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Challenges for Primary Health Care Production*

Desafios para a produção do cuidado na Atenção Primária à Saúde

Retos para la producción asistencial en Atención Primaria de Salud

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Abstract: Objective: to understand the organization of the production of health care in Primary Care. **Method:** qualitative study, carried out with 23 participants of the family health team by means of interview and systematic observation in seven Family Health Units of the central northern region of Bahia, between May and July 2017; data analysis oriented by Gadamerian hermeneutics. **Results:** the entrance door is selective; service flows are regulated by offering focused on some services, with long waiting and difficulties in scheduling appointments, besides being disjointed and insufficient for continuity of care. A lack of materials and precarious working conditions was observed. The evaluation is invisible, with insufficient actions to corroborate user satisfaction. **Conclusion:** there is an evident need for improvement in the organization of primary care and composition of primary care as an organizer of integral and resolute practices in the attention network.
Descriptors: Unified Health System; Family Health; Primary Health Care; Family Health Strategy; Health Services

Resumo: Objetivo: compreender a organização da produção do cuidado em saúde na Atenção Primária. **Método:** estudo qualitativo, realizado com 23 participantes da equipe de saúde da família por meio de entrevista e observação sistemática em sete Unidades de Saúde da Família da região centro

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norte da Bahia, entre maio e julho de 2017; análise de dados orientada pela hermenêutica gadameriana. **Resultados:** a porta de entrada é seletiva; fluxos de atendimento são regulados por oferta focalizada em alguns serviços, com longa espera e dificuldades nos agendamentos de consultas, além de desarticulados e insuficientes para a continuidade do cuidado. Observou-se falta de materiais e condições de trabalho precárias. A avaliação é invisível, com insuficiência de ações que corroborem com a satisfação do usuário. **Conclusão:** evidencia-se necessidade de melhoria na organização do cuidado e composição da Atenção Primária como ordenadora de práticas integrais e resolutivas na rede de atenção.
Descritores: Sistema Único de Saúde; Saúde da Família; Atenção Primária à Saúde; Estratégia Saúde da Família; Serviços de Saúde

Resumen: **Objetivo:** comprender la organización de la producción de la atención sanitaria en Atención Primaria. **Método:** estudio cualitativo, realizado con 23 participantes del equipo de salud de la familia mediante entrevistas y observación sistemática en siete Unidades de Salud de la Familia de la región centro norte de Bahía, entre mayo y julio de 2017; análisis de datos guiado por la hermenéutica gadameriana. **Resultados:** la puerta de entrada es selectiva; los flujos asistenciales están regulados por una oferta focalizada en algunos servicios, con una larga espera y dificultades para programar citas, además de desarticulados e insuficientes para la continuidad asistencial. Se notó la falta de materiales y malas condiciones de trabajo. La evaluación es invisible, con acciones insuficientes que corroboran con la satisfacción del usuario. **Conclusión:** existe la necesidad de mejorar la organización de la atención y la composición de la Atención Primaria como organizadora de prácticas integrales y resolutivas en la red asistencial.
Descriptores: Sistema Único de Salud; Salud de la Familia; Atención Primaria de Salud; Estrategia de Salud Familiar; Servicios de Salud

Introduction

Primary Health Care (PHC) is considered the "gateway" to the Unified Health System (UHS) and is the first contact of the individual with the health services, constituting the foundation of health care. This is based on the reordering of the network and other services, through the coordination of care, considering the link between people and their health needs at all levels of the System's complexity.[1-2]

PHC implies greater equity in its actions and efficiency in health care for continuity and, consequently, less fragmentation of care throughout the network, positively impacting on health indicators.[3] Therefore, it is necessary to understand how PHC operates and relates to the other elements of the care network, in the search for the production of integral care. This is understood as resulting from the

actions of health professionals, operated by technological knowledge that values the field of relationships and inter-subjectivities that touch the needs of users.[1] Therefore, considering it as the organizer of the health care network, we consider the following analytical dimensions in this study: entrance door, attendance flow and evaluation.

