Permanent Health Education and National Program for Improving Access and Quality of Primary Care: a cross-sectional and descriptive study

Educação Permanente em Saúde e o Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica: um estudo transversal e descritivo

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DOI: 10.1590/0103-1104202012403

ABSTRACT The Permanent Health Education, contemplated by the Ministry of Health as an institutional policy, is one of the pillars of strategic potential for the transformation of the processes in the Unified Health System. This cross-sectional and descriptive study investigated the Brazilian panorama of Permanent Health Education, from secondary data of the Ministry of Health, extracted from the external evaluation census of the National Program for Improving Access and Quality of Primary Care in the 2nd Cycle (2013), carried out with Family Health Teams, with adherence to the Program in the period (n=10.213/100%); 90% (n=9.184) of the teams responded to participate in Permanent Health Education activities, with greater frequency in the Southeast, Northeast and South regions; the main Permanent Health Education activities reported were seminars, shows, workshops and discussion groups (n=8.243/80.71%) in addition to presential courses (n=7.808/76.45%). Of the options offered by the Ministry of Health, the least frequent was the Telemedicine University Network (n=475/4.65%); 87.62% (8.948). Family Health Teams had their Permanent Health Education demands met by management. The instrument presents data robustness and contemplates several aspects of management, including important elements of Permanent Health Education that can guide decision making and interfere with their own policies and programs in the services.

KEYWORDS Unified Health System. Continuing education. Health evaluation.

RESUMO *A Educação Permanente em Saúde, contemplada pelo Ministério da Saúde como política institucional, constitui um dos pilares de estratégico potencial de transformação dos processos no Sistema Único de Saúde. Este estudo transversal e descritivo obteve um painel brasileiro da Educação Permanente em Saúde, a partir de dados secundários do Ministério da Saúde, extraídos do censo de avaliação externa do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica no 2º Ciclo (2013), realizado com Equipes de Saúde da Família com adesão ao Programa no período (n=10.213/100%); 90% (n=9.184) das equipes afirmaram participar de atividades de Educação Permanente em Saúde, com maiores frequências das regiões Sudeste, Nordeste e Sul. As principais atividades de Educação Permanente em Saúde relatadas foram seminários, mostras, oficinas e grupos de discussão (n=8.243/80,71%), além de cursos presenciais (n=7.808/76,45%). Das opções ofertadas pelo Ministério da Saúde, a menos frequente foi a Rede Universitária de Telemedicina (n=475/4,65%); 87,62% (8.948) Equipes de Saúde da Família tiveram suas demandas de Educação Permanente em Saúde atendidas pela gestão. O instrumento apresenta robustez de dados e contempla diversos aspectos da gestão, incluindo elementos importantes de Educação Permanente em Saúde que podem nortear a tomada de decisão e interferir em políticas e programas próprios nos serviços.*

PALAVRAS-CHAVE *Sistema Único de Saúde. Educação continuada. Avaliação em saúde.*

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Introduction

Permanent Health Education (PHE) is defined by the Pan American Health Organization (Paho) as a dynamic teaching and learning process, active and continuous, with the purpose of analyzing and improving the training of people and groups, in the face of technological evolution, social needs and institutional objectives and goals. The expansion of the Brazilian health system, which began in the 1970s, and the consequent need to develop human resources for the sector led to the emergence of several training programs, which sought to build political-pedagogical models committed to promoting the dialogue between education and health service training[1].

In this sense, the Unified Health System (SUS), in a more specific context of Primary Care (PC), due to its size and scope, is present in the arena of training processes in the health sector as a privileged place for teaching and learning, especially where health care is provided. Educating 'through' and 'for' work include the assumption of PHE: where there is production of care aimed at integration, shared responsibility and problem solving, there is simultaneously the scenario of pedagogical production, because this is where the meetings between workers and users are concentrated[2-4].

According to Ceccim[5(161)]:

> The identification Permanent Education in Health has been carrying, then, the pedagogical definition for the educational process that puts the daily work – or training – in health under analysis, which is permeated by the concrete relationships that operate realities and that makes it possible to build collective spaces for reflection and assessment of the meaning of the acts produced in daily life. Permanent Health Education, at the same time as it disputes for the daily update of practices, according to the most recent theoretical, methodological, scientific and technological contributions available, is part of a necessary construction of relationships and processes, ranging from the interior of the teams in joint operation – involving their agents –, to organizational practices – involving the institution and/or the health sector –, and to interinstitutional and/or intersectoral practices –, involving policies in which health acts are included.

