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Primary Health Care Reform in the cities of Lisbon and Rio de Janeiro: context, strategies, results, learning and challenges

Daniel Soranz [1]
Luís Augusto Coelho Pisco [2]

Abstract *On the 30th anniversary of Alma-Ata, the World Health Organization published in 2008 the "Primary Health Care Now More Than Ever" Report, calling on all governments to reflect on the need to reflect on four sets of reforms. These included: (i) universal coverage reforms; (ii) service delivery reforms; (iii) public policies reforms that would ensure healthier communities; and (iv) leadership reforms. In this context, in the period 2005-2016, the cities of Rio de Janeiro and Lisbon developed a profound primary healthcare reform, and did so by sharing many of the solutions based on the best internationally recognized organizational practices. Several factors were fundamental throughout Lisbon and Rio de Janeiro's path of reforms, namely: (i) teamwork with professional motivation; (ii) internal and external communication; (iii) strengthening of training activities; (iv) investment in facilities and equipment; (v) commitment to the information system and computerization; (vi) pay-for-performance; (vii) health care contractualisation between funders and providers; (viii) technical leadership; (ix) political leadership; and finally (x) quality and accreditation of facilities by public agency.*

Key words *Health Care Services Reform, Primary Healthcare, Patient-centered care*

[1] Sistema Único de Saúde (SUS), Secretaria Municipal de Saúde da Cidade do Rio de Janeiro. R. Afonso Cavalcanti 455/701, Cidade Nova. 20211-110 Rio de Janeiro RJ Brasil. danielsoranz@gmail.com
[2] Conselho Diretivo da Administração Regional de Saúde de Lisboa e Vale do Tejo, Serviço Nacional de Saúde. Lisboa Portugal.

Introduction

Every path is beautiful if completed /
standing idle halfway through
is letting the dream slip away...
Todo o caminho é belo se cumprido /
ficar no meio é que é perder o sonho ....
Alda Lara – Angolan poet

Portugal and Brazil have a history, a culture and a language that bring them closer together and invite them to work and reflect together. This is what happened with primary health care in Rio de Janeiro and Lisbon in recent years, developing a profound reform of their primary healthcare and doing so by sharing many of the solutions that are some of the best organizational practices known internationally.

On the 30th anniversary of Alma-Ata, the World Health Organization[1] published the "Primary Health Care Now More Than Ever" Report, calling on all governments to reflect on the need to think about four sets of reforms that reflected the integration between primary health care values and citizens' expectations. These included: (i) universal coverage reforms; (ii) service delivery reforms that could reorganize them around people's needs and expectations; (iii) public policies reforms that would ensure healthier communities; and (iv) leadership reforms, toward inclusive leadership based on negotiation and participation and more appropriate to the complexity of current health system.

These reforms advocated by the WHO were implemented as of 2005, in Lisbon, Portugal and from 2009 to 2016 in Rio de Janeiro, Brazil, which have done so by sharing many of the solutions based on the best organizational practices known internationally.

Context description: characterization of the cities of Lisbon and Rio de Janeiro

Greater Lisbon is a Portuguese statistical sub-region, part of the Lisbon Region (former Lisbon Region and Tagus Valley) and the District of Lisbon. It is bordered by Oeste to the north, by Lezíria do Tejo to the east, by the Tagus Estuary (and through it by the Setubal Peninsula) to the south and by the Atlantic Ocean to the south and west. The Greater Lisbon comprises nine municipalities - Amadora, Cascais, Lisbon, Loures, Mafra, Odivelas, Oeiras, Sintra and Vila Franca de Xira[2].

The area managed by the Regional Health Administration and Tagus Valley (ARSLVT)[3], namely, IP, is made up of five NUTS III: Oeste, Greater Lisbon, Setubal Peninsula, Middle Tagus and Lezíria do Tejo, comprising 52 municipalities.

This region covers a geographical area with about 13 thousand km^2 corresponding to 13.6% of the total national territory and concentrates 34.7% of the total population. The population covered in 2001 was 3,475,925 residents, increasing by about 5.3% in the last 10 years (2001-2011), to 3,659,868 residents, a much higher rate than the national one, where the population increased merely by 1.99%.

It is a territory with a high population density, about 3 times higher than the national average (114.5 inhabitants / km^2 in Portugal and 309.4 inhabitants / km^2).

The city of Lisbon was subdivided into 53 counties. However, with the enactment of Law No. 56/2012 of November 8, these were the subject of an administrative reorganization and gave rise to a new map of the city, now with only 24 counties.

