Questionnaire of Shared Diagnosis in Primary Care: typical x expanded Family Health teams

Questionário de Diagnóstico Compartilhado da Atenção Básica: equipes de Saúde da Família típicas x ampliadas

Fábio Franchi Quagliato
Centro Universitário Barão de Mauá. Ribeirão Preto, SP, Brazil.
E-mail: fafranqua@yahoo.com.br

Antonio Ruffino Netto
Department of Social Medicine. Ribeirão Preto Faculty of Medicine. Universidade de São Paulo. Ribeirão Preto, SP, Brazil.
E-mail: aruffino@fmrp.usp.br

Aldaisa Cassanho Forster
Department of Social Medicine. Ribeirão Preto Faculty of Medicine. Universidade de São Paulo. Ribeirão Preto, SP, Brazil.
E-mail: acforste@fmrp.usp.br

Correspondence
Fábio Franchi Quagliato
Centro Universitário Barão de Mauá. Departamento de Saúde Coletiva.
Rua Ramos de Azevedo, 423, Jardim Paulista.
CEP 14090-180, Ribeirão Preto, SP, Brazil.

Abstract

Increase in clientele, relationship between the primary care team and the specialties, health promotion activities, and infrastructure conditions are organizational factors the Family Health Strategy needs to contribute to provide comprehensive care in the Brazilian National Health System. This article aims to compare the results of applying the Questionnaire of Shared Diagnosis in Primary Care (QDCAB), concerning the issues related to comprehensiveness, between typical and expanded Family Health teams in a town in the state of São Paulo, Brazil. The method and QDCAB were applied to typical Family Health teams and those having specialists in the major areas (expanded teams), and the analysis was conducted using the Wilcoxon-Mann-Whitney test, enabling comparison of the distribution of answers between the two team models. Expanded teams establish a rather collective bond (0.0026), however, there was no difference in the results of efforts in this regard between the two team models (0.7227). The low marks assigned to issues concerning the relation of the team to the specialists, overall, reveal the difficulties in ensuring comprehensive care. Health promotion activities were assigned high marks from both models. The adequacy of physical structure in the health center was assigned lower marks from the typical teams (< 0.0001). The relation of the teams to the specialists is an obstacle to ensuring comprehensiveness and, regarding typical teams, excessive demand and the infrastructure conditions also pose difficulties.

Keywords: Comprehensive Health Care; Family Practice; Health Education.

Resumo

A adscrição de clientela, a relação entre a equipe de atenção básica com as especialidades, as atividades de promoção à saúde e condições de infraestrutura são fatores organizacionais necessários para a Estratégia de Saúde da Família contribuir para proporcionar o cuidado integral no Sistema Único de Saúde (SUS). O objetivo deste artigo é comparar os resultados da aplicação do Questionário de Diagnóstico Compartilhado da Atenção Básica (QDCAB), no tocante aos quesitos referentes à integralidade, entre equipes de Saúde da Família típicas e ampliadas em um município paulista. O método e o QDCAB foram aplicados a equipes de Saúde da Família típicas e àquelas com especialistas das grandes áreas (equipes ampliadas), e a análise foi realizada utilizando o teste de Wilcoxon-Mann-Whitney, permitindo a comparação da distribuição das respostas entre os dois modelos de equipe. As equipes ampliadas estabelecem vínculo de forma mais coletiva (0,0026), porém, não houve diferença nos resultados dos esforços realizados nesse sentido entre os dois modelos de equipe (0,7227). As notas baixas atribuídas às questões relativas à relação da equipe com os especialistas, de uma forma geral, revelam as dificuldades para garantir a integralidade da atenção. As atividades de promoção à saúde receberam notas altas de ambos os modelos. A adequação da estrutura física do centro de saúde recebeu menores notas das equipes típicas (< 0,0001). A relação das equipes com os especialistas é um obstáculo para a garantia da integralidade e, para as equipes típicas, o excesso de demanda e as condições de infraestrutura também representam dificuldades.

Palavras-chave: Assistência Integral à Saúde; Medicina de Família e Comunidade; Educação em Saúde.

