

* Original Article

The National Program for Improving the Access and Quality of Primary Care: Reflections on the program design and deployment process

Hêider Aurélio Pinto

MD, Specialist in Public Health, Director of the Department of Primary Health Care of the Ministry of Health.

Allan Sousa

Masters in Political Sciences, General Coordinator of Monitoring and Evaluation of the Department of Primary Health Care of the Ministry of Health.

Alexandre Ramos Florêncio

Masters in Public Health, Deputy Director of the Department of Primary Health Care of the Ministry of Health.

DOI:10.3395/reciis.v6i2.Sup1.624en

Abstract

This paper describes the primary features and elements of the National Program for Improving the Access and Quality of Primary Care (Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica, PMAQ) and evaluates the program's initial deployment based on data on the accession of Municipalities and primary care teams. The article demonstrates how the PMAQ is related to the set of strategic priorities defined by the National Primary Care Policy and other broader movements with the goal of reorienting the way that the Unified Health System is organized. Four phases that define the organization of the program are presented in this paper: accession and contracting, development, external assessment and re-contracting. This paper also analyzes data regarding groups that have joined the program and have used a self-assessment tool offered by the Ministry of Health.

Introduction

Ordinance 1654 of the Ministry of Health, published on July 19, 2011, created the National Program for Improving the Access and Quality of Primary Care (Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica, PMAQ) and for the first time tied the transfer of resources to the implementation and achievement of access and quality standards by primary care teams (equipes de atenção básica, EAB). This ordinance represents a profound change in the logic behind transferring funds to primary care (atenção básica, AB) and introduces similar changes to the financing of the Unified Health System (Sistema Único de Saúde, SUS) as a whole.

Moreover, the PMAQ is a component of the new National Primary Care Policy (Política Nacional de Atenção Básica, PNAB), whose success depends on its ability to mobilize local players to change conditions, care practices, management and participation in accordance with nationally agreed guidelines. The success of the program also crucially depends on fostering opportunities for dialogue, questioning, negotiation and management of change across teams, managers and users, with the power to produce concrete changes in everyday services.

This paper describes the design of this policy, which presents a reasonable degree of originality and complexity, and evaluates the program's initial deployment based on data regarding the accession of municipalities and EABs.

The PMAQ as the primary strategy of the "Saúde Mais Perto de Você" (Health Closer to You) program

The Ministry of Health declares that for the "Saúde Mais Perto de Você" (Health Closer to You) program, which refers both to the set of initiatives of the new PNAB and to the network of Basic Health Units (Unidades Básicas de Saúde, UBS), the PMAQ is the "primary strategy inducing changes in conditions and operation modes of the UBS", aiming for a permanent and progressive extension of the access and quality of the "management practices, care and involvement" in the AB system (BRAZIL, 2011d).

The scope and audacity of the goals of the PMAQ are evident in the PMAQ guidelines outlined in Ordinance 1654 (text in bold denotes the present authors' highlights):

"I – build **comparison parameters** among primary health care teams, **considering the different realities** of health;

II – stimulate **continuous and progressive improvement** in the access and quality standards and indicators involving the **management, work process** and **results achieved** by the primary health care teams;

III – create **transparency** in all of the steps, enabling the continuous monitoring of participants' actions and the societal outcomes;

IV – **engage, mobilize and empower federal**, state, Federal District and municipal **managers**, the primary health care teams and the users in a **process of change in management culture** and primary care qualification;

V – **develop a culture of negotiation and contracting**, involving the **management of resources on the bases of commitments and results** that are agreed upon and achieved;

VI – **stimulate effective change of the attention model, worker development and services guidance depending on the needs and satisfaction of users**; and

VII – operate on a **voluntary basis** for both the primary health care teams and the municipal managers, based on the assumption that the program's success depends on the motivation and proactivity of the subjects involved." (BRAZIL, 2011c).

To achieve these goals, the PMAQ promoted a profound change in the financing of the AB system, linking an important part of resource transfer to the implementation of "standards" that would indicate increased access to services, improved working conditions and improved investment in the quality of care and workers. With the establishment of the "Quality

Component” of the Minimum Basic Health Care variable (Piso de Atenção Básica, PAB), the municipalities gained the ability to double the resources received by their teams by achieving a “great” performance ranking in the “standards” that the PMAQ uses for contracting and evaluation (BRAZIL, 2012d).

Pinto, Koerner and Silva (2012) described the new AB financing design and indicated the priority of this agenda for the federal government. The same article predicts that in 2013, 15% of the variable PAB will be promised to the PMAQ, an impressive value that will come close to R\$ 1.5 billion.

“Quality”, which is often quoted in official documents that address the issue, is understood as a social construct that is determined based on references to the individuals involved, who vary according to historical, political, economic, technological and cultural contexts and the knowledge accumulated regarding the chosen topic (BRAZIL, 2011c, 2011d). At one point, “quality” was defined as “the degree of compliance to quality standards established as rules, protocols, guidelines and principles that organize the actions and practices, as well as the current scientific and technical knowledge, respecting culturally accepted values and considering the competence of the actors” (BRAZIL, 2011e).