Thus, the dispute in the political scene of governmental spheres for ascending educational proposals, which induce changes in health services and that take into account the micropolitics of local contexts, is evident. The complexity of health work and the excess of attributions of the various professionals of PC cannot be learned through specific training[6].

Permanent Education (PE) promotes and produces meanings (hence, the incorporation of the concepts of meaningful learning and problematization): one gives new meaning to the daily routine of training in health; the other understands that learning occurs in the action-reflection-action process, characterized by the commitment and self-involvement of the actors involved[7].

In addition, it aims to value work and workers, the participation of professionals in the teaching-learning process and in the transformations understood in the world of work[8].

It constitutes an indispensable and necessary strategy for the transformation of the reality of PC, in the reinvention of work and consequent change in practices[9]. Therefore, it is necessary to adopt instruments that allow the on-site evaluation of the instituted devices, participation and PHE demands, in order to provide subsidies for decision-making processes, financing and policy formulation supported by SUS principles and guidelines.

PHE contributes to the improvement of professional training and favors the strengthening of SUS, as well as it ensures the development of health workers and institutions, qualifying the management of systems and services[10].

The National Program for Improving Access and Quality of Primary Care (PMAQ-AB) was created on July 19, 2011, through Ordinance nº 1.654 Office of the Minister/Ministry of Health (MH), as a result of a negotiation process and agreement of the three SUS spheres, in debates that formulated solutions for the creation of a program that would allow the expansion of access and the improvement of the quality of PC throughout the Country[11].

In view of the numerous challenges posed by reality, the PMAQ-AB proposes as a model for assessing the performance of health systems the induction of several initiatives to guarantee a quality standard at national, regional and local levels. Among its specific objectives, the following stand out:

> IV – Promote quality and innovation in PC management, strengthening the processes of self-assessment, monitoring and evaluation, institutional support and 'permanent education in the three spheres of government'[11(8)].

The PMAQ-AB is an advance of the MH, which seeks to establish the evaluation culture in the Country and needs qualification and articulation, with planning and formulation of policies in line with the decision-making processes of the actors involved[12].

It consists of three phases, in a continuous cycle of improvement of access and quality of the teams: Phase 1: Adhesion and contractualization; Phase 2: Certification (which includes the external evaluation); and Phase 3: Re-contractualization. In addition to these, it comprises a set of actions developed throughout the cycle, called the Transversal Strategic Axis for Development, composed of five pillars: self-assessment; institutional support; monitoring of health indicators; PE and horizontal cooperation[13].

The program is permeated by the logic of PHE in all its phases, from the adhesion of the teams to the re-contractualization. There is a privileged space for collective production of initiatives for work, and the possibility of articulated development of the various actors of PC with a view to expanding the problem solving and access in the territory. Here, the dialectical relationship (education and work) is evidenced by meaningful learning and permeability to the reality of the territory where the teams act to promote changes and not only to achieve goals and indicators.

The assessment and practice of PHE begin to follow the same path, since the agreement of the indicators will require the reinvention and reformulation of the work processes and operation of the service:

> This is the time for the teams to be evaluated by the PMAQ-AB to demand, propose and develop permanent education actions combined with the needs and offers according to the moment and the context of these teams, assigning greater meaning, value and effectiveness. [...]. This ability to rethink and reflect on the daily work in Primary Care is the prelude to PHE happening in the first phase of PMAQ-AB[14(135)].

In addition to the above, the data obtained in the external evaluation census with the Primary Care Teams (eAB) in the certification phase can provide important inputs for managers, researchers and policy makers at the local, regional and national level.

Objectives

Obtain a Brazilian panel of participation, devices and meeting the demands of PHE of the Family Health Teams (EqSF) in PC, based on the analysis of secondary data from the Ministry of Health, extracted from the PMAQ-AB external evaluation census in the 2nd Cycle (2013).

Material and methods

It is a cross-sectional descriptive study, with the analysis of secondary data obtained in the

2nd cycle of the PMAQ-AB. The responses obtained in the external evaluation census of the EqSF in the 2nd Cycle (2013) were evaluated using the variables of the external evaluation instrument related to PHE in module II – Interview with the health professional in the health unit, as shown in *chart 1* The selected variables were collected by researchers/professors from universities/teaching and research institutes in the external evaluation stage (module II – Interview with the eAB professional) in Cycle 2 of the PMAQ-AB. The following inclusion criteria are used: EqSF with adherence to PMAQ-AB and participation in the external evaluation census of the Ministry of Health (n=10.213/100%). Teams (364/3.44%) were excluded due to the fact that they did not receive censors from the Ministry of Health at the time of the assessment. The data, freely accessible and available at http://aps.saude.gov.br/ape/pmaq/ciclo2/ were treated according to the simple frequency and the percentage of distribution of the variables. Filters and dynamic tables in Microsoft Excel® were used, crossing the data obtained from the selected variables. The research was approved by the Research Ethics Committee, under the consolidated opinion no 2.943.879, of October 5, 2018.