The city of Rio de Janeiro is located in the Southeast Brazil. It has been the capital of the State of Brazil, a colony of the Portuguese Empire, later capital of the United Kingdom of Portugal, Brazil and the Algarve from 1815 to 1822, capital of the Empire of Brazil until 1889 and, capital of the United States of Brazil until 1960, when the seat of government was transferred to Brasilia.

It is currently the capital of the State of Rio de Janeiro and the main international tourist destination in Latin America. It is the second largest Brazilian metropolis (after São Paulo), the sixth largest in the Americas and the thirty-fifth in the world.

Rio de Janeiro is divided into 160 districts grouped into 33 administrative regions; for health management purposes, it is organized into 10 planning areas.

In 2010, according to the Brazilian Institute of Geography and Statistics (IBGE), Rio de Janeiro had 6,320,446 inhabitants[4]. The population density was 5,265.81 inhabitants / km^2. The city is known for its strong economic and social contrasts, with a marked difference in the living conditions of poor and rich - a mosaic of inequalities. While many districts have a Human Development Index (HDI) levels equivalent to Nordic countries (Gávea: 0.970, Leblon: 0.967, Jardim Guanabara: 0.963, Ipanema: 0.962, Barra da Tijuca: 0.959), other districts evidence extreme situations, close to very low-developing countries, such as the Complexo do Alemão (0.711) or the Rocinha (0.732)[5].

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Principles of reform and strategies for change

In general, European health policymakers agree on the central objectives of their health systems: universal access to all citizens, effective care for better health outcomes, efficient use of resources, high quality services and ability to respond to patient concerns[6].

The need for primary health care reform is associated with the need to solve some of the main issues: lack of focus on the user, management distance from territory issues, organization focused essentially on own internal problems, lack of focus on the internal user, with much waste of human talent and a sharp deficit in information systems. From the outset, the main objectives of primary healthcare reform were[7]: (i) increased accessibility and satisfaction of health care users; (Ii) increased satisfaction of professionals involved in care; (Iii) improvement of quality and continuity of care; (V) increased efficiency in services.

In October 2005, Portugal initiated an ambitious PHC reform, based on the Primary Health Care Mission (MCSP), leading to a deep reconfiguration of Primary Healthcare in Portugal. In January 2006, MCSP published the "Priority Action Lines for the Development of Primary Health Care" in which it disseminates its proposed measures in eight areas of action and sets the way to developing the reform[8].

In the Portuguese reform, a set of strategic lines was elaborated and were clustered in the 2007-2009[9] strategic plan, namely: Axis I - quality and organizational change related to issues of leadership and independent management, improved accessibility, with evaluation and monitoring and with the management of information and communication technologies. Axis II - clinical governance and knowledge management addressed issues related to clinical governance, professional qualification and innovative and simplified care delivery. Axis III – sustainability and development associated to issues related to accreditation of services, financial feasibility of primary healthcare and communication with citizens and professionals.

Solutions pointed out by these Axes encompassed professional management, independence, teamwork, demand-oriented culture and professional satisfaction and motivation. The challenges faced by health facility managers were to try to balance efficiency gains with effectiveness gains, manage resources rationally and have costs adequate to objectives, achieve health gains for the community, that is, by the performance of continued quality of service. "Model B" Family Health Facilities were especially established for the development of innovative solutions proposed by these Axes.

The city of Rio de Janeiro began its reform in April 2009, inspired by the Portuguese Primary Healthcare Reform. Eight strategic axes[10] were launched, with specific priorities for each year and recurring processes throughout the reform. Health facilities called "Family Clinics" were established and "Model A" Municipal Health Centers transformed / physically refurbished to develop the innovative solutions proposed by these Axes.

As in Portugal, it was not enough to expand access without increasing primary health care's resolution. In the municipality, these axes were associated with the essential (first contact access, longitudinality, coordination of care and comprehensiveness) and derivative (family orientation, community orientation and cultural competence) attributes proposed by Starfield[11].

Lisbon and Rio de Janeiro reforms aimed at improving the quality of health care, making them citizen-centered, accessible and efficient, always bearing in mind the need to improve the satisfaction of professionals and users[12].

The modernization and reconfiguration of the Health Centers in both Lisbon and Rio de Janeiro and the establishment of Family Clinics in the latter city were based on a set of principles: (i) community-oriented, with strategies adapted to local needs; (ii) organizational flexibility with self-organization and reduced organic strictness; (iii) leadership and teamwork, with establishment of new competences and knowledge management; (iv) simplification of care, improving regulation with more trust in the citizen; (v) results-oriented management, with community impact assessment; (vi) contractualisation and evaluation, with definition of goals before the public administration[13]; (vii) independence and accountability; (viii) continuous improvement of quality as a way of acting.