The so-called “quality standard” is a statement of expected quality that affirmatively expresses the sense of politics produced in the tripartite structures of the SUS governance. The standard seeks to affirm the principles of “comprehensiveness, universality, equity and social participation” (BRAZIL, 2011e) and address the criticisms that have been discussed and accepted as “situations to be overcome” by the “Saúde Mais Perto de Você” initiative. The dimensions and standards proposed by the PMAQ act as a statement of guidelines and a path to overcoming the prioritized problems. The quality is not perceived to be a *plateau* of achievement. Quality is rather perceived as “flow” and “movement” and should thus be the fruits of the involved actors who have the ability to change the scenario. Therefore, obtaining quality requires continuous adaptation and evolution of the policy, its strategies and its tools:

“The PMAQ is expected to be constantly improved to progressively include the diversity of scenarios that will be deployed; the need to adapt the criteria, parameters and assessment and management tools, with a view to the new demands and challenges of Primary Care Policy and the historical moment of establishment of the SUS; and the need for revision of concepts, methodologies and tools, based on the institutional learning from PMAQ deployment and on the collaboration of the different actors involved” (BRAZIL, 2011e).

The PMAQ as a part of broader movements

The PMAQ, in turn, is linked to three broader movements within the Ministry of Health with which the PMAQ was formulated and somewhat anticipated.

The PMAQ cannot be understood outside of the context of effective recovery and definition of the role of AB in the entire network, which included the publication of various normative acts. The regulation of Law 8080, by Decree 7508 of June 29, 2011, defines AB as the “gateway” of the system, as an essential and vital element of a health care region, and as the ordering of “universal and equal” access to the actions and health services of the network (BRAZIL, 2011b). The ordinances that established the “care networks” were careful to describe AB, clearly recognizing its roles as a gateway and first contact.

The PMAQ seems to be a strategy that synthesizes the efforts of affirming AB as a welcoming and stable gateway for health care needs by considering the creation of conditions under which the PMAQ can ensure concrete and coordinated continuity of health care in the regions prioritized by the networks. This synthesis is evident in the PMAQ's intention to shape and evaluate the roles and actions of AB as a part of the priority networks (BRAZIL, 2012b).

A second movement that supports and is linked to the PMAQ is the redesign of the systemic governance and financing of SUS, according to Presidential Decree 7508 of June 29, 2011. Among many other achievements, the Decree and its instruments, in particular the Organizational Contract of Public Action (Contrato Organizativo de Ação Pública, COAP), enable the possibility of a financing method that is more complete and appropriate to unique contexts and local and regional specificities. The decree mentions "performance evaluation of actions and services" in the section "undertaken responsibilities", which considers the subject of a pact regarding "indicators and health targets", "strategies for improving actions and health services" and "criteria for results evaluation and means of permanent monitoring", and adds that the "Ministry of Health may establish ways of encouraging the accomplishment of health care goals and of improving actions and health services" (BRAZIL, 2011b).

Pinto *et al.* (2012) demonstrated that the design of the new PNAB funding implemented in 2011 is consistent with and adheres to the intents of the COAP and its instruments. We emphasize that the PMAQ responds precisely to the new funding component of the AB, which considers contractual commitments, monitoring indicators and the achievement of results.

The Assessment Program for the Qualification of SUS (Programa de Avaliação para a Qualificação do SUS) is the third movement related to the PMAQ and assesses the performance of health systems in the three levels of government. This model aims to measure the possible effects of health policy to support decision making, to ensure the transparency of the management processes of the SUS, to provide visibility of the achieved results, and to strengthen social control and the placement of the focus of the health system on the users (BRAZIL, 2011a). The PMAQ is an integral part of this effort, which also addresses several other initiatives such as the SUS Performance Index (Índice de Desempenho do SUS, IDSUS), all of which are consistent with the objectives of the program.

The PMAQ and its commitment to the production of movements: first phase

The PMAQ is organized into four phases that "complement and conform to a continuous cycle of improvement of access and quality" (BRAZIL, 2011d): "accession and contracting", "development", "external assessment" and "re-contracting", which actually represents the beginning of a new cycle.

We do not intend to present the static design of the PMAQ phases, which is clear in Ordinance 1654, or to put all of the focus on external assessment and what it provides in terms of allocation of resources. This approach primarily reveals the homogeneous actions, which are standardized nationwide, that are repeated across regions (DELEUZE *et al.*, 2003) and misses the dynamic and unique pillar of the program: surface production (DELEUZE *et al.*, 2003), i.e., the activities of care team modification and municipal management that occur in everyday services. We will try to make explicit the strategic investment in the movement in the various documents and instruments of the program. It seems to us that the purposes of the

contracting phase and the external assessment and certification phase are to promote the second phase, motivating leadership and the effort needed to change the EABs and the municipal management.

The first phase of the PMAQ is described as the "the formal step of joining the program" through "contractual commitments and indicators to be signed" by the EABs and municipal managers and the Ministry of Health "in a process involving regional and state pacts and the participation of social control" (BRAZIL, 2011d). The voluntary nature of this participation is associated with the idea that the classification of the service and practical changes will only materialize in "environments in which workers and managers feel motivated and see themselves as essential to its success" (BRAZIL, 2011d). This voluntary participation summons the involvement and leadership of different actors and expands the possibility of constructing participatory dialogic environments in which managers, workers and users are mobilized to commit to common goals.

Each EAB that joined had to sign a "Statement of Commitment" in which they pledged to (a) follow the organizational guidelines for the work process; (b) observe the operation rules of the program; (c) deploy access, co-management, self-assessment, planning, and evaluation procedures related to each of the later stages; (d) be monitored for six months using 47 indicators defined by the Information System of Primary Care (Sistema de Informação da Atenção Básica, SIAB); and (e) undergo an evaluation process that includes self-assessment of performance using 24 indicators and an on-site assessment conducted by external evaluators who visit each team in the third phase of the program.