Chart 1. Variables of the PMAQ-AB external evaluation instrument selected in the study

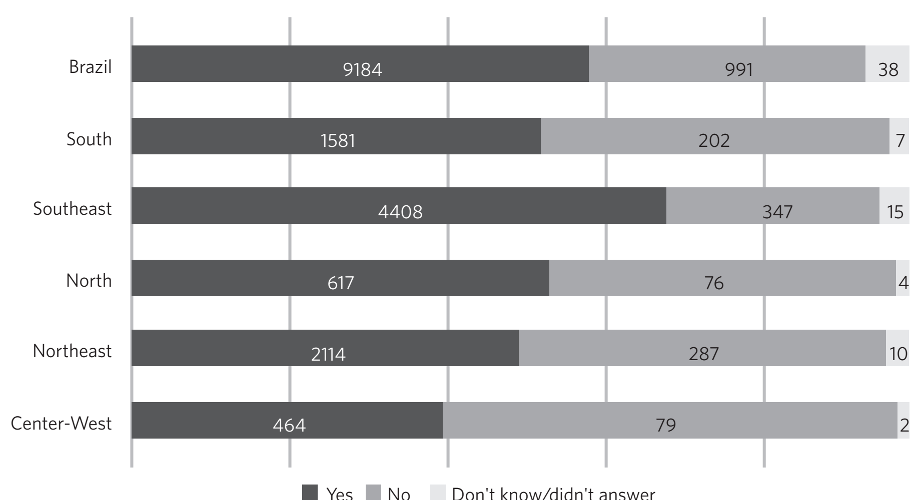
Variable	Question	Possible answers
ES-II.7.1	Does the team participate in permanent education actions organized by the municipal management?	Yes
		No
		Don't know/didn't answer
G-II.7.2	Which action(s) does(do) the team participate in?	Seminars, exhibitions, workshops, discussion groups
		On-site courses
		Telehealth
		Telemedicine University Network (Rute)
		Open University of SUS (Unasus)
		Distance learning course
		Exchange of experience
		Tutoring/mentoring
		The basic unit as a teaching-learning training space for undergraduate, specialization and resident students, among others
		Other
		Does not participate in any permanent education action
G-II.7.10	Do these permanent education actions address the demands and needs of the team?	It contemplates a lot
		It contemplates
		It reasonably contemplates
		It contemplates little
		It does not contemplate

Source: Own elaboration based on the external evaluation instrument for Primary Care teams.

Results

Secondary data collected in the 2nd cycle of the PMAQ-AB were used in the external evaluation phase, in 2013. The data were collected by researchers linked to universities belonging to the PMAQ-AB research network. In this study, EqSF were considered, with a sample of n=10.213. In the first selected question (ES-II.7.1), if the team participates in PE actions organized by the municipal management, the following national panorama was obtained:

Graph 1. Does the team participate in Permanent Education actions organized by municipal management?



Source: Own elaboration.

In this census, 90% of the teams (n=9.184) interviewed answered affirmatively about participation in PE activities. About 10% (n=991) answered that they did not participate in PE actions and 38 (0.37%) teams did not know or did not respond.

Analyzing the data by region, it can be observed that the Southeast (n=3.949/43% of the interviewed EqSF), the Northeast (n=2.112/23% of the sample) and the South (n=1.561/17% of the total) were the ones that most answered in the affirmative about participation in PE actions. The number of EqSF in these regions with adherence to the PMAQ-AB is higher than in the other interviewed during the collection period.

The teams that responded negatively to the PE actions were (n=991/9.7%), and the frequency was repeated.

The second selected question (G-II.7.2) sought to identify which PE actions the EqSF participated in. According to the data collected, in summary, in *table 1*, it can be concluded that, in the Brazilian panorama, participation in PE actions, from EqSF, has been materialized mainly through seminars, exhibitions, workshops and discussion groups (n=8.243/80.71%), in addition to on-site courses (n=7808/76.45%). Of the options offered by the Ministry of Health, the least

frequent was the Telemedicine University Network (Rute) (n=475/1.32%). Some teams reported not participating in any PE action (n=577/1.61%). In the Southeast region, which covered most of the sample, it was also observed that many teams responded using resources such as exchange of experience (3,033 / 16.42%), distance education courses (2,310 / 12.5%), Telehealth (1.754/9.49%) and SUS Open University (Unasus) (1.261/6.83%) as PHE resources.

