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CARE MANAGEMENT IN PRIMARY HEALTH CARE: A CONSTRUCTIVIST GROUNDED THEORY

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ABSTRACT

Objective: to understand care management in Primary Health Care based on the meanings attributed by workers who work in this context and build a theoretical-explanatory model.
Method: this is a qualitative research based on the Grounded Theory on Constructivist Data, developed in the Primary Health Care network of a municipality located in southern Brazil. Participants were selected inductively according to theoretical sampling, totaling 37 workers, divided into four sample groups. Data collection through semi-structured interviews, from January 2017 to November 2018. Data analysis took place in two phases: initial coding and focused coding. The initial codes were classified, synthesized and integrated for the development of the categories, which, articulated, gave rise to the model. To support the analysis, Nvivo®11 was used.
Results: the central phenomenon "Managing care in Primary Health Care" was supported by four categories: "Organizing care management", "Implementing care management in the care environment", "Relating with other subjects for care management"; "Articulated socially and politically". These categories composed the theoretical model supported by the constitution of four interdependent dimensions: organizational, relational, care and sociopolitical.
Conclusion: care management, implemented in daily work, reveals itself in a variety of practices, conditions and situations that integrate the intertwined world of work and the lives of users and workers of healthcare services. The model helps those involved in care management in Primary Health Care to expand and strengthen care practices committed to users.

DESCRIPTORS: Primary health care. Health management. Grounded theory. Health personnel. Public health policies.

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GESTÃO DO CUIDADO NA ATENÇÃO PRIMÁRIA À SAÚDE: UMA TEORIA FUNDAMENTADA NOS DADOS CONSTRUTIVISTA

RESUMO

Objetivo: compreender a gestão do cuidado na atenção primária à saúde alicerçado nos significados atribuídos pelos trabalhadores que atuam neste contexto e construir um modelo teórico-explicativo.
Método: pesquisa qualitativa com base na Teoria Fundamentada nos Dados construtivista, desenvolvida na rede de atenção primária à saúde de um município localizado no sul do Brasil. Os participantes foram selecionados de forma indutiva segundo a amostragem teórica, totalizando 37 trabalhadores, divididos em quatro grupos amostrais. Coleta de dados por meio de entrevista semiestruturada, de janeiro de 2017 a novembro de 2018. A análise dos dados ocorreu em duas fases: codificação inicial e codificação focalizada. Os códigos iniciais foram classificados, sintetizados e integrados para o desenvolvimento das categorias, as quais articuladas, deram origem ao modelo. Para suporte da análise, empregou-se o *software* Nvivo®11.
Resultados: o fenômeno central "Gerenciando o cuidado na atenção primária à saúde" foi sustentado por quatro categorias: "Organizando a gestão do cuidado", "Implementando a gestão do cuidado no âmbito assistencial", "Relacionando-se com outros sujeitos para a gestão do cuidado" e "Articulando-se social e politicamente". Estas categorias compuseram o modelo teórico apoiado na constituição de quatro dimensões interdependentes: organizacional, relacional, assistencial e social-política.
Conclusão: a gestão do cuidado, concretizada no cotidiano do trabalho, revela-se numa variabilidade de práticas, condições e situações que integram o entrelaçado mundo do trabalho e da vida dos usuários e trabalhadores dos serviços de saúde. O modelo auxilia os envolvidos na gestão do cuidado na APS para ampliação e fortalecimento de práticas de cuidado comprometidas com os usuários.

DESCRITORES: Atenção primária à saúde. Gestão em saúde. Teoria fundamentada. Pessoal de saúde. Políticas públicas de saúde.

