

# Implementation of the Improved Access and Quality Program according to Primary Care managers in São Paulo

Implementação do Programa de Melhoria do Acesso e Qualidade segundo gestores da Atenção Básica de São Paulo

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Quality management; Public health policy; Health evaluation; Program evaluation; Education, continuing

## Descritores

Gestão da qualidade; Políticas públicas de saúde; Avaliação em saúde; Avaliação de programas e projetos de saúde; Educação continuada

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## Abstract

**Objective:** To analyze the implementation of the National Improved Access and Quality Program according to Primary Health Care managers. **Methods:** The thematic oral history was used, through semistructured interviews with five managers from Primary Health Care Services who participated actively in the two cycles of the Program in an administrative district of São Paulo City. The subjects answered the question "How do you assess the implementation process of the National Improved Access and Quality Program at this Primary Health Care Service?", among others. The analysis of the testimonies revealed the categories "The managers' perception of the implementation of the National Improved Access and Quality Program" and "Changes in the work processes since the implementation of the National Improved Access and Quality Program".

**Results:** The managers acknowledged the Program as a well-structured proposal, which permits a broader management view on the health services. The interviewees evidenced the use of the quality indicators, which was hardly addressed and understood in the managers and teams' daily reality though. The interviewees demonstrated that they do not understand the concepts of continuing education and institutional support. The external evaluation phase was considered subjective and without standardization, producing data that did not contribute to the assessment of the changes the teams made.

**Conclusion:** The systematic incorporation process of the assessment culture to support the continuing quality improvement in Primary Health Care is incipient. Despite the continuing distance between the proposals of Primary Health Care and the practice at the Primary Health Care services studied, the Program favored the organization of the work processes and contributed to the managers' focus on the teams' practice and their own activities.

## Resumo

**Objetivo:** Analisar a implementação do Programa Nacional de Melhoria do Acesso e da Qualidade segundo gerentes de Unidades Básicas de Saúde.

**Métodos:** Utilizou-se a história oral temática, por meio de entrevistas semiestruturadas com cinco gerentes de Unidades Básicas de Saúde que participaram ativamente dos dois ciclos do Programa em um distrito administrativo do município de São Paulo. Os sujeitos responderam, dentre outras, à questão "Como você avalia o processo de implementação do Programa Nacional de Melhoria do Acesso e da Qualidade nesta Unidade Básica de Saúde?" e da análise dos depoimentos emergiram as categorias "Percepção dos gestores quanto à implementação do Programa Nacional de Melhoria do Acesso e da Qualidade" e "Mudanças nos processos de trabalho a partir da implementação do Programa Nacional de Melhoria do Acesso e da Qualidade".

**Resultados:** Os gerentes reconheceram o Programa como uma proposta bem estruturada, que permite ampliar a visão gerencial nos serviços de saúde. O uso dos indicadores de qualidade foi evidenciado pelos entrevistados, mas pouco trabalhado e compreendido no cotidiano dos gestores e equipes. Os entrevistados demonstraram não compreender os conceitos de educação permanente e apoio institucional. A fase da avaliação externa foi considerada subjetiva e sem padronização, gerando dados que não contribuíram para avaliação das mudanças realizadas pelas equipes.

**Conclusão:** Evidenciou-se um processo incipiente de incorporação da cultura avaliativa de forma sistematizada e como subsídio para a melhoria contínua da qualidade na Atenção Básica. Embora ainda haja distância entre as propostas do Programa Nacional de Melhoria do Acesso e da Qualidade e a prática nas Unidades Básicas de Saúde estudadas, o Programa favoreceu a organização dos processos de trabalho e contribuiu para direcionar o olhar dos gestores à prática das equipes e à própria atuação.



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Conflicts of interest: none to declare.

## Introduction

The Unified Health System (SUS) proposes Primary Health Care (PHC) as the preferred entry door to the public health system in Brazil. PHC is a set of health actions based on scientific principles, which involves the prevention of problems, promotion, diagnosis, treatment and rehabilitation, aiming to respond to the users' expectations. Through the Primary Health Care Services (UBS), PHC is organized and sets guidelines, such as having a territory and population, which permits the planning of health actions focused on the local reality, universal and continuing access to the services, coordination of the integrality between program actions and spontaneous demand, management, multiprofessional work, users' increased autonomy and participation, among other advances.<sup>(1)</sup>

In that context, assessing the outcomes and quality of the services offered is essential, as it supports the managers' decision making, the improvements of the system and the response to the population's needs. Nevertheless, the complexity of assessments and improvements comes with the dimensions and challenges of the SUS.

