

Between legality and the quality of care: A critical analysis of audits in the Unified Health System in Minas Gerais

Entre a legalidade e a qualidade do cuidado: análise crítica das auditorias no Sistema Único de Saúde em Minas Gerais

Entre la legalidad y la calidad de la atención: análisis crítico de las auditorías en el Sistema Único de Salud en Minas Gerais

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ABSTRACT This article critically analyzes audit reports conducted within the Unified Health System by the State Health Secretariat of Minas Gerais, with the aim of identifying patterns of non-compliance and proposing technical criteria for prioritizing scheduled audits. This is a documentary ecological study with a mixed-methods approach that examined 629 audits completed between 2011 and 2024, covering 333 municipalities, using data extracted from the SUS Audit System. Of these audits, 593 (94.3%) presented non-compliance findings, totaling 11,816 records. Textual analysis was performed using IRaMuTeQ software, applying word cloud, similitude graph, descending hierarchical classification, and factorial correspondence analysis. Two main axes of fragility were identified: care-related issues, including access barriers, failures in Primary Health Care, and precariousness of the Family Health Strategy; and governance-related issues, such as lack of planning, regulatory gaps, and inadequate use of resources. A predominance of technical-financial vocabulary and low user-centeredness was observed. The study concludes that, despite the significant volume of audits, there are gaps in the critical systematization of findings, which limit their potential to drive improvements in management and quality of care within the SUS.

KEYWORDS Health administration. Health management. Quality of health care. Health services research. Organizational efficiency.

RESUMO Este artigo analisa criticamente relatórios de auditoria realizados no Sistema Único de Saúde pela Secretaria de Estado de Saúde de Minas Gerais, com o objetivo de identificar padrões de não conformidade e discutir critérios técnicos capazes de subsidiar a priorização de auditorias programadas. Trata-se de estudo documental, de natureza ecológica e abordagem mista, que analisou o total de 629 auditorias concluídas entre 2011 e 2024, abrangendo 333 municípios, com dados extraídos do Sistema de Auditoria do SUS. Destas, 593 (94,3%) apresentaram não conformidades, totalizando 11.816 constatações. A análise textual foi realizada com o IRaMuTeQ, utilizando nuvem de palavras, grafo de similitude, classificação hierárquica descendente e análise fatorial de correspondência. Identificaram-se dois eixos principais de fragilidade: assistencial, caracterizado por barreiras de acesso, falhas na Atenção Primária à Saúde e precarização da Estratégia Saúde da Família; e de governança, relacionado à ausência de planejamento, déficits de regulação e uso inadequado de recursos. Evidenciou-se predominância de vocabulário técnico-financeiro e baixa centralidade no usuário. Conclui-se que, apesar do volume expressivo de auditorias, há lacunas na sistematização crítica dos achados, o que limita seu potencial de induzir melhorias na gestão e na qualidade do cuidado no SUS.

PALAVRAS-CHAVE Administração em saúde. Gestão em saúde. Qualidade da assistência à saúde. Pesquisa sobre serviços de saúde. Eficiência organizacional.

RESUMEN Este artículo analiza críticamente informes de auditoría realizados en el Sistema Único de Salud por la Secretaría de Estado de Salud de Minas Gerais, con el objetivo de identificar patrones de no conformidad y discutir criterios técnicos capaces de subsidiar la priorización de auditorías programadas. Se trata de un estudio documental, de naturaleza ecológica y enfoque mixto, que analizó un total de 629 auditorías concluidas entre 2011 y 2024, que abarcaron 333 municipios, con datos extraídos del Sistema de Auditoria del SUS. De estas, 593 (94,3 %) presentaron no conformidades, totalizando 11.816 hallazgos. El análisis textual se realizó mediante IRaMuTeQ, utilizando nube de palabras, grafo de similitud, clasificación jerárquica descendente y análisis factorial de correspondencias. Se identificaron dos ejes principales de vulnerabilidad: asistencial, caracterizado por barreras de acceso, fallas en la Atención Primaria de Salud y precarización de la Estrategia de Salud de la Familia; y de gobernanza, relacionado con la ausencia de planificación, déficits de regulación y uso inadecuado de recursos. Se evidenció un predominio de vocabulario técnico-financiero y una baja centralidad en el usuario. Se concluye que, a pesar del volumen significativo de auditorías, existen lagunas en la sistematización crítica de los hallazgos, lo que limita su potencial para inducir mejoras en la gestión y en la calidad de la atención en el SUS.

