health care managers were considered

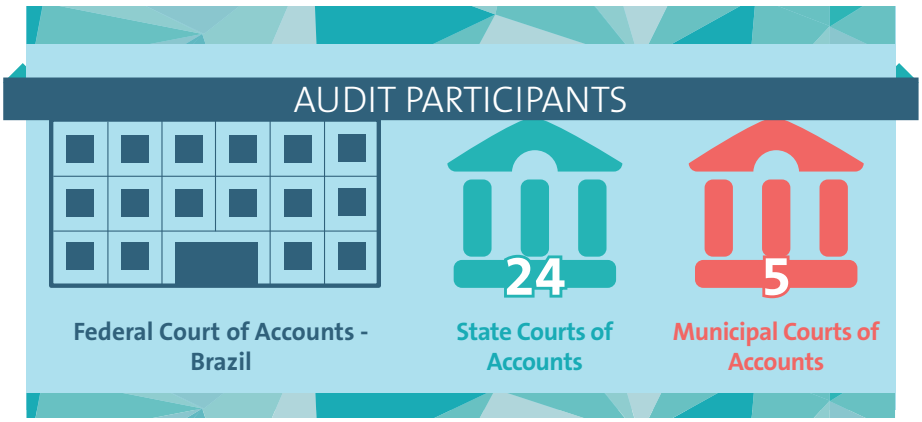
Tools for data collection used – Percentage of teams that held focus groups



Remark: * Both health department directors and primary health care managers were considered.

Besides direct observation, the electronic questionnaires applied (national electronic survey) and the interviews made play testament to an important judgment of the players directly involved in primary health care activities and, therefore, they are suggestive of actions for betterment, and substantiate, along with other applied audit tools, the evidences identified in the audit reports and consolidated in this executive summary.

The coordinated audit developed the following products: TCU team report, addressing the work of the Ministry of Health and presenting primary health care national aspects; independent reports from the participating Courts of Accounts, with state and municipal perspectives; and the consolidation of the works in this executive summary.



1.5 PREPARATION OF THIS EXECUTIVE SUMMARY

Information sources used to prepare this publication:

Data collection form:
Form answered by the team coordinators from 28 Courts of Accounts (except TCU and TCE-PR).
They represent the audit findings concerning 23 State Health Departments (SES) and 317 Municipal Health Departments (SMS)

National electronic survey – Municipal Health Departments:
Electronic questionnaire answered by 2,577 SMS
* They do not encompass the cities from states whose TCE did not adhere to the agreement (AL, MA and SE)

National electronic survey – State Health Departments:
Electronic questionnaire answered by 14 SES

National electronic survey – District health offices:
Electronic questionnaire answered by 175 district health offices

The answers to the form for collecting findings allowed for drawing a portrait of the situation encountered by the audit teams; it was answered based on the analysis of the set of audit procedures used to assess each item. In this executive summary we also made use of information contained in the matrix of findings, which was developed and discussed by the Courts of Accounts in a workshop held in Brasília-DF.

REMARK

The charts referring to the audit findings do not encompass TCU information, because of the focus on the federal management.

The data referring to the State Health Departments encompass the Federal District.

GOOD PRACTICES

Good practices are actions identified during the audit which contribute towards meeting or exceeding the expected performance. A good practice is expected to represent something innovative and to have the potential to be reproduced.

Some of those actions are mentioned in this summary, within the context of each topic, without prejudice to others which also deserve recognition for the initiative, creativity and perseverance of the professionals responsible for their implementation.

02
FINDINGS OF THE COORDINATED AUDIT

2.1 PLANNING

The National Policy on Primary Health Care (PNAB) vests in all government levels the responsibility for developing, making available and implementing information systems for primary health care, according to their duties, as well as actions concerning the planning and setting up this level of care.

It also stipulates the Municipal Health Departments are to organize their primary health care-related actions according to the needs of the population, organizing the flow of users in accordance with such needs.

Within SUS, the planning is supposed to be bottom-up and integrated, from the local level up to the federal level, driven by the problems and needs of the population, specific of each health district, as set by Directive GM/MS 2,135 of 09/25/2013.

Concerning those issues, the audit sought to check whether the planning process for primary health care reflects the needs of the population, takes into account the articulation between primary health care and other tiers of health care, and if it is granted funding from the three government levels.

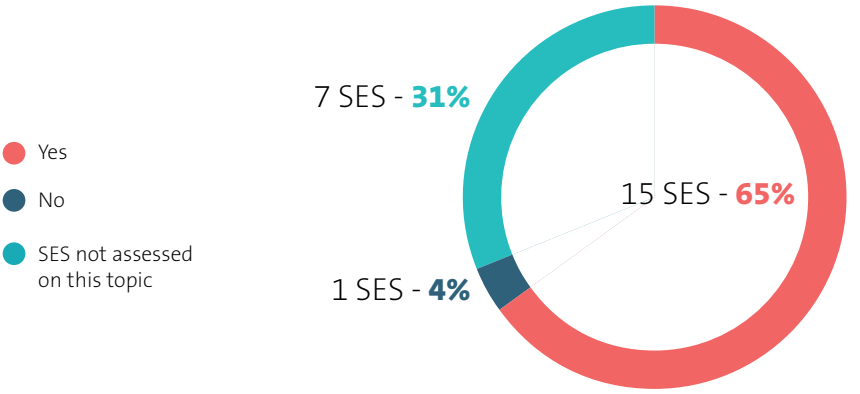
2.1.1 DIAGNOSIS OF THE HEALTH NEEDS OF THE POPULATION

One of the guidelines for primary health care is the use of varied and complex healthcare technologies to aid the handling of higher frequency demands and the needs of the population which are most relevant in their geographical boundaries, pursuant to PNAB. To provide the care services they are supposed to deliver, the health departments must – starting from a diagnosis – plan their actions based on criteria of risk, vulnerability, resilience, and on the ethical imperative according to which all demands, health-related needs or suffering must be cared for.

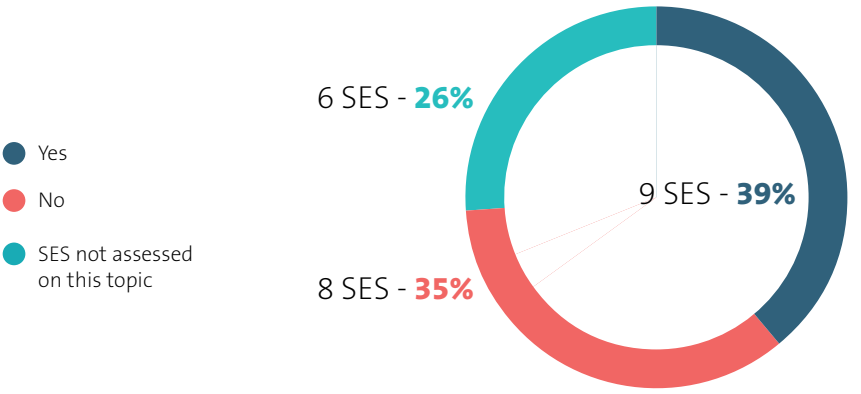
The premise that primary health care services are based on health needs pervades the PNAB, thus showing the importance of the process of identifying needs. However, during the fieldwork phase, the audits performed by the participating courts of accounts identified in 15 of the

23 State Health Departments (SES) flaws in the surveying of health needs of the population and in the planning of primary health care services. In addition to that, in 8 of the 23 SES there was **not** a statewide diagnosis containing local and district peculiarities.

SES displaying flaws in the survey of health needs of the population and in the planning of primary health care services



Existence of a statewide diagnosis containing local and district peculiarities in the SES

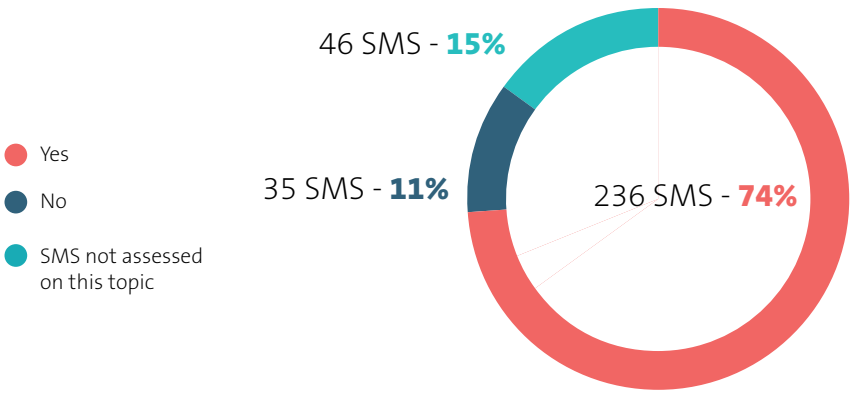


Also noteworthy is the result of the question asked to the SES in the electronic survey: "In your state, does the offer of services by the other levels of health care delivery take into account primary health care demands?" Of all 14 answers obtained, 6 marked the options "sometimes" or "never".

