Objective: to analyze the performance evolution of indicators of variable 3 of Family Health teams, in Program Area 3.1. Method: it is a quantitative, descriptive study. The research population was composed by all the Primary Care Health Units with family health teams. It is informed that the data was collected through the Electronic Patient Record and later analyzed associated to independent variables. Results: it was found that two out of ten groups of performance indicators showed positive evolution, follow-up of children under two years old and follow-up of a pregnant woman. It was observed that, of the four explanatory variables, only the teams with Family Health Nursing residency presented significance for the achievement of performance. Conclusion: it is evident from the analysis that few teams were able to achieve a satisfactory performance in the indicators. In several countries, financial incentives are used to analyze the care given to the teams and their work process. However, it was observed that, for full implementation, it is necessary to focus more on the quality of information systems and new management processes in which the autonomy of health teams in the process of contracting indicators is encouraged. Descriptors: Primary Health Care; Family Health Strategy; Health Evaluation; Evaluation of Professional Performance; Incentive Reimbursement; Quality Assurance of Health Care.
indicadores. Utiliza-se, em diversos países, o incentivo financeiro às equipes como forma de analisar o cuidado prestado e o seu processo de trabalho. Notou-se, no entanto, que, para a sua plena implementação, são necessários um maior foco na qualidade dos sistemas de informação e novos processos de gestão nos quais a autonomia das equipes de saúde no processo de contratação dos indicadores seja incentivada.

Descritores: Atenção Primária à Saúde; Estratégia Saúde da Família; Avaliação em Saúde; Avaliação do Desempenho Profissional; Reembolso de Incentivo; Garantia da Qualidade dos Cuidados de Saúde.

RESUMEN

Objetivo: analizar la evolución del desempeño de los indicadores de la variable 3 de los equipos de Salud de la Familia, en el Área Programática 3.1. Método: se trata de un estudio cualitativo descriptivo. La población de investigación estuvo compuesta por todas las Unidades de Salud de Atención Primaria con equipos de salud de la familia. Se informa que los datos fueron recolectados a través del Registro Electrónico del Paciente y posteriormente analizados asociados a variables independientes. Resultados: se verificó que dos de cada diez grupos de indicadores de desempeño mostraron evolución positiva, seguimiento de niños menores de dos años y seguimiento de una gestante. Se observó que, de las cuatro variables explicativas, solo los equipos con residencia en Enfermería de Salud de la Familia mostraron significancia para el logro del desempeño. Conclusión: se evidencia, a través del análisis, que pocos equipos lograron alcanzar un desempeño satisfactorio en los indicadores. En varios países, los incentivos económicos para los equipos se utilizan como una forma de analizar la atención brindada y su proceso de trabajo. Sin embargo, se señaló que, para su plena implementación, es necesario un mayor enfoque en la calidad de los sistemas de información y nuevos procesos de gestión en los que se incentive la autonomía de los equipos de salud en el proceso de contratación de indicadores.

Descritores: Atención Primaria de Salud; Estrategia de Salud Familiar; Evaluación en Salud; Evaluación del Rendimiento de Empleados; Reembolso de Incentivo; Garantía de la Calidad de Atención de Salud.

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It is observed that the health evaluation process by performance indicators has been implemented in several countries and some municipalities in Brazil, as a way to qualify assistance, proposing different payment arrangements to the health professional, when reaching the proposed goals. It is worth mentioning that, in the city of Rio de Janeiro, the experience with performance indicators started in 2009 and became an example of management in the Family Health Strategy (FHS).

It is worth mentioning that, after being consolidated in smaller municipalities, since its creation in 1993, the Family Health Strategy was challenged to integrate with existing networks in larger and better structured municipalities. Therefore, the Project for Expansion and Consolidation of Family Health (PROESF) was created.¹

With the development of PROESF, a new impulse was given to the evaluation area with the project of Evaluation for Quality Improvement (EQI), in 2005. With this project, it was sought to have an instrument of self-evaluation of teams and managers, aiming at the improvement of the quality of services, fostering debates on the work processes on the part of managers and teams and providing an evaluation culture, with the analysis of quality standards, with positive impacts for the standards of care historically provided in the area of Primary Care.¹²

It is noted that the health evaluation is based in several countries, including the United Kingdom. In this evaluation process in the United Kingdom, a set of tools called Clinical Governance (CG), which has been carried out from the National Health Service (NHS) Reform, considered the gold standard regarding universal public health systems, stands out. It is observed that these measures have influenced health systems all over the world, including Brazil.³

