Municipal health plans and the potentialities of recognition of health needs: a study on four Brazilian municipalities

Os planos municipais de saúde e as potencialidades de reconhecimento das necessidades em saúde: estudo de quatro municípios brasileiros

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Abstract

This study was designed to identify the potential and the limits of the Municipal Health Plan as a management tool for recognition of health needs and vulnerabilities of social groups. A qualitative, documentary study, performed through the organization of data in WebQDA® software and Bardin's content analysis, of Municipal Health Plans (PMS) of the municipalities of Araraquara, Santos, Valinhos and Vinhedo, which met eligibility criteria: medium-sized municipalities in the state of São Paulo; not belonging to the Metropolitan Region; with 50 thousand inhabitants or more; presenting the best Human Development Index and the worst Gini coefficients; and having publicized Municipal Health Plans. The results showed a predominance of a health conception centered on multi-causality; epidemiologically, the scenarios were described from their risk factors, with emphasis on morbidity/mortality indicators; there was no articulation of health-disease profiles to those of social reproduction. In health diagnoses and planning, there was disregard of the interpretative theory of the social determination of the health-disease process. Thus, all the scenarios presented difficulties in identifying social groups, vulnerabilities and differentiated needs, making health management impossible for equity and integrality in care.

Keywords: Public Health Policies; Collective Health; Health Planning; Assessment of Health Care Needs; Health Assessment.

DOI 10.1590/S0104-12902017170046

Resumo

O objetivo deste estudo foi identificar potencialidades e limites do Plano Municipal de Saúde como instrumento de gestão ao reconhecimento das necessidades em saúde e das vulnerabilidades dos grupos sociais. Estudo documental qualitativo realizado por meio da organização de dados no software WebQDA® e da análise de conteúdo de Bardin dos planos municipais de saúde de Araraquara, Santos, Valinhos e Vinhedo, localidades que atenderam aos critérios de elegibilidade: municípios de médio porte do estado de São Paulo; não pertencentes à região metropolitana; com 50 mil habitantes ou mais; apresentaram os melhores Índices de Desenvolvimento Humano e os piores coeficientes de Gini; e publicizaram os planos municipais de saúde. Os resultados demonstraram predomínio da concepção de saúde centrada na multicausalidade; epidemiologicamente, os cenários foram descritos a partir dos fatores de risco, com destaque para os indicadores de morbimortalidade; não houve articulação dos perfis de saúde-doença aos de reprodução social. Nos diagnósticos e nos planejamentos em saúde foi desconsiderada a teoria interpretativa da determinação social do processo saúde-doença. Dessa forma, todos os cenários apresentaram dificuldade de identificação de grupos sociais, vulnerabilidades e necessidades diferenciados, impossibilitando gestão em saúde em prol da equidade e da integralidade na atenção.

Palavras-chave: Políticas Públicas em Saúde; Saúde Coletiva; Planejamento em Saúde; Avaliação das Necessidades de Cuidados de Saúde; Avaliação em Saúde.

Introduction

Health needs involve aspects of the biological dimension of the human being, but also other dimensions, such as psychological, epidemiological, geographic, social etc., which denotes complexity for their understanding and satisfaction (Oliveira, 2012). Thus, the adoption of methodologies that encompass an expanded conception about the health process, involving the identification of health needs through the understanding of people's living conditions, access to and consumption of health technologies, continuous monitoring and encouragement of the autonomy of the subjects are highlighted, since they can potentially contribute to equity and integrality of care (Oliveira et al., 2016).

However, the identification and satisfaction of health needs has been a challenge for health managers, especially with regards to understanding the needs of vulnerable social groups, whose determinants of strengthening and attrition – related to the forms of production and reproduction of social reality, which translate or not into salutogenic living situations – require professionals, models and instruments aligned with the social determination of the health-disease process (Meyer et al., 2013).

Faced with this demand for the development of means to capture the population's health needs at the municipal level, managers have at their disposal the Municipal Health Plan (PMS), whose purpose is to identify the health needs of people from an attached health territory (Brasil, 2009, 2013a, 2016).

In this sense, the PMS subsidizes the actions of planning, monitoring and evaluation of health actions for a period of four years, as recommended by the guidelines of the Brazilian National Health System (SUS), understood as a policy that grounds, through the Health Pact, the preparation of this instrument, which must be in line with the Pluriannual Plan, the Budget Guidelines Law and the Annual Budget Law (Brasil, 2009, 2013b, 2016), which increases the purpose of guaranteeing the transfer of financial resources to the provision of services to the population.

