Innovations in Primary Health Care: Cases of Community Health Center in Pelotas, Brazil

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ABSTRACT

Primary Health Care is characterized by a set of health actions, both individually and collectively, promoting and protecting health, disease prevention, diagnosis, treatment, rehabilitation and health maintenance. In this sense the innovations play a differential response to health needs, increasing changes in system organization and service to the community. Innovation plays a differential in response to global health needs, as it represents the change that encourages the development of organizations and leads to greater efficiency of its processes through the appropriate allocation of resources. This study aimed to analyze the product, process, marketing and organizational innovations in five Community Health Center (CHC) of the city of Pelotas, Brazil, for the period between March 2011 and March 2012. Semi-structured interviews with managers were used to collect data from each unit, seeking information about health care innovations, and by using the instrument Primary Care Assessment tool – PCATool. A qualitative research was done through content analysis and the results showed gaps in the primary care process, such as health care guarantee and the access and the understanding of the services rendered. In relation to the innovations, forty-five innovations were found in all CHC, mainly process wise. The conclusion demonstrates that innovations are driving the changes and improvements in all aspects of Primary Health Care (PHC), corroborating effectively to the recommendations by the Health Ministry to offer health services with Equity, Comprehensiveness and Universality. The article is a contribution; highlight academic-level debate on the quality of services, health actions and innovation stimulating understanding the relationships between them. At the organizational level the contribution presents a diagnosis locus of innovation in the context of the actions of health care, demonstrated by the relationship of the variables to be managed for the proper development of health resources, and the promotion of quality of life for the enrolled population.

INTRODUCTION

The Primary Health Care (PHC) has been the subject of several studies, but a large majority of epidemiological studies prevail. Few studies are devoted to the need for integration between the segments of health care through organizational changes, aimed at continuous improvement across the service chain, from the initial consultation to the basic hospital care. In this sense, the integration of services and their management practices, innovations adopted and comparisons to other care centers constitute a field of opportunity for the researcher to analyze, observe and document the improvements made in managerial practices, emphasizing on...
the values and principles that are expressed by the National Health Policy, and Equity, Comprehensiveness and Universality, according to the Federal Constitution of Brazil of 1988.


The Brazilian Federal Constitution of 1988 calls for the amplitude of the right to health in order to achieve the welfare and social good, by ensuring universal access to health actions and services, contextualized for municipalities. Thus, according to Brasil (2003), since the First National Conference on Science and Technology in Health, in 1994, the administrative structure of government and public policy have directed efforts for the development of innovation, with the aim of ensuring legal assumptions.

However, with the development of a Unified Health System (UHS), this approach was gradually being replaced by the concept of PHC. In the mid-1990s, with the implementation of the Family Health Program (FHP) and the specific financial incentives directed to municipalities - especially the Basic Care in 1998, which resulted in strengthening municipal PHC and FHP, PHC gradually consolidated itself and constituted the beginning of the Unified Health System (UHS), a starting point for the establishment of local health systems (Cassiolato and Lastres, 2000).

The management of these primary health care organizations is complex because each unit has its own specific characteristics and needs, and they interact in a cooperative network of hospitals, clinics and support services. To reach a good level of management and performance, organizations must address the master plan appropriate planning tools to control specific features of its operating resources; ensuring continuity and continuous improvement of administrative procedure (Costa and Pinto, 2002).

In a perspective that innovations are fundamental to the processes of change (Tidd et al., 2005), this article aims to contribute to this questioning: how innovations happen in Basic Health Units (BHU)? To answer this question were analyzed product, process, marketing and organizational innovations in five CHC of the city of Pelotas, Brazil, for the period between March 2011 and March 2012. Semi-structured interviews with managers were used to collect data from each unit, seeking information about health care innovations, and by using the instrument Primary Care Assessment Tool – PCATool.

**Theory:**
The theme of innovation in Basic Health Units constitutes a key element for the operation of the Primary Health Care policy in Brazil. Such concept needs to be merged with the concept of basic health to understand the research’s theoretical framework.