The flow of service is organized through different institutions with multiplicity of agents and social spaces at different levels of technological density. In this sense, it is part of a dynamic and coordinated network, which in a creative way adjusts to the specificities of each place or region.[4] The flows that correspond to the user's itinerary through the network, also called reference and counter-reference, as intrinsic and interconnected parts to the dynamics of regulatory processes, must overcome the excess of norms and bureaucracy and seek to establish links of meanings and directions in the organization of the production of care. Therefore, it is healthy to compose "access, integrality and equity as organizers of health work".[5:4]

The health evaluation device is fundamental to systematize and follow up the actions in a networked way. It is a process that involves different social subjects of the practice and community, whose actions would have to be based on strategic and participatory intervention plans to enable a responsive and systemic attention.[6] Therefore, it seeks to consider and understand the satisfaction of the subjects involved in health production practices, which results in improved systems and response to needs.

The implementation of PHC in the way it was conceived, with the aim of improving the quality of care and reducing inequities with the provision of primary care of varying complexity, requires the overcoming of several barriers, among them, those related to management and care networks.[7-9] Since they result in the

implementation of selective policies and correspond to the obstacles in the way practices are organized and the difficulties related to the access to services in UHS.[10-11]

Another characteristic observed in studies[2-3] on PHC refers to the health model, which values the procedure-centric logic and medicalizing actions, insufficient to respond to health demands/needs. This refers to the indispensability of placing in the discussion agenda of health professionals the way to organize and produce care, implying continuous monitoring and evaluation of the process.[6]

Studies that discussed the dynamics of care production in PHC in the UHS network adopted selectively cut analyses in these dimensions, showing the insufficient capacity of the first level of attention to play a fundamental role in the ordering of network care, due to the lack of continuity of care processes, in the composition of reference and counter-reference.[4,9-12] The analysis of the articles[4,8,13] are centered on the attributes of PHC, such as longitudinality, coordination, completeness, service casts, among others, and the organizational bases of the territory, as a component of the health region, its points and counterpoints in health systems.

The debate on the subject instigates us to relate the organizational dimension of the production of care in PHC, which aggregates the entrance door, the flow of care and the evaluation, as parts of a context that is contemplated and complemented in the observational and discursive composition, through the experiences of the subjects involved, revealing the way in which users and health professionals demarcate the organization of practices.[10-14] Therefore, the research question emerges: how is the production of care in PHC organized? The objective of this article is to understand the organization of health care production in Primary Care.

Method

A qualitative study, guided by the Gadamerian critical hermeneutics referential for understanding narratives, through interview and systematic observation. Therefore, the core of Gadamer's theory is to explain how to escape from the closed circle of previous conceptions in order to maintain a constant interpretation, to the point of replacing pre-concepts, through communication, by new concepts more suitable to the subjects.[15]

The investigation was conducted in a municipality located in the central northern region of the state of Bahia, Brazil, with a population of 75,437 inhabitants and 16 Family Health Teams (FHT), distributed in eight Family Health Units (FHU) with a population coverage of 63.6%.[16] The empirical field included all the Units in the municipality, excluding one Unit for not having a complete team at the time of collection. Therefore, it was constituted by seven FHU, three located in the rural area and four in the urban area. In the selection process of the Units the following criteria were adopted: to have at least one year of operation; to act with a complete team or minimum team (doctor, nurse, nurse technician and community agent, being able to be added of surgeon-dentist and dental assistant, as members of the multi-professional team).[16]

The collection was carried out between the months of May and July 2017. The field was approached through visits, resulting in an average of three to four visits per USF, with presentation of the research project, explaining objectives, risks and benefits, secrecy, anonymity and privacy during data collection. Participants were selected by intentional sample, according to the availability manifested after this initial contact. The narrative interviews were scheduled according to the availability of the participants, after the end of the consultations. Inclusion and exclusion criteria were determined according to the groups:

- Group 1: FHT/health professionals, working at FHU with at least six months of professional experience, excluding those professionals removed from service, on medical leave, pregnancy, premium or removal either for another service or for leave without pay.

- Group 2: Users of the service, over 18 years of age and registered at FHU for at least six months, excluding those who have not used the service for at least one year.

The number of research participants was defined based on the exhaustive repetition of the contents present in the narratives, represented in the process of collecting and analyzing the empirical data, dispensing with the representation of each category by FHU.[17] This study was composed of 23 participants, 17 of them health professionals (group 1): six community health agents (CHA); six nurses; two nursing techniques; two doctors; two dentists; and six service users, dispensing with FHU representation, in view of the saturation of data, as well as the difficulty in accepting to participate and refusal by a professional to be part of the collection.