This idea was discussed by Saliba et al. (2013) by pointing out the absence of some important and established items in law – such as the demographic and epidemiological profile of the municipality – in some PMS analyzed, which puts into question the fragility of this instrument to capture health needs in counterpoint to its use merely for the transfer of financial resources in an asymmetrical way to the demands of the population.

However, in France, municipal agents carry out local health management through an electronic platform that synthesizes the mapping of health needs of the population, the implementation, and the monitoring of health actions (Metzger et al., 2012), emphasizing the relevance of systematization of health management practices aimed at identifying the needs of population groups.

In Brazil, the Management Report Construction Support System (SargSUS) is available to municipal managers to develop and publicize the PMS as well as other municipal management instruments (Brasil, 2016). However, in addition to the importance of clear information systems and methods for municipal health management, it is pertinent to consider the conception of the health-disease process adopted by them, since it can influence the meeting of the health needs of the population.

An example of this evidence was presented by a study whose aim was to analyze the recognition of the needs of vulnerable social groups, identified as working people, women, with psychic distress and coming from poverty areas. In this study, it is possible to see that the municipality managed to map and include these groups in health care, but there was fragility in the articulation of reference and counter-reference mechanisms between care levels, which compromised the effectiveness of the care provided and, consequently, the quality perceived by the population, especially less socially autonomous groups exposed to vulnerabilities (Albuquerque et al., 2011).

This finding denotes the progress with the implementation of PMS as a strategic tool for municipal health management as well as its entire methodological and information system framework (Brasil, 2016).

However, as previously discussed, it still has the connotation of being an instrument that guarantees the transfer of financial resources to the municipality, to the detriment of its purpose aimed at minimizing inequities through the identification of the population's health needs as well as the systematization of actions, objectives and goals (Bueno et al., 2013).

Hence, it is pertinent to analyze the implications of adopting the conception of the health-disease process of this management tool for the satisfaction of the population's health needs, since depending on the theoretical framework for health understanding, the satisfaction of needs may occur totally, partially or not occur at all.

Therefore, our study aims to identify the potential and the limits of the PMS as a management tool for the recognition of health needs and vulnerabilities of social groups.

Method

This is a documentary and qualitative study, based on content analysis as recommended by Bardin's methodology, which, through critical hermeneutics, structures the development and analysis of meaning units in order to systematize the capture of the essence of the phenomenon (Bardin, 2011).

The documents analyzed were the 2010-2013 and 2014-2017 PMSs of the following municipalities: Araraquara, Santos, Valinhos and Vinhedo, which met the following eligibility criteria for sampling: municipalities in the state of São Paulo and not belonging to the Metropolitan Region of the state; having 50 thousand inhabitants or more; having the best Human Development Index and the worst Gini coefficients; and with PMSs available in SargSUS.

The evaluation by a Research Ethics Committee was waived for the execution of this study (Brasil, 2013a), since it considered PMSs, which are characterized as secondary documents and mainly because they are in the public domain, as the basis for this study.

The organization and systematization of data extracted from the PMSs occurred through

WebQDA® software, in which sections of the PMSs that identified the health-disease conception used in these instruments were categorized as well as ideas for identifying the health needs of the general population and vulnerable social groups. To do so, two categories of analysis were used: "conception of the health-disease process" and "identification of health needs," the latter organized from three sub-categories: "sanitary aspects related to housing and basic sanitation," "morbidity/Mortality Profile," and "utilization of the health care network."

In order to ensure anonymity, municipalities were identified by the letters A, B, C and D, followed by the period of validity of the PMS.

Results

From the organization of the data in the analytical category "conception of the health-disease process," as demonstrated in the following sections, there was evidence of multi-causality as a conception of health present in all of the PMS.

> A (2010-2013): In confirmed cases of rubella, there is a fluctuating trend during the period, indicating the need, as already assessed, for **intensifying this vaccination in the municipality**
>
> B (2014-2017): **The families still live with dampness**, health hazards and health risks.
>
> C (2010-2013): In 2007, there were 18 **deaths of children under one year**, and of these, 14 children died due to **extreme prematurity**. These children's birthweight ranged from 550g to 1605g. **We know that the reduction of deaths at birth is directly related to weight.**
>
> D (2014-2017): **Adolescent pregnancy** has been a challenge for health teams and its prevention a priority. Gestation in adolescence has maintained itself around 10% in the period from 2009 to 2013. (emphasis added)

The actions to recognize health needs have been centered on the disease and its respective risks, distancing itself from understanding health as socially determined, thus, from proposing intersectoral interventions that may be able to respond to these needs from the mapping of vulnerable social groups.