PALABRAS CLAVE Administración de los Servicios de Salud. Gestión en Salud. Calidad de la Atención de Salud. Investigación sobre Servicios de Salud. Eficiencia Organizacional.

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Introduction

Health auditing, as a function of evaluating and overseeing public management, is a strategic instrument for the effective implementation of the principles of the Unified Health System (SUS) – universality, comprehensiveness, and equity – established in the 1988 Federal Constitution and regulated by Laws No. 8,080/1990 and 8,142/1990¹⁻³. Since the creation of the SUS, administrative decentralization and the municipalization of management have introduced new challenges for ensuring quality, transparency, and the efficient use of public resources. In this context, it is important to conceptually distinguish auditing from other functions frequently associated with health management, such as control, monitoring, and evaluation.

Control refers to verifying compliance with standards and the legality of administrative acts, while monitoring consists of the continuous tracking of indicators and processes over time. Evaluation, in turn, involves systematic judgment of the performance of policies, programs, or services, considering their effectiveness, efficiency, and impact. Auditing, while engaging with these dimensions, is characterized by a structured, independent analysis aimed at verifying conformity and quality, and may incorporate evaluative elements and generate recommendations. In this sense, it is linked to the concept of accountability, understood as the responsibility of managers for transparency and answerability, and can play a strategic role in promoting quality improvement when its findings are used to provide feedback for planning and to improve management processes⁴.

The National Audit System (NAS), provided for in Law No. 8,080/1990, established by Law No. 8,689/1993, and regulated by Decree No. 1,651/1995, organized audit actions in the three spheres of SUS management, with the purpose of ensuring that services are provided efficiently, effectively, and in accordance with current legislation⁵. At the state level,

the health secretariats play a relevant role in monitoring and supervising municipal actions, seeking to guarantee technical-financial compliance and quality of care⁶.

Although historically associated with documentary and financial verification processes, health auditing can also incorporate qualitative dimensions related to the quality of care and users' experience⁷. This perspective is linked to transformations in health governance, which broaden the focus to system performance, quality, responsiveness, and resource utilization.

In Brazil, however, there is still a gap between the supervisory function and the potential of auditing as an instrument for continuous improvement. Studies such as those by Mendes⁸ and Massuda⁹ show that some of the structural weaknesses of the SUS stem from deficiencies in the planning, regulation, and monitoring of public policies. These shortcomings directly impact the quality of care and the efficiency of resource use.

In Minas Gerais, the use of the SUS Audit System (SISAUD/SUS), established by Ordinance No. 1,467/2006, enabled the consolidation of a comprehensive database of audits conducted in municipalities across the state between 2011 and 2024¹⁰.

However, despite the volume of information generated, the data have not been sufficiently systematized to identify patterns, prioritize actions, and guide evidence-based policies. This study is based on the premise that a critical analysis of these data can reveal recurring patterns and structural weaknesses, thereby supporting the development of technical criteria for prioritizing scheduled audits.

In the international context, countries with universal healthcare systems, such as the United Kingdom, Canada, and Spain, incorporate audits into performance evaluation programs, emphasizing clinical indicators, user satisfaction, and governance¹¹⁻¹³. These models show that auditing, when linked to participatory planning and management processes, can drive innovation and improve services.

Despite the significant volume of data produced by audits within the SUS, these records are still underutilized as systematic support for planning and decision-making. In the state of Minas Gerais, for example, although the audit system is consolidated and covers a large number of municipalities, the frequency of audits carried out over the years and the strategic use of their findings still raise questions about their capacity to induce structural improvements in management and quality of care. Furthermore, the absence of formalized technical criteria for prioritizing scheduled audits may compromise the efficiency and equity of control actions, reinforcing the need for studies that critically analyze this body of data and support the discussion of technical criteria that qualify its use.