GESTIÓN DE LA ATENCIÓN EN LA ATENCIÓN PRIMARIA DE SALUD: UNA TEORÍA BASADA EN DATOS CONSTRUCTIVISTA

RESUMEN

Objetivo: comprender la gestión de la atención en Atención Primaria de Salud a partir de los significados atribuidos por los trabajadores que trabajan en este contexto y construir un modelo teórico-explicativo.
Método: investigación cualitativa basada en la Teoría Fundamentada en Datos constructivista, desarrollada en la red de atención primaria de salud de un municipio ubicado en el sur de Brasil. Los participantes fueron seleccionados inductivamente según muestreo teórico, totalizando 37 trabajadores, divididos en cuatro grupos de muestra. La recolección de datos se realizó a través de entrevistas semiestructuradas, de enero de 2017 a noviembre de 2018. El análisis de los datos se realizó en dos fases: codificación inicial y codificación focalizada. Los códigos iniciales fueron clasificados, sintetizados e integrados para el desarrollo de las categorías, que, articuladas, dieron lugar al modelo. Para apoyar el análisis se utilizó el software Nvivo®11.
Resultados: el fenómeno central "Gestionar la atención en la atención primaria de salud" se sustenta en cuatro categorías: "Organizar la gestión de la atención", "Implementar la gestión de la atención en el entorno de la atención", "Relacionarse con otros sujetos para la gestión de la atención" y "Articular social y políticamente". Estas categorías componen el modelo teórico sustentado en la constitución de cuatro dimensiones interdependientes: organizacional, relacional, asistencial y sociopolítica.
Conclusión: la gestión del cuidado, implementada en el trabajo diario, se revela en una variabilidad de prácticas, condiciones y situaciones que integran el entrelazado mundo del trabajo y la vida de los usuarios y trabajadores de los servicios de salud. El modelo ayuda a los involucrados en la gestión de la atención en la Atención Primaria de Salud a expandir y fortalecer las prácticas de atención comprometidas con los usuarios.

DESCRIPTORES: Atención primaria de salud. Gestión en salud. Teoría fundamentada. Personal de salud. Políticas pública de salud.

INTRODUCTION

The Brazilian experience of Primary Health Care (PHC), configured in Family Health Strategy (FHS) and a structuring part of the Unified Health System (SUS – *Sistema* Único *de Saúde*) was mentioned by several authorities during the Astana Conference - held in October 2018 - as successful model, due to its results in improving access and population's health, reinforcing the need to organize health systems, with the aim of affirming and renewing the political commitment to universal health coverage and sustainable development[1].

PHC, in Brazil, is the fundamental structure for the ordering of care and coordination of the care network, with the potential to support continuous, articulated, comprehensive and quality care for the universality of the population[2]. It establishes the fields of care practice, subjective manifestations, links, the strengthening of intersectorality and popular participation. In this context, workers, through a comprehensive look at care, seek to identify individual and collective demands and provide comprehensive, safe and quality care, connecting services from different points of the health care network, such as knowledge, practices and technological advances.

Therefore, health care management practices are part of a new paradigm for the organization of the health care network and with the capacity to mediate in the complex needs demanded by health system users[3]. It is assumed, then, that care management is embodied in the actions of subjects, managers, health workers and users who inhabit and attend healthcare services, building a collaborative and coordinated network, to ensure continued care to users in an appropriate and more opportune location[4]. In this process, it is also important to pay attention to the improvement of working conditions.

In view of these notes, the relevance and need for a deeper understanding of the theme are highlighted, as much has been said about care management in the context of PHC, but little has been presented as a theoretical-scientific analysis. Therefore, it is believed that understanding the structural process, meanings and conceptions of care management can collaborate to raise awareness in the development of care actions that strengthen PHC within the health system.

Because it understands that care practices are strongly influenced by the meanings and motivations of subjects involved, as well as by the contexts of life and work, this research sought to answer the following questions: how do health workers experience health care management in the context of PHC? What are the meanings attributed to care management?

This study aimed to understand care management in PHC based on the experiences and meanings attributed by workers who work in this context and to build a theoretical-explanatory model.

METHOD

This is a research with a qualitative approach, developed based on the constructivist Grounded Theory (GT)[5].

It was carried out within the PHC network of a municipality located in Southern Brazil, whose estimated population for the year 2020 was 508,826 inhabitants[6]. PHC currently has 152 family health teams (FHt) in 49 health centers, distributed in the city's four health districts (HD).

Health workers with experience and knowledge of the phenomenon investigated and who had been working in the function for at least one year were invited to participate in the study. They were intentionally included in the composition of sample groups, according to theoretical sampling guides the GT[5].