To do so, it is necessary to add, for example, to municipality A an understanding of who are the people that are suffering from rubella, what are their forms of social production and reproduction, and to investigate if the immunization action alone will be enough to curb the transmission of the disease. A similar idea must be implemented in municipality C, in which, according to the PMS, infant mortality due to extreme prematurity has as its main solution weight management, i.e., in addition to understanding that the survival of preterm babies is directly related to weight gain, it is extremely important to understand in what families these children are being born and in what social conditions these children are being cared for.

Regarding municipality B, where there are families living in unhealthy places with a lot of humidity, for the effectiveness of the transformation of the reality of these families, intersectoral actions that analyze in what conditions they are living and why they live in these conditions are fundamental, in order to check if it is due to the lack of perspective of income increase to obtain a residence with better infrastructure, and which can be achieved through professional qualification, schooling, among other actions that, together with health actions, can contribute to the improvement of people's health situation.

In municipality D, when the idea of prevention of adolescence pregnancy is presented as a challenge and priority of the municipality, there is no mention of the characteristics of women who are getting pregnant in this age group. In this sense, the PMS identifies a social group of greater vulnerability, but it does not describe the characteristics of this group, in such a way that intersectoral actions can be directed to the confrontation of the social vulnerabilities.

Thus, the forms of identification of health needs, based on multi-causality, were organized into analytical categories (Chart 1).

Chart 1 – Analytical categories of means of identification of health needs according to the PMSs, São Paulo, 2017

Analytical categories of means of identification of health needs / Municipalities	A	B	C	D
Sanitary aspects, related to housing and basic sanitation	–	X	X	X
Morbidity and mortality profile	X	X	X	X
Quantification of use of heathcare network	X	X	X	X

Concerning the "sanitary aspects, related to housing and basic sanitation," the following passages demonstrate that municipalities B, C and D use the description of these aspects to identify health needs and suggest the mapping of vulnerable social groups.

> B (2014-2017): The **precarious dwellings** are concentrated in well demarcated areas in the city, especially in the hills, in the central part, and the Northwest Zone of the city, with isolated occurrences in other areas. The **peripheral and flood-prone areas of the city** were the **housing alternative for the poor and excluded population**, with aggravation in the decades that followed. Another way of **poor land use are the stilts**, with their wooden buildings suspended in wetlands. These are occupations found in settlements [...]. In this type of placement, infrastructure is almost nonexistent and **accesses occur through alleyways built with wooden boards**. Residents are subject to weather and tidal fluctuations, where flooding and corrosion of foundations often surprise them, accelerating local environmental degradation. [...] One of the most serious problems arising from this type of occupation is the **absence of a sewage disposal system**, which causes it to be released directly into to the river, constituting a major pollution factor.
>
> C (2010-2013): **sewage treatment** plant started its operation in March 2005, and gradual treatment will be implemented until reaching the percentage of 100% of the collected sewage, even in the current year.
>
> D (2014-2017): Regarding **water supply**, the city has nearly 100%, having advanced from 2000 to 2010, without, however, overcoming the level of supply [...]. **Garbage collection** also occurs in almost 100% of the city, following the state and metropolitan area [...], adding the **selective collection** (of recyclable items) that occurs in all the neighborhoods of the city. [...] The **sanitary sewer network** in D reached 82.96% in 2010, below the state of São Paulo, which was 89.75% and the Metropolitan Region [...], which reached 86.99%. It should be clarified that **all collected sewage is treated in treatment plants in the municipality**. (emphasis added)

Among the three municipalities aforementioned, only municipality B has indications, in its 2014-2017 PMS, of the presence of vulnerable social groups in its territory, recognizing the existence of an impoverished and socially excluded social group, to which directed actions are necessary in order to break with production and social reproduction patterns and, consequently, to potentiate the confrontation of vulnerabilities.

