# PMAQ in the view of workers who participated in the program in Region of Health of Paraná

## *PMAQ na visão de trabalhadores que participaram do programa em Região de Saúde do Paraná*

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**ABSTRACT** Qualitative approach that aimed to analyze changes in the accession processes, external assessment and organization of the work process for 21 teams in the 10th Region of Health of Paraná, which participated in the first two cycles of the National Program for Access and Quality Improvement in Primary Care (PMAQ). Results showed better organization and registration of the information; planning based on self-assessment and external assessment as a strategy for mobilizing management and teams. However, more involvement of teams is needed in the contractualization and monitoring of PMAQ indicators, as well as better use of self-assessment tools in local planning.

**KEYWORDS** National health programs. Workflow. Qualitative research.

**RESUMO** *Pesquisa com abordagem qualitativa que objetivou analisar as mudanças nos processos de adesão, avaliação externa e organização do processo de trabalho de 21 equipes na 10a Região de Saúde do Paraná, as quais participaram dos dois primeiros ciclos do Programa de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ). Os resultados apontaram melhor organização e registro das informações; planejamento a partir da autoavaliação e a avaliação externa como estratégia de mobilização da gestão e das equipes. Todavia, é necessário maior envolvimento das equipes na contratualização e monitoramento dos indicadores do PMAQ, assim como melhor uso das ferramentas da autoavaliação no planejamento local.*

**PALAVRAS-CHAVE** *Programas nacionais de saúde. Fluxo de trabalho. Pesquisa qualitativa.*

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## Introduction

Primary Care (PC), as an important part of health systems, is developed through simple and low-cost technologies – that are efficient for this level of care, since they can solve around 85% of health problems – and contributes to the coordination of care in the care network[1]. This has made PC a mechanism for the reformulation of public health policies and for the reorganization of health systems in several countries[2,3].

Primary Health Care (PHC) is the most innovative proposal to rethink the hegemonic model centered on the image of the physician and the treatment of diseases based on specialization insofar as it is based on the work of a multidisciplinary team and on the promotion and prevention of health.

After almost 40 years of the Alma-Ata Conference (1978), which considered PHC as a fundamental strategy for the promotion of health reforms in several countries, including Brazil, the actions currently carried out at this level of care, besides reorganizing the health system, keep alive the debate about its function, highlighting the need to strengthen its potentialities and overcome its challenges[4].

In Brazil, with the creation of the Unified Health System (SUS), in 1988, health actions were decentralized to the states and, mainly, to the municipalities, which widened the scope of the PC with the aim of making services more accessible to the entire population[5].

Since the 1990s, initiatives to expand PC have been implemented, such as the Community Health Agents Program (Pacs), in 1991, and the Family Health Strategy (FHS), created in 1994 as a program, becoming the main strategy for changing the care model.

More recently, in 2011, in order to strengthen PC, the Ministry of Health (MS) created the National Program for Access and Quality Improvement in Primary Care (PMAQ-AB), through Ordinance GM/MS nº 1.654, of 2011, updated in 2015 by Ordinance nº 1.645, of the GM/MS. The program aims to:

> [...] induce the expansion of access and improvement of the quality of Primary Health Care, with a guarantee of a national, regional and local comparable standard of quality in order to allow greater transparency and effectiveness of the governmental actions directed to Primary Health Care[6(8)].

The program was elaborated from a wide process of mobilization of workers, managers of the three spheres of government and users, with the purpose of operating changes in the work process of the teams of PC[7].

The National Council of Municipal Health Secretariats (Conasems) and the National Health Council (CNS) have contributed to this process in order to defend the need for PC qualification, so that it assumes its role as coordinator of integral health care and networks of attention[8].

PMAQ-AB aims to bring about changes in the work process of the teams that adhere to it, through mechanisms that involve analysis, evaluation, intervention and certification, combining the transfer of resources according to the performance achieved in the implementation and development of the aspects that compose it[7].