The thesis in which more effective changes in the management model, including evaluation, require a new cultural and behavioral approach of health professionals is corroborated. It is highlighted that actions should be directed to encourage a new conception of them regarding their practice, including the critical-theoretical evaluation of their know-how.⁴⁻⁵

It can be seen that performance evaluation, always present in these initiatives, is a complex practice, either because the existence of several analysis models leads to the adoption of restricted and fragmented points of view, or because performance evaluation is multidimensional and dependent on the reference values of each interest group present in the evaluation process. Thus, the limits of these evaluation practices are considered, since they are always closely linked to the fulfillment of work processes restricted to certain priority programs and, at most, oriented to some positive results for the health of certain population groups.⁴⁻⁶

It is observed that, in most health services, the remuneration of professionals with excellent performance is still similar to that of other professionals and does not reward those with better
performance. It is understood that, in the fixed payment, an idle time can be generated, without the preference for the assistance demand, causing the professional not to give the necessary attention to the users who do not attend the service. It is related to their remuneration more to the contracted time than to the coverage and the quality of the attention given, encouraging the development of the organization centered on the professional and not on the user. It is understood that the lack of stimulus has as consequence the reduction of the work effort and the tendency is to provide services below the desired level.\textsuperscript{5-6}

It is understood that the payment for performance, a term used in Portuguese, or the English Pay for Performance (P4P), corresponds to one of the models of remuneration in health, and can be defined as the transfer of resources to health services conditioned to results achieved in face of actions or measurable and predetermined goals. It is consolidated as a health evaluation process, aiming at quality improvement, and may be useful to promote the achievement of objectives in health systems. However, it is observed that the results of studies involving more complex actions and contexts still point out that P4P should be used with caution and its application preceded by the rigorous planning of the model to be implemented.\textsuperscript{7}

Three clinical performance measures are emphasized within the P4P: clinical quality, efficiency and patient satisfaction. It is pointed out that, despite questions about the evidence of P4P effectiveness, recent systematic reviews have concluded that P4P contracts affect the behavior of professionals and increase the supply of services in Primary Health Care (PHC), albeit to a limited extent. Factors for this purpose include the age and gender of professionals, previous experience with receiving incentives, the existence of continuing education, payment method, type and scope of goals, volume of activities and type of organization involved.\textsuperscript{7}

Examples in Brazil are some cities like Curitiba, Florianópolis, Janaúba and Rio de Janeiro, which have created their own incentive mechanisms, via performance payment to professionals, aiming at quality. Among the various measures taken in line with Clinical Governance, the proposal for payment per performance (PP) for family health teams, which was implemented in the City of Rio de Janeiro (MRJ), and the focus on professional training of its PHC network, as of 2009, with the reform carried out, stands out. A new health care model was proposed in MRJ, along the lines of the Mission for Primary Health Care in Portugal, which, in turn, was based on the NHS reforms. Based on this Portuguese experience, positive conclusions have been reached in the implementation of this strategy, presenting an improvement in the results regarding the contractual indicators, serving as a conceptual basis for the variable payment methodology presented in this management contract.\textsuperscript{8-9}
Based on this experience, the Rio de Janeiro Municipal Health Secretariat (MHS/RJ) developed a performance payment model, associating quantitative and qualitative indicators to the Electronic Patient Record (EPR) according to the work presented by the teams. The focus of this study is considered the financial or material incentive to health teams. Experiences related to performance stimulation are presented as good examples in the improvement of some fundamental objectives of PHC, which contribute to the achievement of better results.

It became essential, in view of these experiences and the need for scientific study on the subject in the national scenario, to evaluate and discuss these indicators in the form of an analysis of the achievement of the goals of family health teams.

**OBJECTIVE**

To analyze the performance evolution of indicators of variable 3 of Family Health teams, in Program Area 3.1.

**METHOD**

It is a quantitative, descriptive study, developed with information from the Electronic Patient Record (EPR), PRIME model, used in the family health teams of the Program Area Coordination (PAC) in health 3.1, located in the north zone of the city of Rio de Janeiro. The territory of the municipality of Rio de Janeiro is divided into ten health programmatic areas with the purpose of organizing the network.

The research population was composed by all the Primary Care Health Units with health teams of the family of the referred PAC, being, in the first period of analysis, end of 2013, 125 the number of teams, and, at the beginning of 2016, 139.

All the Health Units (HU) of CAP 3.1 were considered as inclusion criteria in the survey, and two units that used another EPR model were considered as exclusion criteria, because, in this case, the different system may present distinct updates and interfere in the result of the indicators.

