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SITUATIONAL STRATEGIC PLANNING IN PHARMACEUTICAL CARE MANAGEMENT

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Abstract: Pharmaceutical Services (PS) are a fundamental part of healthcare services, and their effective implementation within the Brazilian Unified Health System (SUS) is based on the PS cycle to ensure the quality and resolvability of the services provided with qualification and planning, organization, and structuring of the set of activities developed. Situational Strategic Planning (SSP) is the tool for achieving this goal, as it is a participatory method that analyzes reality, diagnoses problems, and creates strategies to solve situations. The work of pharmacists has increasingly contributed to health outcomes, and pharmacies are possibly the first place where sick people go. There is a public that seeks care without much financial investment and excessive spending in the face of the deficient distribution of specific or non-specific medications and due to the lack of assistance that ensures adherence to the treatment of diseases characteristic of the epidemiological profile of a municipality. The question remains of how to ensure compliance with the law on access to medication through pharmaceutical assistance, considering administration and planning in the area of health, the activities inherent to the pharmaceutical professional in this context, and the importance of situational strategic planning. The general objective of this study was to discuss the importance of situational strategic planning in pharmaceutical care using a bibliographic review methodology based on national and international articles and works published after 1983 on the subject. The use of SSP for the development of various skills and competencies essential to the management process allows for the promotion and coordination of the participation of various actors in addressing problems, contributing to the organization and improvement of PH and raising awareness among participants and pharmacists of the importance of strengthening and developing effective, high-quality PH.

Keywords: Pharmaceutical care. Situational strategic planning. Pharmaceutical care management.

INTRODUCTION

Pharmaceutical care (PC) is a fundamental part of health care services, and its effective implementation in the context of the Unified Health System (SUS) is guided by the basic principle of the PC cycle, which must be adequately planned to ensure the quality and resolvability of the services provided (BRASIL, 2011).

In this context, management qualification is possible through the planning, organization, and structuring of the set of activities developed. Thus, Situational Strategic Planning (SSP) emerges as the tool to achieve this goal, as it is a participatory method that allows analyzing reality, diagnosing problems, and creating strategies to solve a given situation (FINATTO, 2016).

Pharmaceutical care encompasses comprehensive, multidisciplinary, and intersectoral activities that focus on organizing actions and services related to medicines in their various dimensions, with an emphasis on the relationship with patients and the community from a health promotion perspective (MARIN et al., 2003). It is important to guide PH and reorient it based on decentralized management, the promotion of rational drug use, the optimization and effectiveness of the distribution system in the public sector, and the development of initiatives that enable a reduction in product prices (BRAZIL, 2011).

Therefore, based on the survey of problems related to PH, much more thought is being given to reorienting care and its relationship with the quality of services provided by pharmacy professionals and the administrative structure through strategic planning related to the PH situation in order to certify and validate PH activities in ensuring the supply of medicines and their distribution to the needy population.

Pharmaceutical care (PC) is a fundamental part of health care services, and its effective implementation in the context of the Unified Health System (SUS) has as its basic guiding principle the PC cycle, which must be adequately planned to ensure the quality and resolvability of the services provided. (CONASS, 2007).

In this context, management qualification is possible based on the planning, organization, and structuring of the set of activities developed. Therefore, based on the survey of the most frequent problems related to AF in small/medium-sized municipalities and the actors involved, much more thought is given to reorienting care and its relationship with the quality of services provided by pharmacy professionals and the administrative structure in order to ensure the supply of medicines and their distribution to the population in need.

Thus, Situational Strategic Planning (SSP) emerges as a tool to achieve this goal, as it is a participatory method that allows for analyzing reality, diagnosing problems, and creating strategies to solve a given situation.

The work of pharmacists has increasingly contributed to health outcomes, and pharmacies are possibly the first place where sick people go. Considering that the public seeks care without much financial investment and excessive spending, and in light of Article 196 of the Federal Constitution, which states that "health is a right of all and a duty of the State, guaranteed by social and economic policies aimed at reducing the risk of disease and other hazards and providing universal and equal access to actions and services for its promotion, protection, and recovery," given the deficient distribution of specific and non-specific medications, due to the lack of assistance that guarantees adherence to the treatment of diseases characteristic of a municipality's epidemiological profile, the question arises: How can compliance with the law on access to medication through pharmaceutical assistance be guaranteed, considering health administration and planning, the activities inherent to the pharmaceutical professional in this area, and the importance of situational strategic planning?