The PMS of municipalities C and D used the description of sanitary aspects, emphasizing the improvements that occurred in the municipality, as a translation of the best health situation of their population. However, such managerial practice denotes the limitation of these PMS, insofar as they do not reach out to the social groups of greater vulnerability, nor does it relate the sanitary aspects to the health condition of the population and its groups with less autonomy for health care.

Another way of identifying the health needs of the population was based on the morbidity and mortality profile of the population of the municipalities, as shown in the passages:

A (2010-2013): The historical series of **Maternal Mortality Rates** in municipality A still shows high rates [...] in 2006 one case of **Dengue Hemorrhagic Fever** and one case of **Dengue with complication** were confirmed [...] there is a predominance of **deaths from circulatory diseases, cancer, respiratory and digestive diseases, in addition to external causes.** Despite the reduction in deaths from infectious and parasitic diseases, diseases by **the human immunodeficiency virus** (HIV) should be highlighted [...] The **AIDS mortality rate** has been decreasing in the municipality [...] **circulatory disorders added to neoplasms** account for 48% of all deaths. [...] **Mortality from alcoholic liver disease** in the municipality has been showing an upward trend and prevalence in males and also a growing trend in female users of alcohol. [...] the historical series of **mortality rate from breast cancer** [...] shows a growing trend of the disease [...] **mortality from cervical cancer** has shown [...] a downward trend. [...] The **mortality from falls** in the population of 60 years and older [...] shows high indexes and fluctuation in the indicator.

B (2014-2017): The **major cause of hospitalization is still from pregnancy, childbirth and postpartum period** (17.89%), **followed by of circulatory system diseases** (12.05%), **respiratory diseases** (10.30%), and, rising to the fourth place this year, **injuries, poisoning and certain other external causes** (10.23%). The hospitalizations that increased in 2012 [...] were those caused by **cancer** followed by those caused by contact with health services and **nutritional and metabolic Endocrine Diseases.**

C (2010-2013): The **neonatal mortality rate** was 12.73 deaths/1,000 live births. Its late fraction was 1.59. The other children who died were born at term and with consistent weight, but with **congenital anomalies.** A child died from an unspecified cause, and two from **Acute Respiratory failure and bronchoaspiration.** [...] In a growing trend, **deaths from cardiovascular disease** took the leading position in number of deaths, followed by **respiratory diseases, ill- defined etiology** and **digestive diseases.**

D (2010-2013): The main causes of death continue to be **circulatory system diseases** [...] which [...] accounted for 35% of deaths [...]. The second leading cause of death was represented by **neoplasms** (Chapter II of IDC) with 19%, and the third **respiratory diseases** [...] corresponding to 16% of deaths [...]. **External Causes** [...] accounted for 6% of deaths. (emphasis added)

Regarding the "Morbidity and Mortality Profile," all municipalities relied heavily on these indicators to identify health needs. There is no clear demonstration of identification in the PMSs of homogeneous social groups, according to their characteristics of social class, gender, generation and ethnicity, in order to allow identification of possible vulnerabilities in these groups.

These findings reinforce the relevance of in-depth studies on health needs in light of the forms of social production and reproduction, which may impact on the pattern of illness and death of specific groups.

In addition to these two forms of identification of health needs in the territory, the "utilization of the health care network" also stood out among the analyzed PMS.

A (2010-2013): The historical series of **rates of hospitalization for acute diarrheal diseases** in children under five years for municipality A in the 2005-2008 period reveals low hospitalization levels for this condition [...]. The **rate of hospitalizations for cerebrovascular accidents** in municipality A is one of the smallest of all the region [...] The **indicator Hospitalizations for Complications of Diabetes Mellitus** aims to assess the availability of basic actions for prevention and control of chronic degenerative diseases [...] The **indicator of seven or more prenatal consultations** [...], despite pointing to better indexes than the established goal for the state of São Paulo in all analyzed years, shows a downward trend [...] municipality A has been successful in vaccination campaign actions with a **satisfactory vaccination coverage.**

B (2014-2017): The **total number of hospitalizations** [...] had a reduction [...] from 18,646 to 18,074 [...] **percentage**

of tetravalent vaccine coverage (90.86%). [...] **coverage of programmatic first dental appointment** in B was 3.4% [...] regarding the **agreed indicator for chronic diseases**, the **percentage of cervical screening in women 25 to 64 years** [...] was 12.1%. [...] By analyzing the **profile of hospitalizations for conditions sensitive to primary care**, B shows a percentage of 19.69%.