Data was collected in the period 2013.4 to 2016.1, through information extracted from the EPR, in the first quarter of 2017. A consolidated data base composed of secondary data was searched in a restricted use information base of MHS/RJ. For the EPR information system, the division of one year into four quarterly periods is considered. This period was selected due to the change of indicators in the PRIME system (EPR), from 2013/4, until the new update that happened after 2016/1. It was also chosen to start with 2013/4 because, from this period, the teams were more integrated with the information system.

The indicators of MHS/RJ performance payment were divided into three components called variables: variable 1 (V1) - management; variable 2 (V2) - family clinic; variable 3 (V3) - family health.
team (Figure 1). Ten indicators considered to be priority (Figure 1) were agreed upon in the municipal health management contract, which allowed evaluating the quality of care in PHC and taking into consideration local specificities, since the professional was provided with the composition of the result of the set of indicators reached.9

An extra resource is configured and proportional to the base salary of each professional, the reach by the team of Countable Units (CU), per user that fits each indicator (Figure 1). It was linked to the proportional reach of CUs, not existing the minimum and considering, as a maximum, 300 CUs per quarter, totaling, in one year, the fourteenth salary of the health professional.9

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>G1</td>
<td>Monitoring in family planning, of a woman in fertile age, per year.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Monitoring in family planning of a woman of fertile age, with IUD</td>
<td></td>
</tr>
<tr>
<td>G2</td>
<td>insertion or preoperative for lacquering.</td>
<td>3</td>
</tr>
<tr>
<td>G3</td>
<td>Monitoring a pregnancy.</td>
<td>8</td>
</tr>
<tr>
<td>G4</td>
<td>Monitoring a child in the first year of life per year.</td>
<td>7</td>
</tr>
<tr>
<td>G5</td>
<td>Monitoring a child, in the second year of life, per year.</td>
<td>3</td>
</tr>
<tr>
<td>G6</td>
<td>Monitoring of one diabetic person per year.</td>
<td>4</td>
</tr>
<tr>
<td>G7</td>
<td>Monitoring of one hypertensive person per year.</td>
<td>2</td>
</tr>
<tr>
<td>G8</td>
<td>Monitoring a person on discharge for cure of tuberculosis.</td>
<td>8</td>
</tr>
<tr>
<td>G9</td>
<td>Monitoring a person on leprosy clearance.</td>
<td>10</td>
</tr>
<tr>
<td>G10</td>
<td>Monitoring of smoking, alcohol and other drug patients.</td>
<td>4</td>
</tr>
</tbody>
</table>

Figure 1: Performance indicators of family health teams. Rio de Janeiro (RJ), Brazil, 2016.

The weights of the CUs given to each group of indicators were considered differently, considering the degree of difficulty of each type of attention that should be given. Items were added to each performance indicator, which needed to be achieved concomitantly for each user who would fit this performance (e.g., child with a current vaccination for indicators of under two years old and annual foot exam for users with Diabetes Mellitus registry).9

As a first step in the analysis process, the data was exported in spreadsheet in the Excel model. The evolution of the number of users per team was analyzed and the multivariate statistical analysis was performed in the cut of the period 2016.1 through linear regression using the following independent variables: team with residence in Family Health Nursing; team with residence in Family Medicine and Community; number of users per team; team whose unit has Family Health Support
Center (FHSC), identifying their representativeness with respect to the dependent variable. The number of independent variables was used as the basis for evaluating the outcome in the independent variables.

Dummy (no = 0 and yes = 1), Nursing and Medical residence and FHSC were categorized as variables. Multiple linear regressions were performed with the four independent variables of the study. It was considered, as a significant trend in the regression, the p less than 0.05, also performing the analysis of residue.

The multiple linear regression models, with Dummy variables, was applied to the following equation: 
\[ Y = b_0 + b_1x_1 + b_2x_2 + b_3x_3 + b_4x_4; \]
- \( y = \text{CUS} \);
- \( b_0 = \) is equal to the value that \( y \) assumes when \( x \) is zero;
- \( b_1 = \) population;
- \( b_2 = \) medical residence;
- \( b_3 = \) nursing residence;
- \( b_4 = \) FHSC.

The research complied with the determinations and norms stipulated by the National Health Council Resolution 466, of 2012. The research project was submitted to the Research Ethics Committee of the Federal University of Rio de Janeiro (UFRJ) and the Municipal Health Secretariat of Rio de Janeiro, approving it under number 62693916 3 0000 5238.

