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RESEARCH

A política nacional de atenção básica nos centros municipais de saúde da área programática 1.0

The national policy of primary care in municipal centers of health from programmatic area 1.0

La política nacional de atención primaria en centros de salud municipal del área programática 1.0

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ABSTRACT

Objective: discussing the national policy of primary care in the Unified Health System with health professionals from three municipal health centers. **Method:** a qualitative, descriptive-reflective and action research. The population was health professionals that serve women and children. We selected all professionals of municipal health centers program area of 1.0. For data collection were conducted three seminars which were recorded and transcribed, with carved minutes. The study was approved by the Research Ethics Committee of the School of Nursing Anna Nery under Protocol No. 37/08. **Results:** the data were subjected to thematic analysis, followed by the construction of four categories. **Conclusion:** the subjects believe that the greatest difficulty in carrying out the principles of primary health care is a lack of human resources to carry out educational activities within the collective as the individual is realized. **Descriptors:** Public policy, Primary health care, Vocational training, Nursing.

RESUMO

Objetivo: discutir a política nacional de atenção básica do Sistema Único de Saúde junto aos profissionais de saúde de três centros municipais de saúde. **Método:** qualitativo, descritivo-reflexivo e pesquisa-ação. A população foi os profissionais de saúde que atendem mulheres e crianças. Foram selecionados todos os profissionais dos centros municipais de saúde da área programática 1.0. Para coleta de dados foram realizados três seminários que foram gravados, transcritos e lavrados com atas. A pesquisa foi aprovada pelo Comitê de Ética em Pesquisa da Escola de Enfermagem Anna Nery, sob protocolo nº 37/08. **Resultados:** os dados foram submetidos à análise temática, seguida da construção de quatro categorias. **Conclusão:** os sujeitos acreditam que a maior dificuldade de realizar os princípios da atenção básica é por falta de recursos humanos para realizar ações educativas no âmbito coletivo já que no individual é realizado. **Descritores:** Políticas públicas, Atenção básica à saúde, Capacitação profissional, Enfermagem.

RESUMEN

Objetivo: discutir la política nacional de atención primaria del Sistema Único de Salud, con profesionales provenientes de tres centros municipales de salud. **Método:** cualitativa, descriptiva reflexiva y investigación acción. La población fue los profesionales que atienden a las mujeres y los niños. Se seleccionaron todos los profesionales de los centros municipales del área programática 1.0. Para la recolección de datos se realizaron tres seminarios que fueron grabados y transcritos, con minuto tallado. El estudio fue aprobado por el Comité de Ética en Investigación de la Escuela de Enfermería Anna Nery en virtud del protocolo 37/08. **Resultados:** los datos se sometieron a análisis temático, seguido por la construcción de cuatro categorías. **Conclusión:** La dificultad en el cumplimiento de la política es la falta de recursos humanos para llevar a cabo actividades educativas dentro de la colectividad como el individuo se realiza. **Descriptores:** Política pública, Atención primaria de la salud, Formación profesional, Enfermería.

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INTRODUCTION

Discussions to reach the final format of the National Primary Care (PNAB) were based on the transversal axis of the Unified Health System (SUS), which are universality, comprehensiveness and equality in a context of decentralization and social control of the management, assistance and organizational principles of the NHS, enshrined in the Federal Constitution of 1988.[1]

The accumulated experience in various management levels served as a complementary strategy to facilitate the regulation of primary care. Thus, the current policy aims to redefine the general principles, responsibilities of each level of government, infrastructure and resources, characteristics of the work process, assignments of professionals, and funding rules, including the specifics of the Family Health Strategy (FHS).[1]

In this historical process, the basic attention was gradually getting stronger and should qualify as a preferred gateway SUS, being the starting point for the structuring of local health systems. It can be stated that the year 2006 has the mark of maturity with regard to basic health care. After all, the Pact for Life made it a priority to "consolidate and qualify FHS as basic center and originator of networks of health care in NHS care model."[1]