Given these gaps, this study aimed to critically analyze audit reports of the SUS, carried out by the Minas Gerais State Health Department (SES-MG) between 2011 and 2024, identify patterns of non-compliance and discuss technical criteria capable of supporting the prioritization of scheduled audits, reconciling compliance with regulatory requirements with the promotion of user-centered and comprehensive care.

Material and methods

This is a documentary, ecological study with a mixed approach (quantitative and qualitative), developed from the analysis of audit reports completed between 2011 and 2024. The classification as an ecological study is justified by the aggregated analysis of data at the municipal level, without individual identification, allowing the identification of collective patterns related to the organization and performance of health services.

All audits completed during the period under SES-MG were considered, totaling 629 records, regardless of whether non-conformities were identified, to support the discussion on technical criteria for prioritizing scheduled audits.

The study's unit of analysis was defined at two levels: audits (considered as units for descriptive quantitative analysis) and findings of non-conformity (used as textual units for qualitative analysis). SISAUD/SUS was used, with the formal consent of SES-MG.

For the quantitative analysis, all 629 audits completed during the study period were included, allowing characterization of the overall audit population. For the qualitative analysis, the 593 audits with records of non-conformities were considered, and their findings were extracted for textual analysis.

Quantitative variables were analyzed (number of audits, number of findings, frequency of terms, proportion of audits with non-conformities, type of establishment, population size of the municipality, and year of audit completion). Absolute and relative frequencies were calculated to describe the profile of the audits during the period.

For the qualitative analysis, the software IRaMuTeQ (R Interface for Multidimensional Text and Questionnaire Analysis) was used for textual processing of audit reports. The textual corpus consisted of non-conformity findings recorded in the selected audits and was previously prepared through spelling standardization, removal of special characters, and organization of the texts in a format compatible with the software. Segmentation was performed automatically into Elementary Context Units (ECUs), according to the IRaMuTeQ algorithm. Only findings recorded in the reports were included, and non-textual administrative elements were excluded¹⁴⁻¹⁶.

Lexical analyses were performed using word clouds to identify the most frequent terms and similarity graphs to analyze the co-occurrence between words in the text, resulting in a linking structure between words that revealed patterns of association and themes present in the textual corpus.

Descending Hierarchical Classification (DHC) was applied to segment the corpus into thematic classes, allowing the identification of discursive patterns associated with

weaknesses in care and governance. The DHC showed a 91.43% utilization rate of the classified text segments (4,703/5,144), indicating adequate stability and consistency of the lexical analysis. The naming of the thematic classes was based on the analysis of the characteristic vocabulary and the semantic context of the text segments.

As a complement to DHC, Correspondence Factor Analysis (CFA) was used as an exploratory procedure to graphically represent the proximity relationships between the identified thematic classes. The CFA results were used to support the interpretation of the classes obtained in the lexical analysis and did not constitute an independent inferential procedure.

The integration between quantitative and qualitative approaches occurred in a complementary way, insofar as the descriptive findings on the audit profile supported the interpretation of the patterns identified in the textual analysis, allowing for a broader understanding of the system’s weaknesses.

Since this is a documentary study based on secondary data, without identifying individuals, there was no need to submit it to the Research Ethics Committee, in accordance with CNS Resolution No. 510/2016. Access to the data was formally authorized by SES-MG.

The authors declare that artificial intelligence tools were used exclusively to support linguistic revision, textual organization, and improvement of the scientific writing of the manuscript, without interfering in data analysis, interpretation of results, or elaboration of conclusions. The authors assume full responsibility for the content presented.

Results

Between 2011 and 2024, 629 audit activities were completed at the state level. Of these, 593 (94.3%) presented records of non-compliance and comprised the analytical corpus of qualitative findings. These audit activities were categorized by the population size of the municipalities. A total of 333 municipalities were analyzed, resulting in 11,816 findings recorded in SISAUD.