Assessment is an important decision support tool in public health, which is permeated by intrinsic values, factors that determine health and disease and political processes strongly rooted in this system. Its operation is complex, requires time to be implemented and well-defined tools that are suitable in the service reality. Different quality improvement initiatives in PHC have been abandoned, such as the Coordination Group of the SUS Performance Assessment in 2004 and, in 2005, the National Primary Care Monitoring and Assessment Policy, the Monitoring and Assessment Department of the Participatory Management Secretary and the Quality Improvement Assessment in the Family Health Strategy. Promising a structured program with more objective criteria, the National Improved Access and Quality Program (PMAQ) was launched and is organized in three phase - (1) Adhesion and Contracting; (2) Certification; (3) Recontracting - and a cross-sectional strategic development axis, which make up a continuing cycle to improve the access and quality of PHC.<sup>(2)</sup>

The start of the PMAQ in 2012 resulted from the updating of the National Primary Care Policy (PNAB), which established the use of a quality component, produced by the Program, to define the fund transfer modality. The PMAQ assesses PHC actions at the three government levels and intends to measure the possible effects of the health policies to support decision making in the services, guarantee the transparency of the SUS management processes and grant visibility to the results achieved. It is also intended to strengthen the social control and focus on the users and to monitor and assess processes through the development of parameters and indicators, which are applicable in the national context and are useful to guide the government actions. The PMAQ proposes a new health care culture, valuing the local management and social control to qualify the health system. The Program covers different scenarios and allows the professionals to problematize, set their priorities in accordance with the local reality and promote improvement actions.<sup>(2)</sup>

Scientific production on the PMAQ is still incipient. Its implementation should be investigated and knowledge is needed to support systemized assessment and continuing quality improvement processes in PHC. Thus, the objective in this study was to analyze the implementation of the PMAQ according to UBS managers.

## Methods

The thematic oral history was used, which allows the interviewee to provide a more restricted story, focused on a theme, in this case the development process of the PMAQ according to UBS managers. We departed from the premise that people's lives are marked by the historical experience. Therefore, the act of listening to their stories creative and cooperatively reveals profound human experiences. Without the effective participation of the people who participated in this study, unveiling the object under analysis would not be possible, as they objectified their experience in the narratives.<sup>(3)</sup>

This study was developed in the city of São Paulo, in an administrative district that consists of 15 UBS, characterized by a high coverage by the Family

Health Strategy. The implementation history of the PMAQ was marked by shared management, social control and the unit managers' active participation. In the city, the manager holds a superior education degree and works exclusively in the service management. The managers were interviewed who participated in the two cycles of the Program, in 2011 and 2013, totaling five subjects. These professionals' average age was 37 years and 80% were female. The average time since graduation was 13 years. The average experience in PHC was nine years, against six years in management. Eighty percent were nurses. Each manager was responsible for one service and, on average, for four family health teams.

The data were collected between April and June 2016 through semistructured interviews, held in private rooms at each participant's workplace. The questions in the interview script were: "How do you assess the PMAQ process at this UBS?"; "How do you assess the external evaluation?"; "How did you participate in the phases of the PMAQ?"; "Did the PMAQ influence yours and the team's work process?"; and "How do you see the institutional support and continuing education in the PMAQ?". The interviews took approximately one hour and were audio recorded and transcribed by the researchers. The analysis steps were: (1) sorting of the interview data; (2) classification of the data obtained in the (empirical and theoretical) texts, relating the analytical (theoretical) and empirical categories; (3) resorting of the interviews, adopting the resource used in the relational analysis; (4) relational critical analysis between the empirical data from the interviews and the selected analytic categories.<sup>(3)</sup> From this analysis process, the following categories emerged: "The managers' perception of the implementation of the PMAQ" and "Changes in the work processes after the implementation of the PMAQ".

The ethical procedures inherent in scientific research in health and strict compliance with the usage conditions of the techniques and their fitness for the problem were present in all phases of this study. The research project was submitted to the Research Ethics Committee of the Municipal Health Department and *Universidade Federal de São Paulo*, under CAEE 52535316.0.0000.5505.

## Results

### Managers' perception of the implementation of the PMAQ

The managers presented diverging opinions on the self-assessment process. While some highlighted the difficulty to achieve a consensus score in the team, others appointed this phase as a moment to reflect on the work performed.

*"[...] we think about it here [...] I don't know either if this self-assessment process is good because you fill out whatever you want. Therefore, I insist on doing this together, but I can't also, if it's a self-assessment and they say ten and I as a manager say: 'No, it's not ten, it's five.'" (G1)*

*"But the different view we have by answering the self-assessment makes it easier, you see things that go by unnoticed in daily work." (G5)*

When they considered the external assessment, the managers unanimously affirmed that this requires reviews. According to the interviewees, the criteria and evaluation modalities differed among the evaluators and among the Program cycles.