As regards the Municipal Health Departments (SMS), in the fieldwork carried out by the participating courts 317 municipalities were found to have flaws

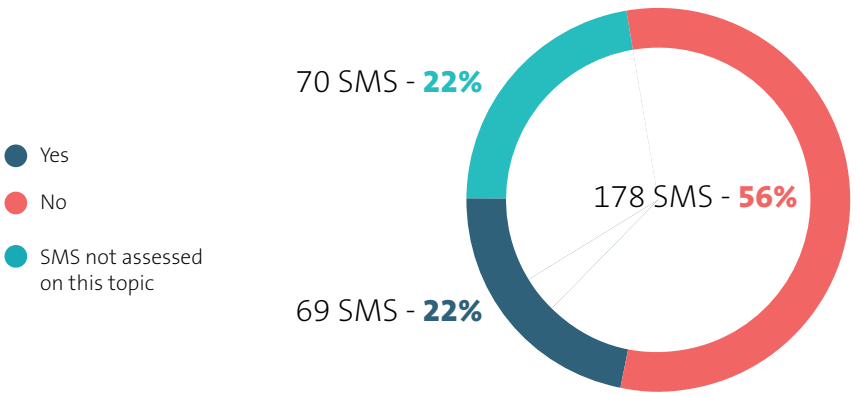
when surveying health needs of the population, and 74% of the departments (236 SMS) were found to be in this condition

SMS with flaws in the surveyof health needs of the population and in the planning of primary health care services



In spite of that, the national survey conducted with municipal managers obtained 2,107 answers; and 1,585 (75%) SMS replied their departments develop some type of survey on the health needs of the population. However, the fieldwork conducted at the 317 SMS conversely showed that in 178 (56%) of them there is not even a formal methodology for conducting such surveying of needs.

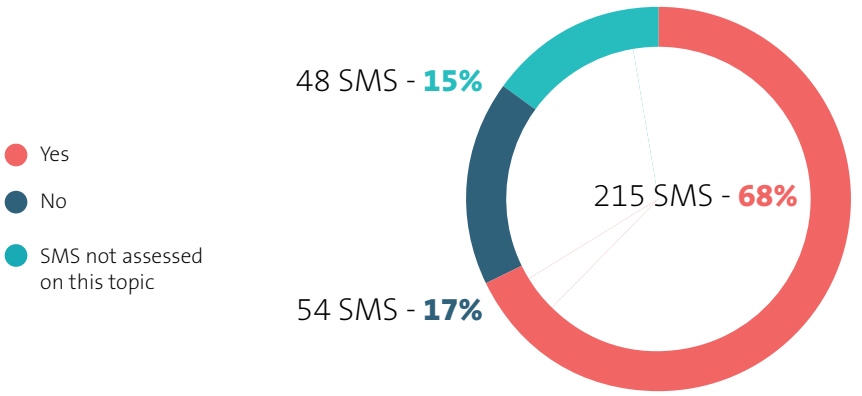
Existence of a formal methodology at the SMS for conducting a survey of the health needs of the population



The analyses also revealed the participation of health professionals working at the UBS is insufficient or non-existent, running counter to the assumption of a bottom-up nature of planning, that is, the contribution from the local

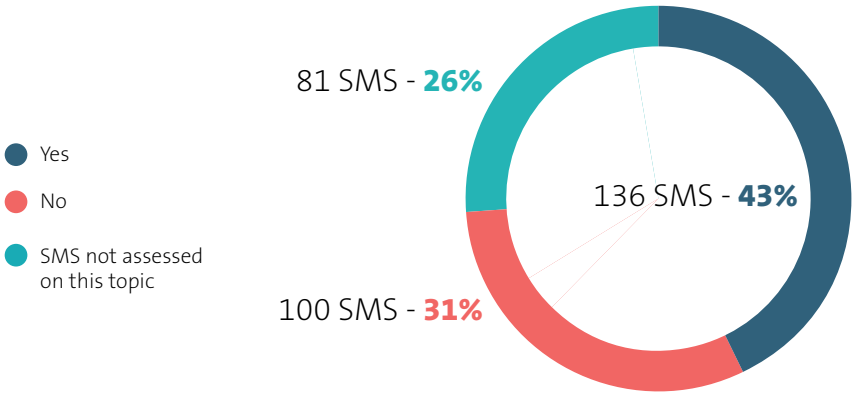
level, established by SUS. The audit fieldwork revealed a faulty participation of the UBS in the planning processes in 68% (215) of the cases.

Quantity of SMS in which a faulty participation of the UBS in the surveying of the health needs of the municipal population was identified



As regards the participation of the Municipal Health Councils, whose duties are defined by Law 8,142/1980, which confers upon them the status of strategy-making bodies and the assignment to control the execution of health public policies in the respective instances, it also includes economic and financial aspects. However, in the process of developing the planning of health actions, the data revealed a worrying situation, as 317 cities were assessed during fieldwork, and in 100 (31%) of them the municipal councils do **not** interact with the health departments in devising the planning of actions for the health of the population.

Participation of the Municipal Health Council in the process of developing the planning of municipal health actions



The social control exercised by the boards, through public conferences, regular meetings, in situ surveillance, consulting and deliberations, is fundamental to the process of building, transforming, and ensuring the quality of health care services. The balanced makeup of the boards, made up by 50% of de users and 50% of health professionals, providers and managers, aims to contribute to strengthening the exercise of democracy

With regard to the assumption of a bottom-up integrated planning, it was found there are weaknesses in the process of surveying health needs, as the Ministry of Health did not submit the identification of national health needs, as set in the Article 17 of Decree 7,508/2011. Moreover, another aspect assessed to be unsatisfactory was the support provided by the federal government to cities and states (institutional inter-federal support), in the form of guidance and recommendations for the process of identification of needs and for the process of devising health plans anchored in the needs that have been determined.

GOOD PRACTICES

- Health Vulnerability Index:

http://portalpbh.pbh.gov.br/pbh/ecp/contents.do?evento=conteudo&idConteudo=151852&chPlc=151852&&pIdPlc=&app=salanoticias

Due to the relations between health and social structure, besides the stratification of the population according to living conditions, the municipality of Belo Horizonte built a composite indicator fusing different socioeconomic and environmental variables to direct the identification of inequalities in epidemiological profiles, allowing for the identification of unfavorable conditions within the urban space, and enabling a more suitable design of the health care network.

The index furthers the planning of health actions, channels the efforts to the more vulnerable segments of the municipal population, and streamlines the deployment of resources, which are normally limited.

2.1.2 ARTICULATION BETWEEN FEDERATED UNITS/ REFERENCE AND COUNTER-REFERENCE

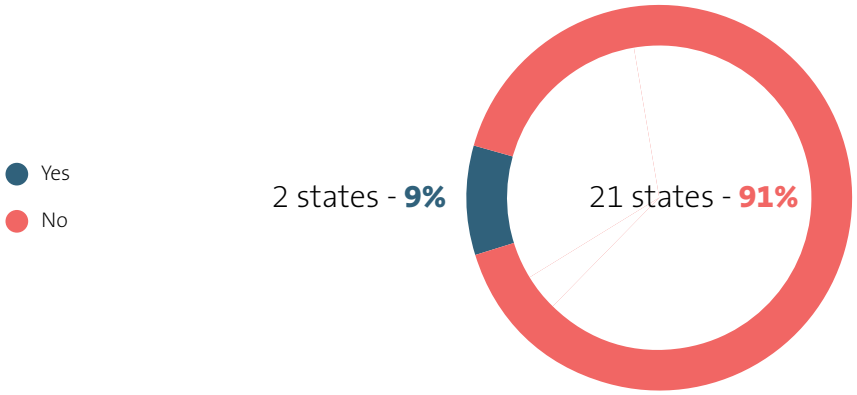
The SUS Organic Law (Law 8,080/90) was regulated by Decree 7,508/2011, and included: organizational aspects of the Unified Health System, planning, health care and the articulation between federated units. The legislation contained innovative assumptions for planning health actions, such as health districts, health mapping, identifying district-level offer of regional services and needs, and strengthening the feasibility of network services.

This new planning vision would be later materialized through the Organizational Contract for Public Health Action (COAP), and it was widely discussed by the District Interagency Committees (CIR), the Bipartite Interagency Committees (CIB) and the Tripartite Interagency Committees (CIT), from the bottom-up perspective of defining individual and concerted responsibilities of the federal entities. Once the responsibilities were defined, the respective agreements could be made.

The Interagency Committees are bodies for creating covenants among federal entities for setting rules for the shared management of SUS, based on the organization and operation of integrated health actions and services in health care networks; and they are: the Tripartite Interagency Committee at the national level, the Bipartite Interagency Committee at the state level; the District Interagency Committee at the district level, recognized by Law 12,466/2011.

However, as shown in the following chart, the adherence to the new planning mechanism has been low, and its critical factor lies in the definition of responsibilities of each entity and the respective funding of health actions.

State adherence to the Organization Contract for Public Health Action



In addition, as noticed based on the data collected through the national survey with city health managers, it is urgent the State Health Departments (SES) provide more support to the work of the City Health Departments (SMS), for when the managing agencies were asked, "Does the SES support the SMS in surveying of health needs of the population and/ or in developing health planning in our municipality?", from the 1,829 answers obtained, 732 (40%) replied they disagree with that statement.

Also, considering the time elapsed since the establishment of the COAP – four years – and the very low adherence by health districts, the work of the Ministry of Health was assessed to be deficient as regards the articulation among states and cities in the process of regionalization, bolstered by the fact that there has been no formal investigation on the reasons for such low adherence, despite the fact there is a COAP adhesion goal set by the 2011-2015 Strategic Planning.

Weaknesses in the articulation between federated units lead to weaknesses affecting care actions. Based on the assumptions of permanence of care and wholeness of health care, the PNAB defined primary health care as the network which receives, solves problems, and moves towards managing and coordinating user health care at other Health Care Networks.

Health Care Networks (RAS) are organizational bodies for health actions and services, with different technological capabilities which are integrated through systems for technical, logistics, and management support and seek to ensure comprehensiveness of health care.