A complete cycle of the PMAQ-AB has an average duration of two years and has three phases: (1) accession and contractualization, (2) external evaluation and certification, and (3) re-contractualization, as well as a transversal axis of development, which includes: self-evaluation, permanent education, monitoring of indicators, institutional support and horizontal cooperation. Since its creation, in 2011, two complete cycles have already been carried out (2012/2013 and 2014/2015) and the third cycle has started (2016/2018).

Under the 10th Region of Health of Paraná, composed of 25 municipalities, 27 teams participated in the 1st and 2nd cycles of PMAQ-AB, passing twice through the different phases of the program, in an average interval of two years, relatively sufficient time for greater knowledge of

the program and to bring about change in accordance with its objectives.

Thus, this article, a clipping of a master's degree dissertation, aims to analyze changes in the processes of adhesion, external evaluation and organization of the work process of 21 teams from this region of Paraná, who participated in the first two cycles of PMAQ-AB.

## Methods

Exploratory, descriptive, field research, with a qualitative approach. The sample consisted of 21 professionals from FHS teams that participated in the 1st and 2nd cycles of the PMAQ-AB of the 10th Region of Health of Paraná. The cutout in FHS was due to the fact that, in the first cycle of the program, only FHS teams could participate. Six teams were excluded by changes in their composition, whose new professionals had not participated in any cycle of the program.

The research data were obtained through a semi structured interview, occurred between May and June of 2016, with professionals who participated in the external assessment and accepted to participate in the research. To preserve the identity of the interviewees, the lines were identified with the letter P (Professional), followed by a number (1 to 21). The professional respondent, according to the program itself, should have a higher education level and have the best understanding/knowledge of the work of the team and the reality of the community, being a doctor, nurse or dentist, if there is oral health.

The interview contemplated issues related to the form of participation of the teams in the different phases of the PMAQ-AB, as well as changes occurred in the work process from the program accession. The interviews were recorded and transcribed, in full, for further analysis. The information derived from the transcripts was organized according to the thematic analysis technique proposed by Minayo[9], which consists of three stages: pre-analysis, material exploration and analysis and interpretation of the results. Based on exhaustive readings, the empirical material was organized into registration units, of which significant parts of the speeches were highlighted, giving rise to three categories: (1) Accession and contractualization: from ignorance to approach to the object; (2) The timing of external assessment and certification; and (3) The contribution of PMAQ-AB in the reorganization of the work process of the teams.

During the data collection, ethical aspects were respected, according to Resolution nº 466/2012, which deals with research with human beings. The research was approved by the Ethics Committee in Research of the State University of the West of Paraná (Unioeste), Opinion 1.567.494.

## Results and discussion

### Characterization of the subjects of the research

Of the 21 professionals who responded to the instrument denominated Module II of the external assessment process of the PMAQ-AB (77.8% of the total number of participating teams), all were women, nurses and coordinated the health team.

The feminization of health work and, especially, in nursing is recognized by authors such as Lopes and Leal[10] and Matos, Toassi and Oliveira[11]. In addition, nursing often appears as the coordinating role of the PC[12] team.

Cavalli, Rizzotto and Guimarães[13] also evidenced the predominance of nursing professionals as respondents of Module II of the PMAQ-AB at the national level in both cycles of the program, being 92.30% of nurses in the first and 93.43% in the second cycle.

Most of the interviewees (67%) were between the ages of 20 and 39 and more than

five years working at the same Family Health Unit (FHU) (81%). Length of stay in the same unit is a positive factor for the knowledge of the health reality of the community, as well as for the creation of links between professionals and users[14].