Results of change

In the first half of 2015, 76.84% of users enrolled in the Lisbon and Tagus Valley region and 72.49% in the Algarve region had a family doctor assigned to them. In Rio de Janeiro, in November 2016, it is estimated that 65% of Rio de Janeiro residents already had doctors working in Fam-

ily Health Teams, except that most of them are undergoing a training process to obtain the title of specialist. In the Lisbon Region, between 2009 and the end of 2015, 931 family doctors physicians retired and 421 new ones joined the system, leading to a deficit of 510 doctors.

In Portugal, some patients are still without a family doctor in the family health units, contrary to the principle underlying the establishment of this type of functional unit. This situation occurs predominantly in places with an increasing trend, particularly in the Family Health Units (USF), as a result of retirement or transfer to other functional units without due replacement[14].

Measures introduced by the Portuguese Ministry of Health of the XIX Constitutional Government to respond to the shortage of medical professionals in the General and Family Medicine career, namely (i) opening of procedures for the admission of professionals, (ii) recruitment of professionals (Iii) increase of normal working hours of the medical special career from 35 to 40 weekly hours, resulting in (iv) increasing the size of the list of registered users per physician from 1,550 to 1,900 users, and (v) incentives for geographic mobility have not been sufficient to achieve a more comprehensive coverage of primary health care provision[15].

In 2016, in Rio de Janeiro, the lack of family doctors in the labor market or in places of extreme violence occurred between 5 and 10% of the teams. In order to respond to this issue, planning was done in medical training so that, in 10 years, all team family physicians could have medical residency in family and community medicine, by stipulating the following: (i) opening 220 annual residency vacancies; (ii) requesting the Ministry of Health to deploy 101 Cuban family doctors to the most difficult areas; (iii) making workload for 20 or 40 hours flexible, as per the professional's decision; (iv) keeping an average of 3,200 patients per team; (v) establishing a career plan with incentive for training; (vi) providing an incentive to geographic mobility; and (vii) investing heavily in the improvement of physical structures of the facilities and offices.

Primary healthcare-sensitive hospitalizations

An analysis was made of hospitalizations for ambulatory care-sensitive conditions (ACSC), which are interpreted as avoidable hospitalizations by efficient primary healthcare. In Portugal, these hospitalizations accounted for 8% of all hospital admissions in SNS hospitals in 2014[15]. The result of the econometric analysis performed reveals that an association of a higher coverage by "B Model" USF leads to a lower ACSC rate, but this estimate is not statistically significant, thus, in the context of this study[16], there is no statistical evidence to support such a conclusion. The proportion of patients with an assigned family doctor appeared as strongly associated to lower rate of hospitalization for ACSC.

Hospitalizations for PHC-sensitive conditions are an indirect measure of the clinical efficacy of primary healthcare for certain health problems. Compared with other capitals of the Brazilian Southeast and South, there was a significant decline in the proportion of sensitive conditions, placing Rio de Janeiro at the second lowest proportion of hospitalizations (10.5%) for sensitive conditions in 2014, behind Curitiba with 8.8% of sensitive conditions against total hospitalizations.

Report of the Portuguese Health Regulatory Authority

In the indicators of preventive health care (indicators of oncology surveillance, screening and vaccination plan) and disease prevalence, "B model" USFs evidenced a better performance, followed by "A model" USFs. In the analysis of the economic performance of PHC facilities, the average expenditure on drugs and the average expenditure on complementary diagnostic and therapeutic means (MCDT) per user based on the agreed price were studied. In all these indicators, it was found that "B model" USFs performed better (lower expenditure), followed by "model A" USFs. Regarding the proportion of billed generic drugs packaging between 2012 and 2014, "B model" USFs used a greater proportion of generic drugs than the UCSPs, notwithstanding the growing trend of this rate observed in all three types of functional units (UF) analyzed. The main conclusions of the study indicate a better performance of "B model" USFs in most of the indicators considered, possibly associated with the financial incentives scheme for the professionals of these UFs, incentives that are not provided in "model A" USFs and UCSPs[17].

Physical activities at Rio de Janeiro's Gyms

From 2009, the Municipal Health Department of Rio de Janeiro implemented a new public policy, institutionalizing physical activity in the

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context of the PHC Reform[18]. In 2014, the program will be part of the list of activities included in the primary healthcare services portfolio.