The data collection occurred after the FHU visits. As a guiding instrument for the interview and participant observation, a common semi-structured script was used with the following items: a) numerical identification of the interviewee and the observed unit; b) narration and/or observation of the organizational dimensions of the production of care, referring to the door entry, flow of care, regulation (reference and counter-reference) and evaluation; other observations or free speech of the interviewee, impression/evaluation of the interviewer about the unit and the narration of the interviewee.

The participant narrated his understanding of these dimensions freely the interviewer's questions, seeking to explore aspects of the dimensions that were not explained by the interviewees. These were carried out in loco, by invitation and scheduling prior to the visits, usually at the end of the services, in a room reserved for this purpose. With an average of 15 minutes per participant, totaling approximately six hours, being recorded, transcribed, interpreted and analyzed. The participating observations occurred concomitantly with the interviews and lasted an average of 168 hours, 24 hours per FHU covering the two shifts of attendance (morning and afternoon) and recorded in the field diary. The observed aspects related to the organizational dimension were gateway, geographic barriers, regulation-flow and

counter flow, and evaluation.

The participant observation composed the analysis of the narratives, because it made possible the intertwining of the information, apprehended with the knowledge about the experiences lived by the people associated to the meanings, activities or events, building the learning present between the representations, activities or events, lived experiences and the observation of reality.[18-20] This analysis was divided into stages for better understanding and interpretation, as follows:

Stage 1 - Phase of distance: it consisted in transforming the spoken language into a written language, transcribing the interviews and recording the observations in text.

Stage 2 - Appropriation phase: it involved the readings and general understanding of the texts in order to appropriate their meaning, transforming them into something familiar, proper, according to their mediations of knowledge, experiences and observed reality.

Stage 3 - Explanation and organization phase of the data: the texts were submitted to the analysis of the NVivo software, version 11 Pro for Windows, to organize the data into analysis units, which emerged from the convergences of the speeches and observations. This strategy sought to provide consistency in the interpretation of data with the storage and systematic description of the units of analysis to follow the other steps inherent to the interpretation, understanding and construction of the representations of groups and what was observed.

Stage 4 - Phase of understanding: an interactive process occurred that allowed the researcher-readers a broad understanding of what was said and observed in the reality of the services, and that depends on the previous knowledge of the reader to unveil it.[18]

It should be noted that this research was approved by the Ethics and Research Committee of the State University of Feira de Santana on April 29, 2017, under the number of protocol 2,039,015, following the rules of Resolution 466/2012 of the National Health Council.