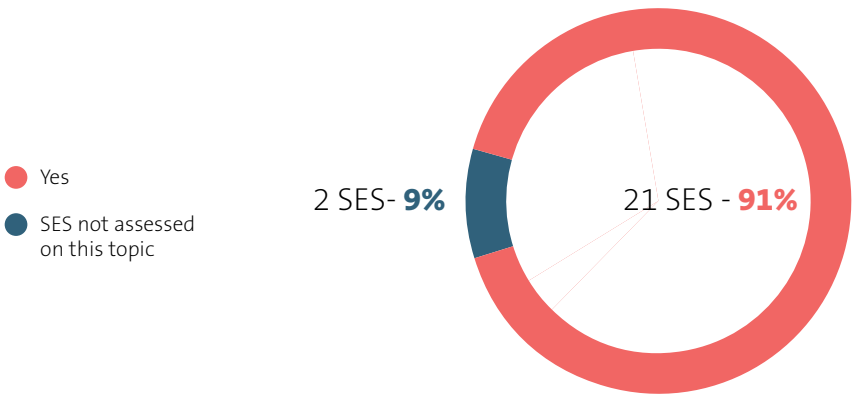
To ensure users are provided care, it is necessary to establish a horizontal, continuous and integrated delivery of care services, so as to bring about shared management of comprehensive health care. It is through the articulation that shared management is established, and that individual and concerted responsibilities of the federal entities are defined. Absent those definitions, developing solutions to the population needs is hampered.

It is worth mentioning that public health actions and policies are structured and fulfilled by SUS through three levels of complexity: primary health care, moderate complexity, and high complexity, which provide care to the patients according to their clinical status.

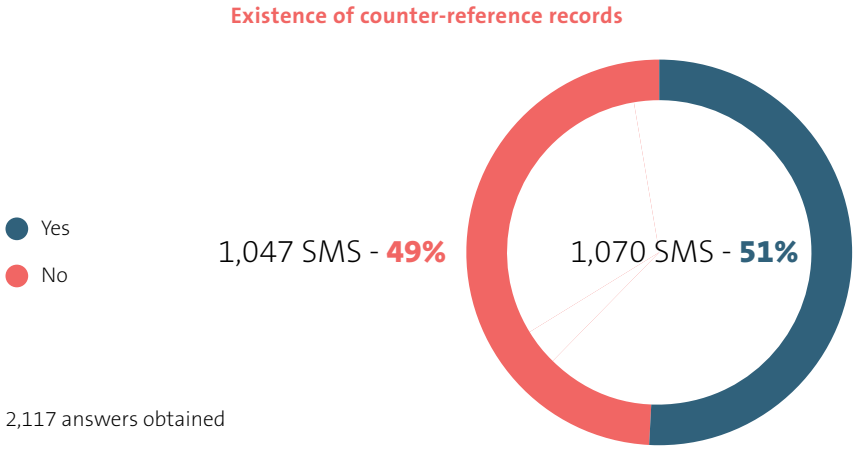
As mentioned before, it is primary health care which receives, classifies, and refers users according to their needs, that is, it sets the reference process in motion. After a clinical case is examined and treated at another level of complexity (moderate or high), the patient is sent back to the Primary Health Care Unit (UBS) where he or she was first seen, which is the counter-reference process. Such reference and counter-reference flows are directly affected by the actions of the articulation between federated units.

That being said, it is worth highlighting that in 21 of the 23 audited states those referrals were found to present deficiencies, especially the lack of flows of reference and counter-reference and the lack of qualification of the UBS staff on the issue, and the scarcity of information technology infrastructure to assist the activities.

SES with deficiencies in the reference and counter-reference processes between primary health care and other levels of health care



From the perspective of the SMS, the answers from municipal health managers to the national survey indicate there is room for improvement of those flows, as 49% of the SMS (1,047 of 2,117 answers obtained) marked there are **no** counter-reference records after the patient from primary health care is sent to other tiers of health care.



As regards the national management of SUS, it was ascertained that the ministry-level work needs to be enhanced with respect to building up actions to support, promote, and monitor the practice of counter-referencing patients within SUS.

2.1.3 PRIMARY HEALTH CARE FUNDING

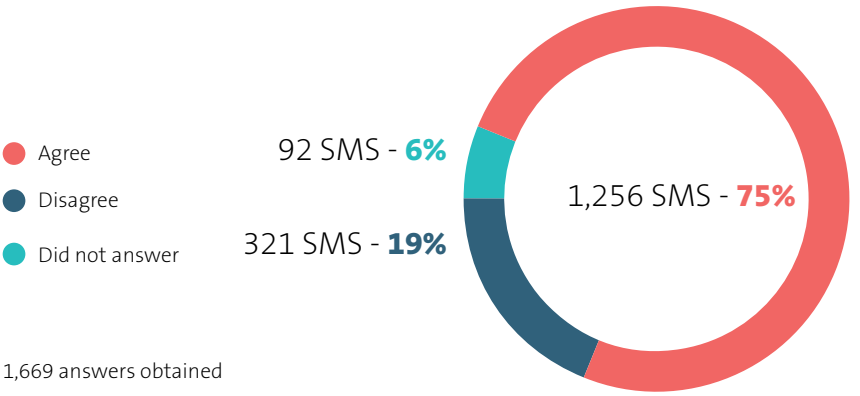
Primary health care funding is on a tripartite basis, with resources allocated by the Federal government, states, Federal District and cities.

The rules do not specify the share of participation of each federal entity. Nevertheless, there are specific criteria concerning the funding under the responsibility of the Ministry of Health (Fixed Primary Health Care Transfers and Variable Primary Health Care Transfers). Also, there is not a common criterion for the states, and in general, the municipalities supplement the funding for the execution of primary health care actions.

The answers from municipal managers to the national survey made it clear the contribution from the federal government and the states is **not** sufficient

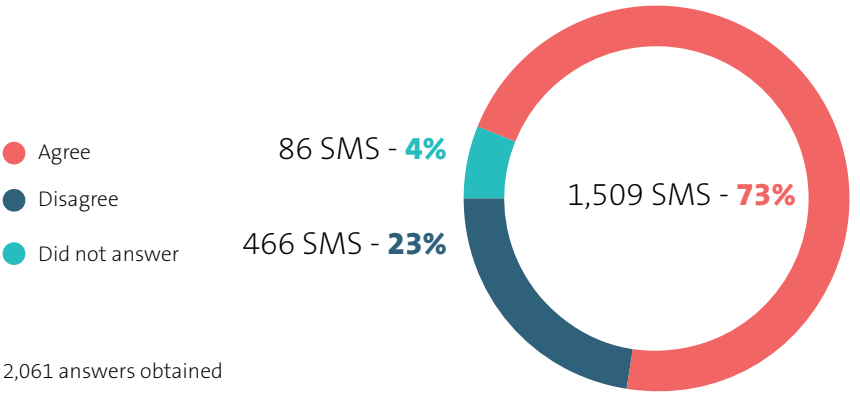
for funding primary health actions, due to the complexity of services to meet the demands of the population, as shown in the following charts:

Answers to the question: "Do you agree on the amount of resources transferred by the state to your municipality to be used on primary health care?"



1,669 answers obtained

Answers to the question: "Do you agree on the amount of resources transferred by the Ministry of Health to your municipality to be used on primary health care?"

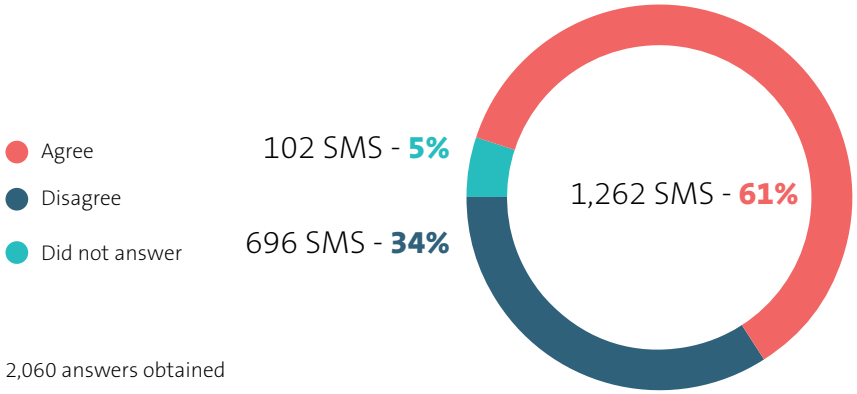


2,061 answers obtained

The planning of health actions by SUS should be based on the population needs; however, because of the amount of resources transferred to cities by the states and the federal government, planning the actions is actually based on the service delivery capacity, as in a great number of cities they are insufficient to tackle the needs of the users.

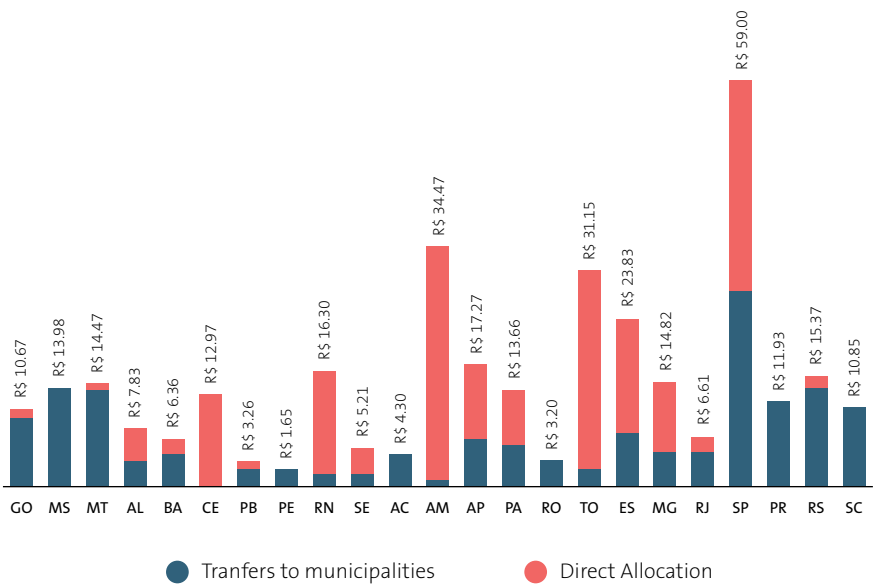
The survey addressed to the municipal health managers also showed a disagreement with the criteria adopted by the Ministry of Health to allot resources to primary health care, as shown in the following chart.