Requiring accession and individualized contracting by the EABs is an attempt to introduce a concrete procedure that enables the inter-subjective recognition of individuals who accept responsibility for a set of actions that can promote increased access to and quality of primary care.

The municipality, in turn, immediately begins to receive 20% of the Component of Quality of the PAB when staff joins the PMAQ. This transfer continues until the completion of the external assessment and the team certification, after which this percentage depends on the performance achieved by each EAB and can be 100% for a "great" performance. Any transfer of the Component can be suspended in case of unsatisfactory performance.

Accession by municipal managers includes registration of the EABs after the previous association with the EABs detailed above and the signing of terms in which the following commitments are made: "(a) the application of resources of the Quality Component of the Variable PAB; (b) the implementation of actions to improve the working conditions of the EABs; and (c) the structuring of AB management to ensure 'operating conditions of the management team responsible for the local implementation of the Program' and to involve the same team in institutional EAB support to conduct self-assessments, to establish collegiate management arrangements in the UBS and to evaluate and monitor indicators for the development of continuing education initiatives and the enforcement of shared actions to overcome the identified problems and achieve the agreed-upon results" (BRAZIL, 2011d).

Importantly, the attempts of the program to create movements of involvement and collegiate management arrangements to manage the change are focused on the development of a dynamic that fosters the establishment of spaces for negotiation and the involvement of

participants. This arrangement clearly seeks to mobilize participants through the possibility of having their interests, needs and desires addressed.

The consolidation of the program as a *modus operandi* (as a culture of negotiation and management committed to change the model of care and management), team development and the guidance of services according to the health care needs of the users are the explicit goals of the PMAQ. Moreover, the program attempts to drive in some way what will be negotiated in this space by proposing content and repertoires for this negotiation. This attempt is made by indicating the direction of the qualification movement using indicators to be achieved and standard access and quality parameters to be implemented.

The PMAQ and its commitment to the production of movements: second phase

The second phase of the PMAQ is understood to be the stage involving the development of actions, which are performed mainly by the EAB and the municipal management but with the support of state administrations and the Ministry of Health, "with the aim of promoting movements for change of management, care and care management that will deliver improved access and quality of AB" (BRAZIL, 2011d). There are investments in four strategies at this stage: self-assessment, monitoring, continuing education and institutional support.

Self-assessment is treated as "the starting point of the development phase", and it is proposed that the process begin "by the identification and recognition, by the teams, of the positive and also the problematic dimensions of their work, producing senses and meanings that are potentially facilitators/mobilizers of change initiatives and improvement" (BRAZIL, 2011d). Self-assessment is expected to function as a device for the collective questioning of the established mode (ALTOÉ, 2004) and the analysis of established processes, relations and working conditions. The expansion of the capacity for self-analysis (BAREMBLITT, 1998) is believed to also extend the ability of the co-management of an organized group to produce (CAMPOS, 2000), to negotiate and to plan ways to overcome problems and achieve desired and agreed-upon goals.

Again, the strategy of the PMAQ relies on devices that may create space for dialogue, negotiation and management of the changes that the program seeks to ensure at the contracting phase, space that ideally would gather the team and would often include members of the municipal management responsible for the EAB, supporters (if possible) and possibly the community (BRAZIL, 2011d, 2011e, 2012a). The insistence on the active participation of municipal management aims to strengthen analyses and shared actions with the greatest potential to change the situations identified as problems.

The Ministry of Health presented the tool "Self-Assessment for Improving Access and Quality (Autoavaliação para a Melhoria do Acesso e da Qualidade, AMAQ)", which could "be combined with other tools, with it being the responsibility of municipal managers and EABs to define the use (...) that fits their needs and reality" (BRAZIL, 2011e). The AMAQ is an extensive tool that aims to address multiple dimensions and that requires the identification of many more problems that the EAB could consider practical action items (CECÍLIO, 1997, 2003). Hence, the AMAQ facilitates (BRAZIL, 2011e) the creation of a dynamic associated with strategic management (MATUS, 1993; CECÍLIO, 1997, 2003; CAMPOS, 2000) in which the tool feeds

the group dialogue so that the group can determine the issues and agree on actions according to their explanations, priorities, interests, dispositions and ability for action.

For the self-assessment to be strengthened as a permanent process for guiding decision making, the PMAQ proposes that the assessment should be enriched by monitoring the indicators proposed by the program (BRAZIL, 2011d) and should include "guiding the process of negotiating and defining goals and commitments between EAB and municipal manager" and "supporting the prioritization and scheduling of actions" among its goals.

In 2011, the Ministry of Health changed the SIAB so that the ministry could access and monitor the system data at a higher level of disaggregation, the team level. With this change, the program invested in the possibility of institutionalizing a permanent practice of monitoring and evaluation by both EABs and municipal management with the ability to "enable identification (...) of challenges"; "recognize achievements, effectiveness or need for improvement through intervention strategies"; and to democratize and provide "transparency" to the management of AB, strengthening user involvement through the "publicity of goals, quality standards and achievements" (BRAZIL, 2011d).