The first sample group consisted of nineteen health workers who were members of the basic team; the second group consisted of ten workers who are members of the Family Health Support Center (NASF - *Núcleo de Apoio à Saúde da Família*); and the third sample group consisted of four health managers working at the district level. Participants in the first three sample groups were linked to the same HD. The Sanitary District included in this study was chosen considering the assessment of the Access and Quality Improvement Program (PMAq), which took place in 2014, in which 61% of assessed teams obtained certification "much above average".

The fourth and last sample group was composed of four health managers placed in the central management of the city's Municipal Health Department. The number of participants in each sample and final group followed the criterion of theoretical saturation, when new data are repeated and new contributions to the consolidation and elaboration of the theoretical model no longer appear.

The professional categories interviewed in this study included: physicians, nurses, nursing technicians, community health workers, physiotherapists, psychologists, social workers, pharmacists and dentists.

Data collection was carried out from January 2017 to November 2018 through semi-structured interviews based on an intensive proposal[4]. Study participants were invited in person or via telephone by the main researcher. The interviews were carried out individually by the main researcher who is a nurse at the PHC in this municipality. Such interviews took place in the workplace itself or in another chosen by participants (e.g., at the researcher's home university). None of the coordinators refused to participate.

To record the interviews, ensure reliability of speeches and enable further analysis, the interviews were digitally audio-recorded, later transcribed in full in a Microsoft® Office Word document, imported into NVivo®, version 11, and then coded. The recordings lasted at least 20 and at most 40 minutes

Data analysis took place in two phases: initial coding and focused coding. In the initial coding, the data were fragmented based on the analysis of words, lines, segments or incidents and coded according to their analytical importance. In focused coding, the most significant initial codes were classified, synthesized and integrated for the development of categories[5].

In the theory elaboration process, other recording and analysis strategies were used, such as memos and diagrams, which start with the initial analysis and evolve throughout the research process. Memos were made up of records about the research process and through the researcher's considerations and feelings. They varied in type and format, such as coding, theoretical, operational and observation notes. On the other hand, diagrams worked as visual mechanisms that showed the relationships between the codes, being an alternative for the realization of ideas, enabling the perception of the relative power, scope and direction of categories as well as the connections between them[5].

Based on the orderly integration of categories, in dialogue with the scientific literature and other supporting references, theoretical elaboration was carried out, i.e., the construction of the theory related to the phenomenon under study.

Throughout the research process, the guidelines and provisions of Resolution 466/12 of December 12, 2012 of the Brazilian National Health Council (*Conselho Nacional de Saúde*) and its complementary provisions were respected. Data collection began after approval by the Institutional Review Board of *Universidade Federal de Santa Catarina*.

All respondents signed the Informed Consent Form (ICF) and were guaranteed the confidentiality of their identity, as well as the right to withdraw at any time during the research.

The interviews were coded with the letter “G” referring to the word “Group” and “A”, “B”, “C” and “D” referring to the sample groups, subsequently enumerated, successively, to ensure anonymity of respondents (e.g., GA1, GC2, GD3). Moreover, all information that identified participants in the interview was modified.

To validate the Model, nine higher education health workers, working in PHC, in the states of Santa Catarina and Rio Grande do Sul and not participating in the study, were invited to participate in the process. The model was approved by all, and was considered applicable, comprehensive and capable of contributing to care management in PHC.

RESULTS

The study participants were mostly women (81%), aged between 31 and 40 years (51%) and with more than 10 years of obtaining the title for the position (67%).

The central phenomenon that emerged after data analysis was called “Managing care in Primary Health Care”, which represents the central idea envisioned in the data. It is supported by four categories: “Organizing care management”, “Implementing care management in the care environment”, “Relating with other subjects for care management”; “Articulated socially and politically”, which underlie the phenomenon based on organizational, care, relational and sociopolitical dimensions. These dimensions are divided into subdimensions, followed by axes transversal to all of them. The dimensions, subdimensions and transverse axes and are shown in Chart 1.

Chart 1 – Dimensions, subdimensions and axes of the phenomenon “Managing care in Primary Health Care”. Florianópolis, Santa Catarina, Brazil, 2021.