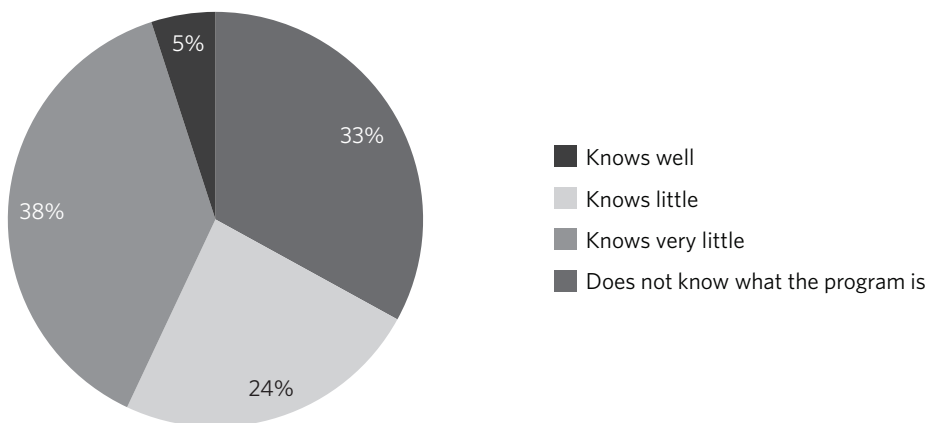
## Accession and contractualization: from ignorance to approach to the object

Accession and contractualization is the first phase of PMAQ-AB and should be done voluntarily by both health teams and municipal managers. It must be "on the assumption that its success [of the program] depends on the motivation and proactivity of the actors involved" [1(10)].

The formalization of the accession is done by the municipal manager through the completion of an electronic form, made available by the MS, and by the sending of an agreement signed by the manager and by one employee of each team that joins the program. In this term, there are targets to be met and actions to improve the results of agreed indicators. It involves, therefore, local agreement, by means of a contractual act, which clearly indicates what it is intended to achieve, based on the autonomy and responsibility of the parties involved[1].

In establishing a 'contract', it is essential to know its objectives, as well as the responsibilities of the signatories. Although the studied teams participated in two complete cycles of the program, a significant portion of respondents stated that the team knows little or very little (62%), or even nothing about the program (5%), as shown in the *graph 1*.

Graph 1. Knowledge of the team about PMAQ-AB. 10th Region of Health/PR, 2016




Source: Database of the researcher, 2016.

A document of the MS[1], which advises on the accession to PMAQ-AB, recommends to the municipal manager to agree with the workers the participation in the program and to discuss the term of commitment with the teams. However, what was observed in the present research were situations of accession made with little knowledge about the program:

> *When I started working in this municipality, in 2011, it was the first year that we had the PMAQ and a person from the administrative sector came to me and said: the Ministry is imposing a program, we do not know to explain to you what it is. You need to read this handout, answer these questions; then, you have to go to the computer: there will be some things for you to answer with a score. Just like that!* (P21).

The few dialogue between the management team and workers of the PC team constitutes an additional difficulty for the implementation of policies and programs in the health area. The distance from the process of discussion and formulation, and, in this case, accession to the policy, makes it difficult to understand its objectives, does not contribute to the co-responsibility of the results, consequently, reduces the possibility of a positive impact on what is proposed.

Dialogue with the aim of sharing governability exempts power and emphasizes political negotiation, valuing the opinion of the other and promoting openness to solidarity projects that can be assumed collectively as a commitment[15]. However, the lack of listening and uniqueness with the team and authoritarianism generate a sense of abandonment by the management, creating obstacles in the development of work and making it difficult to reach the established objectives[16].

The 'handout' to which the interviewee referred to (P21) was the instructional manual of the program and the self-assessment tool; this is considered as a starting point for the improvement of the quality of services, since it aims to internalize a culture of permanent monitoring and evaluation in the teams, through self-analysis, self-management and the establishment of intervention strategies for problem solving and improvement of the service offer. Self-assessment should act, therefore, as an inducing device for the reorganization of the work of the teams and municipal health management[17].

For self-assessment, is made available the instrument: Self-Assessment for Access and Quality Improvement in Primary Care (Amaq), which is based on the National Policy of Basic Attention (PNAB) and addresses the dimensions and sub-dimensions of the program. The Amaq allows the team, and each professional, to evaluate the degree of adequacy of their practices to the presented quality standards and to make local planning, through the construction of matrix and intervention plan, with multiprofessional, interdisciplinary and intersectoral actions, aiming to improve the organization and the quality of the services offered in the health unit[17].