The Rio de Janeiro Gym Program (PAC) meets the guidelines and goals recommended in the Municipal Health Plan, both in the first elaboration in 2009 and in its last cycle started in 2014, which includes the promotion of physical activity as an essential health promotion tool[19].

Physical activity, although known by the population as a way to improve health, is still little practiced. Disinformation and difficult access are the main hindrances.

PAC is an extended concept of promoting physical activity in the territory and aims to develop a movement culture and an active lifestyle, and is not limited to physical equipment exercises. The Program comprises all physical activity practices that will develop and promote health, prevent diseases and their complications. It is a strategy to help human development through good practices actions and that will result in the construction of healthier living habits for the population.

With the average monthly entry of 2,325 individuals, the Program now has a network of 106,722 participants. In 2010, most were females, with 86% of the public. Growth of male participation was set as a goal in order to increase men health care. As a result, there was a positive change from 14% (2010) to 27% in September 2016 in this group of individuals.

In the face of the example and success of Rio de Janeiro, on October 1, 2014, Lisbon inaugurated its first "Movement Gym" in the Health Centers Cluster (ACES) of Western Lisbon and Oeiras. It is the first of a network of Movement Gyms expected in the territory in order to facilitate mobility of the elderly, but also rehabilitation of musculoskeletal pathologies that are the first cause of disability among the Portuguese.

Lessons learned

Several factors were fundamental throughout the path covered by the Lisbon and Rio de Janeiro reforms:

(i) Teamwork with motivation of the professionals: motivated workers are the true engines of reform and change. A good leadership of a primary healthcare facility perceives its culture and uniqueness, creates a participatory climate with autonomy and responsibility, delegation, objective identification of action areas, monitoring, good working environment, promoting a good relationship between people.

(ii) Internal and external communication - publications, magazine, newspaper, website, books, hundreds of papers and local, regional and national reports mostly very positive about the changes introduced.

(iii) Training - In Portugal, the National Institute of Administration (INA), Associations and Universities promoted the specific training of the executive directors, the coordinators of the support and management unit (UAG) and the Technical Council seeking to promote the desired cultural change in organizations[20]. In Rio de Janeiro, the SMS, in partnership with Fiocruz, carried out Technical Courses for Community Health Workers, for Endemic Diseases Agents (Health Surveillance), for hygienists (Specialization Courses), for multiprofessional residents and for masters in PHC. In addition, it has developed workshops for pharmacy technicians. The SMS also established the Residency Program in Family and Community Medicine and Nursing.

(iv) Investing in installations and equipment – A total of 150 new Family Health Units (87 model A and 63 model B) were established in the ARSLVT Region from 2006 to 2016, many of them in new or refurbished buildings and in the municipality of Rio de January, 110 new equipped Family Clinics (as at November 2016) and with the so-called PHC "service portfolios", which comprise the set of items - actions, services and procedures to be developed across the board by all health facilities.

(v) Investing in the information system and computerization - the development of interoperability and individual electronic records of patients allowed monthly monitoring of teams and their indicators.

(vi) Pay-for-performance[21,22] – the method of payment for the work of the teams and, above all, of family physicians is crucial, as it has a relevant influence on clinical practice. With this payment, quality and quantity go hand in hand. It is about rewarding good practices and the associated workload. From the political standpoint, mixed payment models, with well-explained quantitative and qualitative objectives and increased desirability of group incentives are recommended as long as these indicators are updated and revised every one or two years[23]. Pay-for-performance is a payment method and not an absolute guarantee of health gains.

(vii) Contractualisation[24] – it is a process of relationship between funders and providers and is based on a contractual philosophy involving a relationship between assigned funding and ex-

pected results. It is based on the independence and responsibility of the parties and supported by an information system that enables effective planning and evaluation, considering production goals, accessibility and quality as objects of the agreement. Correct and demanding contractualisation is a way to encourage performance, monitor and demonstrate gains.

(viii) Technical leadership – it requires a clinical governance policy that is viewed as a set of quality-based policies, strategies and processes that can ensure continuous improvement in the way the health facility unit cares and treats its patients, in the way it is accountable to the community and to the tutelage and efficiency in managing resources entrusted to it. The effective exercise of clinical governance is not achieved by decree. It is not a matter of achieving a goal, but of going a long way, which requires from the genuine start the will to change and openness to new models of thinking, managing and providing health care.