Axes	Dimensions	Subdimensions
Broadening the look Critically problematizing	Organizing for care management ORGANIZATIONAL	Knowing the reality of subjects, service and territory
		Planning care and seeking strategies
		Articulating networks
	Implementing care management in the care context CARE	Implementing care
		Focusing care on the subject
		Building care plans
	Relating with other subjects for care management RELATIONAL	Working as a team
		Considering subjectivity
	Articulating socially and politically SOCIOPOLITICAL	Recognizing as a social process
		Entering the Local Health Council
		Thinking about public policies

The organizational dimension, *Organizing for care management*, refers to the process of structuring and articulating the service, in an attempt to support care management. From this dimension, four subdimensions emerged, considered strategic and interdependent, which corroborate the process.

Its first subdimension permeates the recognition of reality, from a diagnostic perspective, whether in the individual scope of the subject, considering the different contexts of life, or in the collective scope of the territory as a fundamental space for acts of care, and also in the social sphere

of care relationships that are established within the healthcare services, with all their weaknesses, strengths and challenges. These findings are exemplified in the following statements:

Care management is about recognizing which health problems you have the most, identify or assist in that group, which you are responsible for in the case of a health center, and from this initial diagnosis, you get to know the tools that are available or even creating some possibilities of new tools, you give the possibility for the professional and the patient to have a more focused, more targeted, safer care with less expense, less cost, more effectiveness and focused on the person (GD3).

[...] *care management is giving access to the population* [...] *is being able to work on the surveillance of the territory* [...] *discuss individual care, the quality of individual care, health based on evidence* [...] *is organization of the agenda, organization of the territory, organization of access, longitudinality, coordination of care, I understand that these are the attributes of primary care, attributes of SUS intertwined in a process of qualification of continued care, clinic, individual and collective* [...] *I think about knowing, knowing our area, knowing everything we have as a tool, everything we have as an obstacle, the strengths we have, in our territory, which is one, our community* (GA7).

The second subdimension concerns planning and seeking strategies for care management. It refers to the organization of teams in and for the territory, in the organization of work processes within the service, internal flows, organization of agendas and forms of access for users and their devices, such as social media and the guarantee of inputs of sufficient quality and quantity, as shown in the reports:

Care management is me being able to be close, understanding how that family lives, where they live, the work of the father, the mother, all this thing that can interfere with their health status [...] *in the team meetings, I think it's a time when I think I'm doing care management. In these meetings, the doctor, community workers participate with me, and at that moment we exchange how our area is doing, they bring up the problems found in the community, through this we outline care for that. For example, a community worker found a pregnant woman who is unattended, during the meeting we scheduled an appointment and a home visit. That way we can better control the area and better control our team* (GA9).

So, I believe that we manage care, both in the planning of individual care and in the teamwork process, when we discuss something in the territory (GA17).

[...] *when we receive people in the reception, we do the first listening and organize care, what goes to me and what goes to the doctor. This in a sense is care planning.* [...] *I think it's a way of managing care, at least for a specific group... it's with regard to pregnant women, for example. We are always scheduling and guarding vacancies available to her, without access difficulties, and seeing how many appointments I do, how many the doctor does* (GA15).

The third subdimension permeates the articulation of networks, in the sense of involving the various levels of care in care management, the organization of lines of care along the structuring network, the coordination of care in this process, the guarantee of continuity of care, in the perspective of longitudinality and completeness:

So, for me, management doesn't work alone in what I'm going to plan for that patient, for that user, but what I'm going to do together within the reality in which he lives. [...] *I don't have to look only in a little box: 'today he has this health problem'. No! I have to look at this health problem where he is inserted, he as a family, he as a community, what I have around him that may be interfering with his health, or that can help me to work on improving his health and with that, the partnerships I'm going to make, either with the NASF or with other professionals. So, by activating a care network, I will manage to manage this* (GC3).

The care dimension, *Implementing care management in the care context*, refers to actions related to clinical care practice, the encounter between workers and users.