**RESULTS**

The study evaluated ten PAC 3.1 performance indicators for the period 2013.4 to 2016.1, and only two showed an evolution corresponding to a growth process (Figure 2). The Nursing residency is highlighted as a positive component for teams to present success and improvement of indicators in relation to the independent variables.

It can be seen in the global analysis that one group of indicators (G9) did not account for any user and three others (G4, G8 and G10) reached less than 1% of users and, therefore, this was not accounted for in the evolution chart (Figure 2). In quarters six and seven, abrupt drops in indicators G1, G2 and G7 can be seen. It can be observed that G3 and G5, following a pregnancy and following a child in the second year of life, respectively, reached linear growths. It is noteworthy that groups eight, nine and ten did not obtain consistent data for an analysis of their evolution. For example, in the indicator follow-up of a person on high for tuberculosis cure (G8), only three teams completed a user with all the items achieved in the first quarter of 2016, having reached a total of 232 users in this indicator, in PA 3.1, throughout the period analyzed.
Figure 2: Percentage of users with a target met above 1% in the Performance Indicators in the Program Area Coordination - 3.1, in the eleven quarters evaluated in the period from 2013 to 2016. Rio de Janeiro (RJ), Brazil, 2016.

It is pointed out that the indicators of children under one year old (G4), diabetic patient (G6) and tuberculosis patient (G8) did not represent growth in the evolution analysis of the selected period.

Figure 3 shows in the analysis of the first independent variable, population per team, that the lower number of users per team did not show significant results for the greater reach of the CUs, and having a higher or lower registered population did not represent significance for the reach of the variable. It is assumed that the R² has values between zero and one; the closer to one, the closer the points are to the straight line and the stronger the relationship between the variables. In the population x SCU analysis, an R²=0.0016 was obtained, i.e. very close to zero, not showing a significance between the variables. It is said that a relation between variables is strong when the R² is above 0.6.

Figure 3: Number of Accounting Units reached per Family Health team according to the population registered in the period of 2016.1 at PAC 3.1. Rio de Janeiro (RJ), Brazil, 2016.
It is identified in the analysis applying linear regression (Table 2) that the variables medical residence and FHSC did not obtain results within the expected value, less than 0.05. It is noted, however, that the nursing residence variable presented a value lower than the significance level 0.05 (value of - P), therefore, there was statistical evidence that the variable interferes with the increase of the SCU. It is considered that the lower the - P value, the greater the evidence of relationship between the variables (range from zero to one), and the value used for the representation of significance by - P is a result less than 0.05.\textsuperscript{10}

Table 2. Statistical multivariate regression analysis in relation to independent variables compared to the range of performance indicators. Rio de Janeiro (RJ), Brazil, 2016.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Coefficients</th>
<th>Standard Error</th>
<th>P-Value</th>
<th>95% superior</th>
<th>95% inferior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intersection</td>
<td>44.934</td>
<td>25.328</td>
<td>0</td>
<td>44.837</td>
<td>145.032</td>
</tr>
<tr>
<td>Population</td>
<td>0.0127</td>
<td>0.006</td>
<td>0.068</td>
<td>0</td>
<td>0.026</td>
</tr>
<tr>
<td>Medical residency</td>
<td>-8.073</td>
<td>18.513</td>
<td>0.663</td>
<td>-44.692</td>
<td>28.545</td>
</tr>
<tr>
<td>Nursing residency</td>
<td>57.528</td>
<td>20.077</td>
<td>0.004</td>
<td>17.816</td>
<td>97.24</td>
</tr>
<tr>
<td>Family Health Support Center</td>
<td>32.576</td>
<td>16.08</td>
<td>0.044</td>
<td>-64.383</td>
<td>-0.769</td>
</tr>
</tbody>
</table>

DISCUSSION

The payment for performance was conceived as an extra compensation, rewarding professionals whose teams reached pre-established goals by means of performance indicators, with a link to payment for the achievement of goals each quarter (performance).\textsuperscript{9} With these incentives, it is promised to create conditions for the development of motivational environments for professionals, by attributing to the teams improvements in health units in the physical context of their exercise. The competencies resulting from the facilitation of access to evaluation actions are reinforced, and by attributing to the professionals bonuses associated to performance.\textsuperscript{8,9}