The 47 indicators were chosen according to three criteria. The indicators were restricted to those that could be monitored and evaluated by the SIAB "because that is the only system available for feeding and monitoring individualized teams" (BRAZIL, 2011d), were prioritized indicators historically approved under the Pact For Health and used in the composition of the IDSUS and sought to link the priorities defined by the three spheres of government (BRAZIL, 2011d).

The image that the document (BRAZIL, 2011d) suggests is a collective that makes use of permanent self-assessment and monitoring to control the labor process and its results, thereby increasing motivation and satisfaction with the process and strengthening the ability to create dialogue and shared action with management and the community.

The Ministry, through processes of formation, financing, technical guidance and even appreciation in the external assessment of the PMAQ, began to stipulate that the municipal administrations invest in the adoption of institutional support (CAMPOS, 2003) such as management technology and processes of continuing education (CECCIN, 2005) articulated to change the actions of the program.

The program suggests that "to know and to do in continuing education (CE) is embodied in the concrete practice of health services" because the "change of the model of care imposes the need for qualified health care professionals, and the changes in the processes of health care demand that its actors (workers, managers and users) have greater intervention capacity and autonomy to contribute to the establishment of transformative practices" (BRAZIL, 2011d). The program also considers CE to be an important "management strategy" with great potential for provoking changes in the micro-politics (MERHY, 2002) of the daily services that are "quite close to the actual effects of health care practices in the lives of users" (BRAZIL, 2011d).

The PMAQ suggests a link between the processes of CE and the strategies of institutional support (IS) with respect to "increasing the alternatives for coping with the difficulties experienced by workers in their daily lives" (BRAZIL, 2011d). The PMAQ suggests that IS is a

“management function that seeks to recast the traditional way of doing” health care management.

The program tries to induce the creation of IS teams (BRAZIL, 2011d, 2011e, 2012a) “with appropriate scaling of the number of teams per supporter”, recalling the need to build linkages and create regular meeting schedules (BRAZIL, 2011d).

These IS teams should adopt the objective of implementing changes in organizations, adopt as a “foundation the problems and tensions of everyday life” and operate as “strong trigger processes that provide support to the change movement triggered by collectives”, while aiming to strengthen the collectives, recognize and leverage their efforts and reinforce “subjective processes that produce freedom and commitment” (BRAZIL, 2011d).

In summary, the care and management teams, with the task of creating real changes, should build pacts and actions that trigger movements that view assessment, planning, continuing education, labor management, qualification of the labor process and monitoring of results as excellent opportunities to overcome fragmented modes of action, which lose much of their potency.

The second phase artificially ends with the realization of external assessment procedures that take place six months after a team joins the program. We deem this an artificial end because there is no real way to end the program without also interrupting the care and management actions of the care and coordination teams of the AB in the municipality.

The PMAQ and its commitment to the production of movements: third phase

The third phase is the performance of an external assessment that combines “gathering information for analysis of the access conditions and quality of the EABs” and recognizes the “efforts and results” of the EABs and the municipal managers (BRAZIL, 2012a). This assessment generates a score according to the rules of Ordinance 1654 of July 19, 2011, and the amendments introduced by Decree 866 of May 3, 2012. The assessment results in certification that determines the percentage of the quality component that will be transferred monthly to the municipal health care fund by the Ministry of Health.

The score considers three components. The simple performance of self-assessment by the EAB provides 10% of the total score regardless of the results. An additional 20% depends on the performance of the EAB in 24 indicators that were monitored throughout the development phase (BRAZIL, 2011c, 2011d). The remaining 70% of the score results from the assessment tools employed in the third phase, which are organized into four modules according to the corresponding data collection method: Module I - observation at the UBS; Module II - interviews with the EAB professionals and verification of documents in the UBS; Module III - interviews with the users in the UBS; and Module IV - an online module that is informed by the municipal administration and the EAB and completes the other modules (BRAZIL, 2012a).

The standards are categorized into five dimensions. The dimension “municipal management for the AB development” essentially evaluates the structure and management teams of the AB of the municipality and considers whether the support that the AB team gives to the EAB adheres to the program (BRAZIL, 2012a). This standard also checks the commitments made by the city manager in the contracting phase of the program.

The “structure and operating conditions of the UBS” dimension considers the infrastructure, accessibility, environment, working conditions and the availability of equipment, supplies and drugs important to health care with a focus on the prioritized care lines (BRAZIL, 2012a).

The “employee appreciation” dimension involves the evaluation of EAB member training and the investments made by the municipal management into the professional development, training and CE of the EABs, ensuring labor rights, work contracts, existence of careers and the establishment of desirable devices of work management (BRAZIL, 2012a).

The following aspects (among others) are assessed in the “access and quality of care and organization of the work process” dimension from both the professional and the user perspectives: the access; the establishment of devices such as hosting, shared calendars, care-management tools and collegiate management processes; and the patterns of quality related attention to the prioritized care lines (BRAZIL, 2012a).

Finally, there is the dimension “use, participation and user satisfaction”, which assesses the use of the service by the user, various dimensions of user satisfaction and the establishment of devices and spaces for user participation and social control (BRAZIL, 2012a).