Table 1 presents a general characterization of the audits conducted during the study period, including the total number of audits completed, those with non-conformities, the municipalities audited, the findings recorded, and the distribution of audits according to municipal population size, along with the corresponding proportions with non-conformities.

Table 1. General characteristics of audits carried out by Minas Gerais State Health Department (SES-MG) between 2011 and 2024 by population size

Population size	Audited cities	Completed audits	Non-compliant audits	Audits with non-compliance
Small size I	145	273	254	93.0
Small size II	96	205	193	94.1
Medium-sized	55	106	102	96.2
Large size	37	45	44	97.8
Total	333	629	593	94.3

Source: Created by the authors (2026).

The distribution of audits performed according to municipal population size showed a greater concentration in smaller municipalities. Small municipalities (Type I) represented 43.5% of the audited municipalities (145/333), with 273 completed audits, of which 254 (93.0%) showed non-conformities. In small municipalities (Type II), 205 audits were carried out, with 193 (94.1%) showing non-conformities. In medium-sized municipalities, 106 audits were completed, of which 102 (96.2%) showed non-conformities. Large municipalities accounted for the smallest proportion of audited municipalities (37/333), totaling 45 audits, of which 44 (97.8%) showed non-conformities.

A high proportion of audits with non-conformities was observed across all population strata, ranging from 93.0% in small municipalities (Type I) to 97.8% in large municipalities. Although smaller municipalities accounted for

a greater number of audits, the findings suggest a pattern of increasing non-conformities with increasing population size, indicating that the weaknesses identified are not limited to smaller municipalities but are also present in more complex urban contexts. This pattern reinforces the systemic nature of the non-conformities identified in audits conducted by SES-MG.

Textual analysis using IRaMuTeQ revealed a predominance of technical-financial and administrative terms, with emphasis on ‘health’ (f=3670), ‘municipal’ (f=2339), ‘resource’ (f=1672), ‘service’ (f=1468), ‘legislation’, and ‘payment’, as shown in *figure 1*. In contrast, words such as ‘patient’ and ‘user’ appeared with low frequency. This lexical pattern suggests a predominance of an approach centered on administrative and normative aspects, with less emphasis on elements related to user experience and quality of care.

Figure 1. Word cloud of audit findings

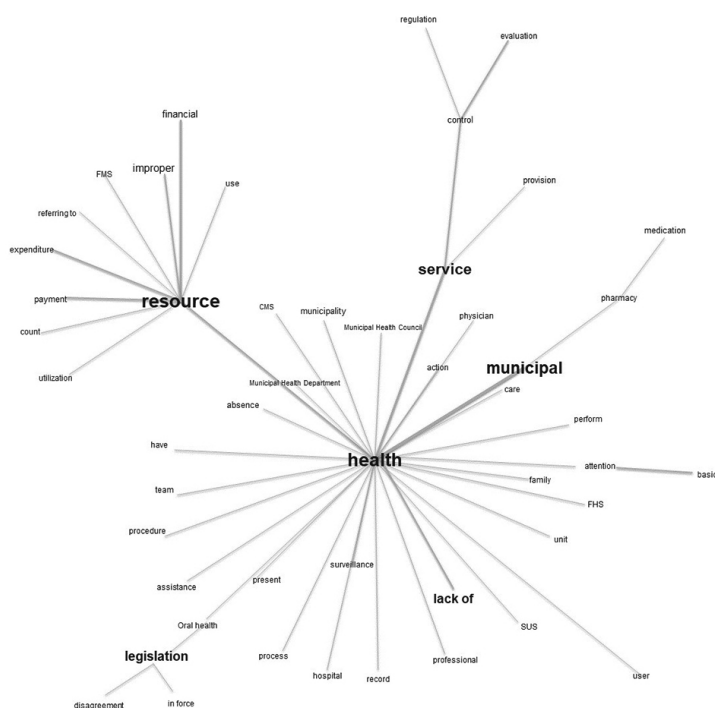


Source: Created by the authors (2026).