Answers to the question: "Do you agree with the current criteria for the allotment of resources among the municipalities, as transferred by the Ministry of Health to be used on primary health care?"



Such argumentation is backed by data presented by the TCU audit team in their audit report, in which we can see information hinting at an unbalanced per capita use of state resources on primary health care, as shown in the following chart.

Expenditures by state on primary health care, *per capita*, in 2011



Source: Department of Health Economics, Investments and Development
Remarks:
1) Based on questionnaires applied to the SES.
2) Maranhão, Piauí: did not answer. Federal District: questionnaire was not applied because if its hybrid characteristics. Acre: answers inconsistent for direct allocations. Roraima: the 2011 spreadsheet features BRL$ 0.0.
3) Data labels with the sum of transfers to cities and direct allocations.

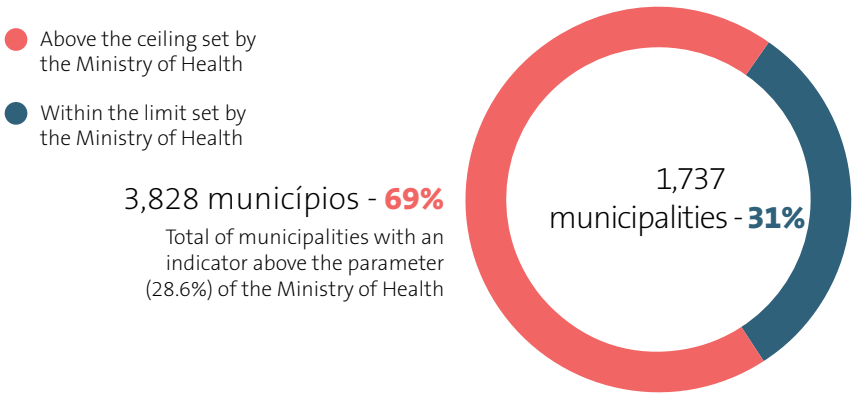
Primary health care under-funding, coupled with management problems – such as, for example, low institutional capacity, understaffed teams, staff turnover – upset the running of the services, and so does the deficiencies in the infrastructure for receiving and referral consonant with user needs; and they contribute to the low problem-solving capacity of primary health care services, and reflect on the "Proportion of Hospitalizations for Ambulatory Care Sensitive Conditions" (ISAB).

This indicator measures the "percentage of hospitalizations for ambulatory care sensitive conditions of residents divided by the total of hospitalizations for medical treatment or surgery per residents in a given municipal over a period under study".

If the indicator is high, it means the hospitalizations for sensitive conditions account for most hospitalizations of moderate complexity, and it indirectly measures the low case-resolving capacity of primary health care. The indicator implies hospitalizations are needed for medical treatment of a range of illnesses, and that among them, there is a subset of sensitive conditions that should be managed in primary care settings. That is, more qualified care actions developed at this level of health care may avoid hospitalizations.

The parameter adopted by the Ministry of Health as the ceiling to this indicator is 28.6% of hospital admissions for ambulatory care sensitive conditions in relation to all hospitalizations for medical treatment. Figures above that index imply low efficacy of primary health care. However, the TCU audit identified a worrying situation when analyzing the Unified Health System Performance Index (IDSUS), for only 31% of cities (1,737 of 5,565 assessed cities) manage to reach the proportion of hospitalizations for ambulatory care sensitive conditions within the limit set by the ministry.

Proporção de internações por condições sensíveis à atenção básica



According to the Court of Accounts of the Rio Grande do Sul State – although not an object of analysis with the municipal departments – regarding the issue of equity in health expenditures across the country, one needs to point out the significant inequality of expenditures per capita on Public Health Actions and Services (ASPS), in the comparison among Brazilian cities.

This reality certainly results from myriad causes, from criteria for refunding the ICMS tax, regional disparities related to economic potential of cities, to the weakness of compensatory policies adopted by the Ministry of Health, despite the constitutional and sub-constitutional provision regarding these aspects (Art. 3 and 198, paragraph 3, Item II of the Federal Constitution; and Art. 17 and 19 of Supplementary Law 141/12).

GOOD PRACTICES

In Pernambuco state, the TCE found out the transfer of financial resources to the cities is based on their level of performance in primary health care. Through this carrot-and-stick policy, the cities area assessed on ten strategic performance indicators agreed upon mutually by the Pernambuco State Health Deparment and the Board of Municipal Health Departments of Pernambuco.

Among those indicators are the percentage of deaths among women in childbearing age; percentage of deaths of children; percentage of live births of mothers with seven or more prenatal visits; and the percentage of people suffering from hypertension. Assessment parameters were defined for each one of those indicators, and the amount of state transfers varies according to reaching those parameters. This practice brings about an improvement of health indicators, and values the performance of cities by assessing their merits.

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2.2 PEOPLE MANAGEMENT

According to the National Policy on Primary Health Care (Annex I, Of the responsibilities, sub-item VI), all government levels share the responsibility of promoting actions for developing technical mechanisms and organizational strategies for qualifying the workforce for primary health care delivery and management, and for valuing health professionals, encouraging and enabling permanent training and education of team professionals, ensuring labor and welfare rights, improving working relationships, and implementing careers which couple the development of staff members and the betterment of services offered to users.

The PNAB acknowledges the upward nature and initiative of permanent education, and how important it is that "each team, each health facility, and each municipality demand, propose and develop actions for permanent education, trying to match peculiar needs and possibilities with more general offers and processes of a policy proposed to all teams and all cities".

As regards this topic, the audit sought to answer how health departments work to promote the staffing, retention, permanent training and education of primary health care managers and professionals.

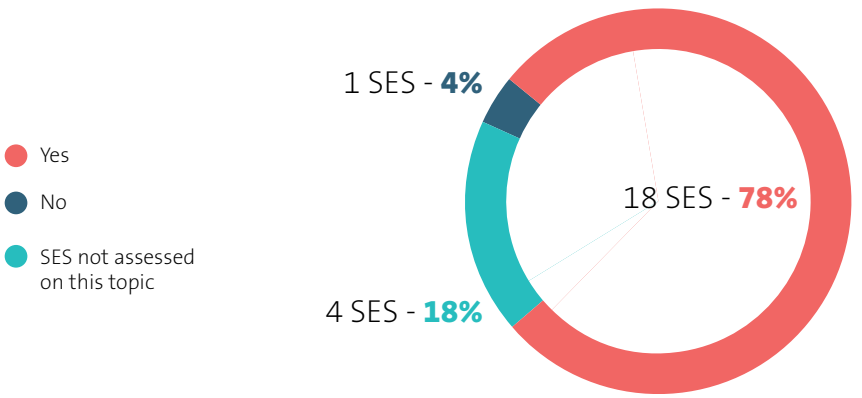
2.2.1 ACTIONS FOR PERMANENT TRAINING AND EDUCATION OF PRIMARY HEALTH CARE PROFESSIONALS

According to the Ministry of Health, training workers is an important component of the process of workforce qualification, as it contributes to the effectiveness of the national policy on health.

In addition to that, under the PNAB, the consolidation and enhancement of primary health care as an important approach reorienting the model of health care in Brazil require knowledge and action in permanent education that are embodied in the actual practice of health services. Therefore, permanent education must be an integral part of the improvement of care practices, management and popular participation.

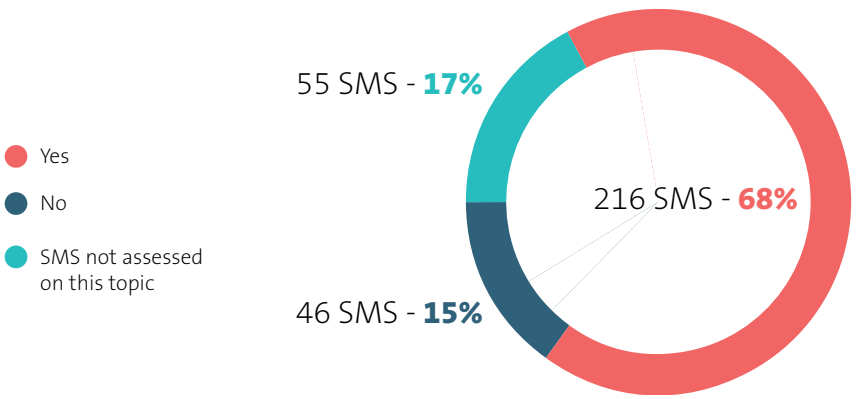
However, of the 23 State Health Departments (SES) audited by the state Courts of Accounts , in 18 of them (78%) deficiencies were found in the development and execution of qualification and training actions for primary health care managers and professionals.

SES with deficiencies in actions for qualification of primary health care professionals and managers



As regards the municipal level, it is important to note that of the 317 municipalities audited by the 28 audit teams (from state and municipal courts of accounts), 216 of them (68%) were assessed to have deficiencies in actions for qualification and training of primary health care managers and professionals.

