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Management and Care Development Plan: A Tool from the Institutional Support/FESF-SUS to Primary Care Management Teams

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Abstract

The management model in municipal health departments (MHD) is influenced by a **hegemonic managerial rationality,** which undermines primary care management, complicates the transformation of the technical care model, and distances the management team from its object of study: care provision by Family Health Teams (Equipes de Saúde da Família – EqSF). One of the goals of the State Foundation for Family Health (Fundação Estatal Saúde da Família – FESF-SUS), created in Bahia in 2009, is the development of municipal management through the **shared management** of contracted services. Strategies to achieve this goal include Management and Care Development Plans (MCDPs), which were developed between the institutional support team and the Monitoring and Assessment Committees (Comissões de Acompanhamento e Avaliação – CAA) and serve guides for monitoring the management contract. The MCDPs were developed in 22 municipalities, and they recommended the identification of priority needs of both the institutional support and the CAAs based on a shared management perspective. An important requirement that some of the CAAs identified was the reorganisation of the work process involved in coordinating primary care and implementing municipal institutional support. Institutional support as a "way of performing" primary care management can transform the teams' work processes in ways that affect the provision of health care.

Introduction

Many municipal health departments (MHD) in Bahia are characterised by management teams[1] that are heavily burdened with administrative tasks (e.g., buying supplies, maintaining permanent equipment, and labour management) for which they are insufficiently staffed. These teams' work processes are overwhelmed by administrative issues, leaving little opportunity for the teams to reflect on and question how the work is proceeding.

These characteristics decrease the MHD's ability to properly organise its primary care network, which significantly weakens their focus on issues that are crucial for strengthening primary care: organising the Family Health Teams' (FHTs) (Equipes de Saúde da Família – EqSF) work process in a comprehensive and multidisciplinary manner, providing continuing education as a management tool, and the organisation of the complex daily routine of the Family Health Units (FHUs) (Unidades de Saúde da Família – USF).

It is understood that this method of primary care management is influenced by a hegemonic managerial rationality, which, according to Gastão (2000, p.23)

> Produces management systems that are based on the imprisonment of will and the expropriation of the majority's possibility to govern. These systems not only buy the workforce, they require workers to renounce desires and interests, replacing them with objectives, rules, and work objectives that are unrelated (strangers) to them.

This rationality has substantially reinforced the verticalised nature of Brazilian public health policies. The management model in primary care has been highly influenced by hegemonic managerial rationality as a result of the way the Family Health Program (Programa de Saúde da Família – PSF) was introduced in the 1990s. This highly centralised funding model has made significant contributions to this verticalisation. Therefore, hegemonically organised primary care management practices have minimal dialogue with care practices and often develop strategies to control them, leading to a decrease in the management's influence on the provision of care in the FHTs.

The State Foundation for Family Health (Fundação Estatal Saúde da Família – FESF-SUS) provides a means for overcoming this weakness. The FESF-SUS is a privately regulated public foundation that has been established in 69 municipalities of Bahia. It aims to develop health care programs, particularly the Family Health Strategy (FHS) (Estratégia da Saúde da Família – ESF), in an articulated and shared manner, with the guiding principles of **institutional support, continuing education, management by results, and statewide intermunicipal careers**. The FESF-SUS belongs to the Unified Health System (Sistema Único de Saúde – SUS) and includes within its guidelines the integration of health policies among all entities of the unified health system in Bahia, in particular, the Ministry of Health, the State Department of Health, the Municipal Health Department, the State Health Council, and the Municipal Health Councils. The FESF-SUS aims to improve, strengthen, and expand health care throughout the state.

The FESF-SUS was established in 2009 after extensive discussions about instances of social control of the Unified Health System in the State Health Conference and the State Health Council and after intense legislative mobilisation that resulted in the passing of municipal laws that instituted the FESF-SUS in 69 municipalities. Jurisdiction was discussed, and the Foundation's Board of Trustees decided that even municipalities that were not founders would be eligible to create a programme contract with the FESF-SUS. Sixty-nine municipalities did so, though not exactly the same ones that created the institution. Among these 69 municipalities, 39 initiated the services described in the management agreement.

The first FESF-SUS program took place nationwide in March 2010. The first professionals began to practice in the contracted municipalities in August of that year.