Thus, three aspects should be emphasized. By focusing on both the micro- and meso-scales of the work process, the PMAQ once more seeks to stimulate the establishment of devices that provoke changes in the daily work process. Thus, the PMAQ is a national policy that encourages the actors involved to use devices such as hosting, shared calendars, care management, performance-related pay, collegiate management, local health care councils, etc. Through these devices, the PMAQ seeks to stimulate critical reflection on the established mode and to cause the collective to actively seek everyday change but does not undertake the additional step of defining forms. Instead, the PMAQ program encourages the teams to “innovate”, “create” and “experience” according to their reality and possibility and to share.

The assessment concerns not only the structure and process but also the more immediate results of health care. Many perspectives and user evaluations of the scene (BRAZIL, 2012a) are also considered. The assessment instruments include concrete results regarding the access to and quality of care for specific groups such as women, children, pregnant women, people with chronic conditions and people with mental disorders, among others. When these considerations are combined with the central positioning of user perspectives, both the results and the direct effects of the changes signify the production of a program with a strong ability to communicate with the general public to inform people about the UBS near their home.

Finally, the evaluation aims to measure the performance, in terms of quality standards, of the changes under the distinct governance (TESTA, 1992) of the EAB, municipal health care and municipal government. We suggest, as an example, that management of the physical structure, connectivity and career planning aspects of the program would require a mayor's efforts, while maintaining the guarantee of supplies and equipment and enforcing UBS operating standards could be under secretarial management. Many other aspects of the program could be guided by the health care teams and the decentralized management team. Therefore, we argue that the evaluation is not “of the team” but rather “per team” because it evaluates a series of elements that represent the shared responsibilities of the groups of local actors but takes the EAB and its workplace, the UBS, as the units of analysis.

Thus, the EAB is clearly concerned with improving working conditions, improving connections, optimizing the structure of the UBS, increasing the availability of instruments, etc., and all of these dimensions rely more on the governance of the manager than of the EAB itself. This perception is not very clear in the documents, and it is important that the mode of dissemination of the results consider this limitation to avoid assigning performance responsibilities to those who exhibit low performance due to a lack of minimum guaranteed conditions.

It is noteworthy that all of the modules of external assessment include questions used for team certification and others used to gather information to guide the improvement of health-care policies. This diagnosis, therefore, is designed to facilitate the certification of all of the EABs of the PMAQ; conduct a census of all of the UBS in Brazil, whether subscribed to the PMAQ or not; and "identify, in scale and depth, the unprecedented realities and peculiarities of AB in Brazil (...) contributing to the planning" and development of "appropriate strategies to (address) differences in the territories, promoting greater equity in the investments of federal, state, and municipal government" (BRAZIL, 2012a).

The PMAQ and its commitment to the production of movements: fourth phase

The fourth phase is the connection phase. This phase involves re-processing, re-starting and re-contracting, and it seems to require a tripartite national effort of balance and trajectory adjustment while focusing its local dimension on renegotiation of rules and effort toward change. According to the program, "at each cycle (...), new quality parameters can be defined, inducing advances toward what is expected in terms of development of the management, the teams and the achievement of population health care results" (BRAZIL, 2011d). The program indicates a combination of unique national patterns and specific "package" patterns that could be chosen by the EABs according to their priorities and needs (BRAZIL, 2011d).

Of all of the phases, the fourth is certainly described the least, perhaps indicating that it is yet to be formulated and is waiting to develop according to the responses that will be acquired as a result of the entire process.

The accession and participation of municipalities and teams in the PMAQ

Considering that the requirements and commitments required for membership are not "trivial", the achieved numbers are impressive and indicate the strong attractiveness of the program.

The municipalities conducted every stage of accession using the System of Programs Management of the Department of Primary Health Care (Sistema de Gestão de Programas do Departamento de Atenção Básica, SGDAB). In this on-line system, the municipalities could access all of the PMAQ documents, answer questions regarding identification and contracting, download and print the Terms of Commitment, sign the terms and upload the signed electronic terms. The person in charge of each municipality controls the EAB's access to the system and can therefore monitor, support and validate the accession of the EAB (BRAZIL, 2011d). The municipal membership was only concluded after all of the EAB participants completed their membership and those memberships were validated by the city manager.

Even with less than 60 days for accession, more than 70% of the Brazilian municipalities joined the PMAQ (Table 01). This is a surprising level of support for a new program involving

voluntary accession and requiring a series of preliminary tasks and the assumption of various commitments for membership.

However, one can clearly see, despite strong national adherence, the existence of some variability when comparing the relative percentages by state. While the states of Ceará, Bahia, Santa Catarina, Sergipe, Rio de Janeiro and Amapá have percentages of accession greater than 80%, the states of Maranhão, Rondônia and Amazonas show percentages below 50%, whereas at Maranhão, the accession percentage was less than 10% of the municipalities.

Moreover, significant variability remains when we compare the percentage of accession by team. At the top end, we find the states of Santa Catarina, Tocantins, Minas Gerais, Rio Grande do Sul and São Paulo, all with over 60% of Family Health Teams (Equipes de Saúde da Família) participating in the program. At the lower end, we find Maranhão, Acre and the Federal District, with less than 30% of teams joining the program.