Thus, Brazil has a new policy on primary care, by virtue of Ordinance No. 648/GM of March 28, 2006 which approved the BANP, setting the revision of guidelines and standards for the organization of primary care for the ESF and the Community Health Agents Program (PACS).[1]

This policy sets up primary care as a set of actions, both individually and collectively, on the first level of care within the health system, focused on the promotion and protection of health, disease prevention, diagnosis, treatment, rehabilitation and health maintenance.[1] So not only is health intervention in disease processes, should also include actions that provide the maintenance or recovery of health status.[2]

This study is part of a research developed at the Center for Research on Women (NUPEM) School of Nursing Anna Nery (EEAN), Federal University of Rio de Janeiro (UFRJ) Health. This research was titled: Primary Health Care of Women and Child - Lines of Care Comprehensive Care and Challenges for Professional Practice and addressed two basic themes: Primary health care and Lines of Health Care and Primary Care of Women and Lines of Care Child Health in Municipal Health Centers program area 1.0 (PA 1.0) in the city of Rio de Janeiro.

In this context the study object, in principle, related to the discussion of care lines full attention to women and children and setting priorities in basic units of AP 1.0 the municipality of Rio de Janeiro. We note that it is the principle, since the methodology of action research not previously defined a "recipe" to follow but methodological guidelines for building pathways or processes to an end.

Thus, the overall objective of the research is to discuss the care lines full attention to women and children. This article answers the first specific objective of the research is to discuss the national policy for primary care in the National Health System with health professionals from three municipal health centers AP 1.0, in the context of integrated care.

In this study we understand how lines of care, as defined by the Ministry of Health (MOH) in 2006:

> There are models of organization of health care aimed at comprehensive care and integrate health promotion, surveillance, prevention and care, targeting the specific group or individual needs, allowing not only to timely and responsible management of patients by the various possibilities of diagnosis and therapy in all levels of care as well as an overview of the conditions of life.[1]

It is known that the integrality in health services encompasses three sets of different meanings, but complementary: the practice of health professionals, the attributes of the service organization and the government's responses to health problems. The first direction is related to the professional attitude, which should seek to grasp the context of life of patients, considering them more of lesions or dysfunctions to be treated, it is necessary to associate prevention assistance. Regarding the organization of services, it is pointed out that the mode of organizing should be open to assimilate the needs of users and guided dialogue between the different subjects that make up the work process in health. As for government responses, they should consider the specificities of the groups affected by health problems, from the context of the subjects about which policies affect.[3]

METHOD

The study was approved by the National Council for Scientific and Technological Development (CNPq) in 2007; by the Ethics Committee in Research of the School of Nursing Anna Nery - CEP / EEAN / HESFA (2008) under protocol 37/08; and the coordination of the AP 1.0 Municipal Health - SMS / RJ (2009). The subjects signed a consent form - IC, two ways getting one with a professional. The final research report was approved by CNPq undemanding.

The research is descriptive-reflective and qualitative type, because the current study aimed to describe the characteristics of a given population and was beyond the simple identification of the existence of relationships between variables, intended to determine the nature of this relationship. The survey also intended to study the level of service of public agencies in a community and raise the opinions, attitudes and beliefs of a population.[4]

The method used was the Action Research, used both in quantitative research, the qualitative nature. This was chosen primarily for taking the interest of researchers and health professionals in the resolution of issues arising from the environment and to mobilize a critical and reflective practice involved approaching the reality studied by inserting them in the field of data collection, while to maintain impartiality in the events.