**The Concept of Innovation:**
For Oslo Manual (2005), innovation means doing things differently than they already happen. The author mentions that innovations can occur as follows: a) as the introduction of an unfamiliar or new product to consumers or with a different quality, b) as the introduction of a new production method—which was not experienced within a certain productive branch, but which not necessarily need be derived from any scientific discovery c) as the opening of a new market, or a market in which the product of an industry never had access to before, whether or not this market has existed before; d) as the discovery of a new source of raw materials or semi-finished products, also independent of any source that may have existed previously, and e) as any reorganization of an industry, such as creating a rupture of in a monopoly position.

Tidd et al (2005) refer which seeks to standardize research on innovation in different countries, defines the “innovative enterprise in product/process as the one that has implemented a new product or process or significantly improved it during the period of analysis.” It classifies innovations into four distinct types: product, process, marketing and organizational.

The author states that product innovation can be innovative when it’s new, or improved, being a product whose characteristics or practices differ from previously produced products.

Regarding process innovations, determines as “the implementation of a new method of production or distribution or significantly improved”. These innovations may involve changes in equipment or in the organization of production, as well as a combination of both, which may derive from the use of new knowledge. In the case of services, it defines it as process innovations that “may involve substantial changes in equipment and software used in service-oriented enterprises or in the procedures and techniques that are employed for distribution services” (Schumpeter, 1934).

Introduced in the third edition of Oslo Manual (2005), marketing innovation is defined as “the implementation of a new marketing method with significant changes in product design or packaging, in product placement in their promotion or pricing”. Finally, Tidd et al (2005) conceptualizes organizational innovation as the “implementation of a new organizational method in business practices of a company, in the organisation of its workplace or with its external relations”. It aims at improving the performance of a company by reducing administrative costs or transaction costs, and by encouraging satisfaction in the workplace.
Organizational innovations are not only a supporting factor for product and process innovations; they also can have a major impact on the performance of an organization. Organizational innovations can also improve the quality and work efficiency, to enhance information exchange and to refine business ability to learn and use knowledge and technologies.

Schumpeter (1934) states that most studies on innovation focus on technological aspects, stressing that innovation is not just a technical term, but also refers to economic and social dimensions. For the author, innovation is an instrument of entrepreneurship that creates new capacity to create wealth, so companies who wish to increase their competitiveness feel the need to invest in practices aimed at a systematic development of new technologies; seeking ways to develop their activities, whether it is by creating new products, services or processes, or even improving the existing ones. This same conclusion seems to be shared by Tidd et al. (2005), since the concept of innovation with purely technological base was withdrawn. In a similar manner Oslo Manual (2005) define innovation through the “4Ps” approach; elaborating on concepts such as product, process, position and paradigm. As product innovation, understood as a change in the products / services they offer the organisation. As an innovation paradigm, such positioning determines how to consider any change in mental modeling that defines what an organization may be looking for in terms of new understanding. The authors state that it is not always easy to classify innovation in one category or another, especially in the case of selecting a specific tool (Damanpour et al., 1989). Such difficulty raises the fact that the concept of innovation is a process that needs to be clearly exploited, since it conceptualizes what people who recurrently engage in transactions with others within an institutional context (Van de Ven, 1986) can define as the development and the implementation of new ideas. Logically, it points the need to understand the factors that facilitate or inhibit the development of innovations. Such view merges with factors such ideas, people, transactions, context and over time, an effective management of the innovation process; so that these factors contribute to the occurrences of innovations.

The concept of innovation may also arise through a research and learning process and be strongly influenced by specific institutional and organizational contexts such as regional diversity or local specificities, since differences occur between the systems of innovation from one country to another, or from one region to another, or even from one location to another within the same region Tidd (1993). In this respect, given the theme of this research, it is crucial to expose the importance of the concept of innovation as a system, where (Brasil, 1988) presents a system of innovation as an interactive model with three main dimensions.