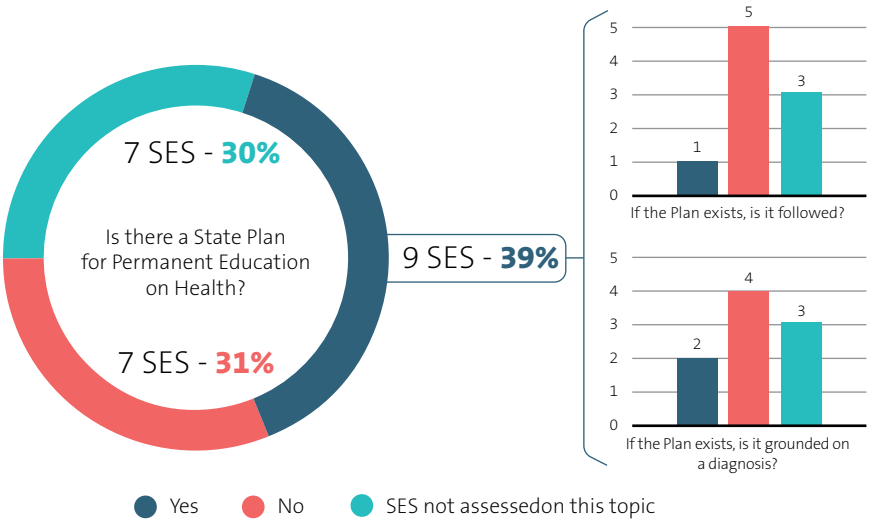
SMS with deficiencies in actions for qualification of primary healthcare professionals and managers



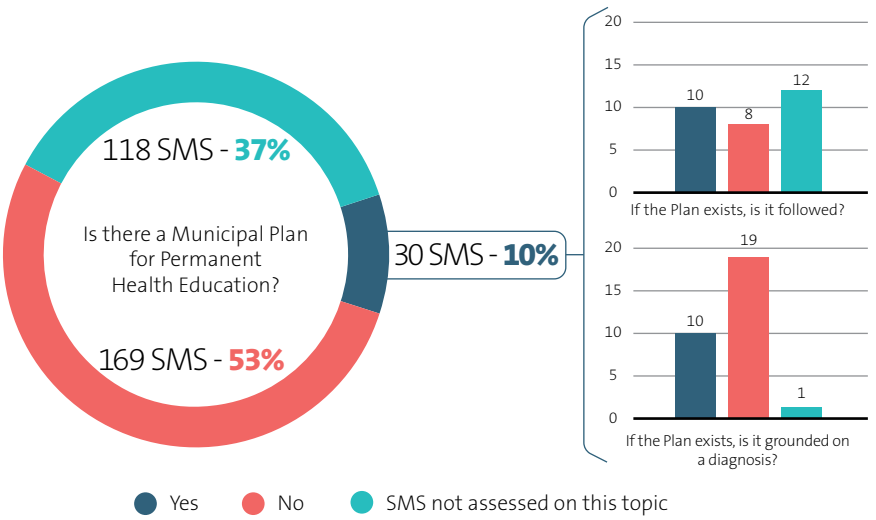
Both at state and municipal levels, two causes, among others, were found to be relevant to cause this finding to occur: the absence of a diagnosis to substantiate the development of plans for permanent education, aiming to

qualify primary health care managers and professionals; and the audited states and cities' lack of their own plans for permanent education. As a result, the quality of the services delivered to users is harmed, and the PNAB principles and guidelines are compromised.

Main causes of the finding, at state level



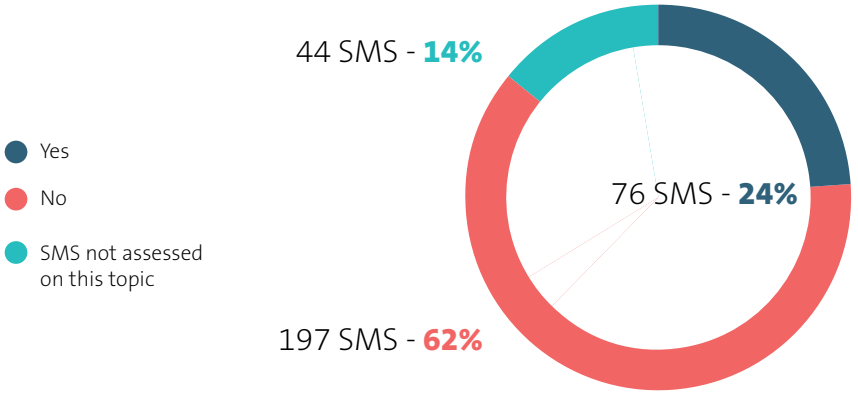
Main causes of the finding, at municipal level



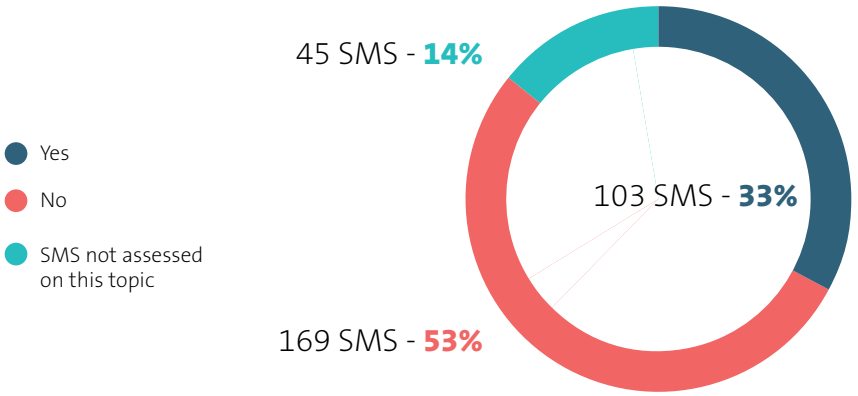
As can be seen in the charts, as regards the Municipal Plan for Permanent Education, out of 317 visited cities, only in 30 (9.5%) the existence of a plan was ascertained, and among them, only in ten cities the plan was implemented and grounded on a diagnosis.

The investigation also sought to verify whether the offer of courses for primary health care was enough to meet the needs that were raised, and whether professionals were asked by municipal managers about their needs for qualification. It was found out that only in 24% (76) of the 317 visited cities there was on offer of courses deemed as enough; and that only in 33% (103) of the cities professionals were asked about their needs.

Is the offer of courses on primary health care considered enough to meet the raised needs?



Does the municipal management ask the primary health care professionals about the needs for qualification?



As for the federal level, as regards the actions of federal management, whose focus was under the responsibility of TCU, the Ministry of Health was found not to be fully carrying out its duties as set by the National Policy on Permanent Education on Health, as it has not systematically planned permanent education for professionals and managers, which is necessary for primary health care.

It was particularly verified that the resources transferred by the federal body are not based on the analysis of the Regional Plans for Permanent Education on Health, and there is not a national survey on the needs for capacity building. There is a need for ministry-led continued actions for permanent education on management processes, aimed to enhance the work of managers involved in primary health care action, as regards, for example, planning, apportioning of resources, knowledge management, communication, and performance management.

GOOD PRACTICES

In Santa Catarina, the TCE identified an action named *Matriciamento* [Matrix Support], in the municipality of Joinville, which seeks to hold discussions on cases among Moderate and High Complexity (MAC) professionals from the Support Center for Family Health (NASF) and from primary health care, aiming to promote exchange of experiences. The initiative allows for a better qualification of primary health care professionals, making them more discerning as regards the cases they are monitoring, and reducing the number of referral to the MAC units.

On the other side of the country, in Rondônia, the TCE found in the municipality of Teixeirópolis an initiative for self-qualification of the Family Health Strategy (ESF) teams, which take place in the UBS, and which they themselves promote. Planning is usually done by nurses, dentists and doctors together with the other team members: community health agents, assistants, nurse and oral health technicians. It has been reported the teams are more motivated, dedicated and involved in the work, which makes them more qualified to cope with the difficulties that arise in primary health care.

- CANAL MINAS SAÚDE [MINAS GERAIS HEALTH CHANNEL]

http://www.esp.mg.gov.br/component/gmg/story/1237-comunicado-canal-minas-saude

It is an instrument for qualification in health using a variety of media resources to reach the target audience (TV, radio, internet and distance learning), aimed to develop information, communication and education activities. According to information on the link above, the initiative was discontinued; however, it is worth highlighting it for the dissemination of knowledge through far-reaching means and at a low cost for the target audience.

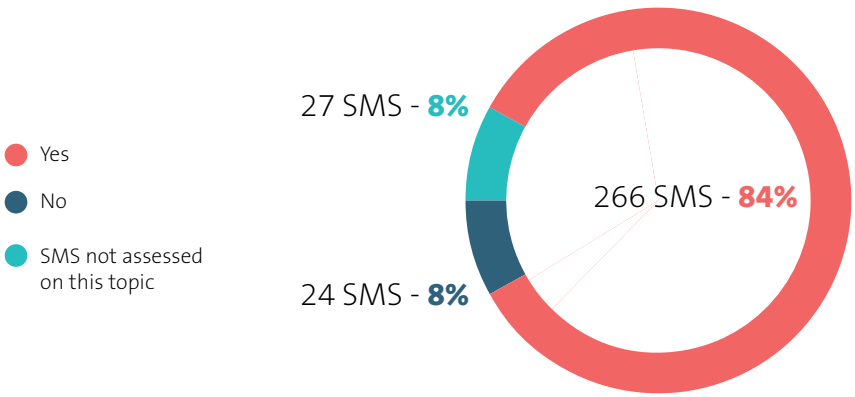
2.2.2 ACTIONS FOR PRIMARY HEALTH CARE STAFFING AND RETENTION

The importance of staffing and retention of health care staff is justified by the very precepts and guidelines of primary health care, especially as concerns the designation of users and the development of a bond and a sense of duty among the teams and the designated population, ensuring the continuity of health care actions and longitudinal care.