The planning of an action research is carried out with remarkable flexibility. Contrary to other designs, does not follow rigidly ordered phases. Thus, the proposed phases do not necessarily need to follow this proposed order: 1) Exploratory Phase: consists in making the diagnosis of the situation. It shall be determined by the priority problems and possible actions. After the assessment of the initial situation, researchers and participants run to establish the main objectives of the research. 2) The theme of research: the choice is a practical problem in the area you want to search. 3) Placement of problems: establish the main issues that will be the focus of the research. 4) The place of theory: expanding the theoretical knowledge that encompasses chosen for the research object. 5) Assumptions: are assumptions that can be modified to be adequate research. 6) Seminar: its function is to examine, discuss and make decisions about the research process. 7) Field observation, sampling and qualitative representation: an action research can cover a geographically concentrated or scattered community. If the size of the selected field is very large, we use sampling and representativeness. In this action research, as the population size is limited in the sample will be deleted. 8) Data collection: the main technique used in this study was the seminar. 9) Learning: is a natural parallel to the research, where researchers learn from the objects of the search and they learn through interaction with researchers' process. 10) Learn formal and informal know: aims to establish or improve communication between researchers and the objects of research.[5]

The study subjects were 22 area health professionals, including physicians (04), nurses (05), social workers (02), psychologist (01), Nutritionists (02), nursing staff (02) and nurses (06) that deal directly with the care provided to women and children, encoded with fictitious names of flowers, fruits and precious stones. The scenarios were three CMS 1.0 of the AP Municipal Health Secretariat of Rio de Janeiro, located in the neighborhoods: New City, Holy Christ and Santa Teresa, and encoded by the numbers 01, 02, and 03, respectively.

Data collection was conducted through two phases; the first through tools to characterize the subject. And in the second stage was held Technique Seminar, according Thiollent[3] with instruments called thematic guides that guided the discussions of the following topics: National Primary Care Policy in the SUS; Health Policy Women and Child Health Policy. All discussions were recorded and signed in ATA. In this article, we present the data to the discussion of the thematic guide to primary care in the NHS.

The data were subjected to thematic analysis, followed by the construction of categories Minayo [6] giving rise building four (04) categories, they are: 1) Overview of the professionals on the policy; 2) Basic health care is the entrance to the SUS; 3) A joint CMS with the ESF is in transition; 4) Differences in training and vocational training.

The process of creating these categories was based on the identification of empirical categories, based on the statements of the subjects and analyzed in the light of national

government proposals for comprehensive health care by determining the analytical categories.

RESULTS AND DISCUSSION

3.1) Overview of professionals on policy

Health professionals claim that according to the degree of involvement of people (users and professionals) whether it has the role of accountability and that the determinations of the official discourse of primary care policy, in view of the SUS, in practice serve to organize services. The completeness and the reception are offered in accordance with the degree of understanding of the problem and its routing services.

Also indicate two complicating factors: one refers to the lack of resources and other flaws in the reference and counter-reference system, making the monitoring of those who seek the system and that even when they are referenced for his return has no record instrument preventing the evaluation and follow-up.

They also report that the principle of solving inherent to both the SUS and the operationalization of primary care depends not only them, but claim that the resolution is given only in cases of low complexity to solve by getting referral or reference to other cases of Units medium and high complexity.

> *(...) I think that this is guaranteed. You have resolute organizer and accountability role. (...) You have to have committed professional, with the involvement, responsibility is involved. When I get involved with each other, I blame myself. And I co-blame her when we divide the pro user who has to do (...) So that's what will make the NHS work (...) The accountability is both individual and collective. We have to give to the patient solving. Then the host does not have to be worried about giving the number and ended. (...) The reference, you have a reference and does not receive a counter, she goes there to do what has to be done, returns for you because I have to return, but returns without having given to us without coming to what was done there. (Flor de Lótus)*

> *(...) We organize care, welcome us, a need and direct accordingly, if we can meet in our level of resolution, is here, but forwarded to other services. (...) It is this issue of reference ever you have a record of answered reference is very difficult there you have answered the reference against. This flows returning to the documents, right? (...) The impression I have is that the user is neither popcorn on the network. (Begônia).*

> *(...) It is resolute in cases of low complexity. The system of referral and counter-referral is still deficient. (Cereja).*

> *If not the steering effort to keep these references we'd be running a unit with almost zero (...) solving. (Esmeralda).*