For semantic associations, the similarity graph (*figure 2*) showed that the term ‘health’ occupies a central position in the network, strongly connected to ‘municipal’, highlighting

the role of local management. The terms 'resource', 'payment', and 'expense' form a financial core, while 'nonexistence', 'legislation', and 'control' make up the normative axis.

Figure 2. Similarity graph of terms present in the audits



Source: Created by the authors (2026).

In thematic classes, DHC identified five main categories (*figure 3*):

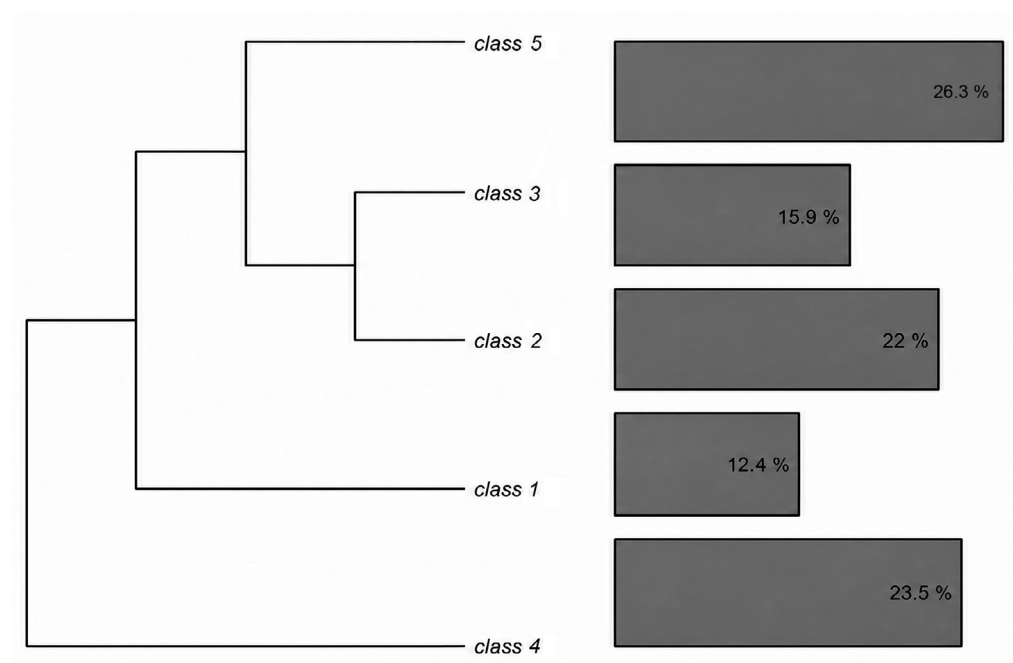
- Class 1 – Deficits in municipal documentation and management: flaws in health plans (AHP), management reports (AMP), and lack of action by Municipal Health Councils;
- Class 2 – Barriers to access and poor hospital management: problems with regulation, admissions, and medical records;
- Class 3 – Weaknesses in municipal regulation and services: lack of standardization and monitoring failures;

• Class 4 – Misappropriation of funds: irregularities in the use of financial resources;

• Class 5 – Precariousness of Primary Health Care in the Family Health Strategy (FHS) and Oral Health Team (OHT): lack of professionals, medications, and home visits.

The thematic categories identified show that the weaknesses observed in the audits go beyond purely financial or bureaucratic aspects, also encompassing problems related to the organization of care, access to services, and municipal management capacity.

Figure 3. Distribution of thematic classes of the Descending Hierarchical Classification (DHC)



Source: Created by the authors (2026).

Analysis of the fragility of health systems, identified through the DHC, revealed five main thematic classes. The most representative was Class 5 (26.3%), revealing problems directly related to the organization of care and the quality of care provided.