The overall objective of this study was to discuss the importance of situational strategic planning in pharmaceutical care, with the specific objectives of discussing administration and planning in the health sector, understanding pharmaceutical care activities, and, finally, highlighting the importance of situational strategic planning.

The methodology used was a literature review based on national and international articles and papers published after 1983 on the subject. For the research, articles and papers published in the *Google* Scholar database were selected using the following descriptors: Pharmaceutical Care, Strategic Planning, and Municipal Management.

ADMINISTRATION AND PLANNING IN THE HEALTHCARE FIELD

The use of concepts, methods, and techniques derived from General Management Theory in the organization of health services in Brazil can be identified with the advent of the Public Health movement, which began with a vaccination campaign. Henceforth, opinions and techniques of administration in the area of health, due to their importance in the overall social organization of services, foresaw the urgency of more theoretical concepts and methods regarding health practices, specifically with the Health Planning movement marked by the document *Programación de la Salud: Problemas Conceptuales y Metodológicos (*PAIM, 1983).

During the 1970s, especially from the second half of the decade onwards, critical reflection in the area was progressively linked to the development of the so-called "health movement" in the country, in a way reflecting and at the same time feeding—not necessarily simultaneously—the direction of the health reform project (PAIM, 2008).

The 1988 Constitution changed the landscape of public health care. The topic, absent from previous constitutions, was included and addressed with very clear principles:

> Art. 196. Health is a right of all and a duty of the State, guaranteed by social and economic policies aimed at reducing the risk of disease and other hazards and providing universal and equal access to actions and services for its promotion, protection, and recovery.
>
> Art. 197. Health actions and services are of public relevance, and it is incumbent upon the public authorities to provide, in accordance with the law, for their regulation, supervision, and control, which shall be carried out directly or through third parties, as well as by individuals or legal entities governed by private law.
>
> Art. 198. Public health actions and services are part of a regionalized and hierarchical network and constitute a single system, organized according to the following guidelines:
>
> I– decentralization, with a single direction in each sphere of government;
>
> II– comprehensive care, with priority given to preventive activities , without prejudice to care services;
>
> III– community participation. (BRAZIL, 1988).

The Unified Health System (SUS) was designed and created according to these principles, regulated by Law No. 8,080 of September 19, 1990, supplemented by Law No. 8,142 of December 28, 1990, collectively referred to as organic health laws. Chapter II of Law No. 8,080/90 deals with the principles and guidelines of the SUS:

> Art. 7 Public health actions and services and contracted or affiliated private services that are part of the Unified Health System (SUS) are developed in accordance with the guidelines set forth in art. 198 of the Federal Constitution, also complying with the following principles:
>
> I – universal access to health services at all levels of care;
>
> II – comprehensive care, understood as a coordinated and continuous set of preventive and curative actions and services, individual and collective, required for each case at all levels of complexity of the system;
>
> III – preservation of people's autonomy in defending their physical and moral integrity;
>
> IV – equality of healthcare, without prejudice or privileges of any kind;
>
> V– the right of patients to information about their health;
>
> VI– dissemination of information regarding the potential of health services and their use by users;
>
> VII– use of epidemiology to establish priorities, allocate resources, and guide programs;
>
> VIII– community participation;
>
> IX– political and administrative decentralization, with a single direction in each sphere of government: a) emphasis on decentralization of services to municipalities; b) regionalization and hierarchization of the health services network;
>
> X – integration at the executive level of actions related to health, the environment, and basic sanitation;
>
> XI – pooling of financial, technological, material, and human resources from the federal government, states, Federal District, and municipalities in the

provision of health care services to the population;

XII – capacity to resolve services at all levels of care; and

XIII– organization of public services in order to avoid duplication of resources for identical purposes (BRAZIL, 1990).

There are many discussions related to administration and planning in the area of health. The issues that are raised are some of the problems faced in the daily routine of services that become significant for managers as theoretical and practical challenges in relation to the dilemmas that range from ethics to political issues within the confrontations.

It is pointed out that administration and planning are problematic as objects of investigation for explaining the origin and constitution of concrete and/or particular forms that the service demands.

The area in question is understood as a broad set of technical and scientific services that traditionally belonged to one of the divisions of public health already called "Health Planning and Administration."

At the same time, health administration and planning served as a basis for bringing together very diverse research topics and proposals for social intervention, such as the management of health units and their sectors, human resources, assistance programs, and the evaluation of service activities and actions, among others.