Its first subdimension refers to the provision of assistance to users, in the sense of implementing care practices, which can occur in different situations of PHC: in the acceptance of demands, such as attentive and active listening, from reception, vaccination room, room from procedures, to medical or nursing consultations; in the performance of collective activities, in home visits or in the territory as a whole, as exposed by participants:

Care management covers from the beginning, when the patient accessed the health center, and then he went through the reception, he went through a consultation, by a healthcare professional, he went to a matrix support service, he used a specialist and all of this is in care management, because it is the answer that the service is giving to this person's need (GC2).

In the procedure room, I think we do a lot of care management. We have a lot of dressings. What we do here whether we like it or not, very welcoming. Often, we notice something, the person comes for the dressing and we can see other things than just the dressing (GA13).

The second subdimension centers care on users, transforming it into the focus of action of workers, which comprises the understanding of their individual and collective needs and the perception of the different health situations that can be found in the territory, always in a unique way. and in order to obtain a person's satisfaction:

We are part of care management, because I think that every health worker will be involved in some way in managing this care, promoting this care, facilitating people's access, facilitating the reception of people both here and in the community or, sometimes, even on the street where they find us, if they are at any time in difficulty. It is the moment they find to ask for this care, seeing how it can be done (GA10).

This is how I see it, welcoming the patient, taking care of that patient, let's suppose if he has a very serious problem, I think there has to be a different look at that patient. [...] *I once arrived at Dona Fulana's house and she already had an open sore, those pressure sores. So I reported everything, took a picture, talked to the nurse.* [...] *So, the nurse takes some time and goes there* (GA14).

The third subdimension, *Building care plans*, in the sense that decision-making must occur together with users, with an expansion of the look beyond the consultation and supervision of care:

I think I manage care, both when I'm establishing a unique therapeutic project for the individual, when I'm thinking about how to address an individual need, and when I sit down with my team to organize the work process in my health team and in the unit as a whole (GA17).

Today there was a lady there, with some problems in her life. So I started thinking, what can I do to help that person. Or I'll talk to the team, look for her team and her grandson, because she talked to me about her grandson. I'm going to look and see how she is, how this grandson is, how she is. It's more when I see something that arouses my interest in going after it, I see that there is some suffering, something like that. It has to have a broader look (GB5).

I understand that care management is really seeing what you have, the tools you have, your resolving capacity, and you, together with the patient, in short, with the group you are working with, you develop a line of beware, something more longitudinal (GD3).

In the relational dimension, *Relating to other subjects for care management*, we talk about the role that the relationship between subjects plays on the path to care management. This is structured in two subdimensions.

In the first subdimension, *Working as a team*, data revealed that workers understand care management as teamwork through the encounter between subjects and workers, in which the acts of care must be shared between the different subjects involved. The aim is to refine work processes with commitment, good relationships and interaction between workers within the service, discussion between the team with joint and shared decision. This reality is exemplified in the speech below:

There are things that we are already able to give some guidance about, what can be done, what path it should follow. And there are things that we can't help at the time, so we bring them to the unit, talk to the nurse, the doctor or even in a meeting. Talk to the entire team and see how we can be offering care to that person (GA10).

In the second subdimension, *Considering subjectivity*, the data showed that the subjectivity of workers strongly influences the agencies carried out in the PHC and towards care management. They permeate the involvement, commitment and accountability of workers with the ability to remain in an empathetic, available, accessible, trust-generating attitude and, mainly, in the daily exercise of accepting the other's desire:

When I think of care management, I remember accountability. So I feel like a doctor for those people who live in that territory. As a referral, I like to know that patients can have a referral doctor they trust, who knows their family and who knows the community where they live, who knows the social and cultural context. I think it is very linked to the issue of attributes [...] *you only manage care if you also have access, if people can access it when they need it. So, you have to be available* (GA5).

In the sociopolitical dimension, *Articulating socially and politically*, care management emerges as a social process. They are the ways in which individuals relate to each other and establish interpersonal and social relationships in the context of life. It reinforces the need for a broader concept of health with observation of social determinants and conditions. Furthermore, it refers to the capacity for articulation, movement and access to other sectors and government instances, as health situations and conditions that go beyond the governability of the healthcare service alone are identified. The role that social control and management play for care management is perceived, in the sense of collaboration in the process of struggles and claims and subsidy through the elaboration and support for the implementation of public policies, respectively. These findings are exemplified in the following statements:

Even the Local Health Council is a care management, because I'm going to use it to improve some things that I have within the health system and within the community as well. I see all this as a very big gain, a positive thing (GA6).