The FESF-SUS currently manages FHS services in a shared manner in 38 municipalities in Bahia. The services include health care development; medical, nursing, and dental surgery services; matrix support (by professionals who comprise the Family Health Support Centre (Núcleo de Apoio à Saúde da Família – NASF)); and municipal management support and development services (through health professionals incorporated into the team). These services are transdisciplinary and aligned with the institution's guiding principles, highlighting the role of institutional support and continuing health education.

The appointment of a monitoring and assessment committee (Comissão de Acompanhamento e Avaliação – CAA) was established as a counterpart to the municipalities for the follow-up, evaluation and monitoring of the services noted in the programme contract. The committee has at least one coordinator and one or more supporters and should be composed of representatives of each MHD's management team, preferably those who deal directly with FHTs. The monitoring and assessment committees are therefore generally composed of primary care coordination professionals.

Care as a management work object

It is important to consider that health care is produced in diverse ways that are often conflict and is a social and subjective construction that continually changes depending on each period's social, political, economic, and cultural contexts. Health practices, in turn, are the result of how health work is organised to provide care.

Merhy (2002) also notes that like education, the product of health work is consumed at the same time it is produced (i.e., during the encounter between health professionals and users); therefore, it is simultaneously an action and a product.

The technical care model[2] in use, referred to as hegemonic medical model (HMM) by Silva Júnior (1996), is a result of these transformations in health work organisation and the resulting practices. Health care practices are ultimately determined by the way each health professional chooses to perform his or her work, using the enormous level of freedom he or she is granted.

However, because it occurs in real time, health work depends on the actors who are present during its delivery. It is therefore understood that tensions will exist depending on the interests that each of these actors brings to the relationship. Despite the unequal power

relationship operating in such encounters, the type of care that will result cannot be precisely determined and is in constant dispute.

This understanding of the subjective nature of care (MERHY *et al.*, 2012) relates to the considerable level of freedom health professionals have in their work and leads us to think that the world of health work is almost not susceptible to control and standardisation. According to Franco *et al.(*2012, p.1):

> ... the standards of Family Health Strategy, which aim to standardise the worker's behaviours according to the rules dictated for program functioning, influence the workers' activity within very strict limits because when these standards meet in the work situation, in relation to the user, it is the user himself in action, in his work process, who defines how this care is performed. Therefore, the ability of management levels to influence each worker's daily activities is reduced and highly differentiated.

However, this also suggests that these areas can be occupied in various ways and are constantly changing; therefore, they are likely to be transformed by the production of other ways to perform care and the meetings that occur in the daily routine of a health service, such as in the Family Health Units, or with the professionals who coordinate primary care in a MHD and those working on a family health team *"in the microcosm into which each one is inserted, and where it micropolitically operates "* (MERHY *et al.*, 2012, p.1).

Taking the example of the Family Health Team, any strategy that aims to engage with its work process to transform it, and thus transform the production of care, must consider the subjectivity of this process.

Transforming the HMM, as expected from the Family Health Strategy, involves creating opportunities to analyse and contribute to the transformation of care production, from the organisation itself to the teamwork process.

Merhy *et al.* (2003) present a critical analysis of the Family Health Strategy proposal and its role in transforming the technical care model. These authors state that

> Team formation, work displacement to the territory, and the encouragement of health surveillance work suggest a change in the way health is produced; however, the micropolitics of the work organisation reveal, especially in clinical activity, a care nucleus that continues to operate a process centred on the instrumental logic of health production (MERHY and FRANCO, 2003, p. 320).

Certainly, with the understanding of the deep complexity of such processes and the limits that changing the management model have in this transformation, it is known that a weak management team that does not have the technology to address the FHT's work process can contribute very little or not at all to the transformation of the HMM, and a strong management team can help strengthen it.

According to Merhy (2007, p.26):

> One cannot discard the different managers' relative empowerment zone designed by the health system. There are levels of system management, together with each health facility, in which the level of freedom allows individual negotiations in their institutional public spaces, on the aspect of the care model to be pursued on a day-to-day basis in making health

interventions. Relying on this provides a very positive weapon for those involved in changes in model direction.

It is therefore understood that the primary care management team of a municipality should be able to understand the complex work process organisation dynamic in an FHT to question it and ultimately contribute to its constant transformation. In short, the organisation of the FHT's work process should be the main goal of these management teams. This goal requires the team to fill its "toolbox" with technologies that can accommodate the complexity of the health care world and primary care in particular.