Introduction

The Family Health Strategy (FHS) has taken on an essential role for Primary Care through its amplification, qualification and consolidation, enshrined in the Health Agreement 2006 (Conill, 2008; Brasil, 2006). Ordinance nº 2,488, of October 2011, emphasizes one of the objectives of the strategy, that of "systematically evaluating and monitoring the results achieved, as part of the planning and programming process" (Brasil, 2011; Sousa; Hamann, 2009).

Among the most important FHS principles, comprehensiveness guarantees that the Family Health Team meets not only the biological but also the socio-cultural demands of the population assigned to them (Takeda, 2004). To achieve comprehensiveness, the population of the territory needs to be properly allocated in relation to staff (Conill, 2008). Otherwise, the team will encounter difficulties in their activities promoting health, prevention, treatment, rehabilitation and maintaining health, and thus fail to completely fulfill their role (Conill, 2008; Facchini et al., 2006).

Moreover, comprehensiveness and longitudinality depend on the bonds created and the responsibilities accepted between the teams and the populations assigned to them, also guaranteeing coordination of care and of continuous health care activities (Brasil, 2011; Sousa; Hamann, 2009). Bonds are necessary for the light technology used by the teams (Coelho; Jorge, 2009).

The territorialization process is an essential form of recognizing resources, permitting interactions that promote the population's own support network and recognizing already established needs (Sousa; Hamann, 2009; Viana et al., 2006).

The referral and counter referral system is also essential in guaranteeing comprehensiveness for constructing health care networks and for minimizing fragmentation of health care between the health care systems various levels of complexity (the authors..., 2012).

Finally, comprehensiveness also depends on the Family Health Strategy professionals' satisfaction and ability to resolve problems, which can be influenced by the physical structure of the health care centers (Facchini et al., 2006). This factor should therefore be considered when evaluating implemen-

tation and qualification of the FHS.

In many municipalities, Primary Care is organized into health care units with traditional teams, typical Family Health teams and expanded Family Health teams. According to ordinance 2.488/2011, the Primary Care Department recognized these combinations of teams in its organization and running, offering different forms of municipal primary network financing (Brasil, 2011).

If they are to be truly effective structures, able to develop stages to survey needs, diagnose and program activities for the population assigned to them, more needs to be known about the process of implementing and qualifying these primary health care models.

The aim of this study is to compare results obtained from applying the method and the Questionnaire of Shared Diagnosis in Primary Care (QDCAB) in the areas concerning comprehensiveness, between typical and expanded Family Health teams in a town in São Paulo state.

Material and Methods

This study was an epidemiological survey.

The method and the Questionnaire of Shared Diagnosis in Primary Care (QDCAB) was used. It was devised and described by Pinto in shared diagnosis in family health care teams (Pinto, 2008) in which the teams are asked to conduct self-evaluation. The method of applying the questionnaire to the team allows for group discussion and collective self-analysis and management.

The results obtained from applying the QDCAB in typical and expanded Family Health teams were compared. The typical Family Health teams had a GP, whereas the expanded teams had a GP, pediatrician and gynecologist, working with two or more teams. Thus, meetings were set up with member of the family health teams in the municipality of Ribeirão Preto which agreed to take part in the study. The QDCAB was applied in these meetings. In this study, the QDCAB items analyzed were as follows: the teams' relationships with the population assigned to them, knowledge of the territory, relationships with the specialists, health promoting activities and infrastructure conditions. These items were selected because of their importance in achieving comprehensiveness.

After applying the QDCAB to the Family Health teams, the responses of the typical and expanded teams were compared using the Wilcoxon-Mann-Whitney test, used for comparing two samples extracted from independent populations (Hart, 2001). The test makes it possible to evaluate whether there are significant differences in the distribution of responses between the two models of Family Health teams. The SAS System was used in this analysis.

The study was approved by the Research Ethics Committee of the Clinical Hospital belonging to the Faculty of Medicine, Ribeirão Preto - USP (Process HCRP nº 8.788/2010).