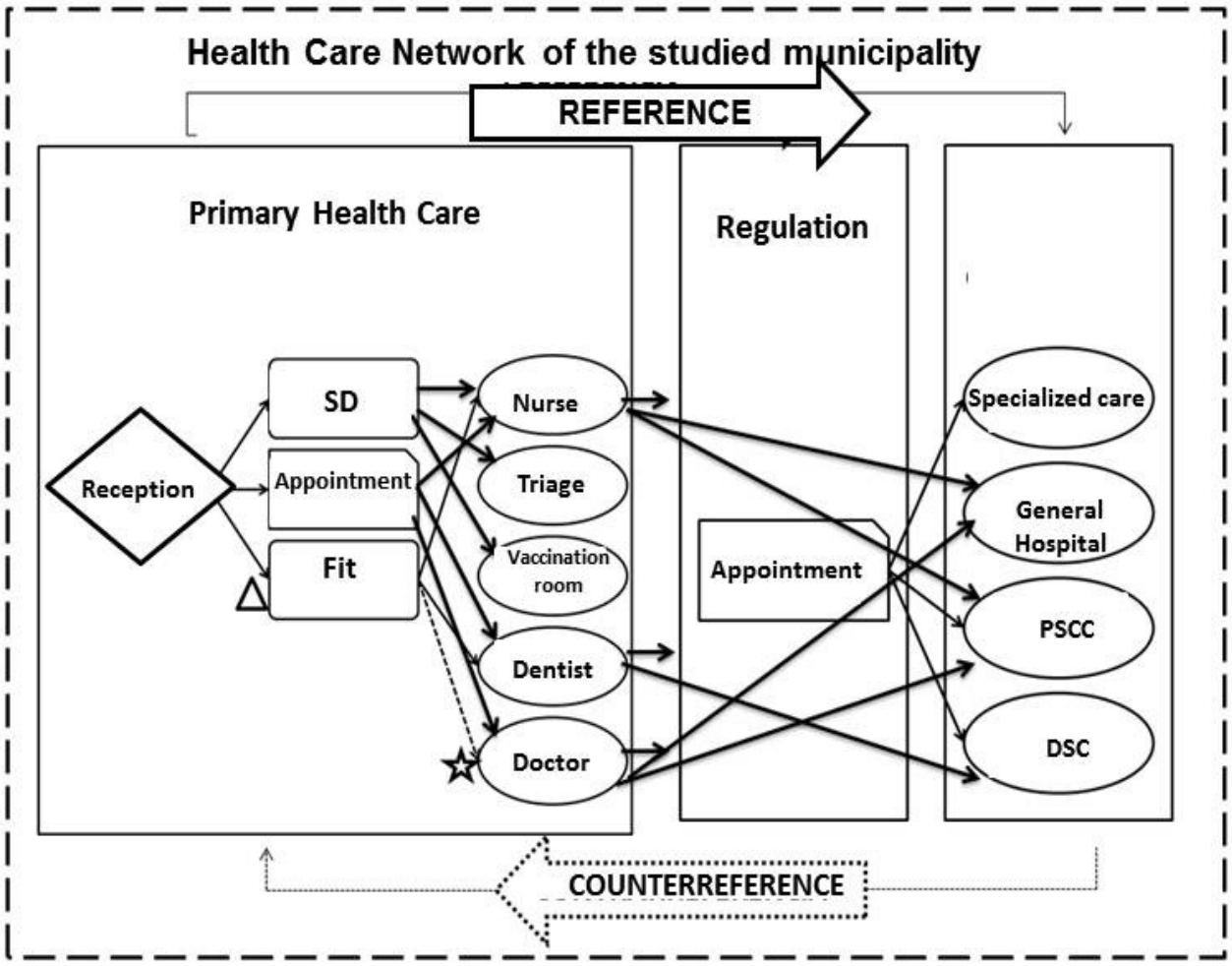
The identification of the narratives is represented according to each group of participants in this study. The names cited after each narrative were coded to safeguard anonymity, and the

professionals were identified by the initial E (Team), followed by a number, and the users identified by the initial U (User), followed by a number, according to the increasing order of each interview.

Results

The summaries of the results of the observations are represented in Figures 1 and 2, complemented by the narratives of the participants (health professionals and users) who operate in the daily life of the PHC, in the FHU space. Therefore, the organizational dimensions of the production of care were cut out, from the doorway to the regulation and evaluation of the process. As a starting point, the organizational flow of care organization in the PHC is demarcated as an integral part of a care network, established in the composition of the reference and counter-reference that is instituted by regulation for services of medium and high complexity (Figure 1).

Figure 1 - Representation of the organizational flow of the production of primary health care in a city of Bahia. Bahia (BA), Brazil, 2017.



KEY

SD Spontaneous demand

PSCC Psychosocial care center

DSC Dentistry Specialty Center

Elements of the Health Care Network

Levels of Complexity

Decisive organization stage of the flow of access to the PHC services

Alternative way of access

Conventional way of access with delay/lateness of time

Services offered

Referral flow

Referral flow with frailty

Most highlighted /demanded service

Negotiated way of access with guarantee of resoluteness

Continuous flow

Frail or discontinuous flow

Figure 1 shows the forms of access and entry into the PHC, having as intervention space the FHU, through the reception that designates and organizes the "gateway" of the UHS network. The service flow is ordered through schedules based on programmatic actions, while the spontaneous demand (SD) or "fit" is characterized by dotted lines, as it is considered one of the weaknesses of the flow organization. The SD consists of an alternative and negotiated form of access among the subjects to access the medical appointments, in case of persistent need or other situations that facilitate their entry into the health service.

The narratives portray how access to the "gateway" of the health system is made operational.