Table 01 – Total number of municipalities, number of municipalities that joined the PMAQ, percentage of municipalities that joined the PMAQ, total number of teams, number of teams that joined the PMAQ and percentage of teams that joined the PMAQ, grouped by Federal Unity (FU), Brazil, 2011

FU	Total number of municipalities	Municipalities that joined the PMAQ	% of municipalities that joined the PMAQ	Total number of teams*	Teams that joined the PMAQ	% of teams that joined the PMAQ
AC	22	11	50,0	137	32	23,4
AL	102	67	65,7	758	340	44,9
AM	62	26	41,9	515	173	33,6
AP	16	13	81,3	144	52	36,1
BA	417	372	89,2	2.744	1.564	57,0
CE	184	171	92,9	1.869	920	49,2
DF	1	1	100,0	111	28	25,2
ES	78	51	65,4	576	323	56,1
GO	246	174	70,7	1.151	684	59,4
MA	217	20	9,2	1.782	115	6,5
MG	853	656	76,9	4.337	2.944	67,9
MS	78	51	65,4	449	184	41,0
MT	141	87	61,7	584	227	38,9
PA	143	100	69,9	948	371	39,1
PB	223	173	77,6	1.248	625	50,1
PE	185	132	71,4	1.867	1.025	54,9
PI	224	136	60,7	1.092	371	34,0
PR	399	301	75,4	1.807	1.007	55,7
RJ	92	76	82,6	1.851	1.071	57,9
RN	167	115	68,9	865	411	47,5

RO	52	20	38,5	275	98	35,6
RR	15	8	53,3	91	35	38,5
RS	496	342	69,0	1.246	829	66,5
SC	293	258	88,1	1.393	1.108	79,5
SE	75	63	84,0	554	273	49,3
SP	645	413	64,0	3.532	2.323	65,8
TO	139	98	70,5	411	299	72,7
BR	5.565	3.935	70,7	32.337	17.432	53,9

SOURCE – Ministry of Health/Department of Primary Health Care

* Jurisdiction October 2011

The enormous observed variation could be associated with a set of context factors that may explain a greater or lesser propensity for PMAQ membership. In this paper, we selected two explanatory variables that, in isolation or interaction with each other, can indicate the existence of societal and institutional characteristics that increase or decrease the likelihood that municipalities will choose to participate in the program: the degree of socioeconomic development as measured by the Human Development Index and the population of the municipalities.

The relative percentage of municipalities that joined the PMAQ increases as the degree of socioeconomic development measured by the HDI increases, revealing some correlation between the two variables (Table 02).

Table 02 – Total number of municipalities, number of municipalities that joined the PMAQ and percentage of municipalities that joined the PMAQ, grouped by Human Development Index (HDI), Brazil, 2011

HDI	Total number of municipalities	Municipalities that joined the PMAQ	% of municipalities that joined the PMAQ
Low	2.505	1.747	69,7
Medium	2.427	1.738	71,6
High	575	450	78,3
Total	5.565	3.935	70,7

SOURCE – Ministry of Health/Department of Primary Health Care

Likewise, when we compare the populations of the municipalities to the percentage of municipalities that joined the PMAQ, we uncover a clear relationship between the size of a municipality and its propensity to participate in the program (table 03). This correlation is highlighted by the observation that for small municipalities, the accession rate for joining the PMAQ reached 67.6%, whereas this rate was 84.6% for large municipalities.

Table 03 – Total number of municipalities, number of municipalities that joined the PMAQ and percentage of municipalities that joined the PMAQ, grouped by population size, Brazil, 2011

Population size	Total number of municipalities	Municipalities that joined the PMAQ	% of municipalities that joined the PMAQ
Small	3.914	2.646	67,6
Intermediate	1.294	987	76,3
Large	3.57	302	84,6
Total	5.565	3.935	70,7

SOURCE – Ministry of Health/Department of Primary Health Care

Obviously, further analyses followed by qualitative verification, which is already in progress, will more robustly indicate the factors that led to a greater or lesser inclination to participate in the PMAQ. For now, we can propose some hypotheses.

In theory, municipalities with higher degrees of socioeconomic development and larger populations develop greater institutional capacity and better conditions for the important dimensions that are the subject of PMAQ evaluation, such as infrastructure, equipment, regularity of supplies, structure and organization of municipal management and elements related to the management of education and labor.

The expectation that the managers of the largest and most developed municipalities will have better conditions for participation and PMAQ evaluation was so clear to the members of the National Council of Municipal Health Secretaries (Conselho Nacional das Secretarias Municipais de Saúde, CONASEMS) that this council proposed a stratification of the municipalities so that the evaluation would not compare the smallest and poorest municipalities with the largest and richest municipalities. Therefore, the program categorized the municipalities into six groups according to indicators related to the degree of development and the population.

We also know that both of the factors, particularly the fraction of the poor and extremely poor populations and the fraction of the population residing in rural areas, are correlated with the professional establishment and stability of teams¹, which are decisive elements in consolidating a good work process. The difficulty of maintaining personnel, especially physicians, and effectively meeting the prerogatives of the family health-care strategy postulated in Ordinance 2488 may also have discouraged some managers from joining the program due to fears that irregularities would be caught during the external assessment, although this assessment is not a function of the program.

Such possibilities were anticipated by the CONASEMS, and an informal reading indicated that a fair increase in the PAB that increases the value of transfers per capita to smaller municipalities and those with the worst socioeconomic indicators (Pinto, Koerner and Silva, 2012) would compensate for the expected low accession to the PMAQ and, conversely, that a smaller increase in the per capita transfers granted to the larger and richest municipalities would be compensated by the PMAQ.