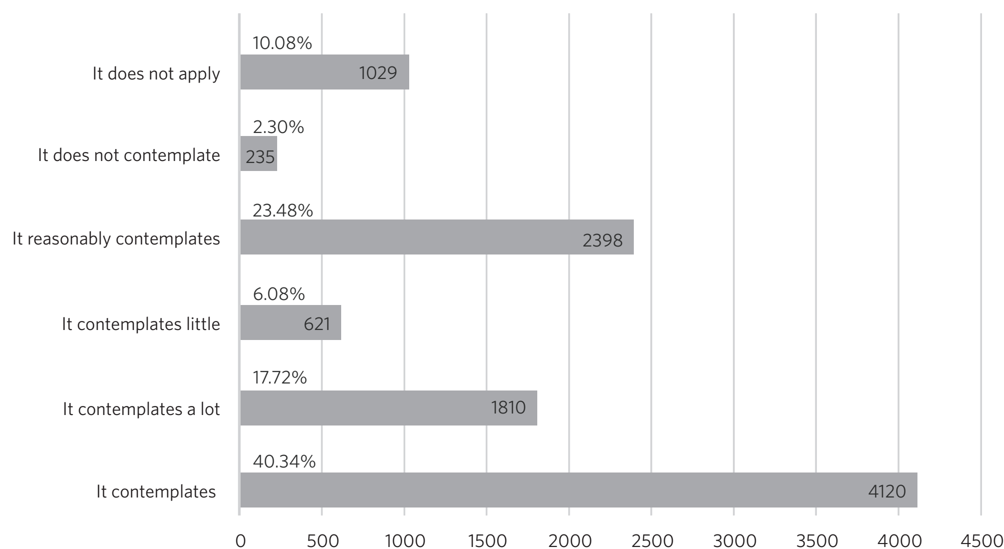
Table 1. Permanent Health Education actions by region and national

Question G-II.7.2 (PE actions promoted by management)	Center-West	Northeast	North	Southeast	South	Brazil
Seminars, exhibitions, workshops, discussion groups	405	1894	571	3867	1506	8243
On-site courses	395	1684	429	3879	1421	7808
Exchange of experience	216	1224	272	3033	1077	5822
Distance learning course	86	461	94	2310	633	3584
Telehealth	108	582	87	1754	831	3362
Open University of SUS (Unasus)	33	288	41	1261	485	2108
Tutoring/mentoring	49	385	100	1182	353	2069
The basic unit as a teaching-learning training space with students	60	220	72	385	195	932
Other	60	220	72	385	195	932
Does not participate in any permanent education action	50	197	60	182	88	577
Telemedicine University Network (Rute)	24	57	21	237	136	475

Source: Own elaboration.

The third question (G-II.7.10) sought to investigate whether the demands and needs of PE of the EqSF were addressed, that is, whether the offers of training actions offered by the management considered the real need of the PC workers. In general, it can be said that the training needs of most workers were met by management.

Graph 2: Do permanent education actions address the demands and needs of the team?



Source: Own elaboration.

Discussion

The PMAQ-AB appears in line with the rights hard won in the Health Reform movements and with the enormous significance of SUS and, in particular, of PC, which is the care provider and coordinator of health care networks: a huge three-dimensional human map in transformation, which is defined as a key concept for the materialization of PHE in work processes, practices, in the production of new knowledge and in the role of all actors involved in the health system (workers, managers and users).

The data described here reveal a national and regional panorama of the PE offers, of the participation of EqSF in these activities and of the opinion of these teams on the contemplation of their training needs. An evaluation of this 2nd Cycle reveals that 90% of the teams claimed to participate in some PE activity, which demonstrates an expansion, when compared to the data treated by MH researchers in 2012[15].

Likewise, the adhesion and participation of the teams in the Southeast, Northeast and South regions in PE activities promoted by the management proved to be greater than in the others surveyed. It is important to note that the allocation of financial resources released by the Ministry of Health (or National Health Fund) to EqSF is the responsibility of the municipal management, which decides where the financial incentives will be allocated.

Another factor that should be considered is the discontinuity in the development of improvements in work processes, which occurred with numerous substitutions for managers and health workers, promoting disruptions in the service's qualification actions[16]. Some studies demonstrate the need for better structuring of management actions with a view to implementing changes in municipal and state programs of PE[17-19].