Results

The data were collected between May 2011 and November 2011. Twenty Family Health teams were interviewed, six of which were expanded Family Health teams and 14 of which were typical Family Health teams, with 137 Family Health Strategy professionals participating.

Of the 137 professionals, 34 were from the expanded teams and 103 from typical teams. Table 1 shows the distribution of professionals interviewed according to type of Family Health team.

Teams' relationship with the population assigned to them and knowledge of the territory

Chart 1 shows measures of position and of variability (mean, standard deviation and median) for the responses to the questions on the team's relationship with the population assigned to them and their knowledge of the territory.

There were no differences in the teams' evaluations concerning efforts made in establishing bonds and contract in the way they interacted with the families in the area covered (0.3614). Both models of teams allocated high marks to this question.

The way in which typical style teams establish individual bonds and contract in the way they interacted with the families in the area covered is more individual than that of the expanded teams (0.0026) and the expanded teams made more contact with new families than the typical teams (0.0001).

Table 1 - Distribution of the number of professionals according to profession and type of Family Health team, Ribeirão Preto, 2011

Teams	Community Health Worker	Doctor	Nurse	Nursing Assistant	Dentist	Dental assistant	Total
Expanded	17	5	5	4	2	1	34
Typical	56	11	10	21	4	1	103
Total	73	16	15	25	6	2	137

Chart 1 - Measures of position and variability for responses to questions on the team's relationship with the population assigned to them and knowledge of the territory. Ribeirão Preto. 2011

Questions	Expanded team			Typical team			
	Mean	Standard deviation	Median	Mean	Standard deviation	Median	p-value
Did the team make an effort to establish a bond in the way they interacted with the families in the area they cover?	9.58	0.93	10.00	9.50	0.77	10.00	0.3614
Is the form in which the team establish a bond in the way they interact with the families in the area they cover more individual or more collective?	6.04	1.84	6.50	4.63	2.30	5.00	0.0026
When a new family moves into the area covered, do the team make contact and establish a bond in the way they act with this family?	9.77	0.65	10.00	7.72	3.42	9.00	0.0001
Overall, how does the team evaluate the results of their efforts?	8.33	1.07	8.00	8.14	1.36	8.00	0.7227
Regarding the bond established with the community, how does the team evaluate the contribution of their efforts?	8.96	0.90	9.00	8.94	0.93	9.00	0.9933
Does the team know/interact with the territory for which it is responsible for health?	9.44	1.63	10.00	8.59	1.77	9.00	0.0028
Does the team (as a whole) make visits in the territory with the aim of getting to know the social, economic and health reality and the resources available for the team and the population to use?	9.00	2.25	10.00	7.05	3.58	9.00	0.0036
Does the team know/interact with community leaders in the territory?	8.78	2.01	10.00	6.08	4.18	8.00	0.0043
Does the team know/interact with health teams (pharmacies, doctors and dentists, laboratories and others) available in the territory?	2.89	4.17	0.00	4.85	4.81	6.00	0.0107
Does the team know/interact with education teams (crèches and municipal, state and private schools) available in the territory?	10.00	0.00	10.00	6.48	3.99	8.00	"0.0001
Does the team know/interact with leisure teams (sports grounds, squares, parks, football fields, football, art or circus clubs etc.) available in the territory?	5.69	3.70	7.50	2.75	3.59	0.00	0.0003
Does the team know/interact with NGOs active in the territory?	4.81	4.12	5.00	3.13	3.83	0.00	0.0370

Regarding the results of overall efforts and for the bonds established with the community, there was no difference between the two models of teams.

The expanded teams allocated higher scores to their knowledge and interaction with the territory in which they were responsible for health, and there were differences in the distribution of marks between the two models (0.0028). Likewise, the expanded teams allocated higher marks to making joint visits to the territory (0.0036).

As for the interaction with community leaders, the expanded teams allocated higher marks (0.0043), although the typical teams interacted more with health teams in their territory (0.0107). Interaction with education and leisure teams and NGOs were all allocated higher marks by the expanded teams.

