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Original Article

Program of assessment of primary care from the perspective of health professionals and managers*

O programa de avaliação da atenção básica na ótica dos profissionais de saúde e gestores

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Objective: to understand the perception of health professionals and managers about the benefits of the National Program for Improving Access and Quality of Primary Care. **Methods:** qualitative study based on the National Program for Improvement of Access and Quality of Primary Care and using evaluative research as methodological reference. Thirty-two health professionals participated in the study. Open interviews were used for data collection and the analytical steps of the Grounded Theory were used for the analysis, with the aid of ATLAS.ti software. **Results:** the Program brought improvements to the practice of care, which before the evaluation were not valued or developed by professionals. However, shortcomings were detected, especially regarding the conduct of the evaluation process. **Conclusion:** according to the study participants, the Program promoted positive experiences, which culminated in the reorganization of some activities. However, shortcomings were pointed out, mainly regarding the normative character of this evaluation.
Descriptors: Health Evaluation; Health Services Research; Primary Health Care; Qualitative Research.

Objetivo: compreender a percepção dos profissionais de saúde e gestores acerca dos benefícios do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica. **Métodos:** estudo qualitativo, tendo como base conceitual o Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica e referencial metodológico a pesquisa avaliativa. Participaram 32 profissionais de saúde. Para a coleta de dados, utilizou-se a entrevista aberta e para a análise, obteve-se as etapas analíticas da *Grounded Theory* com auxílio do *software* ATLAS.ti. **Resultados:** o Programa proporcionou melhorias para a prática assistencial, que antes da avaliação não eram valorizadas e desenvolvidas pelos profissionais. Entretanto, insuficiências foram pontuadas, principalmente no que tange à condução do processo avaliativo. **Conclusão:** para os participantes do estudo, o Programa proporcionou experiências positivas, que culminaram na reorganização de algumas atividades. Entretanto, insuficiências foram apontadas, principalmente quanto ao caráter normativo dessa avaliação.
Descritores: Avaliação em Saúde; Pesquisa sobre Serviços de Saúde; Atenção Primária à Saúde; Pesquisa Qualitativa.

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Introduction

As a product of an important negotiation and agreement process between the three spheres of management (federal, state and municipal) of the Brazilian Unified Health System, in 2011 the Ministry of Health established the National Program for Improving Access and Quality of Primary Care, whose goal was to improve the access and quality of service at this level of care, with a guarantee of a comparable quality standard in all spheres of management[1].

The National Program for Improving Access and Quality of Primary Care encourages managers to improve the quality of Primary Health Care units and the goal is to guarantee a quality standard that provides for monitoring and evaluation of the work of the health teams. This evaluation process involves the transfer of federal financial resources to the participating municipalities, reaching scores that characterize the quality of care offered to the population[2-3].

The investments of the Ministry of Health in the area of evaluation seek to ensure the quality of care. The ideal quality envisages meeting the principles of comprehensiveness, universality, equity and social participation[2-3]. Thus, the National Program for Improving Access and Quality of Primary Care aims to articulate evaluation and accreditation, linking resource transfers according to the performance achieved in the implementation and development of the elements evaluated by the program[1,4].

Incorporated as a health program, the National Program for Improving Access and Quality of Primary Care involves monitoring, follow-up and evaluation of the health system[5]. Because it is a program recently implemented in Primary Care and because its evaluation involves the quality of care and, consequently, all health professionals and managers working in this context, knowing how these social actors understand this process is very important. Thus, the following research question emerged: What is the perception of health professionals and managers working in the Family Health Strategy on the evaluation of the National Program for Improving Access and Quality of Primary Care and its impact on improving care?

Given this context and considering the scarcity of qualitative evaluative studies on the development and applicability of this Program, the objective of the present work was to understand the perception of health professionals and managers about the benefits of the National Program for Improving Access and Quality of Primary Care.