More specifically, in the case of the Pharmacy sector, many approaches to the reality of health services and actions have allowed us to understand this area of study and intervention, which is still underdeveloped.

A specific study of administration and planning in the Pharmacy area allows for a classificatory rearrangement of the importance of the Pharmaceutical Care Cycle (AF) (Figure 1) in its conceptual and practical conception with the quality of an intervention perspective that does not delimit planning and allows for broader administration, overcoming management limits and ensuring the intervention of the pharmaceutical professional.

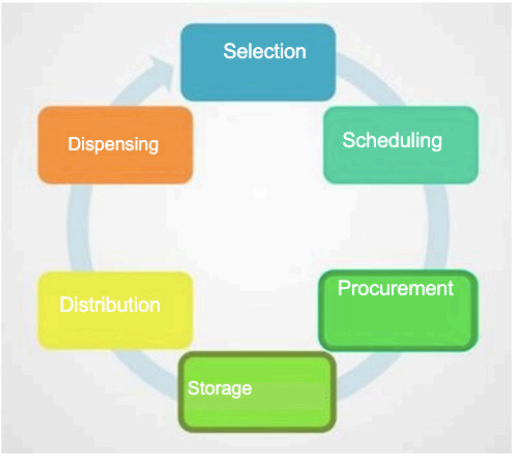

Figure 1 – Pharmaceutical Care Cycle.

Source: https://image.slidesharecdn.com/apresentaoqualificaodefornecedores-140604225731-phpapp02/95/qualificao-de-fornecedores-em-farmcia-hospitalar-13-638.jpg?cb=1401922733

In view of this, when identifying important problems and issues, it is possible to resort to the understanding that selection, programming, acquisition, storage, distribution, and dispensing require attention in administrative practice in order to build

significant changes in health planning, specifically in the Pharmacy sector.

Several administrative points need to be considered in this planning process, in particular the actors (managers, pharmacists, target audience), time frame, and financial resources. Healthcare (direct or indirect) should also be considered as a bias for this aspect of the healthcare system, as well as the possible interfaces between planning/management in the work process, where the fundamental issues are specific healthcare issues, also considering health promotion and prevention.

The PA cycle must also be present in the comprehensiveness of actions for the purposes of coordinated interventions in accordance with the interdisciplinary care model and interaction between multiple professionals, which can ensure the quality of care that is much closer to the perspective of direct production of actions than to the generic care model, generating other issues that address technical effectiveness in the dimension of the cycle, its adherence, and implementation.

Administration and planning in the area of PH contribute as a challenge for the pharmaceutical professional and place them in a context of (re)valuation of the level of professional performance, sometimes even disqualified as the exercise of the health profession.

It is believed that these problems ultimately contribute to other situations, meaning that issues will have to be addressed by managers, administrators, and ultimately healthcare providers, seeking comprehensive actions and interactions that produce direct care for the target population of PA.

The aim of comprehensive actions and interactions contributes to (possible) investigations and integrations between the realistic practice of the PH cycle in clinical care and that of prevention and health promotion programs in care in a "programmatic health action" (Schraiber, 1990; Schraiber et al., 1996).

It is also important to consider how the management issues addressed and the characteristics of managers relate to policy trends in the context of social protection and understanding Pharmacy as part of this policy.

Planning concerns characteristics of technical action, more precisely, of rationalizing strategy that involves more prescriptive knowledge in strategic action. Hence, planning seeks to create, improve, experiment with, and implement technologies of power.

Administration is associated with the notion of management, which, in addition to planning, includes other actions, among them evaluation as an instrument of both technical control and supervision and as an instrument for acting in interactions.

Operationality associates administration and planning with the possibility of work being carried out according to the established dynamics. Finally, strategic effectiveness becomes the measure of the achievement of results in service users that are attributable to the actions carried out and initially planned (Sala et al., 1998).

PHARMACEUTICAL ASSISTANCE ACTIVITIES

Among the principles of the SUS is that of comprehensive care, which is understood as "the coordinated set of preventive

and curative actions and services, individual and collective, required for each case, at all levels of complexity of the system" (BRAZIL, 1990).

Medicines are included in the care provided by the SUS, in all cases, whether in basic health care, medium complexity care (specialties), or high complexity care. The principles of the SUS also advocate for equal care, without prejudice or privileges of any kind.

The provision of medicines to SUS beneficiaries is provided for in Article 6 of Law No. 8,080/90:

> Article 6. The following are also included in the scope of the Unified Health System (SUS):
>
> I – the implementation of actions:
>
> a) health surveillance;
>
> b) epidemiological surveillance ;
>
> c) of occupational health; and
>
> d) comprehensive therapeutic care, including pharmaceutical care.