C (2010-2013): In the **Poliomyelitis Campaign**, children aged 0 to 4 years, 11 months and 29 days are vaccinated [...] In 2007, **57,975 collective procedures were performed (fluoride application, lectures, supervised oral hygiene and epidemiological survey)** and in 2008 there were **61,362 procedures, showing an increase of 5.51%**. [...] Prevention Campaign to Oral Cancer held during the Elderly Vaccination Campaign **assessed the oral health of the elderly over 60 years**, besides promoting **guidelines on oral lesions, dental prostheses, and oral hygiene**.

C (2014-2017): Patients with vascular lesions **seen at the wound dressing room** in the year 2012/2013. **The Municipal ready care service [...] provided approximately 13,000 healthcare services/month**.

D (2014-2017): we had **significant increase in the access to health care at all levels of care**. [...] In 2013, there was **maintenance and slight decrease in primary and specialized care, as well as a significant increase in urgency and emergency care**. (emphasis added)

Regarding "utilization of the health care network," it was evidenced in all of the PMS, which described the amount of use of the services offered by the health care network. However, in none of the PMS analyzed according to this category there was a problematization of the specific social groups that may require more or less use of certain services, nor of differentiated services from those offered to the population as well as difficulty in accessing these services.

This shows the contradiction between what is disclosed as offered to the population through the PMS and the questioning of the effectiveness of the offer of these services against the health needs of groups with greater social vulnerability.

The evidences illustrated the attempt of the PMS to capture the health needs of the population. However, the multicausal health conception does not have the potential to meet the health needs of the population, since the description of the sanitary aspects of the territory, the morbidity and mortality profile and use of the healthcare network services are not very close to the complexity of the population's health problems – which demand an understanding that involves the modes of social production and reproduction, which, in is turn, determine the ways people fall ill and die.

Discussion

Despite Brazilian advances in reducing inequity, it is still latent and demands public policies directed to the recognition and satisfaction of the health needs of the population (Landmann-Szwarcwald; Macinko, 2016), which reinforces the importance of identifying and interpreting health needs for managerial practice based on equity (Pereira; Tomasi, 2016).

Given this importance, an Australian study investigated the effectiveness and the perception of the professionals involved in care about an information system implemented for monitoring chronic degenerative diseases in the local population. This study was justified because of the pertinence of setting managerial priorities in health at the primary level of care, and it demonstrated that for effective monitoring using an information system, it is necessary to have an interprofessional action and to understand health needs beyond the biological aspects, i.e., other aspects of psychosocial character should be considered (Ghosh; McCarthy; Halcomb, 2016).

However, the study by Ghosh, McCarthy and Halcomb (2016), in spite of advancing as it proposes a health monitoring system considering the multiple dimensions of the human being, adopts a functionalist stance for the capture, proposition and monitoring of health actions, which could impact the identification and interpretation of the health needs of the population.

This idea corroborates our findings, in which the interpretive theory of multiple causes of health-disease, of functionalist nature, was adopted in all analyzed PMS, at the expense of what is established by the *Manual de Planejamento no SUS* (SUS Planning Guide), published in 2016 by the Ministry of Health (Brasil, 2016).

This document supports the technical-political education of planning managers in health and recommends ways to capture and interpret the health needs, using the understanding of the health-disease process socially (Brasil, 2016).

This management behavior of opposition to what is recommended by the SUS Planning Guide (Brasil, 2016) denotes the use of PMS as an instrument of access to financial resources without commitment to understand the reality of the population's health process.

Thus, by adopting the interpretive theory of multiple causes, one triggers the distancing of the municipal health manager from the complexity of people's needs, demonstrating a classic contradiction between theory and practice, that is, although there is guidance on the methodological framework, regarding the interpretative theory of the health-disease process (Brasil, 2016), there is the persistence of reproduction in the management practices of a theory with great limitations to understand and explain the health-disease process, which disregards socially determined modes of illness and death, characterized by the forms of social production and reproduction that can often be limiting and, consequently, impact on the survival of social groups of greater vulnerability.

Nevertheless, when the PMSs describe the conditions of basic sanitation and housing, it is necessary to recognize the progress of this practice against the recent history of construction of public health management methods in Brazil, which remits to the Health Management Pact, proposed in 2006 with the aim of implementing and facilitating systematized actions for the operationalization of SUS (Brasil, 2006), materialized as a product of the Sanitary Reform and thus understood as the largest social protection policy in force in the world at the present time.