In my perception, care management is a social process. You think about this issue of the concept of health in a broader way, to observe the determinants and social conditions [...] *we bump into a situation of governability, as far as we can go, what are the situations that we are responsible, where is the issue of health, where is the issue of the ministry of welfare, where is the issue of the ministry of labor* [...] *care management, it is much greater. It's for you to think about public policies* (GB4).

Finally, in the axes "expanding the look" and "critically problematizing" it is verified the relevance of an affective and sensitized look to the needs of the other, capable of looking after care management, as well as providing a critical problematization of the different situations found in daily work:

Because, many times, we stay focused. I have a sore throat, you just look at the throat and sometimes the person has other things. So, you have to see the being as a whole and try to help in the best possible way (GA19).

There is this more charitable look, more affectionate towards the other, towards the needs of the individual who is going through a process. And care has an even longer history in nursing than in medicine. So, perhaps there is this call for an act much greater than the strict medical look. Anyway, for me it would be within these characteristics (GA17).

Both for our work process that helps to organize and for the quality of care provided to the community. If it's not always the same thing and we don't evolve from that, we don't problematize, we don't have a critical eye on things, it doesn't help to improve the whole process (GA7).

If I stop and see, not just that individual in front of me, not just the father and mother, but the family in a larger scope, especially because our patient, they have a very interesting relationship with the neighbors. If you think of the family as father, mother and children is one thing, but often they have a much larger circle, which is often more involved in their lives than those of direct kinship. So, what happens to his neighbor could be affecting his life and this can be seen better (GA9).

The theoretical-explanatory model of the emerging phenomenon is presented below: "Managing care in Primary Health Care". In this perspective, it is possible to visualize the connections built between the dimensions and subdimensions of the phenomenon, already addressed in the course of this study, as illustrated in Figure 1.