Comprehensive care is one of the fundamental principles of the SUS. Medicines should not be considered in isolation, but as one component of treatment. However, they are an essential component, and their availability must be guaranteed. There is a whole legal and regulatory framework governing medicines in the SUS, specifically with regard to the following stages:

On the production of medicines:

- Ordinance GM No. 374 of February 28, 2008: Establishes, within the scope of the Unified Health System (SUS), the National Program for the Promotion of Public Production and Innovation in the Health Industrial Complex.

On the selection of medicines to be used in the SUS:

- Ordinance No. 2,012, dated September 24, 2008: Approves the 6th Edition of the National List of Essential Medicines (Rename).

- Ordinance No. 1,883, dated September 9, 2008: Approves the National Therapeutic Formulary of the National List of Essential Medicines (Rename).

- Ordinance No. 1,254, dated July 29, 2005: Establishes the Technical and Multidisciplinary Commission for updating the National List of Essential Medicines (Rename).

On the acquisition of medicines:

- Law No. 8,666, dated June 21, 1993: Regulates Article 37, item XXI, of the Federal Constitution, establishes rules for public tenders and contracts, and provides other measures.

- Ordinance No. 2,583, of October 10, 2007: Defines the list of medicines and supplies made available by the Unified Health System, under the terms of Law

No. 11,347/2006, to users with Diabetes Mellitus.

- Ordinance No. 1,818, of December 2, 1997: Recommends that public purchases and bids for pharmaceutical products carried out at the federal, state, and municipal levels by government services, affiliated with and contracted by the SUS, include requirements regarding quality standards to be met by the manufacturers and suppliers of these products.

On the traceability of medicines:

- Law No. 13,410, dated December 28, 2016: Amends Law No. 11,903, dated January 14, 2009, to provide for the National Drug Control System, which creates "the National Drug Control System, aimed at controlling the production, distribution, marketing, dispensing, and medical and dental prescriptions and, if it contains drugs for human use, veterinary prescriptions, as well as other types of movement provided for by health controls."

Article 2 of the law determines that federal health surveillance has the authority to define, in its own regulations, the categories of drugs produced, distributed, marketed, dispensed, or prescribed in the national territory subject to the National Drug Control System.

- Resolution of the Collegiate Board No. 319, of November 12, 2019: Provides for the implementation phase of the National Drug Control System (SNCM), specifically, ANVISA will publish a Normative Instruction with a list of drugs and members of the distribution chain to which the provisions of this standard apply, as well as the respective deadlines and conditions for sending drug distribution data, considering that the packaging for transporting drugs subject to the SNCM must have its own unique identification code that allows it to be linked to the Unique Drug Identifier (IUM).

On the prescription and dispensing of medications:

- Resolution No. 480, dated September 23, 1999: Publishes the updated lists of substances subject to special control (Annex I) in accordance with Article 101 of the Technical Regulation approved by Ordinance SVS/MS 344, dated May 12, 1998, republished in the Official Gazette on February 1, 1999.

- Ordinance No. 344, dated May 12, 1998: Approves the Technical Regulation on substances and drugs subject to special control.

- Ordinance No. 1,179, dated June 17, 1996: Approves the Brazilian Common Names (DCB), in accordance with the annex to this Ordinance.

On financing:

- Ordinance No. 1,928, dated September 17, 2008: Amends the population data for Brazilian municipalities listed in Annex III of Ordinance No. 3,237/GM, dated December 24, 2007, regarding the financial resources of the Basic Component of Pharmaceutical Assistance.

- Ordinance No. 362, dated February 27, 2008: Approves Financial Incentives to support pharmaceutical assistance actions within the scope of the National Program for the Reorientation of Professional Health Training - PRÓ-SAÚDE.

- Ordinance No. 3,237, dated December 25, 2007: Approves the rules for the implementation and financing of pharmaceutical assistance in primary health care.

- Ordinance No. 204/GM, dated January 29, 2007: Regulates the financing and transfer of federal funds for health actions and services, in the form of financing blocks, with the respective monitoring and control.

On the policy of medicines and pharmaceutical assistance:

- Ordinance No. 1,869, dated September 4, 2008, amended on October 21, 2008: Amends Annex II of Ordinance No. 2,577/GM, dated October 27, 2006, which approves the Exceptional Dispensing Medicines Component.