> *Only then, at the time of scheduling that it takes a while. The appointment takes time, sometimes we come and there is no vacancy [...] Only this issue even at the time of appointment that is too difficult* [...]. (U1)

> *My husband works in health, so it's all easy. He has to make the appointments at the appointment house, then I come to be attended. And that's how it happens. You have to be patient to wait your turn. [...] I got there and I needed it, it was a situation where I didn't have a vacancy anymore, but the attendant went there and spoke with the professional and he gave the vacancy.* (U5)

> *When I get here, the reception staff, will only book 11 hours [...] And the patient who arrived at 8am, will do as? He'll be back to come at 11 o'clock?* (E04)

> *I look for the community workers to see if they have a doctor, I ask: "Ah, who is consulting there?" Because also, they are missing a lot. [...] I always come to the doctor, my medical record is with her. [...] Community workers always inform well, the day they have a doctor, the day they are taking an exam, always, and there are two community workers, who are neighbors, who always inform well.* (U6)

> *The person is in need of the consultation, comes here and sometimes is badly received. It's even happened to say there are no vacancies, and other people get [...]. We go to a place, we want to be welcomed and it's not.* (E3)

The understanding of users is highlighted through the difficulties in access from the "doorway" that would be essential for the continuity of the therapeutic process, pointing out obstacles in appointments and schedules. This situation has reflexes on dissatisfaction and ways to face the problem, such as waiting for the appointment, or the inclusion of the user in the attention to spontaneous demand, through negotiation and dialogue with health professionals. Figure 2 highlights these characteristics.

Figure 2 - Organizational Dimensions in Primary Health Care in a City of Bahia. Bahia (BA), Brazil, 2017.

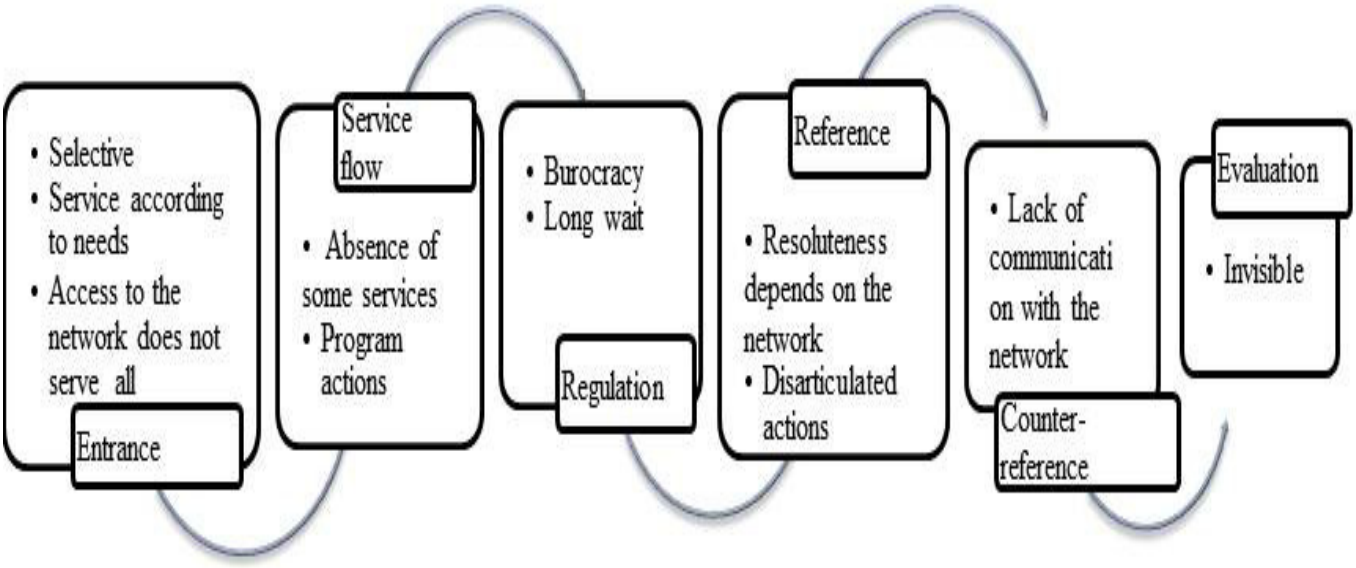


Figure 2 shows that the "entrance door" is selective and organized according to the needs focused on specific demands, such as specific aggravations related to programmatic actions, such as the Hypertension Program, Immunization, among others. The attendance flow is regulated through the offer of services such as: nursing consultations, medical consultations, screening, vaccine room, dental attendance and pharmaceutical assistance. In some units it was observed the offer of services such as consultations of specialists. In particular, the units in the rural area do not have the medical professional in the team, or he only serves sporadically on alternate days of

the week. It was also noted that in other units, the flow is impaired by insufficient materials, equipment and their maintenance, as demonstrated in the summaries of the narratives:

> *These days, the chair is also having a problem and the dentist is not seeing anyone.* (E15)

> *If you don't have a well-equipped room, if you lack a stretcher to attend an emergency, for that patient who demands more care and doesn't have a stretcher, you don't have an air conditioner in the room to make an appointment, so that the environment is more receptive and pleasant to that user.* (E9)

> *When I come, I take medicine when there's no medicine, I get it in the street [in another FHU*]. (U2)

> *I contacted the nurse, who even without the car to take to the distant place where the lady lived, made herself available to go and make this dressing, on foot, even.* (E10)

Regarding the observed attendance flow (Figure 1 and 2), the reference happens by the referral of the nurse, doctor or dentist who directs the user to the other points of the attention network, according to the demands that are presented in the unit. Moreover, the regulation for access to other services occurs through appointments at the central marking, or at the unit itself, made possible by a quota system, in the cases of units in the rural area. The speech cutouts elucidate such perceptions:

> [...] *patient who needs a specialty urgently, or the doctor refers, I already try to schedule from here with the central appointment. But, when it's a patient that we can wait, then we refer him, by request, and he goes to the appointment center, makes this appointment and makes the service.* (E14)

> *He [the patient] brings the request of the exams, the request of specialists. He comes here; we have the quota, with the weekly amount for that, and every Monday the driver takes to the appointment central, so that the patients don't need to go to the city to schedule.* (E18)

As for references to emergency cases, these do not require an appointment and are performed directly at the hospital or center of dental specialties, as well as cases that require the services of the Psychosocial Care Center (PSCC), which also do not require an appointment. The Center Psychosocial Care Center I, which focuses on adult users with severe and persistent mental disorders (PSCC-I) and Center of Psychosocial Care - Alcohol and Drugs (PSCC -AD). The counter-reference is represented in Figure 1 by dotted lines, is characterized as fragility, since in many cases there is no return of the attention process, referred by the user himself and/or by the community health agents (CHA).

> *If I send the patient for reference, in the counter-reference, the charts are not shared, and the counter-reference sheet does not send to the team.* (E5)

> [...] *there is hardly any return. There is no return from the professionals themselves in being counter-referencing that patient so that that care is given continuously.* (E9)

> *On the back of it [chip] is to be made the counter-reference and these chips never came back. [...] forward to the network and they [health professionals] don't give back. Then we can't close a case.* (E13)

Moreover, as for the evaluation of services (Figure 2), it is not systematized nor established in a continuous way, whose expression becomes invisible in the services, which is configured as a mismatch for the continuity and coordination of care. The empirical data, therefore, show an organizational flow of care production in PHC that is fragmented and in disagreement with integral practices and that in fact responds to the needs of those who demand attention.

> *The last thing I did here and it didn't work out. It didn't work, so it was a preventive that I did and the result didn't come.* (U3)

> *I feel cared for, a little bit. Because my exams I don't do as the doctor asks. Because there is no way to score. There is no vacancy. But other than that, I feel a little taken care of.* (U5)

In addition, it is worth mentioning the prominence of the nurse, highlighted in the following narratives, as the organizer of the production of care, with responsibility in various services, from the definition and organization of schedule to the access of users. The interventions are based on programmatic actions, educational practices and coordination of the FHU.

> [...]*the nurse who coordinates the care, the professionals, the unit itself.* (E12)

> [...]*who coordinates, in fact, are the two nurses.* (E14)

> [...] *the majority of the activities who ends up taking sides, in this case, I can say that it is me, if it is a programming of an educational activity, if it is the [pause] realization of the schedule, of the unit, if it is to do, to help in the health program in the schools, finally, all the activities who ends up taking initiative is the nurse.* (E18)

The results of the narratives and figures complement each other in the evidence of the organizational elements captured by the instruments, making possible the triangulation that will be discussed below.