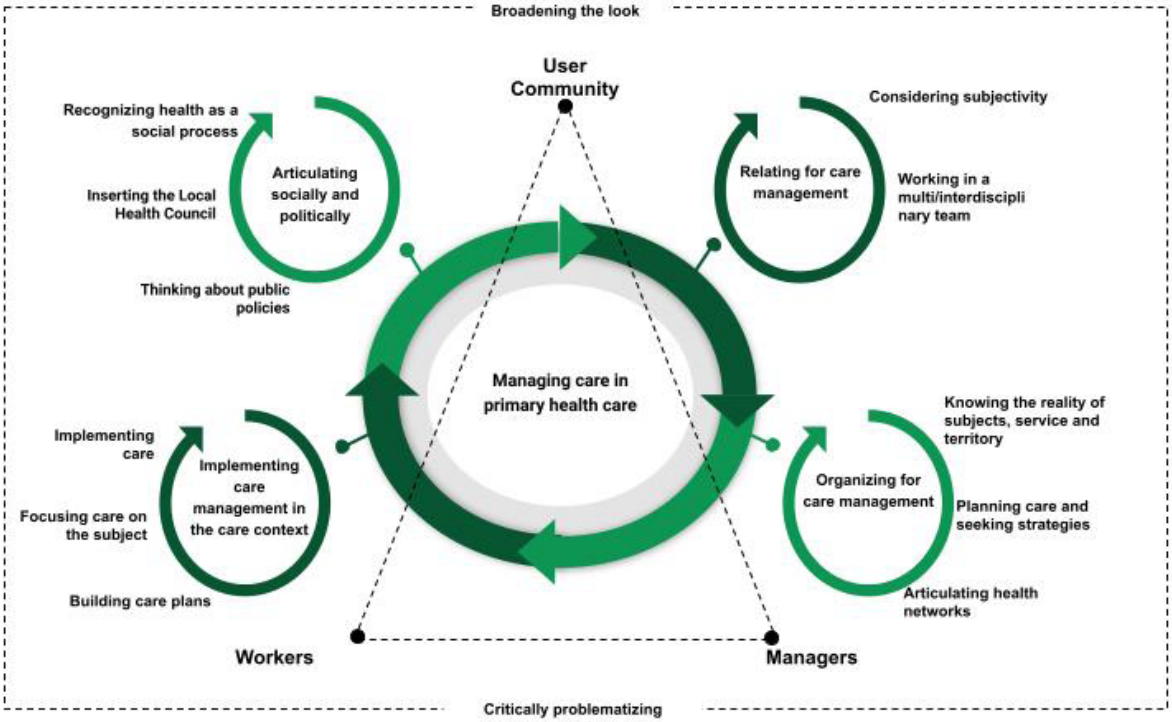

Figure 1 – Theoretical-explanatory model of the phenomenon: Managing care in PHC. Florianópolis, Santa Catarina, Brazil, 2021.

The Model presents the emerging phenomenon in the central region of the spiral, surrounded by organizational, care, sociopolitical and relational dimensions, and their respective subdimensions. It is observed care management is implemented in daily work and permeated by the complexity of the relationships between managers, workers, users and the community - the main actors in the scene. At the base of the pyramid, there are workers and managers, whose gaze, with regard to care management, should be focused on users and the community, the main focus of all actions. Still, it is possible to envision the entire action being critically problematized by workers and managers who use a broader view to understand and implement this reality.

DISCUSSION

The results of this study make it possible to think about care management in PHC as a variability of practices, conditions and situations that integrate the intertwined world of work and the lives of users and workers of healthcare services. Everyday life is full of challenges, as a result of the complexity that is simply existing in this world. In this deep scenario, demands emerge, sometimes from users, sometimes from workers themselves, sometimes from the community, and it is in this environment of adversity that care and health practices are inserted. Therefore, during care management, it is essential that those involved keep their eyes widened and critically problematize all the dimensions and subdimensions revealed here.

Regarding the organizational dimension, it is highlighted that through understanding the health reality where users are inserted and the analysis of the health situation, it is possible to identify health care needs that are also linked to social issues, to the historical process of the community in which we live and the weaknesses in access to health systems, especially to PHC. Thus, these actions are essential for workers, managers and healthcare services to make the needs of users the center of attention in their practices[7]. Based on these actions, then, and by the logic of comprehensive care, workers, in a multidisciplinary and interdisciplinary way, can reflect on how to organize healthcare services so that care strategies for the person, family and community are effective, both in PHC and in different devices and points of the health care network, when necessary.

Demands brought into daily life must be constantly checked, measured and reassessed so that new strategies can be planned and put into practice, when bottlenecks are found that limit access or significantly increase the search for healthcare services[8]. Access is linked to reception as a practice of attentive listening, as it proposes an inversion of the logic of organization and functioning of the healthcare service. It starts from the premise that it is necessary to listen to all people who seek care in the healthcare service, and then guide and guide them based on their need, considering the organizational structure of the healthcare service and the health care network. services in which it is inserted.

In this sense, the investment of health workers and management in care organization and management strategies[9], such as protocols for access to specialties, protocols and guidelines for the diagnosis and treatment of diseases relevant to care by the PHC, development of permanent education processes for workers in the system, among others.

In order to organize the health care network, it is necessary to define institutional accountability, strategies for its composition, maintenance and monitoring, in addition to identifying, overcoming or circumventing the challenges and difficulties for its installation, maintenance and articulation. There is a need for a governance system where managers and health workers can remain articulated, seeking to consolidate the principles of SUS and PHC as its gateway. It should be noted that tripartite financing is essential for the network to have operational and logistical operations guaranteed and established by agreements to carry out its actions[10].

In the care dimension, health workers exercise care with and for users, in a shared and unique way, and when interacting, they interpret perspectives and understand mutually expectations[11]. Workers need to perform skills and abilities that exceed their technical capacity, i.e., it will be necessary to develop skills related to attentive listening and communication between the team and between them and users, a transparent attitude about the real possibilities of the service to care, within the scope of PHC and at other levels of care, shared decision-making, inclusive and focused on the empowerment of users-worker and user-caregiver binomials (when this exists), building bonds of trust and affection, respecting the possibilities of workers as health teams and centered on users.