The evaluation of Primary Care is justified by means of instruments that encourage changes in the work process, aiming at the improvement of assistance, by the capacity of building new practices aiming at new knowledge, producing an evaluative conscience that provides new technologies for this model of health care, encouraging the actors to rethink, generating new outcomes and making the necessary changes.\textsuperscript{11} With the implementation of the evaluation process encouraged by performance, good opportunities for professionals are produced. Some are listed as the increase of autonomy, the incentive to team work, the space for dialogue, the recognition of local and macro indicators, the reflection on the care process, the improvement of quality and the possibility of improving and organizing users' access to the service.\textsuperscript{11}
In the analysis of this study, it was observed that the family health teams presented difficulties in reaching most of the qualitative indicators proposed by the Rio de Janeiro Municipal Health Secretariat. For most of the period selected for the study, a small variance in the number of family health teams was presented, maintaining a standard of coverage and assuming that the reach of the indicators could represent a linear and increasing growth, because the teams would be familiar with the system. However, a process of evolution of the indicators marked by increases and decreases was revealed, revealing a difficulty of the teams to maintain a growing performance.

As a difficulty presented during the data analysis, the changes suffered by the system for improvement and necessary corrections were put forward, and sometimes this information is passed on to the assistance professionals late or without further technical specifications, generating doubts regarding the correct functioning and use of the system. In this way, it becomes the satisfactory range of inconstant and sometimes unattainable performance. It is considered that, in this period, according to MHS/RJ, the ERP went through an update, which resulted in changes of parameters for these indicators, which may justify the reduction verified. Another aspect exposed was the deficit of PAC analysis in relation to the evolution of indicators, and the area's information system team found it difficult to explain the abrupt falls of early 2015.

These processes were reflected in obstacles of a better quality of the informed data, although the improvements in the system are to meet the demands of the teams and achieve better quality in the tool and end up weakening the process of analysis of the indicators, making it reptilian.

Other studies have proven that the implementation of financial incentives in PHC by management has generated changes in the profile of professionals, increased motivation and commitment to work.\(^1\) In a study in Janaúba (MG), where the municipal health department began a new model of payment management to professionals linked to the results, among other innovative processes, an increase in the percentage of children under four months with exclusive breastfeeding. Compared to the year 2000, this percentage was about 40%, doubling in 2006 to 83.36%.\(^{13}\) Breastfeeding is understood to be an important indicator linked to the infant mortality rate.\(^{14}\)

In relation to the pregnancy follow-up indicator, an important growth in prenatal care observed in the specific criteria was perceived, generating quality through the indicators achieved and reducing the risks of obstetric complications, as well as maternal and neonatal mortality. This rise can be assessed by increasing the coverage of FHS in MRJ.\(^{15}\)

The follow-up of a hypertensive person was maintained as the only indicator with high rates, but even though it was the most achievable by the teams, a constant evolution of this phenomenon was not identified, a fact possibly explained by the changes in the systems, as mentioned above. It is,
however, a condition that requires continued care, and the increase in performance by the teams can be verified, speaking in favor of improving access and continuity of care.

It was also verified that the variable population registered per family health team did not change the indicator for better when it has a smaller number of users. The population limit per team is continuously discussed at FHS. Since the beginning of Family Health, the maximum value of users per team has been reduced in order to adjust the quality of care to minimum teams, considering that the latest update of the National Primary Care Policy (NPCP) brings a maximum limit of 3500 thousand users and an orientation of fewer users to territories considered vulnerable according to the socioeconomic profile.16

It can be justified, regarding statistical evidence, that the Nursing residence variable is related to the increase of the CUs by the teams and that Nursing has a greater training for management activities and health surveillance, corroborating the practice of monitoring and evaluation of the work, including through performance indicators.17 It is known that the Family Health Nursing Residency Program (FHNRP), started in 2015 by MHS/RJ with 24 vacancies, currently has 80 vacancies/year and glimpses the quality of care and the challenge of changing the health model.18

It shows a strong potential for analysis of the work process linked to indicators and surveillance of the team in training through the model of Residence allied to the historical foundation of Nursing management and administration. In this sense, it is important to emphasize that qualified and specific training interferes in the health indicators and projects an improvement in the care to users.