Next, Class 4 (23.5%) points to the persistence of financial irregularities and inconsistencies in the execution of public resources, exposing weaknesses in internal and external control mechanisms. This finding aligns with the literature by indicating that auditing, in the context of the SUS, still faces challenges in consolidating effective practices for monitoring and holding management accountable.

Class 2 (22%) underscores difficulties related to regulating access, the occurrence of inappropriate hospitalizations, and inconsistencies in medical records, indicating weaknesses in both the organization of the network and the quality of care. This scenario reinforces the centrality of auditing as an instrument not only for oversight but also for driving improvements in care quality.

Subsequently, Class 3 (15.9%) points to gaps in the coordination of access and in the articulation between levels of care. It encompasses structural obstacles that affect the effectiveness of health actions, including resource limitations, failures in the organization of work processes, and difficulties in implementing regulations. These elements show that auditing challenges go beyond the technical dimension, involving organizational and political aspects that shape managers' responsiveness.

Finally, Class 1 (12.4%) reveals inconsistencies in the preparation and use of fundamental documents, such as management plans and reports, as well as weaknesses in the performance of health councils. These findings suggest limitations in the institutionalization of planning and evaluation practices, indicating that document production, although formally required, does not always translate into an effective tool to support decision-making.

To complement the interpretation of the classes obtained by the DHC, CFA was used to graphically represent the proximity

relationships between the identified thematic axes. *Figure 4* presents this exploratory synthesis, showing that CFA corroborated the thematic organization previously identified

by the DHC, without producing new analytical categories. Thus, its contribution lay in strengthening the integrated interpretation of the relationships between the thematic classes.

Figure 4. Correspondence Factor Analysis (CFA) diagram showing the clustering of fragility axes



Source: Created by the authors (2026).

The results highlight the analytical potential of health audits as a strategic source of information for identifying structural weaknesses in the system and supporting planning and decision-making processes in public management.

Discussion

The findings of this study reveal that health auditing within the SUS in the state of Minas Gerais, during the analyzed period, remains predominantly focused on normative and financial aspects, with limited incorporation of qualitative dimensions related to user experience¹⁷. This characteristic aligns with what has already been identified in other analyses of Brazilian public audits, in which documentary compliance and resource accountability play

a central role^{7,18}. The predominance of terms such as ‘resource’, ‘payment’, and ‘legislation’ in the reports, as evidenced by the word cloud and similarity graph, indicates that auditing practices still concentrate on verifying the legality and cost-effectiveness of services, to the detriment of evaluating the effectiveness and resolution of care. This scenario reinforces the criticism of Paim¹⁸ and Mendes⁸ that the SUS faces a cycle of structural inefficiency, in which deficiencies in governance and management negatively impact the care offered to the population.

Understanding auditing as a governance tool goes beyond mere oversight. Michael Power¹⁹, in his work ‘The Audit Society Revisited’ argues that auditing has become a dominant form of control and legitimation in modern organizations, shaping the very nature of management. In this sense, auditing in the SUS, by focusing

excessively on compliance, may inadvertently divert attention from deeper issues of performance and value. Hood et al.²⁰ complement this view by discussing how auditing fits into a broader system of risk management and accountability, in which transparency and responsibility are fundamental.

Healthcare deficiencies demonstrate a challenge to the principles of comprehensiveness and universality. It is possible to identify, through the DHC classes related to the healthcare axis (Classes 2 and 5), barriers to access, precariousness of Primary Health Care (PHC), a shortage of professionals, and failures in care processes. These problems directly affect universality and comprehensiveness, fundamental principles of the SUS, and corroborate studies such as that of Massuda⁹, which points to underfunding and discontinuity of policies as critical factors for the decline in PHC performance in Brazil. The precariousness of the FHS, in particular, reflects insufficient investment and a lack of strategies to retain professionals, which compromises the system's ability to resolve most health problems at the point of entry²¹.