However, the monitoring and assessment committee and the FHT often interact to address goal setting, employee complaints related to problems with infrastructure, distancing, and emptying and estrangement. Conversely, the primary care coordination process, for instance, is usually focused on solving immediate problems related to labour management (e.g., dismissal, admission, and vacation periods) and infrastructure (e.g., equipment maintenance and repair, providing materials and supplies for the FHUs, and scheduling vehicles to ensure home visits). A low capacity for self-analysis is also very common in these management teams, particularly in relation to the organisation of their work in terms of scarcity of spaces for meetings, committees, and planning workshops. Even when these areas exist, they have the significant inherent weakness of being predominantly operational.

The FESF-SUS understands that improving and strengthening primary care in Bahia involves developing strategies, devices and technologies that strengthen the management teams working in the contracted municipalities' MHDs. Regionalised institutional support, shared management of contracted services, and continuing education that integrate all performed actions, are the main tools used for this purpose.

One of the services the FESF-SUS offers contracted municipalities through the management contract is institutional support, which aims to develop municipal management to improve primary care. Institutional support is a set of activities directed at institutions, organisations or groups of subjects and conducted by one or more external agents, known as institutional supporters, and guided by the Wheel or Paideia Method (CAMPOS, 2000). The Wheel Method

> is a method to support the co-management of complex production processes. It was based on the critical reading of experiences and traditional texts from the fields of politics, planning, institutional analysis, and continuing education (CAMPOS, 2000, p. 185).

Furthermore, the Wheel Method "aims to support the production of values of usage and organised collectives.... In this sense, it is a management method.... It simultaneously supports the development and implementation of projects and the construction of organised collectives" (CAMPOS, 2000, p.185).

Institutional support entails a particular "way of performing", combining the deployment of a particular political project (in the case of health care, this project is a given technical care model) with the goal of achieving specific results. Institutional support recommends collaborations between two or more actors to establish dialogue, mediate conflicts, and negotiate priorities. It also provides offers and constructions of knowledge and technologies to expand the actors' ability to analyse situations and improve their ability to address identified problems.

In the context of the relationship between the FESF-SUS and contracted municipalities, the actors who participate in these institutional support meetings are primarily the institutional supporter from the Department of Contracts and Institutional Support (Coordenação de Contratualização e Apoio Institucional – COCAI) of the FESF-SUS and the members of the municipalities' monitoring and assessment committees (Comissões de Acompanhamento e Avaliação – CAA).

Organisation and characterisation of FESF-SUS's institutional support

Bahia is divided into nine macro-regions based on the Master Plan for Regionalisation (Plano Diretor de Regionalização – PDR) (BAHIA, 2012). Institutional support is one the services that FESF-SUS offers contracted municipalities, and it is accomplished via reference institutional supporters for a set of municipalities, distributed regionally and according to the master plan for regionalisation.

The support team consists of nine approved professionals who are public employees of the FESF-SUS and were invited to act as institutional supporters because of their training and professional experience; these professionals include nurses, dental surgeons, and psychologists. The supporters' work process consists of building a supporting relationship with the municipalities' MHD, specifically by coordinating the primary care and FHT professionals with the FESF-SUS's workers.

The institutional supporter helps to coordinate the FESF-SUS's offers and actions with municipal, state, and federal health policies in the territory in which the FESF-SUS operates. Therefore, the institutional supporters act as reference sources for these municipalities, developing a close relationship with them and becoming one of the main links with the FESF-SUS. The institutional supporters are in constant contact with the MHD and the FHTs, both through visits to the municipalities and by phone or e-mail. The FESF-SUS supporters also align their work in the territory with the work of institutional supporters from the Department of Primary Care (Diretoria de Atenção Básica – DAB) and the State Department of Health (Secretaria Estadual de Saúde – SESAB) and with teams from the Regional Health Boards (Diretorias Regionais de Saúde – DIRES) linked to the SESAB.

The supporter's role is based on solidarity, dialogue, and pedagogy development with the municipal actors to produce an environment for exchange and growth, combined with shared service management and constant development; continuing education as a structuring guideline; and the improvement and strengthening of primary health care as ultimate goals.