In carrying out the self-assessment, the professional constructs a historical line of his actions, with the aim of proposing improvements and strategies that allow new approaches in his/her work environment, which provoke satisfaction. Through the self-assessment, the health professional has the opportunity to reflect on their performance, based on the health model in which he/she operates. According to Silva and Caldeira[18], health professionals, in general, present, in greater quantity, positive evaluations of their actions in relation to users, however, without questioning whether satisfaction is reciprocal.

The accession to the PMAQ-AB by the municipal administrations, to a great extent, was made due to the transfer of resources, which, in some cases, mobilized the PC teams:

> *For us came the email by the regional health; then, we came in, talked to the secretary about whether or not it would be convenient to join the*

*PMAQ, because it is an improvement program and it also comes with funds...* (P16).

In many situations, however, accession occurred without the participation of the team, who only became aware of the program during the external evaluation, that is, in its second phase:

*Who makes it is the administrative part of the Secretariat [...] actually we came to know about this PMAQ, when they came to do the evaluation.* (P13).

*It was the manager who said we would have a visit, but he didn't explain what it was, he did not explain anything, he just said that he had registered our unit in a program and he came, like that, out of the blue. We didn't know what it was, nothing!* (P10).

The non-sharing of information and the lack of dialogue between management instances and the tip of the system can generate a feeling of exclusion and non-belonging. Although decision making can be considered a management function, it is more effective when it integrates the different actors involved in the process of construction of the alternatives[19].

In the second cycle of the PMAQ-AB, different processes were observed, both by the fact that the teams had already completed a full cycle and a greater understanding of the managers about the program.

The changes from the 1st to the 2nd cycle, in relation to the accession and contractualization process, showed that the workers had already reached a greater understanding of the program, either through the experience of participation in the first cycle, or because of their own interest in knowing more about the proposal:

*[...] we got already interested, then, about knowing what the program was. We went after to know how our grade was or was not. We wanted to know what it was like, not the grade, right? But, our rating, how it was.* (P15).

*It was a little easier, because, then, I already knew where to research, and what we should do. After those intervention matrices we do, it was a little easier than the first time, that we didn't even know what we were doing right.* (P20).

The interest about the performance in the program and the willingness to improve are relevant characteristics to be highlighted, which indicate that the methodology has achieved greater involvement of the team. Seidl et al.[20] affirm that it is essential that the health worker participate in the moments of discussion and decision, to feel part of the construction process and, consequently, to take responsibility for it.

## The moment of external assessment and certification

External assessment and certification comprise the second phase of the PMAQ-AB, which involves, also, verifying self-assessment and analyzing the performance of contracted indicators. Although the program seeks to overcome the negative, historical burden that evaluation carries, it still assumes the character of punishment:

*The second cycle was more peaceful. Sometimes we were anxious when the evaluators came, because, like this, if we did not get a good grade, we were afraid of the management; sincerely, we are afraid of the management, we end up having this fear.* (P5).

However, knowing the process better contributed to reduce the anxiety of the group at the time of external evaluation:

*It was less tense, because, the first one we did not know how it would be assessed and even the manager did not have much notion of what would come. He commented that there would be*

> *a team to assess, with innumerable questions – and indeed, there are many items – and that we were not supposed to lie and omit, we were supposed to say what was being done. In the second one, I was more prepared, I organized the meeting minutes, everything to facilitate, because everything is very fast to present to those who come to do the assessment.* (P4).

In the proposed molds by the PMAQ-AB, the external evaluation is understood

> as a permanent strategy for decision making and central action to improve the quality of health actions, which is considered as a fundamental attribute to be reached in SUS[17(12)].

For these purposes, it involves direct observation, interviews and observation of records, which are often seconded in the team work process, although essential for planning at the local level.

The contracted indicators, at the moment of accession, represent 30% of the performance percentage of the team; self-assessment, 10%, and external evaluation, 60%. The indicators concern: a) the Access and continuity of care; b) the Coordination of care; c) the Resolution of the primary care team; and (d) the Coverage of service provision. Such indicators are evaluated based on information extracted from the health information system, the e-SUS[1].