- Ordinance No. 2,577, dated October 27, 2006: Approves the Exceptional Dispensing Medicines Component as part of the National Pharmaceutical Assistance Policy of the Unified Health System, in accordance with the terms set forth in Annex I to this Ordinance.

- Amendment to Ordinance No. 2,577, dated October 27, 2006. - Ordinance No. 816, dated

May 31, 2005: Establishes the National Management Committee for Care Protocols, Therapeutic Guidelines, and Technological Incorporation in Health, and makes other provisions.

- Resolution No. 338, dated May 6, 2004: Approves the National Pharmaceutical Care Policy.

- Ordinance No. 3,916, dated October 30, 1998: Approves the National Drug Policy, the full text of which is included in the annex to this Ordinance.

On the rational use of medicines:

- Ordinance No. 2, dated February 1, 2008: Approves the Internal Regulations of the National Committee for the Promotion of the Rational Use of Medicines.

- Ordinance No. 1,555, dated June 27, 2007: Establishes the National Committee for the Promotion of Rational Use of Medicines.

- Final Report of the 1st National Conference on Medicines and Pharmaceutical Care.

It is necessary to analyze some aspects of the rules listed above. It is appropriate to begin with Ordinance No. 204/GM, dated January 29, 2007, which establishes some important points: 1) the financing of health actions and services is the responsibility of the three levels of SUS management; 2) federal resources allocated to health actions and services are organized and transferred in the form of funding blocks, namely: I - Primary Care; II - Medium and High Complexity Outpatient and Hospital Care; III - Health Surveillance; IV - Pharmaceutical Assistance; and V - SUS Management.

When dealing specifically with pharmaceutical assistance, the ordinance provides:

> Art. 24. The funding block for Pharmaceutical Assistance shall consist of three components:

I – Basic Component of Pharmaceutical Assistance;

II – Strategic Component of Pharmaceutical Assistance; and

III– Exceptional Dispensing Medicines Component

I – Basic Component of Pharmaceutical Assistance (CBAF): intended for the supply of medicines and supplies for the early and adequate treatment of the most common and/or priority problems that can be addressed at the basic level, including those related to specific health conditions and programs. In order for users to have access to Primary Care medicines, they must seek Pharmaceutical Assistance from their municipality for guidance and/or referrals, which includes programs for diabetes, women's health, high blood pressure, mental health, and the prison system.

II– Strategic Component of Pharmaceutical Assistance (CESAF): according to the Ministry of Health (MS), all medications used to treat endemic diseases, whose control and treatment have established protocols and standards and which have a socioeconomic impact, are considered strategic. These are diseases that affect or put communities at risk and whose important control strategy is the treatment of those who have them. The following health programs and conditions are part of the Strategic Component: STDs/AIDS, Tuberculosis, Leprosy, Smoking, Influenza, and Focal Endemic Diseases.

III– Exceptional Drug Dispensing Component or Specialized Pharmaceutical Assistance Component (CEAF): this is a strategy for accessing drugs within the SUS, characterized by the search for guaranteed comprehensive drug treatment at the outpatient level, whose lines of care are defined in Clinical Protocols and Therapeutic Guidelines published by the Ministry of Health. The drugs that make up

Part of the care lines for the diseases covered by this Component are divided into three groups according to different characteristics, responsibilities, and forms of organization:

Group 1: Medicines financed by the Ministry of Health, divided into:

Group 1A: medicines centrally purchased by the Ministry of Health and supplied to the State and Federal District Health Secretariats, which are responsible for scheduling, storage, distribution, and dispensing for the treatment of diseases covered by the Specialized Pharmaceutical Assistance Component; and

Group 1B: medicines financed by the Ministry of Health through the transfer of financial resources to the State and Federal District Health Secretariats for the acquisition, scheduling, storage, distribution, and dispensing for the treatment of diseases covered by the Specialized Component of Pharmaceutical Assistance.

Group 1 was formed according to the following criteria: I - greater complexity of disease treatment; II - refractoriness or intolerance to first- and/or second-line treatment; III - medicines that represent a high financial impact for the Specialized Pharmaceutical Assistance Component; and IV - medicines included in productive development actions in the health industrial complex.

Group 2: Medicines financed by the State and Federal District Health Secretariats, which are responsible for the acquisition, programming, storage, distribution, and dispensing for the treatment of diseases covered by the Specialized Pharmaceutical Assistance Component.