The designation of users is a process of creating a bond between people, families and groups to professionals and teams, aiming to be a reference for their care; the bond builds up a relationship of affection and trust between the user and the health care worker, allowing for deepening the process of co-responsibility for health; and, in its turn, longitudinal care is the continuation of the clinical relationship, through building the bond and shared responsibility between professionals and users over time and on a permanent basis, monitoring the effects of health interventions and other elements in he life of users.

Concerning that, 266 (84%) of the 317 audited cities were assessed to feature weaknesses as regards staffing and retention of primary health care professionals.

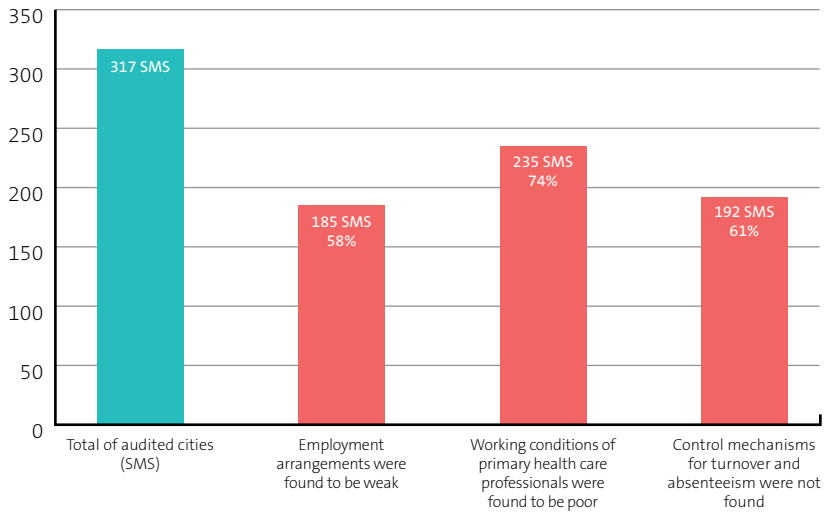
SMS with weaknesses in actions for staffing and retention of primary health care professionals



Among the findings, three of them stand out: the audit teams found out in 185 (58%) of the visited cities the employment arrangements are weak; in

235 (74%) working conditions are poor; and in 192 (61%) there are **no** control mechanisms for turnover and absenteeism of health care workers.

Exemplos de fragilidades identificadas nos municípios auditados



Also, the national electronic survey conducted with the Municipal Health Departments revealed meaningful situations for understanding the weaknesses that were found. As an example, 1/3 of the respondents (1,708 of 2,544 answers obtained) informed the SMS does not have a survey on the needs for staff deployment for the UBS. Besides that, 3% (1,063 of 2,445 answers obtained) reported in the municipality there are **no** tools for promoting staffing and retention of primary health care professionals.

The same survey identified a number of causes for doctors quitting their work at the UBS. Among them, the required work load is the main reason (1,843 answers); followed by the distance from big centers (1,127 answers), low pay (1,108 answers) and the profile of doctors unsuitable for working in primary health care (995 answers). A total of 2,571 answers were collected, and more than one alternative could be marked.

The actions for staffing and retention were not addressed at the federal level, as they are basically performed by local management

2.3 MONITORING AND ASSESSMENT

According to the PDCA cycle (Plan, Do, Check e Act), a management tool created in the 1920s and widely spread in the 1950s by quality expert William Deming , management must go through a cycle comprising the phases of planning, executing, checking and acting or adjusting, so as to strive for a continuous improvement of its processes and products.

In the PDCA cycle, monitoring and assessing activities are part of the checking phase, which allow managers to compare planning against execution and adopt corrective measures, readjust strategies or strengthen practices. Therefore, managers must monitor and assess the results reached, compare them against the goals that were set, and analyze what was defined during the planning against the way it was executed, so as to identify the cause of possible disagreements and contradictions.

In such a context, monitoring means the oversight in a regular and systematic basis of the development of activities, the use of resources and the attainment of results, comparing them against the initial planning; and it is expected to produce reliable information and data to provide input for analysis and possible decisions about reviewing and correcting the planning. In its turn, assessment implies judging and deciding, based on an analysis of what has been done or of the yielded results, compared against a reference value considered as an ideal to be aimed at.

The coordinated audit sought to assess whether states and cities feature structure, indicators and information technology (IT) technology support, in a way that the monitoring and assessing system contribute to the betterment of health care management within their areas of responsibility.

2.3.1 INSTITUTIONAL STRUCTURES AND TECHNICAL TEAMS FOR MONITORING AND ASSESSING PRIMARY HEALTH CARE

Pursuant to Article 15 of Law 8,080/1990, which stipulates the conditions for promotion, protection and recovery of health, organization and functioning of the related services, the federal government, the states, the

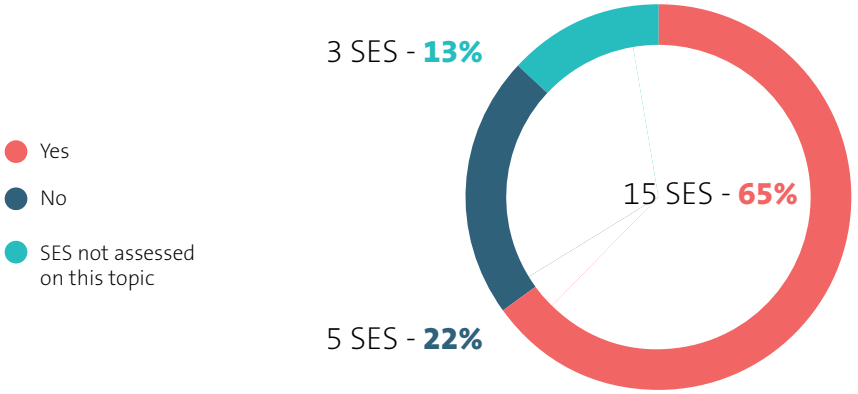
Federal District and the cities shall perform within their administrative range of action – among others – the following assignments: definition of control bodies and mechanisms, assessment and audit of health care actions and services; monitoring, assessment and disclosure of the health status of the population; organization and coordination of the health information system.

The PNAB also provides for that, as they are duties shared by all government levels, pursuant to paragraphs VIII and IX: plan, support, monitor and assess primary health care; and also set up mechanisms for controlling, regulating and systematically monitoring the results achieved by the primary health care actions.

In its turn, the Ministry of Health, through Directive GM/MS 1,654, of July 19, 2011, established within SUS the National Program for the Improvement of Primary Health Care Access and Quality (PMAQ-AB), which must be implemented, among other actions, through monitoring to be carried out by primary health care teams, the SMS, the SES from the Federal District, the SES and the Ministry of Health, partnered with the District Interagency Committees, based on the indicators agreed upon.

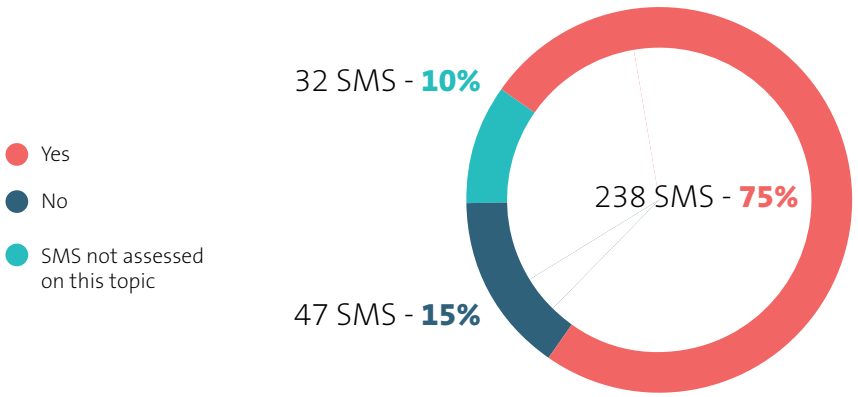
Nevertheless, as regards the structures for monitoring and assessment actions, the analyses by the state Courts of Accounts participating in this audit identified the lack of inadequacy of structures and technical teams to monitor and assess primary health care in 15 (65%) of the 23 audited SES.

SES with weaknesses in structures meant to monitor and assess primary health care



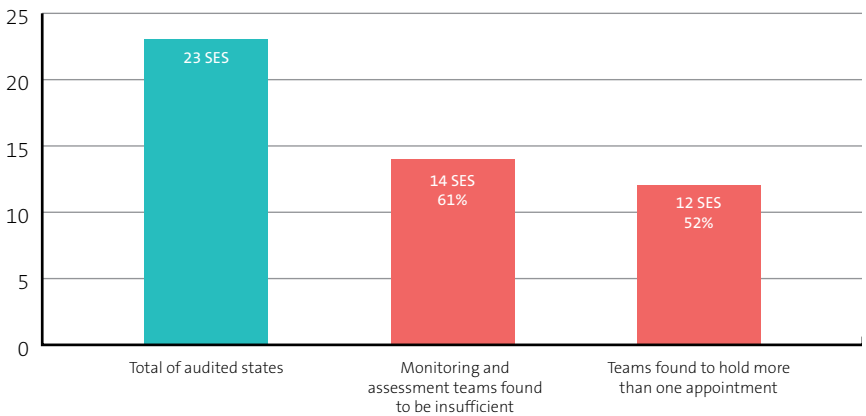
A similar situation was observed at the municipal level. In 238 (75%) SMS, out of a total of 317 audited cities, the teams from 28 courts of accounts also identified lack or inadequacy of structures and technical teams for monitoring and assessing primary health care.