The triple helix is a concept which lists the industry, the State and the universities as key integral actors of innovation. In its various configurations, the three actors may change their positions and importance, but none of them ever leaves the scene (Etzkowitz, 2000).

**Primary Health Care – PHC:**

PHC is considered the main entrance of the health system and the organizational strategy for comprehensive care, reaching all municipalities of the country and characterized by a decentralized process of the SUS (Bodstein, 2006).

PHC is characterized by a set of health actions, both individually and collectively, to cover the promotion and protection of health, disease prevention, diagnosis, treatment, rehabilitation and maintenance of health. In a wider sense, the integration of health is a process that includes the creation and the maintenance of common governance through the actors and autonomous organizations for the purpose of coordinating their interdependence, allowing them to cooperate for the realization of a clinical collective project (Contradiopoulos, 2001).

The current health practices, such as the FHP, aim to reorganize health care in new bases and replace its traditional model, by offering to closer health service to the family and by improving the quality of life of Brazilians. The object relies in breaking the passive behaviour of the CHC and to extend their actions to the community (Brasil, 2003).

In view of the fragmentation problems inherent to the health care models, the integration of health services appears to be linked to the reforms of public policies based on PHC aspect. In that context, the concept of integration refers to the coordination and the cooperation among providers of health care services for the creation of a true health care system (Hartz and Contradiopoulos, 2004).

Actually in Brazil, the Ministry of Health has taken the initiative to expand the PHC strategy, investing in technology assistance innovations for integrated services, which reveals boldness and promising adherence of the municipal managers to the guidelines of integrity and the policies of regionalization (Giovanella, 2002).In that context, such integration would align the expanded concept of wholeness as a social action resulting from democratic interaction between the actors in their everyday practice for the provision of health care, the different levels of care system (World Health Organization, 1978).

Many Brazilian organizations in PHC and Hospital management are run by professionals from diverse backgrounds, where the principal criterion of choice relies on the trust from the board members. Such scenario may lead to administrative disorganization, promoted by either amateurism or conflict of interest, and also
hindering the entry of the sector in the market economy, delaying the professionalization of management and strengthen and maintain governance structures inadequate (Giovanella, 2002).

**Method:**
This article is based on a research whose main objective was to verify the innovations in five CHC of the city of Pelotas, Brazil, which are either managed or linked to local universities. Were realized five interviews with CHC managers, seeking innovations in the four dimensions proposed by (Tidd et al., 2005) that occurred for a period of one year, from March 2011 to March 2012. The interviews were conducted in April/2012 and analyzed qualitatively.

The search strategy was the case study, which aims to describe and analyze the phenomenon in its context (Gonçalves, 2002), being used in a descriptive fashion and seeking to make associations between variables (Robson, 2011). Thus, as this study seeks to understand the innovations in the context of each CHC, relating and seeking to associate or distinguish contexts phenomena, a multiple case study is the most appropriate research strategy.

To collect data, were used semi-structured in depth interviews and a questionnaire with open and closed questions, and analysis of some local CHC documents. The questionnaire was developed, validated and used in a similar survey conducted in the city of Caxias do Sul, Brazil (Nodari et al., 2012). The interviews were realized with the Pelotas CHC managers in two steps: 1) the first one was to collect information about the Primary Care context, using the instrument Primary Care Assessment Tool – PCATool (Brasil, 2010), which was developed to assess how health services health are oriented with the PHC attributes, in structure and processes; giving priority to access, continued service (longitudinal), coordination, comprehensiveness, family orientation, community orientation and cultural competence. 2) The second phase was based on Tidd et al. (2005), which addressed the issues related to product innovation, process, marketing and organizational (Nodari et al., 2012).

After the data collection process, it was analyzed qualitatively through content analysis Starfield et al., 2001). These analyzes, aligned with a robust literature review, made possible to establish a clear statement on the innovations adopted by the CHC. The table below summarizes the definitions of the types of innovation according to Tidd et al. (2005) and the criteria used in this work to classify the innovations.