The Management and Care Development Plan (MCDP) as a tool from the FESF-SUS institutional support

To assist this process, the FESF-SUS has developed some work tools for the supporter that can also be used to produce actions. One of these tools is the Management and Care Development Plan (MCDP). The MCDP is an action plan developed by the FESF-SUS's institutional support and the Monitoring and Assessment Committee based on an analysis of the primary care situation in each municipality and the identification of priority problems that must be resolved to advance in the construction of an agenda between the institutional support personnel and the Monitoring and Assessment Committee. This agenda is based on concrete possibilities of

action from the institutional support and aims to strengthen the shared management of services.

The development of the MCDP is one of the management contract's goals. The MCDP should occur yearly in each contracted municipality and should be reviewed and redirected through the negotiation of and agreement on a new plan with the Monitoring and Assessment Committee.

The process of dialogue, analysis and plan-building in conjunction with the Monitoring and Assessment Committee is initially triggered by the municipality's institutional supporter at the end of a six-month period of FESF-SUS service in the municipality. To create this plan, meetings are held between the Monitoring and Assessment Committees and the FESF-SUS's institutional supporter, who seeks to establish planning spaces via a survey of the municipality's priority demands, negotiations about which of these demands are likely to be addressed jointly by the municipality and the FESF-SUS, and the creation of a plan of action.

The Management and Care Development Plan therefore constitutes a "nautical chart" that will guide the institutional supporter's work in the municipality and serves as a base for creating a visiting schedule for each municipality and the supporter's goals. It also provides a way the municipality to follow, monitor and assess the work of the institutional supporter, thus bringing transparency to this process.

Some reflections on the consequences of developing management and care development plans

Despite the development of a model instrument for developing the Management and Care Development Plan (i.e., an action plan), each municipality followed a unique process that depended on the institutional supporter, the relationship between the supporter and each management team, and the local context. Therefore, formal plans were not always produced; instead, the process resulted in guidelines for the relationship being built between the actors.

Workshops for building Management and Care Development Plans were held in 22 municipalities. In some municipalities, the process arose from an offer from the FESF-SUS, making it difficult for the municipal management to accept the plan as a device for rearranging its work. In other situations, the construction of the Management and Care Development Plan occurred in an almost natural way as an unfolding of the relationship between the institutional supporter and the Monitoring and Assessment Committee.

The development of the Management and Care Development Plan in the municipalities enabled a maturing of the team of Institutional Supporters, leading to the identification of their weaknesses and potentials. This directly impacted the team's internal agenda and led to the use of COCAI's weekly collective spaces for the exchange of experiences, the development of theoretical insights on a particular subject, and corrections of trajectories in the organisation of their work.

There is also a strong element of subjectivity in primary health care management. As in health care production, primary care management occurs (or should occur) through meetings between the primary care management team and the FHTs. It could therefore be noted that the members of the Monitoring and Assessment Committees have experienced different

processes, including resistance to change; adhesion to the proposal, which was viewed as an opportunity to produce changes they thought necessary but could not achieve on their own; and moving outside comfort zones. It is clear that these processes occur, to a greater or lesser degree, in all meetings between FESF-SUS's institutional support and the Monitoring and Assessment Committee; however, the prospect of establishing an "external" relationship with FESF-SUS based on agreements and a longitudinal relationship arising from shared management has produced unique results.

The following demands arising from the development of the management and care development plans were highlighted: the implementation of municipal institutional support; the development of planning, programming, and monitoring tools; the development of continuing education; and the implementation of co-management spaces in the MHDs (e.g., primary care boards).

Municipal institutional support: another way to organise management

An important feature observed in the primary care management teams' work process was that they provided minimal support to FHTs. Traditional management logic was prevalent in this relationship. Such traditional models do not offer opportunities for reflection, collective construction, or subjective expression and establish a vertical power hierarchy that creates distances between those involved (CAMPOS, 2000).

Traditional management logic is characterised by management practices that are distant from health care professionals' provision of care. Another feature is diminished meeting and dialogue spaces and the building of contracts between MHD management and primary care workers.

It was therefore very interesting to note that the implementation of municipal institutional support was an important demand in several municipalities. This fact caught the attention of the supporters and was understood as a desire to transform management practices. This led the team to develop a project to implement municipal institutional support (which would be presented, discussed, and implemented as needed in each municipality) in a structured manner.

It was assumed that institutional support in a municipality's primary care programme could have at least five possible results:

· The establishment of a reference team for FHTs;

· The reorganisation of the primary care management teams' works processes, with repercussions throughout the entire MHD;

· The establishment of a closer, more solidary and more horizontal relationship with the FHTs;

· The reconstruction of the primary care management team's goals, bringing into focus the FHTs' work processes;

· The development of offers from the reference team to the FHTs that contribute to the organisation of the FHTs' work process in accordance with the technical care model recommended by the Family Health Strategy.