SMS with weaknesses in structures meant to monitor and assess primary health care



Among the observations grounding such understanding, at state level we highlight the following: of the 23 audited SES, in 14 (61%) of them the primary health care monitoring and assessment teams are inadequate for developing the activities; and in 12 (52%) departments, the teams take on duties of more than one department. It was found out that also in the cities the teams for monitoring and assessing primary health care are not sufficient for developing the activities (in 168 SMS – 53%), and that the teams hold more than one appointment (112 SMS – 35%).

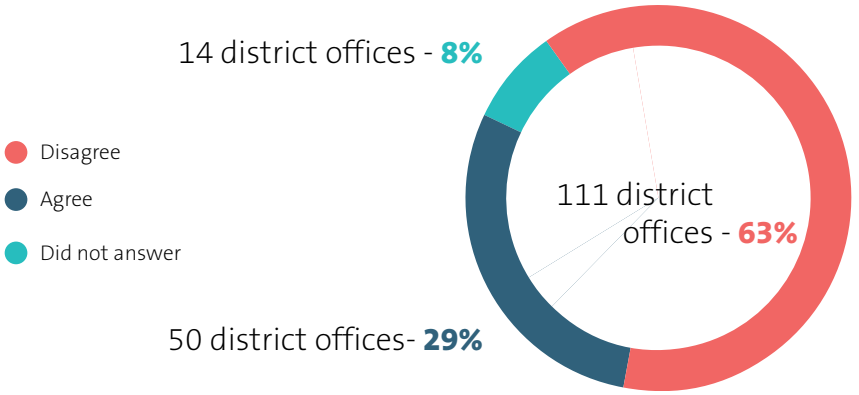
Examples of weaknesses identified in the audited SES



Examples of weaknesses identified in the audited SMS

Furthermore, the national survey conducted with district health managers, which collected 175 answers, endorses what the courts of accounts found during their visits, as 63% of the responding district managers disagreed with the following statement, 'What's your opinion about the statement, "The number of people I have in my team for monitoring and assessing primary health care indicators is enough"?'

Sufficient staff for monitoring and assessing primary health care, according to district health managers



When state managers were interviewed, they stressed the existing SES structure is insufficient, and that district health offices need better structured teams for developing monitoring and assessment activities.

In sum, the situation that is verified is that the system for monitoring and assessing primary health care is compromised, the assessing capacity of the SES and SMS is harmed, strategic information for decision-making and adoption of corrective measures falls short, SMS and SES technical staff is overloaded with more than one appointment, and that primary health care planning is inadequate due to poor assessments.

The existence of structures and teams for monitoring and assessing primary health care was not an object of the audit performed by the TCU, as such structures at the federal level are organized under the Ministry of Health, be it in a ministry-level focus (Department for Monitoring and Assessment of the SUS of the Executive Secretariat) or in a specific focus on primary health care (Office of the General Coordinator for Monitoring and Assessment of the Primary Health Care Department of the Health Care Secretariat).

2.3.2 INDICATORS

The indicators are valuable instruments for monitoring and assessing health status because they are parameters used do examine whether the intended results have been achieved; and they are developed based on a pre-defined set of criteria.

The importance of using indicators does not lie in just allowing for the analysis of a result-based performance, but also the performance of processes, as well as the causes leading to such performance. This way, they serve for measuring results and managing performance, substantiating the critical analysis of the achieved results and decision-making, contributing to the continued betterment of organizational processes, streamlining performance planning and control, and enabling the comparative analysis of the performance of the organization.

Pursuant to article 2, paragraph II, of Directive GM/MS 1,654/11, from the Ministry of Health, which established the National Program for the Improvement of Primary Care Access and Quality (PMAQ-AB), the Program has as one of its guidelines to forward a continued and progressive process of improving the standards and indicators of access and quality involving the management, work process and the results reached by primary health care teams.

That being said, it is worth highlighting most indicators found to be used for monitoring and assessing primary health care are those of the Ministry of Health. In the national survey carried out with municipal health managers, 1,729 Municipal Health Departments (SMS) informed they use the indicators set by the Ministry of Health, 1,230 use the indicators set by their respective State Health Departments (SES), and only 231 use their own indicators. It should be noted that respondents could mark more than one alternative, and that answers were collected from 2,530 SMS.

Nevertheless, through examination done by the courts of accounts of the documents submitted by the audited SES and SMS, the used indicators were generally found to be insufficient to assess the management and quality of services delivered by primary health care. Notwithstanding the diversity of indicators used in primary health care, the management processes were found to lack measurement by indicators, such as those involving strategy, planning, decision-making, allocation of resources, knowledge management, communication and performance management.

Despite the set of rules defining monitoring and assessment of primary health care as a duty of all entities, 18% of the municipal managers (414 of 2,334 answers obtained) which responded to the electronic survey previously mentioned informed the SMS does **not** use indicators to assess and monitor service management and quality. In addition to that, according to data collected by the survey, 34% of the municipal managers (784 of 2,327 collected answers) stated they do **not** disclose the primary health care results in their cities, thus showing weaknesses concerning transparency of information. Those figures are meaningful, as good health care results derive mostly from well- implemented and measured management processes.

Confirming those facts, the analysis of the electronic survey conducted with the SES – where 14 answers were obtained – found that a considerable number of state managers (five, about 1/3) disagreed with the following statement, "The indicators set for monitoring and assessing primary health care comprise aspects related to primary health care management".

A similar scenario was noted at the level of the ministry, as, according to the TCU report, the indicators adopted by the Ministry of Health are not sufficient for fully monitoring and assessing primary health care, especially as regards aspects related to management processes which support services delivered at this level of health care.

Due consideration was given to the fact that, historically, the indicators mostly used in health are result indicators, in view of the fact that planning considers the health status of the population, which is measured by result indicators. Despite that, it was highlighted that planning actions must not be only result-oriented, as they may incur structuring flaws in management processes which affect results.

Therefore, what is noticed is the little use of indicators for monitoring and assessing primary health care management, a situation which affects federal, state andmunicipal planning actions, and which reflects on the betterment of management at this level of health care.

GOOD PRACTICES

In Minas Gerais, the TCE team highlights the *Caderno de Indicadores* [Indicator Document], a document made by the state government containing result indicators of two programs in an annual report: the Minas Gerais Plan for Integrated Development and the Result Agreement. The programs are management tools with final outcome indicators which allow for monitoring the results achieved by the diverse stakeholders in public policies. The initiative favors transparency, social control and the use of information by the stakeholders.

2.3.3 INFORMATION TECHNOLOGY STRUCTURE FOR MONITORING AND ASSESSING

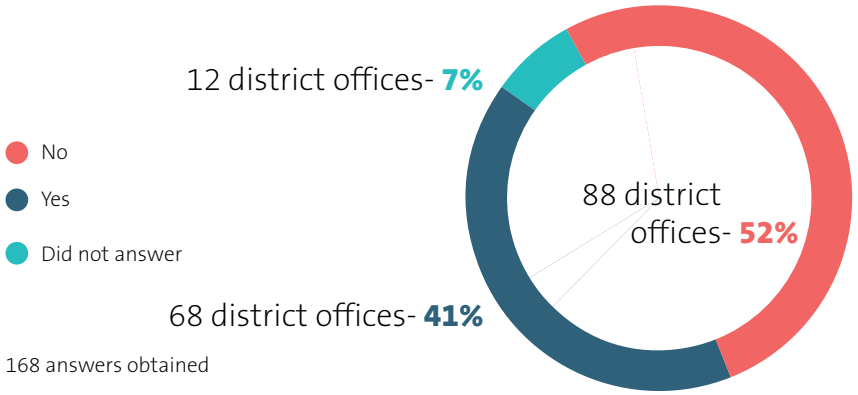
According to the National Policy on Primary Health Care (PNAB), in paragraphs III, VII and X on the responsibilities shared by all government levels, the Ministry of Health, the SES and the SMS must provide the necessary infrastructure for the operation of Primary Health Care Units (UBS); develop, make available, and implement primary health care information systems; and disclose information and attained results.

The Policy also establishes that the SES are mandated to analyze the data produced by information systems that are of interest to the state, use them in planning, and disclose the achieved results. They are also assigned to examine the quality and consistency of the data submitted by the cities through computerized systems, send information back to the municipal managers, and also to consolidate, analyze, and forward to the Ministry of Health the files from the information systems sent by the cities according to flows and deadlines set for each system.

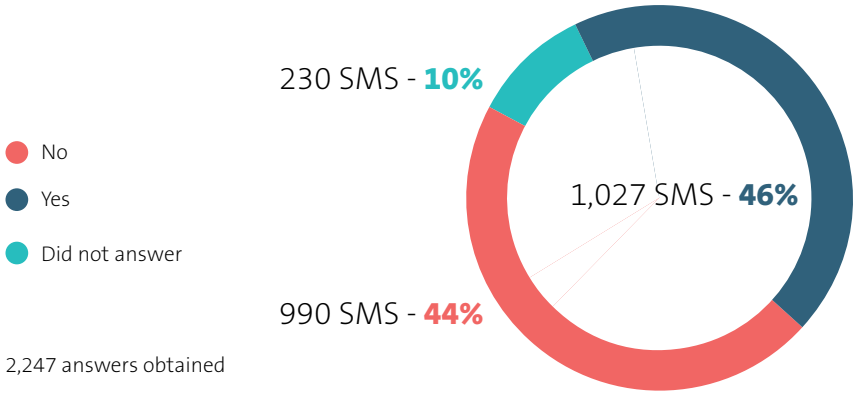
The Resolution 5 of June 19, 2013 by the Tripartite Interagency Committee established the rules for the process of aligning guidelines, objectives, goals and indicators for 2013-2015, aiming to strengthen SUS planning and to implement the Contract for Public Health Action (COAP). The article 2 of that Resolution establishes that the process for SUS planning, the guidelines, objectives, goals and indicators agreed upon must be harmonically expressed in the different documents adopted by the health managers, and it will serve as a basis for monitoring and assessing the entities of the three levels of government.