Relationship with specialists

Chart 2 shows measures of position and variability (mean, standard deviation and median) of the responses to questions on the teams' relationships with the specialists.

Both models of team allocated low marks to the form of requesting referrals, due to the bureaucracy involved, with no difference between them (0.1061). There was a difference regarding the marks allocated to waiting times between requesting referral and it taking place, with the expanded teams perceiving this to be worse than the typical teams (<0.0001). Specialists' interaction with patients received poor marks from both models, with no difference between them (0.2828). The technical quality of the referral was better in the view of the typical team than that of the expanded team (<0.0001). There was no difference in distribution of marks concerning returning results from the referral to the team, with rather low marks allocated. The marks received for specialists' interaction with the teams were better from the typical teams (0.0017), as was the teams' ability to overcome fragmentation in health care when the patient was being treated in various specialties. Interaction with the home care and care teams received higher marks from the expanded teams (0.0095).

Chart 2 - Measures of position and variability of responses to question on relationships with specialists, Ribeirão Preto, 2011

Questions	Expanded team			Typical team			
	Mean	Standard deviation	Median	Mean	Standard deviation	Median	p-value
Regarding requests for referrals, how is the team's relationship with the specialists?	2.05	2.80	0.00	3.33	3.49	2.00	0.1061
What is the waiting time between requesting the referral and it taking place?	1.80	1.98	2.00	4.78	2.15	5.00	<0.0001
How is the specialist's positive interaction (politeness and quality of relationship) in patient contact?	4.32	1.75	5.00	3.84	2.05	4.00	0.2828
What is the technical quality (satisfactory and trustworthy responses to doubts) of the referral?	3.74	2.03	5.00	6.01	1.49	6.00	<0.0001
How are results from the referral returned to the team?	1.46	2.18	1.00	1.94	1.97	2.00	0.1974
How is the specialist's positive interaction with the team referring the patient?	0.00	0.00	0.00	0.99	1.78	0.00	0.0017
What is the ability of the team referring the patient to overcome fragmentation in health care when the patient has referrals to various specialists?	4.35	2.48	3.50	6.23	1.69	7.00	0.0024
Does the primary care referral team interact with the home care/care team?	7.38	3.85	10.00	5.85	2.16	5.00	0.0095

Health promotion activities

Chart 3 shows measures of position and variability (mean, standard deviation and median) of the responses to questions on health promotion activities.

Concerning conducting health education activities, there were differences between the two models of teams (0.0153), with higher marks allocated by the expanded teams. There was no difference between models concerning conducting self-care educational activities with patients and families (0.1329), with both groups allocating high marks. The expanded teams gave higher marks to lifestyle guidance and to conducting group health education activities. There were no differences between the two models of teams interviewed concerning evaluating patient adherence to regular follow up, evaluating patient's self-care abilities, encouraging patients towards such self-care and evaluating the patient's social support network. The typical teams gave higher marks to encouraging patients to form social support networks (0.0011). There was no difference in the distribution of marks regarding evaluating patients' family ties and evaluating whether they live with family members.

Chart 3 - Measures of position and variability of the responses to questions on health promotion activities, Ribeirão Preto, 2011

Questions	Expanded teams			Typical teams			
	Mean	Standard deviation	Median	Mean	Standard deviation	Median	P-value
Does the unit conduct health education activities to make it easier for patients and their families to be part of promotion, prevention and recovery?	9.28	0.98	10.00	8.48	1.51	8.50	0.0153
Does the unit conduct activities to educate patients and their families in self-care (handling probes and catheters, caring for the injured and changing dressings, taking medication appropriately, among others)?	9.28	0.98	10.00	9.63	0.69	10.00	0.1329
Does the referral team provide guidance on lifestyle?	9.76	0.66	10.00	9.42	0.84	10.00	0.0241
Does the referral team conduct group health education activities?	9.82	0.59	10.00	8.30	1.91	9.00	<0.0001
How does the team evaluate patient adherence to regular follow up of their health problems with the team?	7.41	0.50	7.00	6.89	1.77	7.00	0.5768
Does the referral team evaluate whether the patients have adequate self-care abilities (autonomy?	9.27	1.12	10.00	9.13	1.31	10.00	0.5637
Does the referral team encourage patients to achieve adequate self-care conditions (autonomy)?	9.50	0.91	10.00	9.50	0.72	10.00	0.6620
Does the referral team evaluate whether the patients have social support networks to adequately meet their needs?	9.14	1.39	10.00	8.57	1.51	9.00	0.0640
Does the referral team encourage patients to form social support networks?	5.18	2.04	6.00	7.11	3.13	8.00	0.0011
Does the referral team evaluate whether the patient has close family ties?	9.57	0.73	10.00	9.55	0.71	10.00	0.8708
Does the referral team evaluate whether the patients live with family members?	9.83	0.58	10.00	9.89	0.32	10.00	0.8131