Methods

This is a qualitative study with the policy that underpins the National Program for Improving Access and Quality of Primary Care[1] established by the Ministry of Health as conceptual basis, and evaluative research as methodological reference[6]. The study scenario was a medium-sized municipality, located in the southern region of the country. A total of 32 primary care professionals participated in the study. Of them, 29 worked in Family Health Strategy teams. They were five nurses, five physicians, four nursing assistants, and 15 community health agents. The other three participants were health managers (two local managers units of Basic Health Units and one municipal manager).

The health professionals of the Family Health Strategy Teams and the managers involved who had been evaluated at least twice by the said Program were considered eligible for inclusion in the study. As exclusion criterion, Family Health teams without nurses were excluded because of the important participation and leadership exercised by these professionals along with the other members of the team; and Family Health teams without professionals of Oral Health teams, for not being linked to all municipal teams during the period of data collection.

For recruitment of these participants, the Primary Health Care units that had been evaluated at least twice were identified in the Health Department. The units were selected by lot to start the data collection. Data collection was terminated with basis on the

principles of theoretical saturation, that is, when further interviews do not add new data. This method led to a scenario of five teams that integrated five Basic Health Units, totaling 29 professionals and three managers linked to them.

Data collection took place through open interviews from January to May 2014 conducted by the main researcher and performed individually in rooms provided by the managers of the Basic Health Units. All the interviews were recorded in electronic audio devices, had an average duration of 60 minutes, and started with the following guiding question: How do you evaluate the National Program for Improving Access and Quality of Primary Care in the municipality? Other questions were asked in order to deepen the subject and to understand how this evaluation takes place, what contributions this process brings to the care provided, how the teams are organized for the realization of this process, and which point of view the professionals have about the Program. The principles of theoretical saturation were respected to suspend data collection.

The data of the interviews were transcribed and analyzed with the aid of the software ATLAS.ti 7.1.7. Data were analyzed with the analytical steps of the Grounded Theory[7] from which the steps of open coding were adopted. In this moment, a microanalysis was made, with survey of codes, using the perception of health professionals and managers about the National Program for Improving Access and Quality of Primary Care as reference, as well as axial coding which codes in two axes that allowed the construction of the categories presented in this study. The categories were titled: Benefits of the National Program for Improving Access and Quality of Primary Care to the practice of Family Health Strategy professionals and Shortcomings of the evaluation process of the National Program for Improving Access and Quality of Primary Care.

The judgments and inferences that supported the evaluative research adopted in this study were based on the National Program for Improving Access and Quality of Primary Care[1], which allowed an analysis of data geared to this document.

All participants signed the Informed Consent Form. The secrecy and anonymity of the participants were preserved and they were identified using the profession or position held, followed by the letter P and a number corresponding to the inclusion of their interview in the ATLAS.ti software. The study complied with the formal requirements contained in the national and international regulations regulating research involving human beings and was approved by the Ethics Committee of Research involving humans under Opinion nº 466.855, and had the authorization from the Municipal Health Department.

Results

From the point of view of health professionals who work in Primary Care, the National Program for Improving Access and Quality of Primary Care is a program that has both positive and negative points. Some professionals identified changes and benefits that the program has brought to the service within the scope of improvements to the practice of care. However, shortcomings were also noted in its implementation.

Benefits of the National Program for Improving Access and Quality of Primary Care to the practice of Family Health Strategy professionals

The health professionals participating in the research identified that the National Program for Improving Access and Quality of Primary Care comprises a complex evaluation that aims to evaluate various aspects at this level of care, including structure, process and results. The evaluation is carried out by external evaluators from public universities who work in partnership with the Ministry of Health. *In 2011, we began to get ready to go through this evaluation and our evaluation was very good, 70.0% of our Primary Health Care Units are above average, with a bonus of 100.0%. This program has the aim to improve the care; it makes an evaluation with a huge questionnaire* (Manager-P34).