Group 2 was formed according to the following criteria: I - lower complexity of disease treatment compared to Group 1; and II - refractoriness or intolerance to first-line treatment.

Group 3: Medicines under the responsibility of the Federal District and Municipal Health Secretariats for procurement, scheduling, storage, distribution, and dispensing, which is established in a specific normative act that regulates the Basic Component of Pharmaceutical Assistance.

Group 3 was defined according to the medicines included in the Basic Component of Pharmaceutical Care and indicated by the Clinical Protocols and Therapeutic Guidelines, published in their final version by the Ministry of Health as the first line of care for the treatment of diseases covered by the Specialized Component of Pharmaceutical Care (Ordinance GM/MS No. 1,996/2013).

It is understood that medications intended for chronic and elderly patients belong to the Basic Component of Pharmaceutical Care, regulated by Ordinance No. 3,237, of December 25, 2007, which determines in Annex I:

> Art. 1 The Reference List is composed of medications and supplies intended to address prevalent and priority conditions in basic health care and are contained in Annex II of this Ordinance.
>
> § 1 The medicines are part of the current RENAME.
>
> § 2 Other drugs listed in the current RENAME that are indicated for primary care, according to local/regional needs, may be included and form part of the Reference List, provided that this is agreed upon by the Bipartite Interagency Committees (CIB), and may be financed with the financial resources defined in this Ordinance.
>
> § 3 Without prejudice to the guarantee of supply/dispensation of medicines for the treatment of conditions cared for in primary health care and in accordance with the local/regional epidemiological profile, the availability of all medicines included in the Reference List is not mandatory.
>
> § 4 The supplies that make up the Reference List are intended to complement pharmaceutical assistance actions in primary health care, in accordance with Law No. 11,347 of 2006.

The financing of basic pharmaceutical assistance is the responsibility of the three levels of government, in the amounts and

modalities of execution defined in Ordinance No. 3,237/2007, and supplemented by agreements in the Bipartite Interagency Committees of each federal unit. The implementation of the pharmaceutical care component is decentralized, with the acquisition and dispensing of medicines and supplies being the responsibility of the municipalities and the Federal District (BRAZIL, 2007).

The Bipartite Interagency Committee (CIB), composed of nine representatives from the State Health Secretariat and the Council of Municipal Health Secretaries, is the forum for negotiation between the state and municipalities in the implementation and operation of the Unified Health System.

SITUATIONAL STRATEGIC PLANNING IN PHARMACEUTICAL ASSISTANCE

The main limiting factor for health systems worldwide is the budget. The discovery of new treatments and drugs, the sophistication of procedures, the creation of new tests, the aging population, the high price of patented drugs, among other factors, all contribute to an upward cost curve. Countries use their available means to address these costs. In Brazil, the adoption of co-payment models would be unfeasible, given the low purchasing power of the majority of the population. Co-payment can be understood as a service whereby the user (population) pays a small amount each time they use a particular service. Co-payment is seen as a way of agreeing on drug costs between individuals, insurers, and governments, so as not to overburden any of the parties and to improve access to pharmacological treatments (GIBSON et al., 2005).

However, the effects of this type of policy depend on the price elasticity of demand for medicines. In scenarios of low elasticity, the impact of policies tends to focus only on income redistribution, with no impact on health. Thus, treatment is not affected by the costs of medicines, but only by the medical expenses of the patients who benefit. In the context of high elasticities, in addition to the redistributive impact, co-payment can have direct effects on health indicators by influencing medical treatment (LEXCHIN; GROOTENDORST, 2004).

According to the World Health Organization (WHO), adherence to appropriate drug treatment for diseases is only practiced by half of patients in developed countries. In developing countries, the scenario is even worse, reaching only 26% due to difficulties in accessing medications. The WHO also points out that this deficiency in the recommended dosage can reduce the effectiveness of health treatment, compromising its results (WHO, 2003).

Thus, co-payment policies are expected to have greater impacts on the health of patients with lower per capita income, since they tend to have greater price elasticity of demand for medicines (LEXCHIN; GROOTENDORST, 2004). Similarly, co-payment policies are expected to have a greater impact on health in developing countries, where it is generally assumed that the population has relatively lower incomes and relatively greater price elasticity of demand for medicines.

Comprehensive and free healthcare implies high costs to be covered by the State (federal, state, and municipal govern-

ments). The inadequacy of public healthcare in Brazil stems from a chronic shortage of resources due to lack of provision or misuse of funds, as well as managerial failures. Normatively, the SUS has improved over the years since its creation.