However, by not articulating the findings of the PMSs with the forms of social production and reproduction, starting from the social determinants and not from the social determination of the health-disease process, as discussed by Spiegel, Breilh and Yassi (2015), there is reductionism in the understanding of the ways of illness and death of vulnerable social groups, which indicates the fragility of this management practice due to the reduced effectiveness of health actions to be implemented, since these actions are not aligned with the capture of the population's health needs.

In order to overcome this managerial practice, it is necessary to analyze reality from the Theory of Social Determination of the Health-Disease Process and Critical Epidemiology, whose references perceive and understand reality by addressing socially determined strengthening and attrition aspects, represented by the forms of production and reproduction of reality, which impact on the forms of illness and death of individuals, social groups and collectivities (Breilh, 2013, 2015; Egry; Fonseca; Campos, 2013), since they have greater potential to identify health needs in an extended way.

In order to respond to this idea, municipal health management instruments should be leveraged from dialectical conceptions of the health-disease process, and the professionals involved in management and care of the population should be aligned with these methodological references, since, as pointed out by Spiegel, Breilh and Yassi (2015), when health is understood from its process of social determination, possibilities of action based on the emancipation of the subjects directly or indirectly involved in care are more assertive and, consequently, the individuals' and social groups' health needs are more likely to be recognized and satisfied.

On the other hand, a superficial and inarticulate understanding of health needs illustrates social alienation by assuming that, if understood out of the social context, they may be able to illustrate particular aspects of reality (Arreaza, 2012), such as, for example, to propose understanding the health needs of the population using, solely and alone, the morbidity/mortality profile or the healthcare

network use, focused on disease rather on the forms of social production and reproduction.

Thus, the capture of health-disease patterns from the perspective of social determination, that is, as recommended by Collective Health as a field of knowledge, significantly contributes to the perception of well-being, which interacts directly with the understanding of the emancipated individual, that is, how to be free, supportive, self-realized and socially participant (Arreaza, 2012), which qualitatively contributes to the effectiveness of municipal health management (Brasil, 2016).

Therefore, given a health system that is centered on the management and complications from diseases rather than on the salutogenic aspects of living, the services start to reproduce their actions in a functionalist way, by increasing the supply of health services in a way that is disconnected from reality, that is, unable to address the density and complexity of health needs, which are presented by the forms of social production and reproduction that result in ways of living reality in a socially determined context.

In this sense, reinforcing the importance of focused management practices for the detailed investigation of vulnerable social groups, in order to characterize these groups and propose effective measures for enhancement of people's health process, since, as discussed by Macinko et al. (2016), it is urgent to improve the performance of health services provided to the population, especially those directed to primary health care, since these are meant to coordinate health care and respond to most of the population's health problems – as anchored in the SUS principles –, which in turn can only be achieved from the adoption of interpretative theories of the health-disease process that encompass the complexity and density of the conception of health, which involves its social determination.

Therefore, future studies are needed for proposing and investing in effective models of identification of the health needs of the population grounded on the Theory of Social Determination of the Health-Disease Process, considering the identification of the health needs of vulnerable social groups and their forms of social production and reproduction that unfold in specific unique profiles of illness and death, which, currently, through the PMS, are not covered, impacting directly on the perception of the effectiveness of health services offered to the population for satisfaction of their needs.

Conclusions

The PMS adopted the multi-causal concept for understanding the health-disease process, hence the identification of health needs in the territory is related to the description of sanitary aspects, morbidity and mortality profile, and use of health services.

One of the analyzed municipalities showed, though in an incipient way, an attempt to address features that can serve as directions for the identification of specific vulnerabilities of social groups. However, it still demands maturation from the theoretical and methodological point of view, given the relevance of readjustment of PMS that propose further research on the ways to produce and reproduce of these groups, with limited autonomy to position themselves for the sake of better living conditions.

Disregarding the social determination of the health-disease process has implications concerning the difficulty of identification of the health needs of socially vulnerable groups; negative impact on management practices, which do not translate into equity; and dissatisfaction or partial satisfaction of the health needs of the population.

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Authors' contribution

Nascimento designed the research, as part of the doctoral thesis, collected and analyzed the data and prepared the scientific report. Egry discussed the design of the research as a counselor, helped in data ordering and collaborated in the discussion of the results.

Received: 01/23/2017
Resubmitted: 08/27/2017
Approved: 10/12/2017