Infrastructure conditions

Chart 4 shows measures of position and variability (mean, standard deviation and median) of the responses to questions on infrastructure conditions.

The marks given concerning patients' privacy were lower among the typical teams (<0.0001), as were those for availability of alcohol gel to disinfect hands (0.5212). The appropriateness of the physical space of the health center received lower marks from the typical teams (<0.0001). Concerning the cleanliness of the unit, there was no difference between the models of team (0.4067), with low marks from both groups.

Chart 4 - Measures of positon and variability of responses to questions on infrastructure conditions, Ribeirão Preto, 2011

Questions	Expanded teams			Typical teams			
	Mean	Standard deviation	Median	Mean	Standard deviation	Median	p-value
Does the unit have the minimum conditions necessary for patient privacy?	9.90	0.44	10.00	7.08	2.69	7.00	<0.0001
Conditions for the team to wash their hands (sinks, soap and paper towels in the dispenser)?	9.24	1.48	10.00	7.85	1.92	8.00	0.0009
Is glycerin alcohol available for the team to disinfect their hands?	9.14	1.31	10.00	8.89	2.57	10.00	0.5212
Is the physical space within the health center appropriate?	8.29	1.68	9.00	4.68	3.39	5.00	<0.0001
What are the cleanliness conditions of the unit?	6.10	1.70	7.00	6.04	2.36	5.00	0.4067

Discussion

The municipality of Ribeirão Preto has 24 Family Health teams, 8 being expanded and 16 typical. Of the expanded teams, 75% took part in the interviews, and 93.75% of the typical teams agreed to complete the questionnaires, with one team participating only in the pilot project. This adherence to the research may show greater availability on the part of the typical teams to discuss the problems they face and possible solutions as a team. Moreover, the presence of family and community doctors was more frequent during application of the questionnaire, as of the 14 teams interviewed, the doctors from 11 of them participated. In the 8 expanded teams, of the 10 doctors who were part of the unit, including GPs, pediatricians and obstetrician-gynecologists, only 5 participated.

The team's relationship with the population assigned to them and knowledge of the territory

The expanded teams established bonds in the way they interacted more in collective than individual activities, in contrast to the typical teams. This may be due to the fact that home visits, professional care and reception are important resources used by the typical teams in order to establish bonds, and which occur in an individual manner.

The greater contact with families new to the area covered in the form of establishing bonds on the part of the expanded teams may be due to the fact that typical teams have a demand and population assigned to them that is greater than is possible to absorb, hindering them from registering new families in the territory. Thus, the families already registered are given priority in the teams' contact, to the detriment of new families or those which have not yet made use of the health care unit.

In spite of these differences, the result of their efforts to establish bonds seems to be the same for both types of Family Health teams, who gave this question high marks.

Concerning knowledge of the territory, the expanded teams allocated higher marks to knowledge and interaction with the territory covered. However,

57.14% of the typical teams had been formed fewer than five years ago, whereas for the expanded teams, 33.33% had been formed fewer than five years ago. The expanded teams gave higher marks to joint visits to the territory than the typical teams, possibly as their professionals had had a longer period of preparation and training, as the teams were older, some dating back to the establishment of the Family Health Strategy in the municipality. The more recently formed teams were started to meet the population's care needs, without time for due preparation.