**Results:**
The Pelotas Health System currently counts 51 CHC, 45 under the Municipal Health Department management, 03 under the Federal University of Pelotas (UFPEL) management and 03 belonging to the Catholic University of Pelotas (UCPEL). The Family Health Strategy (FHS) program is installed on 17 CHC, totaling 29 Family Health teams, serving 22% of the local population, which include three philanthropic and two private hospitals, serving the city and about twenty neighboring counties as part of the 3rd Regional Health of the State.

The activities of Primary Health Care analyzed in the five CHC include the following health services: internal medicine, pediatrics, gynecology, surgery, teaching/educational (Housing in Social Medicine and Psychiatry) services. These units belong to Hospitals School network of the medical faculties of the local Universities. A brief description of each of these units is given below in Table 1, which describes the current organization of each unit.

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<tr>
<th>CHC</th>
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- Specialties: Medical Clinic, Pediatric Clinic, Surgery, Gynecology Clinic, Dermatology, Physiotherapy, Dentistry with Residency Programs in Social Medicine, Children’s Health, Psychiatry, Oncology;
- ** FHS – Family Health Strategy.

Source: Authors

The CHC have the same capabilities, interests and skills that could be better managed for completeness at attention.

In the five CHC, the access for patients is limited from seven am to six pm, with no service on Saturdays and Sundays. The vast majority of patients can call or have quick advice when necessary without prior appointments through daily screening conducted by the Nursing Unit.

Within that context, the unit staff and management provides comprehensive care to patients within their primary care level, creating management processes to support patient access with guaranteed service and screening of cases that need to be analyzed at the time. Such quality concern is maintained by the management of each unit, as highlighted in the findings of (Bodstein, 2006), which reinforces an autonomous coordination of
the health unit to perform a collective clinical project. However, there is no support for any patient after the aforementioned schedule, where they burden the responsibility to seek any other medical care unit, or hospital, usually by going to a nearest emergency unit, mostly overcrowded; considering that such care should have been resolved at a CHC. Such reality shows a lack of coordination and cooperation between service providers (Brasil, 2003).

With respect to the continued service, it is observed that there is no guarantee of return of the same doctor from the first visit, which may lead to diagnosis difficulties and “distance” in the doctor-patient relationship. A patient normally gives to the doctor expectation of resolving its health problem at the first visit. This lack of continuity generates not only distance but lack of diagnosis complete understanding from the doctor’s point of view. The patient is then at the “mercy of luck” to encounter the same doctor from the first consultation.

The lack of continuity is already an established priority for the Government (NOAS-SUS 01/2001), which emphasizes on the importance of evaluating health systems offered to citizens in order to drive reforms in the provision of services, in accordance with one of the guiding principles of the NHS: completeness in assistance (WHO, 2005).

The coordination of the five CHC is performed by physicians; four of them have a PhD and coordinate both the medical and administration aspects of the unit. The nature of diplomas of the coordinators can be linked to the link of the units with universities, which provides a greater amount of knowledge. In this case, this finding vary from other studies, in which Brazilian Primary Health Care units are administered by professionals from diverse backgrounds (Giovanella, 2002).

In the case of this study, which includes institutions linked to universities with a recognized source of knowledge and research, they have not been characterized with the opportunity for improvement in management and care processes, since the entry of these professionals occurs through competition and their leading position in the unit is defined by demonstrated competency over their work.

In reference to the item “patient”, which refers to the referrals of specialist consultations, it was noted that there was divergence on the commitment of each CHC in the solution of this practices. Three units had an articulate process of referrals with the Department of Municipal Health, and explained the process to their patients, and two others did not have such process established. The two CHC that do not participate to this process leave their patient to manage their own documentation and orchestrate their appointment with the doctor, on an availability basis.

The findings demonstrate that despite the efforts and Public Policy focused on completeness and resolvable health problems of the population, many failures in integration and management services still exist; since the orientations and policies on integration are based on three languages: structural (modification of boundaries of the organizations), clinical (changes in professional practices) and cooperation (new formats of negotiation and agreements between actors and organizations) (Touati et al., 2001). In this sense, the CHC should receive a patient through an already articulated scheme, where clinical health protocols should be used as guiding assistance, establishing a routine to be followed in any level of attention.