(ix) Political leadership - clear and unequivocal support from the highest political officials, in particular the Minister of Health of Portugal and the Mayor of Rio de Janeiro.

The then Minister of Health, Professor Doctor António Correia de Campos, followed the reform step-by-step. He intervened when necessary, unlocking the required situations. Thus, we can affirm that the process of USF field implementation was a permanent exercise of concessions, creativity, adjustments, ingenuity and goodwill. After a period of stagnation of the reform that occurred concurrently with a period of serious economic crisis, the current government appointed a coordinating group for its relaunch[25].

The strength of the USFs as "savings generators" in a period of economic crisis is also evident in the external support agreement negotiated by the Portuguese government with the troika – consisting of individuals from the International Monetary Fund (IMF), the European Commission and European Central Bank (ECB), which clearly recommends the expansion of "B Model" USFs (the model differentiating payment incentives for professionals). Actually, the chapter on the Memorandum of Understanding on the health system contains specific guidelines on strengthening primary healthcare.

The Rio de Janeiro Reform was only possible thanks to the direct support of the then Mayor Eduardo Paes and Minister of Health José Gomes Temporão, who defined as an absolute priority the area of Health and especially the expansion of primary health care by Family Clinics.

(x) Quality and accreditation – In 2009, Order No. 69/2009 of the Ministry of Health of Portugal approved the official and national accreditation model of the National Health Service facilities. This has already been implemented for almost ten years in the autonomous province of Andalusia (Spain), where it was developed and validated by the Andalusian Agency for Healthcare Quality (ACSA)[26]. Its adherence in Portugal represents significant time, efforts and resources savings, since the process has already been validated. The Andalusian model is based on three basic pillars: process management, clinical management and competence management. It evaluates the interaction of these processes, as well as the level of compliance with the contractual management agreements, through a three-year results panel and its development trend. It requires the integration of the various levels of health care delivery and the evaluation of the effectiveness and quality of measures taken through a set of indicators.

Rio de Janeiro has to establish a public accreditation agency for the validation of health services that stimulates the advancement of quality and can independently give greater transparency to clinical management processes, processes and results[27].

Prospects

Ten years after the implementation of the Primary Healthcare reform, with the creation of the first Family Health Units (USF), no ex post evaluation has yet been conducted by the Ministry of Health of Portugal, whose results could evidence economy, efficiency and effectiveness gains associated with each type of functional unit, nor people's health gains. This failure has recently been remedied by the commissioning of two evaluation studies to two academic institutions and the appointment of a follow-up group.

In its evaluation of the Portuguese health system, the OECD[28] considers that the health system has responded well to the financial pressure of recent years, balancing the need to consolidate public accounts with improved quality. Nonetheless, the organization recommends a "strategic reflection" in the area of PHC, especially with regard to the balance between traditional health centers and USFs, in order to ensure that "high quality care is accessible to all the Portuguese population".

In Rio de Janeiro, between 2012 and 2014, external evaluations carried out with the Primary Care Assessment Tool (PCAT) in the health

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professional and user versions by the team coordinated by Prof. Dr. Erno Harzheim[29,30] pointed out that, despite the need to improve the attribute of "access - first contact", one can already observe, from the perspective of users, a reform marked by longitudinality and coordination of care, both recognized as being the responsibility of the Family Health Teams. The challenges relate mainly to the issue of providing more vacancies of other outpatient specialties by state and federal public service providers, including university health facilities, in order to reduce waiting time for consultations and procedures in some areas.

The PHC reforms in Rio and Lisbon highlight the values on which public management should be based: solidarity, in order to contribute to reducing inequalities that affect the most vulnerable; equity, so that the health system has a quality supply for all; integration of care, to ensure coordination with other resources involved in health care delivery; and public service ethics, to promote efficiency, citizen participation and the active commitment of professionals.

The future of Family Medicine and the Family Health Strategy is linked to success or failure of dealing with training and research. It will depend on whether winning or losing the battle of information and communication systems, losing or winning the battle for efficiency, management, clinical governance, quality, good practices, teamwork, work conditions and spaces, with motivated professionals who enjoy their work and enjoy dealing with others.

Issues such as patient safety, citizens' rights, good care practices, the right attitude at the right time, ethical behavior, handling complaints, evaluating user satisfaction should be intuitive and shared by all health teams.

We must be prepared to take advantage of the windows of political opportunity, such as those observed in both the city of Lisbon and Rio de Janeiro.

Collaborations

D Soranz and LAC Pisco participated equally in all stages of preparation of the article.

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