*"I think the external assessment was mechanical. Professionals who were trained to complete a questionnaire, many of them did not know any strategic logic and then it was a 'there is there isn't' according to their own interpretation, because we know that, at some services, some things went by while at others they didn't... so it was very subjective, nothing concrete." (G1)*

The disclosure of the results was also discussed in the testimonies. The professionals affirmed that the scores are forwarded to the manager and that no action whatsoever is taken in response.

*"We only received the end result. I think there was much more discussion in the process, before the assessment, because after the external assessments we had few discussions. We kept on discussing the PMAQ itself, the process, but not based on the end result." (G5)*

What the use of the indicators is concerned, according to the interviewees, the team does not understand the meaning of the data.

*“I am sure that they [team members] do not stop to analyze [the indicators] during the year. That did not become part of their routine, it only comes up when the external assessment is expected, then they need to organize things and look.” (G2)*

The interviewees also emphasized the lack of discussions among the team, managers and supervision about the indicators obtained and the supervision's lack of knowledge about target levels of indicators.

When asked about the institutional support, all interviewees treated it as a synonym of continuing education.

*“As for the institutional support and space for discussion, I think that needs further investments. At first it was frequently discussed and afterwards I think that influences the teams. There is no way the discussions there were [in the first cycle] are not going to happen.” (G5)*

### **Changes in the work processes after the implementations of the PMAQ**

The managers unanimously agreed that the Program contributed to improve the work process and guide the activity organization and information recording. Three out of five interviewees referred to the PMAQ as a practice guide.

*“And I think the PMAQ should not be punitive, but a matter of organization really, it should actually be understood as organizing.” (G2)*

*“It cannot be seen as a monster [PMAQ] or an impediment for something, but to direct, guide an action.” (G4)*

*“I think like: the PMAQ, I see it like, as a guide, the ideal, what we need to have and implement in a health service.” (G1)*

All interviewees affirmed that, in the first cycle, the team considered the PMAQ as a cause of a heavier workload. Some managers perceived the change in this view throughout the process and others identified the lack of inclusion of the Program fundamentals in the work teams' conception.

*“When it [the Program] came, they [the team] thought it would be more work, something more for us to do. But after we worked on their perspective they noticed that it was what they were already doing, all*

*you need is to organize what they already do. Today it's easy and part of the routine.” (G2)*

*“Some teams still say ‘There she comes with the PMAQ!’, as if it were yet another part of the work to be done, something more than what we already do. I actually think that, in the PMAQ's current form, the standards are things that take time, so we haven't been able to incorporate the PMAQ yet in a more practical manner.” (G5)*

During the phases of the Program, the managers worked with the teams in different ways and modified their activities based on the positive or negative experience of the previous cycle.

*“In the first [during the self-assessment], I went with them as a listener and enquirer, asked the reason for the score (...). Today, as the team is more mature, I didn't need to.” (G2)*

*“With some teams, I participated more in the self-assessment, with others more in the preparation for the external assessment (...). I think that I answered according to the teams' needs as well. I participated a little in each phase of the teams.” (G5)*

The managers also used different strategies to guide the creation of intervention matrices for the teams. One of the interviewed managers chose equal matrices for all teams.

*“At first we said ‘Let's have each team make two matrices.’ That would result in 12 matrices, it would be crazy. Then we said ‘It's just one service, one team.’ We talked to the technical team and today woman's health and smoking it's one situation for all teams.” (G2)*

Other managers delegated the choice of the intervention matrices' themes to the teams.

*“Each team created its matrices, not only in the specific themes, but in other standards as well.” (G5)*

In addition, the interviewees declared that, today, the use of the intervention matrices is part of the teams' strategic planning.

*“The intervention matrices happen in the planning. Before the planning, I notice that the teams look at the latest situation and how it's being done and even some attempts to resume, try differently. But sitting down and looking at the result happens during the planning really, once per year.” (G5)*



## Discussion

Evaluating presupposes issuing a value judgment according to a given historical, social, economic and cultural context,<sup>(4,5)</sup> which supports the interviewees' perception of the subjective nature of the self-assessment. Despite a recommendation, the Ministry of Health does not require the adoption of strict quality standards for scoring<sup>(1)</sup> and the score in the final ranking merely considers the execution or not of the self-assessment, which weakens its impact in the result.<sup>(6)</sup> Hence, its importance lies in the objectives of arousing collective critical reflection on the teams' work process and disclosing points for improvement.