The Brazilian care model based on FHS has been pointed out in the literature as a driver for changing practices and directed towards an expanded clinic centered on user demands. In a research, whose object of study was the production of care in daily work in PHC, it was found that FHS show a notable effort for care acts based on the health needs of users in their territory, distancing themselves at times organizational protocols of FHS, and the entire process was managed by the various difficulties and complexities that interfere with the care process[12].

Patient-centered care, understood as care that is respectful and responsive to patients' individual preferences, needs and values and that ensures that patient values should guide all clinical decisions, was included as one of the six attributes of quality in health, in 2001[13]. Among the technologies that make it possible to build patient-centered care plans and changes in the production of care management, the Therapeutic Project in PHC stands out[14].

In the relational dimension, teamwork and meetings between workers and users are events that express the production of care. The performance of the teams is characterized as highly complex due to territories' social dynamics, in which they are inserted[12]. The subjective crossings that operate in daily work of PHC may, in many cases, not be perceived by workers, but it is based on them that the worker makes choices about their practices, work technologies and the way they will relate with their peers and users[15].

Relationships in FHS also require looking at the subjectivity present in the act of caring, associated with the way the worker means work, aims at their structured knowledge, dialogues with their feelings, expectations and interests and how they relate to others. In meetings between health workers, involving the different categories in action, there may be power relations that circulate in micro-relationships and that can, in turn, generate tension at work and, consequently, harm user care. Thus, for care management, it is also necessary to equip workers with tools so that each one can find legitimacy to broker changes, openness to present ideas and collaborate with teamwork, in addition to building a body of own knowledge, horizontalize knowledge and empower the team to take care of people[16].

In the relationship with users, the care provided by the health worker needs to be guided by an attitude that combines technical competence with sensitivity, affection and respect, adopted based on an empathetic attitude, in which there is involvement and commitment to the other[17]. This attitude is able to strengthen the bond, improve clinical communication and, as a result, enhance adherence to care established in a shared way between health workers and users.

With regard to the sociopolitical dimension, it is necessary to recognize that health is a constitutional right and, therefore, it is part of a public policy, i.e., the State is responsible for providing access to health through specific programs and actions for the society[18]. At the same time, popular participation in the management of healthcare services through health councils is constitutional[19]. It is then up to health workers to empower PHC users to actively participate in the Local Health Council (LHC), with a focus on promoting health in the territory, claiming municipal funding, as well as state and federal funding in other spheres (State and Municipal Health Council), and thinking about public health policies.

Despite the above, there is a difficulty for LHC to leave invisibility, since users, even when linked to counselors, services and health workers and with an understanding of the routine of health units, ignore the existence of LHC, as a result of these councils rarely divulge information about meetings, functions and activities[20]. In this study, the LHC was pointed out as a place of production of health as a social process, in which health workers, together with counselors and the population, are able to increase the governability of healthcare services. It is reflected that the greater the participation of the community in this popular participation device, the greater its strength in managing the care provided by healthcare services.

As a study limitation, there is the fact that it was carried out in only one Brazilian municipality, due to the large geographic space and sociocultural diversities and it does not include other realities experienced during the process of care management in PHC. Thus, it is considered relevant to highlight the need for further investigations, in order to confirm these findings, seeking to investigate other realities.

CONCLUSIONS

Managing care in Primary Health Care represents an organized abstraction, built on the basis of interactive data analysis through the meaning and experiences of workers in the practice of care management in the context of PHC. The theoretical-explanatory model of the phenomenon presents care management implemented in daily work and permeated by the complexity of the relationships between managers, workers and users, the latter being the central focus of all actions. This was constituted by four interdependent dimensions that permeate care management, namely: organizational, care, relational and sociopolitical.

The data from this research reinforce the complex nature of PHC services. It is believed that the results can contribute to the reflective process of all workers involved in care management in PHC and, based on this stage, can collaborate to the expansion and strengthening of care practices that are increasingly committed to users in shaping the care network. Still, it can serve as a basis for studies that aim to investigate the dimensions and subdimensions of the phenomenon addressed here.

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NOTES

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CONTRIBUTION OF AUTHORITY

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There is no conflict of interest

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