A map of the FHTs' work process was performed in municipalities where the need for municipal institutional support was addressed in the MCDP. This allowed everyone involved to identify previously unnoticed aspects and create an achievable image-objective. Interestingly, the results of these maps, which were created in at least five municipalities, were very similar, indicating an organisational that was reproduced in different situations.

Obstacles and powers of shared management

It is important to note that the construction of the MCDP is one way of achieving one of the FESF-SUS's pillars: shared management. This embodiment of the associated management of health services was proposed with the implementation of the FESF-SUS in Bahia in 2009, under the new management models for the Unified Health System. This process is extremely new and challenging and requires considerable effort from those involved to ensure that innovations result instead of repetitions of the old processes.

To advance in this perspective, it is necessary to create logics of negotiation and agreement that involve the micropolitical dynamics of management practices and consider the subjectivity of people performing these practices in complex situations and are intersected by several types of interests and disputes in the social arena that is the health field. Such practices remain very incipient in primary care. Despite the lack of proposals that can cover each of these aspects individually, it is possible and necessary to develop management technologies that encourage and value the participation of all the actors, allowing them to address their projects, their truths, and the meanings built around their work and providing the forms of organisation to achieve them.

To produce changes in the planning and management forms used in the Unified Health System, such authors as Merhy *et al.* (2007), Cecílio (2007), Campos (2000), Onocko Campos (2003) and Franco *et al.* (2007) have produced a critical debate within the context of Brazilian health reform. In the course of this debate, these authors have questioned hegemonic managerial rationality and the current methods of health planning. The resulting proposals such as adaptations of situational strategic planning, flowchart descriptors, and analytical maps, among others, can help produce perceptions about the micropolitics of work process and care provision that may not be obvious on day-to-day basis in health service and can increase the number of supportive encounters between the actors involved in health care and management.

However, these proposals did not emerge as tools and devices alone; rather, they were created in a broader context as a theoretical, technical, and political methods for transformations of health services within the context of a particular technical care model.

It is therefore important that strengthening and management development processes focused on primary care be accompanied by other strategies that address the same issues. These include the improvement of professional contracts in the FHTs, decreased turnover of health care professionals, continuing education, and career development in Family Health Strategy. The FESF-SUS arose from the desire to address all of these issues and has already advanced in some areas, such as the improvement of professional contracts, career development, and strategies for continuing education.

The MCDP was proposed to municipalities contracted with the FESF-SUS and integrated with other actions and offer, in a concerted effort to create management and care technologies committed to strengthening and developing primary care in Bahia in a shared manner. However, the Monitoring and Assessment Committee must have some degree of governability, possibly including active participation from and involvement with Health Secretary, considering that the process involves negotiation and the selection of priorities and agreements that can have significant effects on the organisation of the work process.

Some degree of anxiety was often observed in the Monitoring and Assessment Committees that participated in MCDP participation. This anxiety arose because the committees did not have the full support of the health authorities to produce more substantial changes in primary care management. Even when the Secretary of Health actively participated in or supported the process, there was no close dialogue between the MHD and other municipal government departments. Some difficulty was noted because the implementation of municipal institutional support, for instance, required the redirection of duties previously assumed exclusively by the coordination of primary care for other sectors, which was made clear by maps of the management team's work process.

Conclusions

The process, rather than the tool, was most important during these meetings. Therefore, the appreciation of the subjectivities of day-to-day management and the creation of a change in management practices are central to a shared management relationship. This appreciation will improve the agreement and development of those involved.

The management improvement tools used by FESF-SUS's institutional support, such as the MCDP, should function as devices that interact with local reality and are of value for municipal management teams; otherwise, they become yet another plan that is built and then left behind by those who built it. Actor involvement ensures the success of the MCDP and supports the agreements made during its development.

Unlike standardising strategies, strategies that create new existential territories in health care have great power to influence the way health care is provided when they serve as devices in the production of care based on bonding, care, accountability, and problem solving and value, the creative and innovative potential in each health workers' interactions with users. These strategies can and should be offered to FHTs by municipal management teams and should support and encourage initiatives along that path.