> *This resoluteness does not depend on us (...). Now solving is not something that only bumps in you to be resolute. You depend on others, you depend ultrasound, x-ray, lab, get it? (...) And so, the difficulty in exits in formal references is very large. (Pérola).*

In these reports, it appears that the principle of problem solving ability as to give a solution to the problems of user health service properly, the closest to your residence or refer them to where their needs can be met according to the level of complexity location according to the definition in the official documents of the policy on primary care, applies the reality of services in part only for service users with problems of low complexity.[7] In particular, it should be noted that users with problems medium and high complexity are unhappy not to have alternative solutions to their grievances which have come seeking medical care and prescriptions for their problems; for these professionals no formality in the system to meet the reference and counter-reference.

The lack of problem-solving generates a controversy for managers, professionals and users, implying for all behaviors / negative attitudes towards responsibility and quality of health services, because by not solving your problem it is known that the patient is still at risk of suffer as a consequence diseases / complications to their health and empower service.

It is perceived by 'speech that is guaranteed by solving them in cases of low complexity, getting on the resolution of other cases that will depend on other professionals, and local services. In these cases, the phenomenon of pilgrimage, in which the user goes from unit to unit requesting service on its own when not attended, arises. Thus the municipal responsibility is transferred to the user and their families together to experience pain and suffering by the denial of a right legally constituted.[8] For research professionals the main complaint is the difficulty in getting a positive response from counter-referral (when they refer to some user), a registered or an inter-service consultation, which usually leaves the professional user in question and how they were resolved and what still needs.

These situations, on rare occasions, with a high degree of sensationalism by the media and high degree of sensitivity and impotence on the part of patients and their families, people we see on television after having wandered for many services / locations for health and when met, the problem is so severe that even die or become incapacitated and family resorts to court for failure to save. In our understanding this is one of the problems that we characterize as an unconstitutional public act (failure to honor the patient's right to health and the denial of the state's duty to guarantee it).

Health professionals also claim they serve users as a whole, holistically, and not only their needs and / or complaints at query time, according to some accounts the host is given based on the sensitivity and understanding of being (as a social entity) and referral to specialists:

> *(...) So we have to be sensitive to each other as a whole. Completeness - see the other as a social being, emotional. That's what we have to learn to succeed in health, understand? And like people. (...).(Flor de lótus).*

> *There in clinical medicine, where has query first time, or when I see a person needs, if you are overweight, I forward to the nutritionist. If you need for the psychologist, because you will not acupuncture, why do not you go in shiatzu, because you will not in Dra? (...).(Rubi).*

Clarifying the concept of completeness, we view this as a guarantee of supply of an integrated and continuous set of actions and preventive, curative and collective, required in each case for all levels of complexity of care.[1] Encompasses the promotion, protection and health recovery which in reality exposed there was a denial of that precept . For professionals reported that no formality in the routing system, there is no guarantee of this service where the patient is referred and that much less they follow what was provided in the referenced services.

In health services studied, the basis of completeness is not fully put into practice by the varied and complex problems that reality offers services: failure of integration of program activities and service to spontaneous demand, lack of coordination of actions to promote health, disease prevention, health surveillance, treatment and rehabilitation, working in an interdisciplinary manner and staff, not management care coordination services in the network.

In this context it is necessary to consider the entirety of the SUS as a guideline, is influenced by socio-cultural and organizational factors that shape health practices in the interaction of stocks and intra / intersectoral work aimed at treating all the needs of the individual, so that the use of services could result in an interaction between consumers and providers of services.[9] This meaning, of great political and social magnitude, appearing in official documents, strictly speaking, it is urgent to be investigated in studies that will clarify "non-technical phenomena" to meet the principle of completeness.