The qualification of pharmaceutical care management is possible through the planning, organization, and structuring of the set of activities developed, aiming to improve the services offered to the population.

Situational Strategic Planning (SSP) is a management tool for this purpose, as it is a participatory planning method that aims to define a set of operations that must be carried out to change reality (MARIN et al., 2003).

To achieve good results in any activity, it is necessary to establish clear objectives and identify where you want to go. Those who do not plan their actions and activities do not know how to act strategically and are not managing. Only through a situational analysis, a starting point, can one intervene in reality and move forward with improvement processes. It is necessary to break the managerial routine consumed by short-term thinking, responding to spontaneous demands, and trying to solve an endless number of emergency problems when there is no assessment of priorities.

Planning is a systematic, dynamic, continuous, rational, participatory, realistic, pragmatic process of understanding and intervening in the local reality in order to achieve a desired situation.

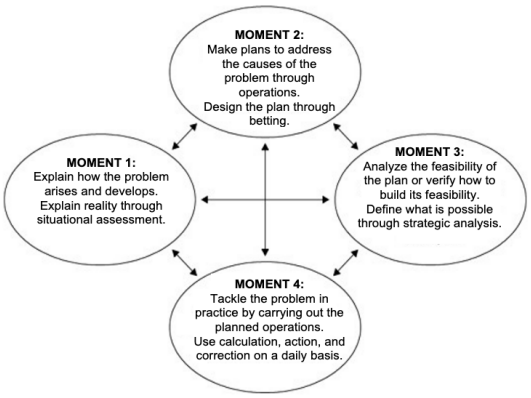

Figure 2 – The four PES moments.

Source: https://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-530X2002000200005

The product of planning is the action plan, which, in simplified terms, can be described as a document prepared based on the identification of problems, for which objectives and actions/activities are developed to resolve them, in accordance with an implementation schedule that answers the following questions: how, who, when, and how much (CONASS, 2007).

Pharmacists emerge in this scenario with the attempt to be managers involved in all stages of healthcare, from activities related to medication management to the responsible provision of clinical services and care to the community. It should be noted that pharmaceutical professionals do not have training in management (except those who specialize in the area of Pharmaceutical Management), and the lack of such training makes it difficult to manage their professional activities.

It is important for pharmacists to plan activities with the healthcare team and understand all the processes involved. Building a comprehensive SUS, capable of fully meeting the health needs of the population in a and responsibly, requires its managers to make serious commitments to structuring

PC and its qualification, with pharmacists being an important ally in ensuring rational and safe use (Finatto; Schwambach, 2016).

TRACEABILITY AND THE IMPORTANCE OF ENGINEERING OF TELECOMMUNICATIONS

It is understood that Situational Strategic Planning requires specific monitoring at all stages inherent to the pharmaceutical care cycle, and traceability extends throughout this cycle, from selection and acquisition to storage, distribution, and dispensing, allowing the medication to be monitored from its origin to the point of consumption and final use by the patient, ensuring the safety and efficiency of the process. Therefore:

- Selection: Monitor the origin of the medication to ensure that it meets the necessary quality and safety standards.
- Acquisition and Storage: Control the supply chain, from purchase to proper storage, preventing losses and fraud.
- Distribution: Track the medication's journey through the logistics chain, ensuring it reaches its final destination without interruptions or losses.
- Dispensing: Know the history of the medication to identify the patient who received it, which is crucial in cases of adverse reactions and for cost control.

The main objective of traceability is to ensure a safer, more efficient, and higher quality healthcare system for patients by identifying the origin and route of each medication and providing a complete history of its use (PINTO, 2016).

It should be noted that the SNCM requires each member of the drug distribution chain to transmit data on the circulation of products to a central database.

Traceability brings with it the importance of responsibility for establishments in the drug chain with regard to communicating all necessary information about the movement of each product, while also ensuring control. In this regard, Telecommunications Engineering provides support to enable efficient data transmission and storage systems, allowing each movement to be recorded in real time and shared among the different links in the chain.

Through advanced communication technologies, such as secure networks and automated tracking systems, it is possible to monitor the path of medicines from manufacture to dispensing to the patient, ensuring not only the integrity and authenticity of the products, but also the rapid detection of inconsistencies or deviations that could compromise pharmaceutical operational safety.

In addition, Telecommunications Engineering contributes to the integration of databases, facilitating interoperability between hospitals, pharmacies, and distributors, promoting a continuous and reliable flow of information. This digitized and interconnected monitoring helps reduce losses, combat drug counterfeiting, and comply with regulatory standards, reinforcing transparency and accountability within the healthcare sector.