The completeness of support is unanimous for the five CHC analyzed, demonstrating the effectiveness of actions in relation to general counseling, assessments, guidelines for personal, family, health, pregnant women, children and the elderly. In relation to specific actions aimed at risk groups such as infectious diseases (Mendes, 2007), the findings show completeness to the extent that the CHC is accountable for support, being the first contact with the health problems of the population.

The Family Orientation Program is conducted with families in their homes, with the help of Community Health Agents (CHA), taking into account the context of the life of each family, their financial resources and family support. Its main task is to facilitate and guide the caregivers how to take care of a sick family member, to support the whole family, to understand aspects of disease and disease prevention. Also, the socio-educational character of such relationship brings proximity between the agent and the family, facilitating the transfer of health information and the opportunity of specific guidance to individuals who are part of it; more specifically in relation to guidance on contraception, drugs, food and so on.

In working with The CHC unit which collaborate in FHS Program demonstrate intense care, and facilitate the understanding of the human existence in all its aspects, because the CHA must realize a mapping of the territory where they will act and make daily visits to check if those individuals who are doing the treatment, do it in the right way, providing guidance and redirection when needed. All families in the region are visited at least once a month and, those who are patient with injuries every day.

Regarding both CHC that offer community orientation through the FHP, a greater involvement of these units was noticed. The social context of the patient’s beliefs, values, family and social organization were classified as very important, because of the intense involvement of the staff on a day to day with the local communities; generating satisfaction and trust. In the other units, such information has an important internal factor, but without the supply of details that provide home visits.

These findings are in synchrony with what is recommended by the Ministry of Health, concerning that any assistance to an individual should take into account its social and economic reality, the affective and emotional
bonds of their family, for a perfect understanding of its reality and propose accurate health care actions (Contradiopoulous, 2001).

Based on the concept of cultural competence, the results show that all CHC have continued training programs with pre-established agenda planning and, some internal actions that take into account the cultural diversity of the community, its beliefs, customs and religion. Since each CHC has a link with a local university, such knowledge approach and local diversity can serve as a field of research relevant behaviours, habits and attitudes, disease and other related topics.

Discussion:

According to the theoretical postulates about innovation (Schumpeter, 1934; Tidd et al., 2005), innovations may occur through the introduction of a new product, to provide differentiation in order to perform activities. As shown in the following table, from the 45 listed innovations, 23 were identified as process innovations, with a constant concern to properly equip the units.

Table 2:

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<td>CHC 2</td>
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<tr>
<td>CHC 3</td>
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<td>1</td>
<td>1</td>
<td>6</td>
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<tr>
<td>CHC 4</td>
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<tr>
<td>CHC 5</td>
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<td>Total</td>
<td>13</td>
<td>23</td>
<td>2</td>
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<td>45</td>
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Consequently, it demonstrates a concern from the Units to improve and continually readjust to provide a suitable environment for medical practice, as shown in Table 2.

One of the CHC shows strong results in terms of product innovation, by having three teams of the Family Health Strategy and the implementation of new services offered the population. Cited authors in (Tidd, 1993) emphasize that innovation should be in a search and learning process, socially determined and strongly influenced by specific contexts, such as regional diversity or local specificities. These findings corroborate with the work done in this CHC, with intense involvement with the local community, through direct evaluation of their health issues and specific Primary Care strategies toward the community.

Out of the 29 identified innovations, nine of them are classified as hybrid, as both product and process at the same time, which involve substantial improvements in the characteristics of the service offered but also the methods, equipment and skills used to perform.

This research drew attention to little engagement of the CHC with innovation in Marketing, considering the little knowledge of marketing of the technical teams who provide care in the CHC; even their incapacity to implement strategies that would have justified the population to seek or use the available services, and health information. As process innovation was identified the development and the implementation of new ideas by the actors who recurrently engage in transactions with others within an institutional context. Perhaps the lack of organization of an innovation process is a reflection of the lack of management training for managers (all physicians).