The quality of care, according to the classic model of Avedis Donabedian²², should be evaluated in terms of structure, process, and outcome. Our findings, by indicating flaws in the structure (lack of professionals, registration problems) and in the process (failures in home visits, incomplete medical records), suggest that auditing plays a crucial role in identifying deficiencies that directly impact the population's health outcomes. The low frequency of terms such as 'patient' or 'user' in the audit reports, as identified in the textual analysis, points to a gap in the perspective of patient-centered care, an essential dimension of quality according to the Institute of Medicine (IOM)²³. The valorization of PHC, advocated by Barbara Starfield²⁴ as the coordinator of care and preferred point of entry, is fundamental to the effectiveness of the system, and audits should be able to diagnose problems and propose solutions for its strengthening.

International experiences demonstrate that audits incorporating clinical indicators, waiting times, and user satisfaction are better aligned with the real demands of the population. In the United Kingdom, for example, the National Health Service (NHS) uses clinical audits that monitor both compliance and care outcomes, integrating analysis of processes and results¹¹. In Canada, performance auditing mechanisms evaluate everything from access indicators to patient-perceived quality, with reports that support immediate adjustments in the network. This perspective, focused on results and user experience, is crucial to transcend mere formal verification and promote an audit that truly contributes to improving the quality of care.

Weaknesses in governance impact transparency and planning. The governance axis (Classes 1, 3, and 4) focuses on documentary flaws, lack of social control, deficient regulation, and inadequate use of financial resources. These problems relate to previous discussions on weaknesses in coordination, management, and governance in the SUS^{25,30} compromising transparency and the capacity of municipalities to plan and execute policies consistently. The absence or inoperability of Municipal Health Councils, identified in some of the reports, reveals weaknesses in social control, a pillar established in Law No. 8.142/1990³. International literature highlights that effective social participation in audit and evaluation bodies can increase accountability and reinforce the legitimacy of decisions^{12,20}. Ineffectiveness in regulating services, such as Out-of-Home Treatment (TFD), and the lack of standardization and monitoring indicate the need to strengthen the regulatory capacity of municipalities to ensure the organization and control of care flows²⁶.

The findings show that auditing remains predominantly driven by a normative and technical-financial logic, with less emphasis on care dimensions and user-centeredness. This pattern reinforces the need to redefine auditing as an instrument of institutional learning,

capable of producing knowledge applicable to management and inducing improvements in care processes.

The decentralization of the SUS, although a democratic advance, imposes complex challenges of inter-federative coordination and local governance, as well described by Viana and Lima²⁷. Dependence on federal transfers can condition local policies, as pointed out by Arretche²⁵, and auditing, in this scenario, should act as a mechanism to induce good practices in financial and budgetary management, ensuring that resources reach the point of care and are used effectively. Governance in health, according to the World Health Organization (WHO)²⁸, involves the government's responsibility for the direction, regulation, and performance of the health system, including the use of information to guide policies and strategies. This perspective aligns with the weaknesses in social control and planning identified in our study.

The integration between auditing and strategic management is a path to efficiency. The analysis of the similarity graph and CFA demonstrates that administrative and care aspects are interdependent. Ineffective financial management compromises the service delivery structure, while failures in regulation and planning generate wasted resources and inefficiency in care. This cycle reinforces the need for an integrated approach between auditing and strategic management. Auditing cannot be seen merely as a post hoc inspection process, but as a tool to support decision-making and continuous process improvement.

In countries like Spain, healthcare auditing is linked to management contracts and care goals, allowing findings to be immediately incorporated into the decision-making process. This integration contributes to the rational use of resources and the continuous improvement of services. In the Brazilian context, the National Humanization Policy (PNH)^{29,30} offers guidelines for auditing to incorporate the dimension of care and user experience, promoting a more comprehensive and less bureaucratic view of service quality. The impact assessment of health

policies, according to the Ministry of Health guide³¹, reinforces the need to go beyond compliance and focus on effective results for the population. The use of evidence in the formulation of public policies, as advocated by Nutley et al.³², is a way for audit findings to translate into concrete, data-driven actions, moving beyond the mere identification of problems to the proposition of effective solutions.