Knowing and interacting with community leaders, leisure and education teams and NGOs appears to be greater on the part of the expanded teams, although the typical teams have smaller territories that perhaps do not possess these resources. Interaction with these teams varied considerably between each of the teams, both expanded and typical, revealing the inadequacy of the pattern of urbanization in unevenly distributing resources (Conill, 2008; Viana et al., 2006, 2008).

Relationship with specialists

In general, the relationships of the Family Health teams, both typical and expanded, was viewed as fairly inadequate by the professionals interviewed, considering the low marks allocated to the questions on this topic. Although there are differences in perception of the waiting times between requesting referral and it taking place, technical quality of referrals and interaction between specialist and team, marks were poor from both models interviewed.

Difficulty accessing other levels of care, a factor that compromises comprehensiveness, was also identified by Conill (2008) in Florianópolis. The results reflect this difficulty through the poor marks allocated to the bureaucracy of requesting referrals to specialists and the waiting time between the request and the appointment with the specialist. Although the typical teams perceived the delay for referrals to be shorter, marks were low from both models.

Moreover, the areas assigned to the teams interviewed are peripheral, with populations that lack public services, similar to municipalities of over 100,000 inhabitants in which Family Health teams were established in historically neglected areas, compromising the integration of the health care network and the organization of the entire system (the authors..., 2012). Another characteristic of the municipality that contributes to the deficiency of the referral and counter referral system is the large number of complex outpatient cases and the historical hospital coverage in Ribeirão Preto, making it difficult to organize the Family Health Strategy as a priority care model (Viana et al., 2006).

The principle of comprehensiveness may be compromised by insufficient specialist-patient interaction. The marks were allocated according to the professionals' perception of interaction between specialist and patient. There were clearly no differences in this perception between the two models of teams, i.e. both groups demonstrated that the patients' information and opinions, on which the professionals based their marks, showed dissatisfaction with the referrals.

The teams' ability to overcome fragmentation in care when the patient is treated in a variety of specialties was greater in typical teams, possibly because of their greater facility in sharing information between the different professionals and their greater commitment in terms of taking responsibility for their assigned population. In any case, difficulties in overcoming this fragmentation are largely due to precariousness in returning results from referrals to the teams and to the almost non-existent interaction between specialists and Primary Care professionals. The relationship with specialists appears to be one of the weaknesses of the system, for both the expanded and the typical teams.

Health promoting activities

The marks given to health promoting activities were high for both models of team, being higher from the expanded team concerning conducting educational activities in general. However, one of the points raised by the typical teams was the difficulty in programming collective activities due to the high demands for individual care, as the assigned population was greater than the recommended 800 families per team (Coelho; Jorge, 2009; Sousa; Hamann, 2009; Takeda, 2004). This is reflected in the difference in marks allocated to conducting group health education activities, higher from the expanded team. Even so, all teams conducted col-

lective activities, aiming to guide the population on promoting health, prevention and recovering health. A characteristic that varied between teams was the participation of the different professionals in these activities, as the expanded teams did not have a medical team when conducting health promotion activities.

As with general health promoting activities, specific activities to provide guidance on self-care and to enable patient autonomy received high marks, contributing to the success of treatment and providing greater patient collaboration.

The high marks given to the questions on this topic show that the typical and expanded Family Health teams, which work according to the logic of the strategy, focus more on programmatic activities in the sense of establishing bonds with the community than traditional Primary Care teams, as shown by Facchini et al. (2006). This reality should be encouraged by assigning the population in such a way that demand is not excessive to the point of compromising such activities being conducted.

Encouraging patients to form social support networks is greater in the typical teams, contributing to identifying resources in the communities to solve or handle users social or even health problems (Coelho; Jorge, 2009).

Infrastructure conditions

Infrastructure conditions clearly differ between typical and expanded teams. This is due to the fact that 10 of the 14 typical teams work in units adapted to be Family Health units, i.e. they were not constructed for that purpose, whereas the expanded teams work in units that provide appropriate care conditions. This reality demonstrates the lack of commitment and planning for adequately establishing the Family Health Strategy in the municipality.