We agree with Pinto *et al.* (2012) that this balance is not about “compensation”. We believe that the new funding design simultaneously favors the municipalities with greater needs and

¹According to an as-yet-unpublished study performed by the Department of Primary Health Care (DAB)/Ministry of Health using the base of the CNESS, which generated a technical note that guided the decision to use these parameters in defining the municipalities and priority areas for the PROVAB and FIES.

those that strive and are able to achieve better results, rather than opposing or excluding either. However, we understand that the CONASEMS proposition was appropriate, and we venture to propose that this stratification might have stimulated many smaller municipalities to join the program because, although there is considerable statistical variation, 67.6% and 69.7% of membership are not low numbers. Thus, after the accession results, we conclude that the anticipation of the problem produced a solution that we believe may have contributed to minimizing a manifestation of the problem.

Another important indicator of accession, in this case involving the EABs in addition to the municipal administrations, is the number and percentage of the teams that conducted the self-assessment process.

When we assessed the data (Table 04) regarding the use of the self-assessment tool provided by the Ministry of Health, the AMAQ, we noted significant use of the tool. More than 75% of the primary care teams that joined the PMAQ used the AMAQ. The highest percentages for the use of this tool are observed in the states of Santa Catarina (96.2%), Paraná (88.5%), Minas Gerais (86.7%) and Ceará (86.1%).

Table 04 – Total number of teams that joined the PMAQ, number of teams that used the AMAQ and percentage of teams that used the AMAQ, grouped by Federal Unity (FU), Brazil, 2011

FU	Total number of teams that joined the PMAQ	Teams that used the AMAQ	% of teams that used the AMAQ
AC	32	15	46,9
AL	340	290	85,3
AM	173	57	32,9
AP	52	27	51,9
BA	1.564	1.297	82,9
CE	920	792	86,1
DF	28	0	0,0
ES	323	198	61,3
GO	684	408	59,6
MA	115	84	73,0
MG	2.944	2.553	86,7
MS	184	81	44,0
MT	227	183	80,6
PA	371	220	59,3
PB	625	494	79,0
PE	1.025	588	57,4
PI	371	229	61,7
PR	1.007	891	88,5
RJ	1.071	539	50,3
RN	411	316	76,9

RO	98	69	70,4
RR	35	19	54,3
RS	829	704	84,9
SC	1.108	1.066	96,2
SE	273	226	82,8
SP	2.323	1.636	70,4
TO	299	136	45,5
Brasil	17.432	13.118	75,3

SOURCE – Ministry of Health/Department of Primary Health Care

These numbers are more impressive when we consider several other factors. As we detailed above, the AMAQ is an extensive tool that is not simple and that requires extensive mobilization and articulation of the EAB and support of the municipal management. Another very important point is that the AMQ, a similar tool previously proposed by the DAB and from which the AMAQ was derived, was used by just over 2,500 teams in six years. To clarify, the AMAQ was used five times more than the AMQ within a period six times shorter.

The key difference is not in the tool itself, although there are some differences, but in the context and articulation of the self-assessment process regarding all of the strategy proposed by the PMAQ and discussed in this article. Proposing a self-assessment as a way to trigger the processes of reflection and formation of collective change, enrich the self-assessment with monitoring, support the collective through continuing education and institutional support, give practical attention to problems revealed during the self-assessment process and finally recognize this effort during external assessment may partially explain the differences in use.

However, despite the impressive rate of voluntary use of an offered tool, it is important to investigate why 25% of the teams did not use the tool. Why did these teams not use the AMAQ? Did they use another instrument? Did they participate in another collective constitution and movement process? These questions must be explored and answered in time to shape the next steps of the PMAQ.

Final considerations

The present article aimed to describe the primary features and elements of the PMAQ and to evaluate the initial process of its implementation based on data regarding the accession of municipalities and EABs.

We demonstrated that the PMAQ relates to the set of strategic priorities defined by the National Primary Care Policy and other broader movements for reorienting the SUS, such as Decree 7508 of June 29, 2011, the establishment of care networks and the Assessment Program for Qualification of SUS.

Then, we reviewed the four phases that define the logical structure of the program and emphasize its dynamic nature as well as the strategies used to “make it happen”, including the rules that structure the design of each strategy.

We observed that the first phase, the stage of formally joining the program, includes voluntary accession as one of its primary aspects, based on the idea that service quality and practice will only change in environments in which workers, managers and users feel motivated and perceive themselves as central actors in their success, resulting in the creation of agreed-upon spaces for dialogue, negotiation and transformation of management that are agreed upon in each context.

The second phase of the PMAQ is considered the central stage of the program. This stage of change is primarily performed by the EABs and municipal management. The design of the second phase aims to expand the analytical capabilities of the collective through self-assessment and monitoring strategies and to strengthen the collective's capacity for action through institutional support and CE. The four strategies proposed are articulated to expand the capacity for analysis and management of collectives that should enact changes in conditions, relationships and practices.

The third phase is the external assessment. Based on a survey that obtains information regarding access to and quality of the EAB, the third phase certifies the teams participating in the program and recognizes and values the efforts and results achieved by the EAB and municipal managers in the AB qualification process. In the process of external assessment, the teams will be assessed based on factors related to the management of primary care development, the structure and operating conditions of the UBS, the appreciation of employees, the access to and quality of care, the organization of the work process and the program's use, participation and user satisfaction.

The fourth phase is intended to connect everything that was developed during the earlier stages and those to come using a feedback process in which the advances and obstacles serve as guides for the revisions of contracts and the ongoing process of primary care qualification.