The fragility patterns identified in this study demonstrate the feasibility of using technical criteria to prioritize scheduled audits. Among these criteria, the frequency and severity of non-conformities, their potential impact on access and quality of care, the recurrence of governance weaknesses, and the organizational and socioeconomic characteristics of the municipalities stand out. Integrating these components into a classification index represents a promising strategy to support the planning of audit actions, allowing for objective, transparent, evidence-based prioritization of tasks.

Using technical and transparent criteria to prioritize audits can optimize resources, maximize impact, and align audit work with the equity and comprehensiveness objectives of the SUS. This would allow auditing bodies to focus their efforts on municipalities and establishments that present the greatest risks or the largest gaps in service delivery, promoting more efficient allocation of available human and financial resources. This proactive, risk-based approach is fundamental for complex health systems with limited resources, in which intelligent prioritization can generate a significant impact on continuous improvement.

In this sense, the systematic use of audit findings can contribute to strengthening health governance by supporting evidence-based decisions, improving planning, and increasing the effectiveness of actions within the SUS.

The limitations of this study stem mainly from its documentary nature and the use of a secondary database from SISAUD, whose findings depend on the form and quality of the records made by auditors. The non-standardized

nature of the textual corpus limits the research's ability to explore the qualitative dimensions of care in depth, focusing the analysis on legality and compliance, to the detriment of a more user-centered perspective.

Conclusions

Health audits conducted by the State Department of Health in Minas Gerais between 2011 and 2024 reveal a set of structural and interdependent weaknesses within the SUS, spanning governance and service delivery. The prevalence of findings related to documentation issues, regulatory shortcomings, lack of planning, and inadequate resource utilization shows that auditing – beyond merely identifying non-compliance – must be capable of driving systemic improvements.

From a healthcare perspective, precarious working conditions in PHC, insufficient staffing, and access barriers directly compromise the universality and comprehensiveness of care. The findings suggest that these weaknesses are systemic and not limited to smaller municipalities or those with less administrative capacity. When analyzed systematically, these results offer relevant insights for planning, prioritizing, and improving management practices within the SUS.

The results reinforce the need to move beyond a narrow conception of auditing focused exclusively on regulatory and financial compliance, expanding its use as a strategic instrument for institutional learning, knowledge production, and strengthened governance in healthcare. In this sense, integrating auditing into planning and decision-making processes can increase its capacity to induce organizational and care-related improvements.

The results of this study show that the use of technical criteria derived from the identified fragility patterns can help improve the planning of scheduled audits. Systematically integrating these criteria into a classification index

constitutes a potential strategy to support the definition of priorities, optimize resource allocation, and strengthen the performance of the SISAUD system within the SUS.

Among the study's limitations, the use of secondary data from administrative records stands out, as these are subject to variability in report quality and heterogeneity in auditing practices throughout the analyzed period.

By consolidating itself as a comprehensive and strategic evaluation mechanism, health auditing can decisively contribute to improving the quality of care, the efficient use of public resources, and the strengthening of the SUS, ensuring the right to health in a more equitable, effective, and needs-oriented way for the population.

Authorship contributions

Ferreira LMP (0009-0000-9833-6300)* contributed to the conception of the work; data collection, analysis, and interpretation; article writing; and critical revision of the manuscript. Lima PHC (0000-0002-1608-4988)* contributed to the writing of the article or critical review and final approval of the version to be published. Rocha NB (0000-0003-3366-0032)* contributed to the critical review of the intellectual content and final approval of the version to be published. Leal DL (0000-0003-4817-9006)* contributed to the conception, acquisition, analysis, and interpretation of data for the work and revision of the manuscript. Nascimento AR (0000-0001-7094-0987)* contributed to the conception, acquisition, analysis, and interpretation of data for the work and revision of the manuscript. Moura RNV (0000-0002-8947-2797)* contributed to the conception, acquisition, analysis, and interpretation of data for the work and revision of the manuscript. Pinto RS (0000-0002-6169-7708)* contributed to the conception, acquisition, analysis, and interpretation of data for the work and revision of the manuscript. ■

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