Working in units that do not provide appropriate conditions to function as health care services even compromises patient privacy, as the poor marks the teams allocated to this question show. Moreover, the satisfaction of the professionals who work in units with inadequate, improvised and precarious infrastructure can also be compromised (Facchini et al., 2006).

Conclusions

The differences found between expanded and typical Family Health teams show that excess demand, caused by assigning greater populations than recommended to the typical teams, lack of infrastructure and difficulties in relationships with specialists may compromise the performance of expanded and typical teams. An effective referral and counter referral system, more investment and planning in establishing the Family Health Strategy in the municipality and better division of the territory are essential to achieving better results and indicators.

References

BRASIL. Ministério da Saúde. Secretaria Executiva. Departamento de Apoio à Descentralização. Coordenação-Geral de Apoio à Gestão Descentralizada. *Diretrizes operacionais dos Pactos pela Vida, em Defesa do SUS e de Gestão*. Brasília, DF, 2006. (Série A. Normas e Manuais Técnicos). Disponível em: <http://189.28.128.100/dab/docs/publicacoes/pactos/pactos_vol1.pdf>. Acesso em: 13 fev. 2011.

BRASIL. Portaria nº 2.488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). *Diário Oficial da União*, Brasília, DF, 21 de outubro de 2011. Seção 1, p. 48-55.

COELHO, M. O.; JORGE, M. S. B. Tecnologia das relações como dispositivo do atendimento humanizado na atenção básica à saúde na perspectiva do acesso, do acolhimento e do vínculo. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 14, p. 1523-1531, 2009. Suplemento.

CONILL, E. M. Ensaio histórico-conceitual sobre a Atenção Primária à Saúde: desafios para a organização de serviços básicos e da Estratégia Saúde da Família em centros urbanos no Brasil. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 24, p. S7-S27, 2008. Suplemento.

FACCHINI, L. A. et al. Desempenho do PSF no Sul e no Nordeste do Brasil: avaliação institucional e epidemiológica da atenção básica. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 16, n. 11, p. 669-681, 2006.

HART, A. MannWhitney test is not just a test of medians: differences in spread can be important. *BMJ: British Medical Journal*, London, v. 323, n. 7309, p. 391-393, 2001.

OS AUTORES respondem: quinze anos de uma agenda em construção: diálogos sobre o PSF no Brasil. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 14, p. 1343-1345, 2012. Suplemento 1. Disponível em: <http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S1413-81232009000800006&lng=pt&nrm=iso>. Acesso em: 10 fev. 2012.

PINTO, C. A. G. Diagnóstico compartilhado no trabalho das equipes de saúde da família. In: CAMPOS, G. W. S.; GUERRERO, A. V. P. (Org.). *Manual de práticas de atenção básica*: saúde ampliada e compartilhada. São Paulo: Aderaldo & Rothschild, 2008. p. 298-322.

SOUSA, M. F.; HAMANN, E. M. Programa Saúde da Família no Brasil: uma agenda incompleta? *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 14, p. 1325-1335, 2009. Suplemento.

TAKEDA, S. A Organização de Serviços de Atenção Primária à Saúde. In: DUNCAN, B. B.; SCHMIDT, M. I.; GIUGLIANI, E. R. J. *Medicina ambulatorial*: condutas de atenção primária baseadas em evidências. Porto Alegre: Artmed, 2004. p. 76-87.

VIANA, A. L. D. et al. Modelos de atenção básica nos grandes municípios paulistas: efetividade, eficácia, sustentabilidade e governabilidade. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 11, n. 3, p. 577-606, 2006.

VIANA, A. L. D. et al. Atenção básica e dinâmica urbana nos grandes municípios paulistas, Brasil. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 24, p. S79-S90, 2008. Suplemento.

Authors' contributions

Quagliato was responsible for designing the project, for the activities collecting information and drawing up the text. Forster contributed to the data analysis and designing the project. Ruffino Netto contributed to designing and analyzing the data.

Received: 05/05/2013
Approved: 14/10/2013