Finally, we presented some information about the accession process and implementation of the program after the use of a self-assessment tool offered by the Ministry of Health. Regarding the accession, we found that even with less than 60 days for access, more than 70% of Brazilian municipalities joined the PMAQ, revealing a surprising level of voluntary accession to a new program that requires a series of pre-tasks and the assumption of various commitments for membership. At the same time, over 75% of the primary care teams that joined PMAQ used the AMAQ, revealing that the teams exhibit significant interest in the use of tools for identifying and recognizing major needs and major advances related to increasing the access to and quality of primary care.

References

ALTOÉ, Sonia (Org.). **René Lourau**: analista institucional em tempo integral. São Paulo: Hucitec, 2004.

BAREMBLITT, Gregório F. **Compêndio de Análise Institucional e outras correntes**: teoria e prática. Rio de Janeiro: Record, 1998.

BRAZIL. Ministério da Saúde. Secretaria Executiva. Departamento de Monitoramento e Avaliação o SUS. **Programa de Avaliação para Qualificação do Sistema Único de Saúde**. Brasília, DF, 2011a.

BRAZIL. Presidência da República. Decreto 7.508, de 28 de junho de 2011. Regulamenta a Lei no [8.080](#), de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde - SUS, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências. **Diário Oficial da União**, Brasília, DF, 29 de junho de 2011b. Disponível em: http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2011/decreto/D7508.htm>. Acesso em 25 jun. 2012.

BRAZIL. Ministério da Saúde. Portaria no 1.654, de 19 de julho de 2011. Institui, no âmbito do Sistema Único de saúde, o Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB) e o Incentivo Financeiro do PMAQ-AB, denominado Componente de Qualidade do Piso de Atenção Básica Variável - PAB Variável. **Saúde Legis**, 2011. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt1654_19_07_2011.html>. Acesso em 25 jun. 2012.

BRAZIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. **Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ):** manual instrutivo. Brasília, DF: 2011d. Disponível em: <http://www.saude.mt.gov.br/upload/documento/165/pmaq-manual-instrutivo-%5B165-040412-SES-MT%5D.pdf>>. Acesso em 25 jun. 2012.

BRAZIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. **Autoavaliação para a Melhoria do Acesso e da Qualidade da Atenção Básica: AMAQ.** Brasília, DF, 2011e. Disponível em: <http://189.28.128.100/dab/docs/sistemas/Pmaq/amaq.pdf>>. Acesso em 25 jun. 2012.

BRAZIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. **Documento Síntese para Avaliação Externa do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ).** Brasília, DF, 2012a. Disponível em: http://189.28.128.100/dab/docs/sistemas/pmaq/Documento_Sintese_Avaliacao_Externa_2012_04_25.pdf>. Acesso em 25 jun. 2012.

BRAZIL. Ministério da Saúde. Portaria nº 866, de 03 de maio de 2012. Altera o prazo para solicitação da avaliação externa no Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB) e as regras de classificação da certificação das equipes participantes do Programa. **Saúde Legis**, 2012. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt0866_03_05_2012.html>. Acesso em 25 jun. 2012.

BRAZIL. Ministério da Saúde. Portaria nº 1.089, de 28 de maio de 2012. Define o valor mensal integral do incentivo financeiro do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB), denominado como Componente de Qualidade do Piso de Atenção Básica Variável (PAB Variável). **Saúde Legis**, 2012. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt1089_28_05_2012.html>. Acesso em 25 jun. 2012.

CAMPOS, Gastão Wagner de Sousa. **Um método para análise e co-gestão de coletivos.** São Paulo: Hucitec, 2000.

CAMPOS, Gastão Wagner de Sousa. **Saúde Paidéia.** São Paulo: Hucitec, 2003.

CECÍLIO, Luíz Carlos de Oliveira. Contribuições para uma teoria da mudança do setor público. In: CECÍLIO, L. C. O. (Org.). **Inventando a mudança na saúde**. São Paulo: Hucitec, 1997.

CECÍLIO, Luíz Carlos de Oliveira. Uma sistematização e discussão de tecnologia leve de planejamento estratégico aplicada ao setor governamental. In: MERHY, E. E. (Org.). **Agir em saúde**. São Paulo: Hucitec, 2003.

CECCIM, Ricardo Burg. Educação permanente em saúde: desafio ambicioso e necessário. **Interface: comunicação, saúde, educação**, São Paulo, v. 9, n. 16, p. 161-77, set. 2004/fev. 2005.

DELEUZE, G; GUATARRI, F. **O Anti-Édipo: capitalismo e esquizofrenia**. Lisboa: Assírio & Alvim, 2003.

MATUS, Carlos. **Política, planejamento e governo**. Brasília: IPEA, 1993.

MERHY, Emerson Elias. **Saúde: a cartografia do trabalho vivo**. São Paulo: Hucitec, 2002.

PINTO, H. A., KOERNER, R. S.; SILVA, D. C. A. **Prioridade se traduz em mais e melhores recursos para a atenção básica**. Rede de Pesquisas em Atenção Primária à Saúde, Associação Brasileira de Saúde Coletiva. Disponível em <<http://www.rededepesquisaaps.org.br/2012/06/18/prioridade-se-traduz-em-mais-e-melhores-recursos-para-a-atencao-basica/>> Acesso em 25 jun. 2012.

TESTA, Mário. **Pensar em Saúde**. Porto Alegre: Artmed, 1992.