The PMAQ-AB also seeks to integrate the PHE activity offerings and support the intra-team qualification processes through

changes occurred in the program. The treated data show that the participation of EqSF in PE actions occurs mainly through seminars, exhibitions, workshops and discussion groups (n=8.243/80.71%). The role of health workers in training and educational actions is evidenced through the light and light-hard technologies[20] used in the daily work of PC. Team meetings, the construction of therapeutic projects, educational groups, inter-consultations, workshops and matrix support, among other resources, denote the exchange of knowledge and the dynamics of enormous wealth for the production of care and knowledge within the scope of SUS.

In the current political situation, the countless difficulties faced in a context of historical underfunding of the system, ruptures and discontinuities of some programs and a wave of setbacks promoted by the abysmal freeze on health spending and fiscal austerity must be considered. In addition[21], other factors, such as the option of some managers who favor production (goals) to the detriment of the inclusion of health professionals in training and PE initiatives, and the precarious infrastructure (space, computers, internet and mobile devices) impose on teams the creation of contingent strategies to reinvent work and reality itself. Thus, in a complex and multifaceted reality, the need for greater investments and qualification of PC workers is recognized.

The offer of on-site courses was the second most frequent answer (n=7.808/21.74%), demonstrating that the hegemonic training practice[22] (of punctual, transmissive and transitory training) has not yet been broken and that, given its complexity, PE needs to be deepened, as well as an understanding of its meaning for health managers and workers.

Some teams reported that they did not participate in any PE action (n=577/1.61%), which revealed a worrying data in several aspects, which need more clarity: they may come from a lack of understanding about the meaning of PHE, from absence of offers for management, work overload and/or lack of interest from workers/managers, which requires an approximation with the reality of these teams.

The third question sought to investigate whether the demands and needs of PE of the EqSF were addressed, that is, whether the offers of training actions offered by management considered the needs of PC workers. The active participation and protagonism of PC workers in decision-making processes is an assumption of PHE and the data collected showed that most teams (n=8.949/87.62%) answered that their needs were met by management.

Rizzotto et al.[18], analyzing data on work management and PHE in the state of Paraná, reveal that, although 80.4% of the interviewees affirm that there are PE actions, only 58.1% of the workers stated that the actions met the team demands, revealing a contradiction with the PE's assumption, which must arise with the full demand and participation of workers. Comparing the statement of the authors with the data of the 2nd Cycle in that state, there is an evolution in the relationship between the demands of workers and management, since 85% (n=535) of the teams claimed to participate in PHE actions and only 2.99% (n=16) teams did not have their training needs addressed.

In Mato Grosso do Sul, a study[23] on PHE actions demonstrated a privileged position of the capital over hinterland municipalities and found the need to address the problems inherent in PHE policy. After evaluating the responses of the participating teams, it cannot be said if there were significant changes in the processes during the period, since the sample evaluated in the study does not have EqSF (n=27) adhering to the PMAQ-AB in the capital.

Despite the amount of data on PE collected in a pioneering and innovative evaluation process[24,25], the instrument used to establish management policies and decision-making processes demonstrates a modest appropriation of the meaning of PE, which should be the subject of new studies with qualitative

methodological approach in the municipalities where the program is adhered to. Several works converge to the relevance of investments that strengthen participation and commitment in an articulated way with the interests and needs of SUS workers[15-19].

Final considerations

Through the selected variables of the external evaluation instrument, it was possible to identify that the Program investigated the training processes in a macropolitical way when considering the great Brazilian geopolitical regions, and in a micropolitical way when it looked at the intra-team locus in Basic Health Units. In general, a PHE panel was obtained, in which almost all the teams adhering to the PMAQ-AB claimed to participate in PE actions, with their training needs addressed by the management. The instrument presents robust data and includes several aspects of management, including important elements of PHE that can guide decision making and interfere in PHE policies and programs in services. Given the privileged position of PE, particularly in SUS, greater investments in educational research are recommended, considering other variables not included due to the limits and applicability of the instrument.

Collaborators

Oliveira IV (0000-0002-2726-1281)* contributed to the conception, planning, analysis and interpretation of data and writing of the manuscript. Santos JMM (0000-0001-5454-5792)* contributed to the final review of the article. Almeida FCS (0000-0003-3745-2759)* and Oliveira RN (0000-0003-0990-4834)* contributed significantly to the preparation of the draft, critical and final review of the manuscript content. ■

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Received on 04/29/2019
Approved on 09/13/2019
Conflict of interests: non-existent
Financial support: non-existent