Despite what has been established by the PNAB, the data from the national survey conducted with district health managers and the Municipal Health Departments showed that 57 % of the respondents from the district offices (100 of the 175 answers obtained) and 48% of the respondents from the SMS (1,031 of 2,159 answers obtained) disagree that the information technology (IT) structure is adequate for developing of activities for monitoring and assessing primary health care. However, when asked if the agency (health district office or SMS) has some diagnosis of the IT structure needed for monitoring and assessing primary health care, they replied as follows:

Existence of a diagnosis of the IT structure needed for monitoring and assessing primary health care actions in the district health offices



Existence of a diagnosis of the IT structure needed for monitoring and assessing primary health care actions at the SMS



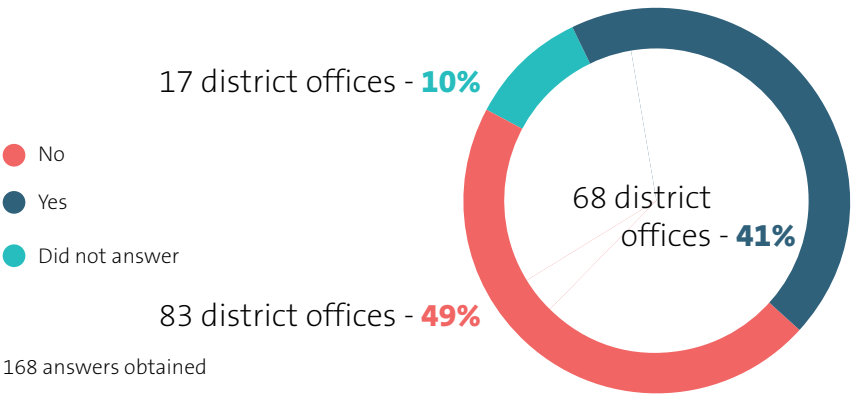
The charts show that although a considerable number of managers from the surveyed district health offices and from the SMS consider the available IT structures in their agencies inadequate, a similar number of managers do **not** have a diagnosis of the IT structure needed for monitoring and assessing primary health care to guide the improvement of such structure.

Also in regard to the IT structure, 70% of the district health managers (117 of the 168 answers obtained) and 51% (1,136 of the 2,247 answers obtained) of the municipal managers who replied to the survey said they do **not** have IT planning encompassing actions to fulfill the needs for monitoring and

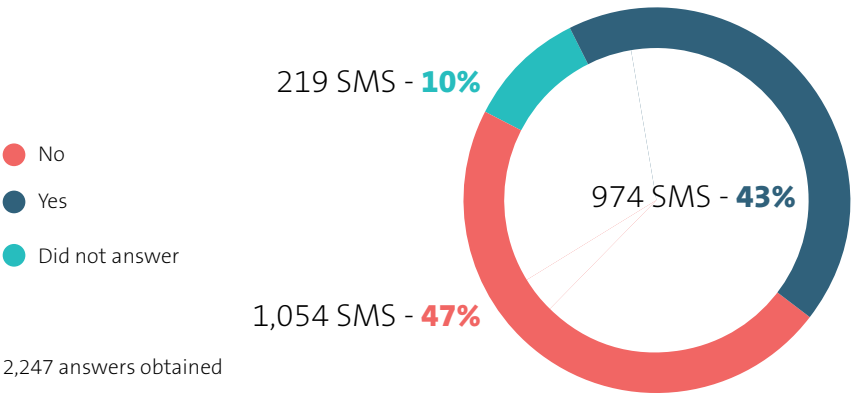
assessing primary health care, thus compromising the possibilities of change and betterment of the current structure.

In regard to the availability of information systems for monitoring and assessment, another fundamental condition for the adequate development of those activities, the following charts show the situation revealed by the national survey in the area of responsibility of the managers of district offices and of the SMS who responded to the survey:

Availability of information systems to assist actions for monitoring and assessing primary health care at the district health offices



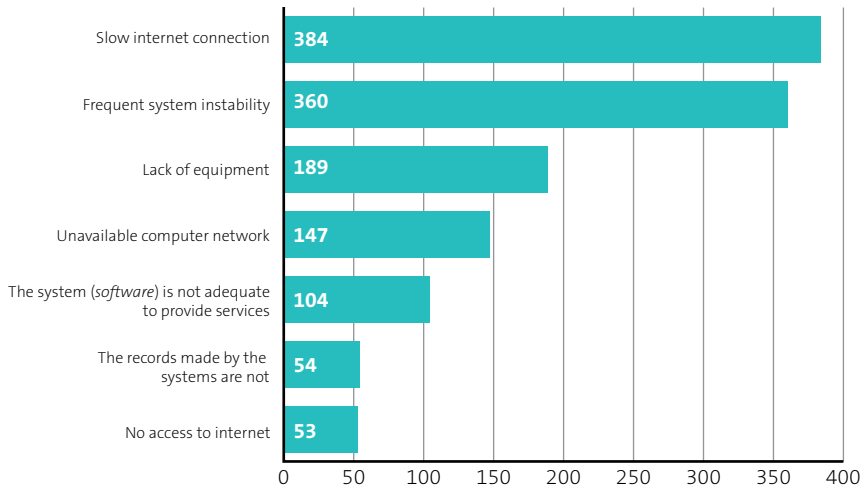
Availability of information systems to assist actions for monitoring and assessing primary health care at the SMS



The answers reveal a significant universe of district health offices and SMS without access to IT system for that task. Going further in the investigation of the IT systems among those who have it, 91% (59 of 65 answers obtained) of the responding district health managers and 68% (528 of 771 answers

obtained) of the SMS managers stated there are problems with using those systems. The following chart shows the problems usually faced with by SMS managers; and the ranking order of the problems made by the district health managers was the same.

Identification of the problems related to IT systems at the SMS



Remark: It was possible to mark more than one alternative

When asked if all UBS have access to information systems, 49% (391 of 793 answers obtained) of the responding municipal managers marked **no**, showing some degree of lack of information in a large number of health centers in the country.

Another important finding of the national survey with municipal and state health managers concerns the reliability of the data fed by cities, as 54% (1,213 of 2,192 answers obtained) of the municipal health officers and 44% (75 of 172 answers obtained) of the district health managers who responded to the survey said there are no procedures to verify the reliability of data related to primary health care fed by cities into information systems, which shows a low level of reliability of the data informed and made available.

The Ministry of Health was also found to lack a detailed and structured diagnosis of the needs for Information Technology resources in states and cities, necessary for the adequate delivery of primary health care services, thus compromising the planning aimed to provide balanced care and support instruments developed by the federal agency.

GOOD PRACTICES

As pointed out by the TCE, the municipality of Sapeaçu, in Bahia, has the *AtendSaúde* Program, which promotes the computerization and automation of the activities performed by community health agents (ACS) for collecting fieldwork information, through the use of mobile devices (tablets) and geo-referencing technology.

http://www.sapeacu.ba.gov.br/noticias/379/tecnologia-implantada-na-sade-de-sapeau-ser-apresentada-em-congresso-internacional.html

The tablets made available to community health agents reproduce in digital format the forms that the Ministry of Health defines for the work, allowing for faster, safer and timely data collection. Also, the information can be filtered and grouped in a simple way, allowing managers to have a variety of displays and analyses based on several criteria, including geographic ones.

In Rio Grande do Sul, the TCE identified the project called Strategic Management Room of the 18th District Health Coordinating Office, responsible for coordinating, assessing and monitoring 23 cities located in the Greater Metropolitan Region. The room is a virtual and physical space in which information on health is systematically analyzed by a technical team to characterize the health situation of a population. Among a number of actions, the works performed by the program members are aimed to plan and assess health-related actions; provide support to the development of programs and policies for improving health; assess the quality and access to services; support public health surveillance; guide the response from health care services in emergency situations such as epidemics or natural disasters, and spread information on health to the community, interacting and furthering health promotion.

GOOD PRACTICES

In Florianópolis, according to the TCE, the *Planeja Floripa* Program, carried out by the SMS, is worth highlighting, as it describes the motivations and the whole process of developing the municipal-level planning in this area. Two projects especially stand out: the PDCA Health and the Award for Good Practices in Health. The first is a web-based system which enables the care units to monitor the planned actions, allowing them to follow up, assess, and make the adjustments needed to the proposed actions. In its turn, the award is aimed to bring visibility to successful practices which may contribute to the work process, both care and managerial, based on a wide-ranging discussion and exchange of experiences.

Another distinctive feature of the *Planeja Floripa* Program is the fact that it provides a set of integrated tools , aligning all departments and work units of the SMS to the Municipal Health Plan, as well as the SMS itself to the other Departments of the Florianópolis City Hall and other external bodies, such as the SES-SC and the Ministry of Health, thus fulfilling a governance role.

03
AUDIT REPORTING

The performance audit reports of the Courts of Accounts contribute with an analysis on the assessed topic; and they include recommendations for reducing or solving the deficiencies that were found.

These reports are pored over in each Court, and subsequently they devise action plans with public managers which, based on the recommendations, contain the commitment to execute actions, with deadlines and assigned responsibilities to ensure the improvement of public services delivered to society.

The Action Plan is the basic document with which the Courts of Accounts perform the monitoring, a process which will serve to verify the compliance with its deliberations and the results originating from them.

The reports issued by the Courts of Accounts are expected to lay the groundwork for decision-making processes of authorities in charge of crafting and executing public policies on primary health care, as instruments for social control, and also to foster research in the area.

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