As to the offered care, health professionals say the care is not longitudinal and it depends on the user. Moreover, the user does not give continuity to referrals and only back to when CMS is in poor health and in need of medical care:

> *(...) People look here at the center, has solved that problem and stopped the pain is no longer with problem goes away, does not have the longitudinal care. (...) Here we even creates bond because the person is, but it is another bond reliability. And here they come more to solve immediate problems. (...) Lack of continuity but by most of them (...) and accessibility as well (...).(Maçã).*

> *I do care, do they all come with motherhood newborn baby, she comes and we headed for family planning and in the beginning they give continuity, then stop coming (...).(Cristal).*

For the NHS and primary care longitudinality requires the existence of regular supply of care by the health team and its consistent use over time, in an environment of mutual respect between staff and humanized health, individuals and families.[1]

In this sense it is necessary to emphasize that the primary health care requires the fulfillment of the following grounds: allow universal and continuous access to quality health

services and resolute, characterized as the preferred gateway of the health system, with ascribed territory so to allow decentralized planning and programming, and in line with the principle of equity.[1]

We note that CMS under study would not be able to contribute to the care longitudinality because according to professionals such centers, the main deficiency in care is the lack of resources, joint and formality between services hampering the continuity of the actions unit and those with which we have to articulate.

3.2) The primary care services is the preferred entrance to the SUS

All health professionals recognize that primary care is the entry to SUS, however, they claim that spontaneous demand is greater than the scheduled. This finding, in a way, for them, shifts the focus of primary care that is the promotion and protection of health, through scheduled appointments, and outpatient clinics and health education activities. The professionals interviewed also recognize that there is a lack of rights and duties in the SUS, both by them and by population.

> *(...) The gateway system is the basic attention is here that he has to go, it does not help go to the Souza Aguiar, an exam that there do not come here. [...] It is the gateway pro system. The unit, it works well, it is each individual responsible (...)(Flor de Lótus).*
>
> *In dentistry the demand is much greater than supply ability, this is where the reality (...)(Uva).*
>
> *Scheduled demand is very interesting now our reality is the spontaneous demand (...) (Kiwi).*
>
> *There is a distance, still considerable, about what it preaches law and health facilities, including the one I work to offer answered populations (...)(Begônia).*

According to the National Primary Care Policy, basic care should be preferred gateway to the NHS, and the starting point for the structuring of local health systems.

Professionals report that there is a lack of coordination between health units with respect to the reference and counter-reference the internal dimension of the shares, it undermines service and does not warrant the resolution of the problems nor the host and the external dimension complicates the structuring of local systems. However, they also say that the accountability of professionals who engage in work to guarantee this principle into your workplace to give solving the user is required.

For professionals there is a gap between theory and constant official discourse of public policies of government than actually occurs in practice in health facilities, especially those CMS health. This, according to participants undermines the professional assistance and makes recognition of the constitutional rights of users.

When the spontaneous demand of users is greater than the programmed demand, this may mean that users are looking for less health facilities to consult with professionals and information about health promotion and prevention, only when looking for units already

are with any grievance related to their own health, while recognizing that the provisions of the policy states that spontaneous demand is preferentially targeted primary care, this is not exclusive.

Therefore, we know that access to services and information about your rights and duties of users generates behavior change, facilitates the identification of programs offered, enables a care / self-care quality and makes the CMS health reference be avoiding reference diagnosis and treatment of disease.

3.3) The articulation of the Municipal Health Center with the Family Health Strategy is in transition

Currently there is a movement of the Municipal Health Secretariat of Rio de Janeiro which is characterized by motivation and encouragement for professionals and managers of CMS, towards the implementation of the ESF in primary care.[1] However, health professionals do not feel prepared to shift the focus of primary care, which is with its inclusion in the ESF. In addition, they report that missing or is in transition to the relationship between CMS and the ESF; conflicts between professionals and CMS FHS ie lying; these cases to characterize the CMS as a mixed unit. What does it mean that there is a gap between the government and the reality of the proposed services:

> *(...) Our model is getting outdated because of the stimulus itself that exists to implement the family health strategy which is now in terms of primary care so that trying to implement. (...) What happens at that point is that not everyone is prepared for this change. (...) And understand what the difference is than we were then and now? The health of the family today. What is the municipal health center? It is a stable unit, stop waiting for the patient to enter. The health of the family does. (Flor Begônia).*

> *(...) There is no unit interface with the program of family health; I believe that missing link between the spheres. This causes estrangement from theory to practice (...) But what is missing here is the rule to say what role within the NHS, which is the hierarchical power. (Margarida).*

Currently, Family health is a priority for the organization of the Primary Care Strategy, as it is perceived by the state as a strategy for reorienting the health care model, operationalized through the implementation of multidisciplinary teams in primary healthcare units. These teams are responsible for monitoring a set of families, located in a defined geographical area number, the teams with actions for health promotion, prevention, recovery, and rehabilitation of diseases most frequent disorders, and in maintaining the health of this community. Therefore, in this conception, the health of the family as a structuring strategy for local health systems has led to an important movement in order to reorder the model of the SUS.[1]

The expansion and qualification of primary care, organized by the family health strategy, make up part of the overall policy priorities set by the Ministry and approved by the National Board of Health This concept is developed through management and health, democratic and participatory practices in the form of teamwork, targeted at populations of

defined territories for which they take responsibility, thus overcoming the former proposition character exclusively focused on the disease.

Although labeled program, PSF, for their specificities, evades the usual other programs designed in MS design, since it is not a vertical and parallel to the activities of health services intervention. Rather, it is characterized as a strategy that enables the integration and promotes the organization of activities in a defined territory with the purpose of providing coping and resolution of identified problems. Thus, PSF elects as the central point for bonding and creating bonds of commitment and shared responsibility between health professionals and the public.[1]

However, we can see by the CMS speech that there is a government stimulus to implement the strategy of family health, perceived by professionals as the main current focus on primary care. However, this new strategy of primary health care causes confusion with regard to the concepts and limitations of health professionals by the CMS and the ESF, to be conflicts between them. These problems hinder the integration between the spheres of primary care and the implementation of actions in the FHS.

The professionals of CMS recognize that promotion, prevention and even forwarding do not fit the traditional "functional and organizational culture" of them, which one called "Stop institution" while the "ESF is in motion."

This "movement" of the FHT professionals, their reports and observations during the workshop, it should be that they act in the collective with users and community workers that are the interface and direct dialogue with users and the FHS team and with this CMS. Here comes the conflict of the phenomenon "Stop institution (CMS) versus movement (ESF)", ie, the joint does not happen in an effective and resolute manner. Strictly speaking, this phenomenon should be further explored and expanded on further studies.

3.4) Differences in training and professional training

Based on these reports below found that professional training is identified by professionals as essential to quality management and attention, as the responsibility of government and for the benefit of all involved in the system. We note that reports are clear about expectations and goals of training / qualification: must basically be systematic, coordinated with the reality of the service and for all.

> *There is a lack of training and updating of health professionals in the NHS standards (...)(Margarida)*
>
> *Are sporadic and spaced training. Here in general within the gynecology deficit we also have staff, also of the personnel, training, training in dealing with customers, training in basic technique to assess whether the patient is good or not for whom he shall direct. (Açaí).*
>
> *It would be wonderful if there was unity in lectures, training courses, seminars. We must be updated to improve our technical level, learning new things to use for the benefit of all. (Maça).*
> *We work in that sector learns the routine that sector and if you do not have to delve own interest to seek alone. (Morango).*
>
> *Basic health care is deficient need for professional updating, engaged professionals, disclosure, hi. (Amora).*

> *Governments should be enabling professionals (...).(Cacau).*

> *It is sporadic. So, beyond the capabilities are sporadic, I think they fall into nothingness because this training, she had to be local. She had to be systematic, regular and local. (Esmeralda).*

> *So well, suddenly appears, as appears whenever a training that day appears. So I have to leave, because I'm the only one there, right're representing for there to be working with the group. 'm The only one at the time, then suddenly fell to a training course that day I go, I would not. Get it? (...) But, when it does not, does not, because of this professional deficit. (Ónix).*

Capacity building and training are included as important and necessary for health professionals to learn and act. For some of the study participants CMS empowers, however others recognize that there is lack of training and knowledge of the operating rules of the SUS. Yet these learning modalities should suit this lack of conceptual / programmatic elements that assist in learning and improve the quality of care, for example, the humanization.