Discussion

PHC as the "gateway" to the UHS network encompasses the loco regional characteristics and takes into account the community context. The approach of the subjects narrows relationships and makes the whole environment fertile to care relationships, constituting Family Health as a social space where the user's entry into the health system should be achieved.[8]

The empirical data show barriers such as difficulties in access to consultations, geographical barriers related to the units in the rural area, slowness in access of users that stiffen the relationships of care and result in fragile and low or insufficient resolubility of assistance experiences. Access at the "gateway" that would be essential to the initiation of progressive

networked care suffers the impact of organizational difficulties that are reflected in the barriers faced in the daily lives of PHC and that bring characteristics that limit access to this level of care, fruit of inefficiency and fragmented attention. Thus, although PHC provides an opportunity for an initial approach between individuals and the health care network, it faces difficulties in access and connection, which are considered essential for the formation of responsive and integral care.

The CHA, in the course of its practice, can contribute to the improvement of the access and the flow of the attendance, being a link with the community. It can facilitate access at the "gateway" through the work of recognition of its area of operation and territorial demarcation, strengthening links with users and integrating demands/needs with the family health team. The CHA develops the role of appropriation and belonging, triggering such meanings in users who can share their experiences, needs and traditions in common.[21]

In this study, the orientation of the flow happens according to the model of medicalization of the health, centered in the illness, with focus on the complaint for professional conduct, having as limiting aspects the selectivity in the first contact and between the levels of attention; and the organization of the attendance guided in programmatic actions or by the prioritization of specific aggravations.

A study carried out in the PHC about the health orientation of children in Brazil identified the permanence of characteristics of the medical-hegemonic model, which triggers limitations to the central principles of basic care as part of a public policy, which still do not have the family as the focus of attention, predominating the curative actions in health.[9] In addition, it was learned in the experienced reality that difficulties in the flow of users can result in weaknesses in the resolution of care, weaknesses in referral to the network of care and discontinuity of care and assistance.

In view of the above, the organization of the service flow occurs in a limited way, as was highlighted in the observations (Figure 1 and 2) and in the narratives of the participants.

Situations that often begin at the moment this user arrives at the unit, either for the search of the service or through the CHA. This fact leads to the segmentation of the service and its dissatisfaction in search of meeting its needs.

Therefore, it is necessary to strengthen the mode of organizing care through initiatives that expand the supply of vacancies for care, supply of inputs and materials, and improvements in infrastructure by increasing funding and resources for PHC. In addition to training and strengthening the links between teams, providers of primary care.

In view of the above, it is considered that the difficulties faced within the units lead to the discrediting of the services offered in APS. Corroborating with similar results to other studies in which users doubted the power of resoluteness that this level of care has.[1,12] Other difficulties considered significant refer to the lack of materials and precarious working conditions in the FHU, according to the narratives of the interviewees, often compromising practices and service, making them limited and not very resolute, contributing to the dissatisfaction of professionals and dissatisfaction of users.

A similar finding was found in the study,[9] having presented the structural problems of inadequate physical space with improvisational character, inappropriate working conditions for care and the scarcity of equipment and fundamental work instruments as an obstacle to the production of care and solubility of PHC, leading to the discrediting of users in the service.

Furthermore, the lack of a doctor in some units, especially in rural areas, corroborates the absence of essential services in family health, representing a commitment to access, care, quality of care and integral practices.[1, 9-12] These studies corroborate the reality found when entering the FHU in rural areas where there is a high turnover of professionals, especially doctors, with little linkage of professionals, and consequently, superficial and incipient practices.

Regarding the service flow,[22-23] This is a mismatch for the continuity of care, understood as essential for the maintenance of the production of care in a coordinated and perennial way, even

if by different professionals or levels of complexity, either by the construction of isolated practices and knowledge, or by the maintenance of a network that communicates little, disfiguring PHC as coordinator of the UHS network. The results of the present study are in line with these findings, since the referencing of users was regulated according to the needs of each one, who are then referred to different services such as PSCC, medical specialists or hospital services.