A strategy that offers support as a "way of performing" primary care management and as a pillar of this strategy can be a beneficial catalyst for change in teams' work processes, for the production and support of co-management spaces in the units, and for the improvement of care.

Similarly, involvement with this process can support the organisation of structured demands to improve municipal management, with ongoing analysis of the work of the FESF-SUS's institutional support and the municipal management team (especially that of primary care). Furthermore, such involvement enables a transformation in these teams' objectives, bringing them closer to the work process of the FHT.

References

BAHIA. Plano Diretor de Regionalização. Available at: <http://www1.saude.ba.gov.br/mapa_bahia/PDR_POP2009_atualizado18-06-2012.pdf>. Accessed on 15 jun. 2012.

CAMPOS, G. W. S. **Um método para análise e co-gestão de coletivos**. São Paulo: Hucitec, 2000.

CECÍLIO, L.C.O. Uma sistematização e discussão de tecnologia leve de planejamento estratégico aplicada ao setor governamental. In: MERHY, E. E.; ONOCKO CAMPOS. v.1, p.151-167.

FRANCO, T. B.; MERHY, E. E. **Mapas Analíticos**: um olhar sobre a organização e seus processos de trabalho. Rio de Janeiro: Universidade Federal do Rio de Janeiro; 2007. Available at: <http://www.medicina.ufrj.br/micropolitica/textos/mapas_analiticos. pdf>. Accessed on 15 jun. 2012.

FRANCO, T. B.; MERHY, E. E. O Reconhecimento de uma produção subjetiva do cuidado. Available at: <http://www.professores.uff.br/tuliofranco/textos/reconhecimento-producao subjetiva-cuidado.pdf>. Accessed on 15 jun. 2012.

FRANCO, T. B.; MERHY, E. E. Programa de Saúde da Família (PSF): contradições de um Programa destinado à mudança do modelo tecnoassistencial. In: MERHY, E. E. et al. (Org.). **O trabalho em saúde: olhando e experenciando o SUS no cotidiano**. São Paulo: Hucitec, 2003. v. 1, p. 55-124.

FRANCO,T. B.; SILVA BUENO,W., MERHY, E.E. O Fluxograma Descritor e Projetos Terapêuticos em Apoio ao Planejamento: o caso de Luz-MG. In: MERHY, E.E. et al.(Org.). **O trabalho em saúde: olhando e experenciando o SUS no cotidiano**. São Paulo: Hucitec, 2003. v. 1, p.37-54.

MALTA, D. C.; MERHY, E. E. O percurso da linha do cuidado sob a perspectiva das doenças crônicas não transmissíveis. **Interface.** Comunicação, Saúde e Educação, v. 14, p. 243-255, 2010.

MERHY, E. E. **Saúde:** a cartografia do Trabalho Vivo. São Paulo: Hucitec, 2002.

MERHY, E. E. Um dos grandes desafios para os gestores do SUS: apostar em novos modos de fabricar os modelos de atenção. In: MERHY. E. E. et al. (Org.). **O trabalho em saúde: olhando e experenciando o SUS no cotidiano**. 4 ed. São Paulo: Hucitec, 2007. v. 1, p. 15-35.

MERHY, E. E. et al. Em busca de ferramentas analisadoras das tecnologias em saúde: a informação e o dia a dia de um serviço, interrogando e gerindo trabalho em saúde. In: MERHY, E. E.; ONOCKO CAMPOS, R. (Org.). **Agir em Saúde: um desafio para o público.** 3 ed. São Paulo: Hucitec, 2007. v.1, p.113-150.

ONOCKO CAMPOS, R. **O Planejamento no Labirinto**: uma viagem hermenêutica. São Paulo: Hucitec, 2003.

SILVA JÚNIOR, A. G. **Modelos Tecnoassistenciais em Saúde**: o debate no campo da saúde coletiva. São Paulo: Hucitec, 1998.

Notes

1. Here, despite the understanding that all of the people involved in shaping the health system are managed in their areas of activity (workers, managers, and users), those who are formally involved in health management in the municipality are considered managers/the management team, with a focus on primary health care.

2. Emerson Merhy's concept (2002, p.22) is used here. According to this concept, the technical care model "constitutes the organisation of service production from a particular knowledge arrangement in the area, as well as specific social action projects, such as the political strategies of a particular social group."

3. The shared management of contracted services among municipalities and the FESF-SUS refers to the idea that these two entities are responsible for service delivery and management, as defined in the management agreement.