It is necessary to emphasize that empower expresses the sense of become skilled and able to perform a function, the person is qualified for a particular job. And training refers to train, enable, and empower them to an activity or work. Empower empowering for professional performance and enables train for the activity, and the set of activities would set performance. Ie need to empower themselves of theory and practice, and need to train yourself to practice the activities. Therefore, we realize that these two terms have a common point, which is the professional continuing education, one that prepares man for the workplace.[10]

The training as described in its procedural form requires three stages: training, development and training. Vocational training is understood as the process experienced in schools and / or colleges under the guidance of an educator (institutional). Development refers to growth over the experiences of service (personal) process. And, we also understand as an educational training process applied systemically during their applied course work or outside it, by training people learn theoretical and practical (professional) knowledge. In people develop attitudes and skills according to defined objectives to qualify his performance at work .10

Thus, the CMS surveyed, it was found that the BANP the perspective of the NHS, it confronts the reality of services, with a great challenge to the qualification of management and attention. This relates to compliance with the enhancement of health professionals primarily through the stimulation and the constant monitoring of your training / qualification / training and competence of the Ministry of Health at the federal, state, municipal and local levels and, in conjunction with the Ministry of education. As a result, we found in this study in an aggravating professional qualification for his performance in innovative government proposals in primary care which states: concern, motivation and risk in acting according to programmed and supposedly trained.

CONCLUSION

The SUS is today the most important and advanced public health social policy underway in the country, as conceived philosophically and technically defined by the government as well recognized by national and international scholars and, dare we say also recognized by health professionals.

This recognition is required of managers and professionals in the NHS, a constant movement of changes and adjustments, the path of reform or incremental innovations and expansion of health care coverage. However, we can infer that this model seems to be exhausted for several reasons. Primarily by three complicating: a) difficulty of imposing general rules to be as large and unequal country; b) fixing technical and normative content of procedural character, treated quantitatively in general with high complexity and excessive detailing and, c) maintenance of inadequate attention to the quantitative / qualitative resources necessary to achieve the principles and actions programmed set of policies.

Despite BANP be based on transverse axes of universality, comprehensiveness, fairness, and accountability longitudinality; care practice does not address in its entirety, is quite evident in the reports of the professionals that there are serious problems between the official discourse and everyday services, among others, the inadequacy of the physical area , the lack of human and material resources, which lead to adaptation professionals and the impracticability of compliance with the guiding principles of the NHS. What undoubtedly compromises the assessment of the impact of service and assurance solving, accountability, longitudinality and completeness of care provided and in relation to the primary care model.

For professionals the problems, controversies and conflicts experienced in the application of rules, actions and assignments in primary care is an indication to treat the divergence between training, capacity building and training with practical work of professionals which for them is sporadic, it is not specific every sector and non articulates activities between CMS and the ESF. This is a factor that makes the integration between the spheres of primary health care and the implementation of actions in primary health care.

Finally, the development of this research in nursing enabled the construction of a body of knowledge itself, providing empirical support in locus in basic health units, to obtain facts / events, concepts / perceptions that they can argue and / or substantiate

debates / discussions, reflections / critiques, actions / proposals and the search for alternative solutions to the problems experienced daily.

The assertion that ensure quality of care and access to services is related joins the collective, joint and innovative work in the internal / external framework and relates the effectiveness of the system of reference and counter reference, which would ensure the continuity of actions the prospect of a proper organization of services aimed at institutional / professional accountability.

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