Also noteworthy is the residency program in Family and Community Medicine of the Municipal Health Secretariat of Rio de Janeiro (PRMFC-MHS-RJ), which began in 2011 with the opening of 60 vacancies, currently offering 150 vacancies per year. One of the main characteristics of the program is its clinical focus, with the capacity to solve 90% of the health problems of the population in which it operates.19 There is, however, a teaching deficit in care surveillance issues in medical training, which is historically based on the clinic.20

It is also verified that the FHSC variable did not show significant value in the regression analysis. The objective of the implementation of FHSC in 2008 by the Ministry of Health was, among others, the de-medicalization, the participation in the permanent education of family health teams, the increase of the principle of completeness, and the resoluteness of the PHC.21

Since its creation, however, there have been doubts about the work process of both the professionals linked to the nuclei and the professionals of the FH team. The lack of understanding about the role of FHSC in the FH units becomes a difficult principle. It also represents, as a barrier to reach the objectives, the still very restricted number of FHSC teams, making the task of supporting the FH teams in their interdisciplinary needs tortuous.21
Adhesion is given to the payment for performance by the teams according to the results of the work process. Two possible phenomena for the achievement of the payment are exposed, didactically: the teams appropriate the tool, search for information, discuss the indicators, define the most relevant for their territory and organize themselves in the best way to promote the achievement of the goals and, consequently, the financial return in front of an organized work process and with an efficient and constant vigilance of the priority groups and the adequate completion of the EPR. In this example, payment for performance becomes a genuine process, of natural reach.

By reaching a percentage, teams are encouraged to seek a gradual process of evolution. With the evaluation process of the indicators, the perception of vigilance of the work process and the planning routine according to the expected results and the proposed objectives are triggered.\textsuperscript{11-2}

It was observed, as a negative point and of difficulty to increase the goals in this analysis, the delay in passing on the payment to the teams, which can cause frustration in the professionals regarding the work developed and make it difficult to continuously evaluate the indicators. It was also observed that few teams were able to achieve a satisfactory performance that would favor the financial incentive. From this point of view, it was exposed the fragility of the teams' monitoring of the indicators.

However, good practices are encouraged, and the rewarding of good results within qualitative processes shows the motivation of the professional in obtaining the goals and organizing the service. Professionals are sometimes heard questioning why they receive the same salary as the colleague who does half of their work.

It is considered important, in an evaluation process, to formulate parameters and indicators that are possible and consistent with the local reality. This evaluation process requires criteria that are achievable and appropriate for each reality. Therefore, the practice of monitoring and evaluation in the PHC is fundamental.

It is perceived, in many aspects, that the financial incentive is seen as a positive factor of change, considering the achievement of goals and the quality of care. It corresponds not only to material values, but also to intrinsic values of personal success and professional recognition, generating satisfaction and pride in the teams. The continuous monitoring of incentive programs is understood as a fundamental factor to determine the effectiveness of financial incentives and their possible unintended effects on the quality of care, and it is an evaluation suggestion for the creation of a specific Working Group, which performs and corroborates the municipal management and teams.

On the other hand, it is understandable that bad habits of use of the systems can lead to non-real numbers for the desire of financial reward. However, operational change is considered a gain, and
the potential inducer is a result achieved even if it is not a value paid directly. Awareness of vigilance and evaluation, of self-image, of seeing oneself implicated in local management, thinking about practices that glimpse the quality of care, is created when an analysis of the work process is proposed.

CONCLUSION

It is evident in this survey that the performance of the V3 indicators of the Family Health teams in the Program Area Coordination 3.1, in the city of Rio de Janeiro, underwent significant changes during the analyzed period. However, it was evaluated that it was not possible to affirm a regular evolution throughout the study, since only two of the ten evaluated indicators obtained this profile. It was verified, when comparing variables that could impact quality indicators, that the Nursing residence factor was the only one that presented relevance for the performance payment.

The following factors are associated as possible factors of limitation in the attainment of the V3 objectives, evidenced by the analysis, the training of professionals, the training deficit and the management follow-up in relation to the difficulties encountered by the teams, indicators that are not the reality of the territory and sub-items at some moments unattainable.

In this context, meritocratic characteristics are often presented in relation to performance pay, since not all present the same working and training conditions. Training is considered here as one of the conditions favorable to achieving results, one of the tools in the qualification process of the system. There is also a need for greater discussion of the social, motivational, personal, and specific attributions of each actor, as well as an understanding of the attributes of the PHC, which complement and facilitate the development of skills and abilities necessary for the consolidation of UHS.

It is evaluated that discussing new models of remuneration in the health sector becomes fundamental in face of a new epidemiological profile and growing health expenditures. It is understood that the concept of evaluation and recognition of its users, often only made possible by the financial incentive, is a gain to the system, thus, the investment in health requires a prioritization to its main resource, the human. It is considered that the strengthening of the system should be based on the teaching-to-service relationship, theoretical-practical, in the certainty that the knowledge produced in and by the work process meets the defense of the right to health.

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