The teams' autonomy, resulting from people's engagement in the construction of their own actions, boosts improvements. That happens when the assessment of these actions is seen as a part of the work process instead of an imposition merely aimed at reaching targets.<sup>(7)</sup> The assessment process should be broad and provoke changes,<sup>(8)</sup> a daring and innovative proposal that demands time to mature and incorporate it into the work culture of the Primary Health Care services.

The fragmentation of the assessment in cycles and the alternation of the intervention themes make it difficult to measure the improvements in the long term and to continue previous projects in new cycles, which can lead to frustration and inhibit the development of the quality culture. This fragmentation is related to the managers and teams' limitation to understand the planning, monitoring and assessment as parts of an ongoing work process for improvements.<sup>(7)</sup> This discontinuity emerged in the interviewees' reports about external assessment.

There is still inconsistency between the results obtained and the planning actions that should result from their analysis.<sup>(4,7)</sup> To support the transformation of reality, the results should be disseminated and discussed<sup>(9)</sup> among the manager, team and evaluators, a gap the study subjects appointed. Result-based financial incentives have been more effective to produce short-term changes instead of promoting great transformations,<sup>(10)</sup> by supporting decision processes, improving the organization of Primary Health Care, communication, management transparency and the education of the subjects involved.<sup>(7)</sup>

According to the interviewees, the managers and teams hardly work with standards and indicators. Their use disseminates the quality culture and favors the modulation of the professional profile,<sup>(6,11)</sup> which can contribute to overcome the fragmentation of the work processes in PHC. On the other hand, the team members do not participate in the formulation of the indicators, determined by official documents, which distances them from this understanding and promotes alienation.<sup>(6)</sup> Therefore, the question is raised how quality and efficiency can be achieved without the prominence of the workers involved in this process.

Analyzing and discussing indicators with the team would help to change this scenario. The managers often treat the assessment as supervision and punishment, as they charge the achievement of targets and the improvement of indicators without qualifying and encouraging the professionals in parallel.<sup>(7)</sup> In addition, the services' shortages are observed, which the management should improve through continuing education and improvements in the structures and work relations.<sup>(12)</sup>

The interviewees treated continuing education and institutional support as synonyms. Continuing education is intended to integrate the theoretical knowledge into professional practice. It departs from the problematization of the actual scenario as the base to seek information and produce knowledge and serves as the base to enhance the capacity to self-assess, self-manage and be autonomous.<sup>(13)</sup> It qualifies segments of management, attention and social control.<sup>(7,14)</sup>

The institutional support actions favor the planning and democratic organization of the work processes.<sup>(7,14)</sup> They rest on the existence of a supporter to stimulate the professionals' development and, with a strategic view, to offer tools and orientations for this purpose.<sup>(15)</sup> The supporter should be inserted in the team and, to respond to the Program objectives, (s)he should propose ways and assess results. PHC requires self-managing professionals with technical, administrative and political competences and a constantly expanding set of knowledge,<sup>(16)</sup> which becomes possible when continuing education and institutional support go together.

In line with some studies,<sup>(7,17)</sup> the professionals understood the PMAQ as a guide for the work processes, which indicates the achievement of the Program objectives in terms of improving the processes and the use of information in line with the local reality.<sup>(2)</sup> On the other hand, they appointed that the PMAQ entailed more work for the teams, demanding a more detailed analysis to understand the reasons for this finding.

The perception of the PMAQ as a facilitator may have contributed to the improvement process, but the results did not generate active reflection and action. Therefore, actions are needed that articles these results with the professionals' practice and favor the understanding of the assessment as part of the continuous quality improvement process in PHC and, consequently, in the SUS.

Although the methodological design of the study does not presuppose generalizations, the fact that the results represent local experiences of one administrative district and, consequently, of the strategies adopted there to implement the PMAQ. Digressions about the study theme in the national context or other locations should take into account the possible influences of each conjuncture.

## Conclusion

After two completed cycles of the National Improved Access and Quality Program, the interviewed managers demonstrated an incipient incorporation process of the systemized assessment culture to support the continuous quality improvement in Primary Health Care. Despite the notorious distance between the proposals of the National Improved Access and Quality Program and the practice and the Primary Health Care services studied, the Program favored the work process organization and contributed for the managers to focus on the teams' practice and their own activities. It was also evidenced that specific dimensions in the implementation of the National Improved Access and Quality Program, such as institutional support, continuing education and external assessment, lack clarifications and improvements.

## Collaborations

Silva LMC and Ferreira LR collaborated with the conception of the study, data collection, analysis and interpretation, writing of the article, relevant critical review of the intellectual content and final approval of the article for publication. Rosa AS and Neves VR contributed to the analysis and interpretation of the data, writing of the article, relevant critical review of the intellectual content and final approval of the version for publication.

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