During the data collection process, it was found that the user's referral to another service did not always meet their needs due to the lack of vacancies, isolated practices and no interaction of health professionals in team work for the production of care, keeping the focus of attention only on the demand that originated the referral.

In view of the above, such difficulties have repercussions on the dynamics of care provided to the user, with fragmentation of the therapeutic process in the path of the UHS network. In this sense, the reference and counter-reference, which are essential devices for care and for the consolidation of a comprehensive PHC, prove to be fragile, discontinuous and with insufficient resolution.

Similar studies[11,22] corroborate these disagreements, including the work of the incomplete family health team, the lack of recognition about the functioning of the network, and the lack of articulation and communication between the levels of attention. This work is fragmented, translating into a lack of return of the services to which the user was referred and low accountability of some team members involved in the care, which often compromise the effectiveness of reference and counterreference systems. Such systems encounter resistance and impasses for their effectiveness, being necessary the awareness and permanent education in health to the professionals about the attention network, in order to offer the user an integrated, multidisciplinary and interdisciplinary care.[22]

The findings translate as an alternative for this limitation of cooperation/communication between professionals and levels of attention, that the team seeks this information with the user

himself, at different times of the production of care: in return consultations with the doctor, in the care of the nurse and in the interlocution with the CHA, which collects the information at home, as soon as the users return from the services to which they were referred. This corroborates with other published studies. [11,22-24]

Although care is recognized as a practice that can be performed by all health professionals and built among the levels of care, especially at the "doorway" of the UHS, in practice no teamwork was observed. Such difficulties affect the way professionals perform care built in the network, which is the limit to the assessment, a crucial element that makes up the organizational dimension.[6] It appears from the empirical data analyzed that the evaluation can be considered as invisible in the services, because although it requires institutional mechanisms to carry it out, it apparently leaves the impression that it occurs without systematization, or even transparent criteria by the health unit.

As an essential device for systematizing and monitoring actions in a networked manner, it can be seen how these steps in the evaluation imply discontinuity of care, since just as it requires the involvement of different subjects, be they professionals or users, they also imply the implementation of actions based on intervention plans in a strategic and participatory manner.[6] Thus, the absence or incipiency in its realization have an impact on the little knowledge about the users' satisfaction, as well as on the proposal of improvements in the health practices that respond to the real needs.

In addition, the role of the nurse as organizer of the unit and with a committed and responsive practice in various PHC services, involving the provision of care, is highlighted in order to elucidate its relevance in the therapeutic process and management of the unit. The study evidences the protagonism of this professional as an articulator of the organizational process, acting on several fronts, as leaders of the family health teams.[21] The leadership of the nurse is considered salutary in the strengthening of bonds, in the resolution of conflicts and in

the conduction of daily assistance situations, influencing directly the process of health work.

The limitations of this study are in defining only two segments of participants (health professionals and users) from the FHU of a municipality. On the other hand, the findings may support further studies that seek to understand the organizational dimension from the narratives of other subjects, including UHS managers, other municipalities and other components of the health care network.

Conclusion

The results of the study indicate that PHC has not yet become a "gateway" to the UHS network, being selective and organized according to specific demands and specific problems. The flow of care is ordered through schedules based on programmatic actions and spontaneous demand is an alternative negotiated between subjects to access medical appointments. The processes of evaluation of the organization of care are assystematic and invisible in mismatch with the continuity of care and coordinated and integral practices.

According to the analyzed reality, it was possible to understand how PHC is organized in the family health intervention space, as well as the importance of re-signifying the organization of care production, overcoming selective attention to integral practices with accountability of professionals at different levels of complexity of the system.

However, efforts need to be provoked and assumed in order to generate the necessary changes for the establishment and realization of the FHT as the preferred form of organization for PHC, through improvements in the health levels of the population to be shared and disseminated by studies focusing on creative and innovative practices to transform fragilities into potentialities.

The study contributed to the recognition of the way in which the organization of care production is understood and carried out, as well as to the strengthening of the organization of

practices in primary health care and the identification of weaknesses that need attention and commitment from health professionals. It is worth mentioning the performance of nurses who have played a leading role in articulating and coordinating activities in family health units, a situation identified in the empirical data, favoring the strengthening of the profession, as a committed and responsible care provider.

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