Few interviewees (28.5%) demonstrated that they knew something about the indicators contracted by the team at the time of the accession:

> *Contractualization? Not that I remember. It was all, like that, as a shock: it was being done, it was happening. As far as I can remember there was no information in that sense, no.* (P14).

Those who remembered, did not know to inform what indicators were contractualized: *"There was agreement, yes, I cannot remember now, exactly what agreement it was. I cannot remember"* (P5); or cited indicators linked to other programs, which also have a transfer of resources, linked to the achievement of goals: *"The only thing that we have as goals is the coverage of preventive and vaccine"* (P10), but that are not computed in the PMAQ- AB.

> *What I remember was the issue of pregnant women: if I'm not mistaken, to follow 100%. There was the SISCAN, breast cancer and cervix, which at the time was also indicative. The children and I think there was one more, it was more or less like that, I cannot remember properly.* (P18).

Despite certain advances, in the phase of re-contractualization of the teams – regarding the indicators to be monitored during the development of the cycle –, ignorance was observed, an aspect that deserves greater attention from the management bodies of the SUS and the health team itself.

PC produces important data about the local reality, which are stored in free access information systems. They allow to obtain information on socioeconomic reality, indicate morbimortality, contribute to evaluate the efficiency of actions and monitor the health situation in a defined geographic area. This all favors the planning of health actions[21].

The monitoring of local health indicators contributes to the construction of the health profile of a certain area of coverage, as well as favors the evaluation of actions developed by the health service[22].

## The contribution of the PMAQ-AB to the reorganization of the work process of the teams

The work in PC is complex, requires knowledge from different areas of knowledge and is performed collectively, since no professional can perform his/her work without the collaboration of other professionals who make up the health team. In addition, because it is characterized as live work, consumed in the

act, it involves, also, users and community, since its main objective is to meet health needs and intervene in risk factors that can cause diseases and health problems[23,24].

One of the challenges for PC is the interaction of multiprofessional work for the quality and problem-solving of care[25]. However, for this, teamwork is necessary, in which participants can unite their knowledge and practices in search of the same goal[26].

For the accomplishment of the collective activity, of PC itself, registration of information is fundamental. In the present research, there was, by the interviewees, a recognition that the program encouraged them to register their activities, which facilitated the development of team work.

> *We see that it has improved a lot, we have advanced a lot in this aspect – like – of mainly improving the records. I saw the lack that it was, of having nothing recorded. In this we have improved a lot, of course there is still a lot left, because, as I say to the team: our goal is to reach 100% of this resource.* (P2).

> *Some things, we started registering: we end up doing it and did not put it anywhere and it was accounted for by PMAQ [...] we used to do it, but we had not the habit of registering, it ended up being lost.* (P6).

The registration of information generated by the health team, either by registration data, or through the actions carried out by the various workers, contributes to the improvement and quality of access to services, given the possibility of observing and visualizing the results of the work produced. This is for evaluating efficiency and for new behaviors. The action of registering the activities performed by the professionals is evidenced in a study developed by Neves Montenegro and Bittencourt[27], which describes the conditions of production and registration of the information generated in the health units. For them, the information aims:

> [...] to diagnose the individual and collective health situations of a population, guiding the actions of professionals and local systems, with a view to becoming more effective, minimizing inequalities. In addition, adequate appropriation of this information is extremely important so that the management, allocation and expenditure of public resources at all levels of attention of the health system in the Country are done with reliable parameters[27(757)].

Some interviewees also stated that PMAQ-AB was an important guide to help and organize the work to be carried out by the health team:

> *The PMAQ came to give us a better direction, for us to organize better.* (P5).

> *[...] the PMAQ kind of directs us, helps the planning itself and to develop the activities of the strategy. It came as a manual to me [...] my instrument of work, which guides me, for me, it was very good that it came.* (P1).

They are indicative that the program has contributed to health planning and evaluation in health at the local level as teams use the tools available to organize and manage their work process.