The only CHC that used a marketing strategy refers to pamphlets distribution, which may be considered as incipient in terms of efficacy. It was identified as a local initiative, nor in an organized and networked pattern. Such action demonstrates the creativity and commitment of such team and the recognition of the local community to get the population to improve their health condition. These findings are in agreement with the view of Oslo Manual (2005) and Schumpeter (1934), where organizations feel the need to invest in practices aimed at systematically developing new ways to develop their activities, whether it is creating new products, services or processes, or even in the improvement of existing ones.

Regarding organizational innovations, the results show unanimity on the fact that each CHC sought to modernize their internal work routines, with modernization agendas, the reception of patients and the management of work teams. These innovations are considered as incremental since they seek to optimize or solve the problems of existing products and services, bringing innovation which although small are of great impact, as the authors point out (Damanpour et al., 1989).

These organizational changes are frequent and always aim to improve care and attention offered to patients as well as providing clarity on the actions and understanding of organizational routines. Such routine form of organisation always strives for organizational innovation as a basis for development of other innovative actions (Oslo Manual, 2005; Tidd et al., 2005).

Conclusion:

Innovations in PHC may be considered as necessary to increase the improvement of health care provided to a community. In this sense, according to the purpose of this research, it can be inferred the presence of real
commitment from all CHC in improving service delivery, either by acquiring equipment, with improvements in the internal organization of the unit and its routines, or through change in their clinical and managerial processes. Such characteristic for continuous improvement may be associated with high educational level of its managers which is linked to universities, where the premises continuous improvement, learning and skill development is a constant. In this sense, integration expertise through individuals is associated with the development of organizational skills and routines. These skills knowledge and performance reinforce the business activities in which the organisation is particularly skilled (Teece and Pisano, 1994).

Is it important to note that most of the investment were jointly done with the universities, in the procurement of goods, software and other actions that would be beneficial to all involved, such as the community that uses the CHC, the university students that have access to the highest quality medical care equipment for the development of their studies, and the managers who are not dependent on scarce municipal resources to develop their units (Nodari et al, 2013). This demonstrates the importance of the triple helix model to study innovation, considering that CHC s focus somehow on the three helix of such model (Etzkowitz, 2000).

The results also demonstrate the link between the presence of the Family Health Strategy and the highest number of innovations occurred. These innovations may be associated with engagement and the proximity of teams with the local community, checking their care desires and needs, which in turn generate specific strategies to meet those needs attention. Such initiative is supported by the nationwide strategies for quality improvement in health.

In relation to the context of primary care provided by the CHC, there are still some flaws in the process, as the guarantee of medical care and continuity. Such change in behaviour requires further analysis from the CHC management and a more effective evaluation of the clinical protocols, as recommended by the World Health Organization.

Another factor that was highlighted in the context of assistance to the community was a different conduct of the units in relation to referrals. Two CHC did not have a set routine, leaving the patient to be responsible for seeking care in other health services. Such conduct still contradicts the orientations given by the Ministry of Health, where completeness care should be available to all Brazilian citizens. It can also be observed that there is no standardization in the management of the units and their welfare objectives, each being organized their primary care routines, as defined by their medical officers. This form of organization should be roughly equal for all CHC, since all of them are connected to the Municipal Health Bureau, which organizes the health of the city, their campaigns and treatment guidelines.

Through this study, it was confirmed that product, process, marketing and organizational innovations drove the improvements in all aspects of the units, corroborating effectively to improve access for patients, encouraging continued service, cooperating to improve the coordination of services and integrity, encouraging the integration with universities for better community orientation and development of cultural competence. Thus, further studies should be conducted to compare those findings to demonstrate the importance of innovation in health services and to improve the healthcare supply of primary care, whose goal is to provide health services with equity, comprehensiveness and universality.

REFERENCES