In this context, and in order to ensure the traceability of information, Telecommunications Engineering plays a crucial role in providing the technological means necessary to implement the routine effectively. Integrated information systems, real-time communication platforms, and secure data networks allow pharmaceutical managers to track the distribution and consumption of medicines, monitor performance indicators, and make decisions based on reliable data through the implementation of situational analysis tools, such as interactive dashboards and tracking software, which allow them to visualize usage patterns, identify bottlenecks, and anticipate problems before they compromise patient care. With this technological support and all the technical requirements provided by Telecommunications Engineering, PES becomes more dynamic and adaptable, allowing for quick adjustments to changes in the healthcare environment and strengthening the management of the drug chain.

The integration between situational strategic planning and telecommunications engineering therefore results in more organized, secure, and transparent pharmaceutical care, aligning technology, management, and patient care in an efficient and strategic manner.

Consider also aspects related to:

- Confidential Information: information contained in the database and treated as such, which can only be accessed by members of the chain on a limited basis to enter new data on the movement of medicines in their custody.
- Regulation: ANVISA is responsible for regulating the operational aspects of the National Drug Control System.

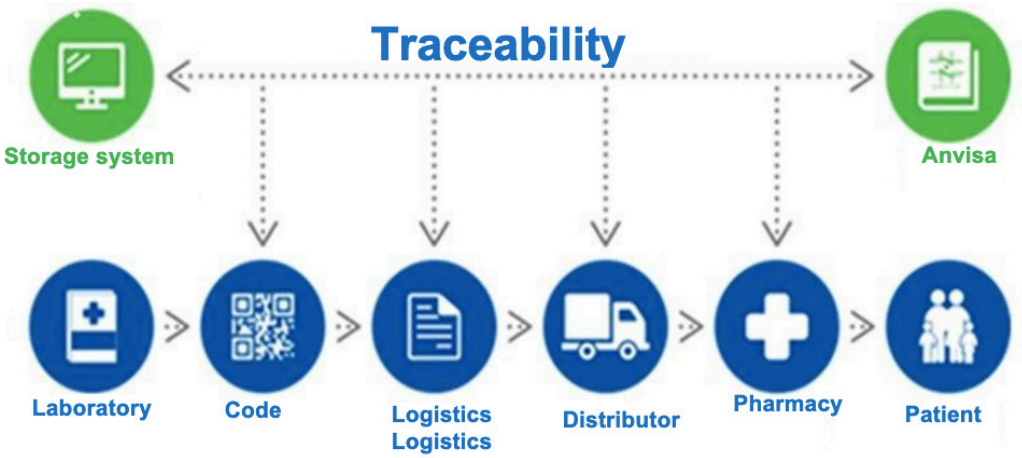

Figure 3

Source: https://www.doisamaisfarma.com.br/home/industrias-farmaceuticas-se-empenham- por-adequacao-lei-da-rastreabilidade-de-medicamentos/

The traceability of medicines is a pillar of strategic planning for pharmaceutical care, ensuring the safety, efficiency, and quality of medicine supply through the use of a Unique Medicine Identifier (UMI), which allows the product to be traced from production to consumption. Its importance lies in optimizing logistics, reducing costs, preventing fraud, and ensuring the rational use of medicines, directly impacting public health.

Thus, we suggest the widespread application of the PES methodology in PC due to its ease of application and its strategic-situational characteristic in the possibility of involving various actors to address problems, contributing to the organization and improvement of PC and raising awareness among participants and pharmacists of the importance of strengthening and developing effective, high-quality PC provided to the population.

FINAL CONSIDERATIONS

PES is an appropriate tool for project management, as it allows for real-time analysis of the situation, with the possibility of defining a new situation, constructing a viable plan, and monitoring it. Its implementation allows for the development of various skills and competencies essential to the management process, with notes on difficulties or problems, in addition to the organization of operational plans for future improvements (Matus, 1997).

The work in question presented the usefulness of the procedures provided for in the PES to analyze and solve problems in the field of pharmaceutical management.

The prioritization of problems is directly related to patient health. In this context, the pharmacist plays a central role in the execution of action plans. The PES methodology is useful in helping AF managers organize the problems faced by the sector, so that they can then examine them in detail in search of causes and consequences. The objectivity and ease of application of the methodology make it an interesting support tool for managers, especially those who do not have much management knowledge in their technical training.

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