The monitoring of indicators of the PC was also highlighted as a positive aspect of PMAQ-AB:

> *I have created, a kind of a habit after the PMAQ evaluation. We have managed to get into the habit of being aware of these issues: the amount of preventive I have to collect here in the unit, my particular goal is to exceed 300/year.* (P4).

The various phases of the program collaborate to organize the work of the teams. Although it does not present great innovation, the conduct contemplates the main attributions of the work in the PC and causes the group to better plan its actions,

starting from a process that begins with the self-assessment.

> *Some indicators that we did not pay attention too much in running after, at that time we stopped and saw how low they were. This served us to demand a little more of the CHA, for them to run after too, to be improving.* (P11).

Health indicators are important mechanisms in processes of monitoring and evaluation. For this purpose, the information systems that catalog the health data generated in the city, state and Country are used. The data are analyzed and serve to follow the care technology used by the teams and how they organize themselves in their work process[28,29].

Certain components of the work process in the PC were retaken and/or valued from the accession to PMAQ-AB:

> *It drew attention to what we should look, right? And the management too, that it's important for us to know this and plan the actions; some things, which were not given much attention, came to be valued.* (P15).

Administrative activities (and their development), such as planning and team meetings, are essential for the improvement of work and are tools that help organize the service and value the actions developed[15].

Another aspect emphasized by some interviewees was the transfer of part of the resources of the program, such as the financial incentive to health professionals, which proved to be a motivating agent:

> *Now the team knows about that incentive, so, they are willing to improve, let's work for it.* (P10).

> *When it stirs with your pocket, there is a greater concern about reaching the goal, improving service, achieving goals, even if that should happen without recourse. That moves people, makes people participate more.* (P17).

Financing for PC, which comes from PMAQ-AB, allows the inclusion of recognition mechanisms and transfer of resources to workers, in the form of incentive for performance, through municipal law. It can be understood as a reward system that aims to retain, motivate and attract potential workers.

Barreto[30] demonstrated that reward systems encourage the achievement of goals within the health systems,

> especially in short-term changes and on-time actions that require less effort from health service providers, but should be used with caution and rigorous planning[30(1510)].

The search for workers who stand out in the market for their capacity and ability to produce more and more and in less time increases; and, with that, institutions create rewards systems as strategies to attract them[31]. These systems have, as their main objective, to link the interests of consumers and those of the institution, rewarding employees for actions that benefit both parties[32]. These mechanisms also occur in public institutions, not to make profits on productivity, but to minimize costs with the services offered.

In this research, it was possible to identify that professionals who receive salary increases, resulting from PMAQ-AB resources, recognize this incentive in a special way and feel valued, which results in more motivated workers.

## Final considerations

Although PMAQ-AB is a relatively recent program, positive results have been observed, with the adoption of practices that can improve the quality of services in PC, such as, for example, the registration of the activities performed and the organization of the documentation to be presented in the external assessment. Such records can contribute to the reflection and analysis of the

team about their work process as well as local planning.

The interest in broadening the knowledge about the program, especially from external assessment, is a positive factor for the understanding and implementation of public policy. However, although PMAQ-AB predicts the involvement of the team from the moment of joining the program, this has not been carried out to the satisfaction, since the discussion and decision still remain very centralized by the municipal management.

In the implementation of the policy, external assessment proved to be an important strategy for mobilizing the health team and management to meet the standards foreseen in the program. However, it still has a negative charge, associated with punishment, and is not seen as part of a continuous, evolutionary and formative cycle.

Another aspect that drew attention was the valorization of professionals, through the mechanism of financial incentive for performance, whose effects deserve more empirical studies, since they can generate competitions instead of solidarity among the workers and, even, substitute a policy of valorization of all the workers of the municipality.

## Collaborators

Bertusso FR. Developed all the steps of this study, for the elaboration of the dissertation of conclusion of the Master's degree.

Rizzotto MLF. Adviser of the master's dissertation, participating in the correction, elaboration and contribution in all stages of the study. ■

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