For some professionals, the Program brought benefits to the service because some Family Health teams, after passing the evaluation, were able to identify gaps in care, as well as the need for improvement for the next evaluation. They started to implement actions that could improve aspects that had not been well evaluated, such as the implementation of local councils in some Primary Health Units, which were non-existent; development of care focused on smokers and adolescents; and increase in the interest of some community health agents for the work developed. *With the Program we have achieved many things* (Manager-P34). *We are trying to put together the smoking group, because they say we need to have it. There was a group that ended with one person. So, whatever the Program requested, we went after that. I liked it because it forces the team to work* (CHA-P21). *There was an improvement, and the ones who improved with this were the community health agents, mainly in the issue of their salary. They always go after change when we say it is the goal of the Program* (Nurse-P27).

After the implementation of the Program, its directions directly influenced the work in Primary Care, and the main incentive was the financial incentive coming from the result of the evaluation. *In the last assessment of the Program, an annual plan was sent for us, which was done in accordance with what the Health Department wanted; now, things will be in accordance with what the Program establishes! We are receiving benefits to improve the service* (CHA-P22). *This month we received the financial resource and it was very good. It is an incentive for us to get organized, because we were previously in the comfort zone, we would only do a few different things when the Health Department demanded them from us, but now with the incentive of the Program, we are meeting our goals* (Nursing Assistant-P6).

It is noteworthy that the financial incentive that is passed on to the teams by virtue of the result of the evaluation stimulates changes in the practice and, consequently, the improvement of the quality of the service. *We received money from the Ministry of Health as a benefit and 60.0% of this comes to management and goes to the bottom. You have to do this calculation and share it among the teams, with their ratings and scores, because they are different incentives and different transferences. When the scores are disclosed, I have to see which team was good and which value they have to receive. This money only serves for funding, and for the Ministry, funding corresponds to all that is consumed. I cannot buy furniture, I cannot do Basic Unit, but I can use it for transportation costs in qualifications. The Municipal Law determined that 25.0% of the money that enters the fund can be passed on to professionals in a meritocratic way, equal to all, with a very simple calculation basis. This is a breakthrough, because I had never seen the meritocratic payment to health personnel, this is very good* (Manager-P34). For the management, the financial compensation of health professionals is a positive thing, and it is something agreed by Municipal Law, recognized as a transparent process.

Shortcomings of the evaluation process of the National Program for Improving Access and Quality of Primary Care

As a shortcoming mentioned by the study participants, it was pointed that not all professionals in the Family Health Strategy are involved in evaluating the National Program for Improving Access and Quality of Primary Care, nor with its results. The activities related to the evaluation process end up being left to nurses, without a joint involvement of other Family Health Strategy team professionals regarding the changes and the necessary improvements for the care practice. *In fact, nurses are the ones with the most direct contact. So, I can't tell much, what we do is to fill the questionnaires they request* (Physician-P31).

Some participants criticized the way in which the Program conducts the evaluation process. They pointed out some shortcomings and flaws, as expressed in the following discourse: *The evaluation itself I find it very weak, very easy to manipulate, the evaluation ends up not evaluating which team is doing things and which is not. I think a better evaluation could be done* (Nurse-P27).

From the point of view of some health professionals, the Program is not able to evaluate the care practice because the evaluation is based on objective questions regarding the team structure and the care practices merely based on documental analysis. *In general, the evaluation does not do much, does not try to know if there were improvements; it only wants to know how many people came*

and received care, if there is a protocol, and if all reports are available. They do not check the quality of the service. Perhaps, for some teams that were very bad, there has been improvement. But, we who always try to improve, we do not receive an option on how to improve our care (Physician-P30).

Besides the perception that the Program is not able to adequately evaluate, the professionals also consider that the evaluation result does not contribute to an effective change of practice, since it does not guide or indicate how professionals should improve. *The Program comes to evaluate the service in primary care. But it's of no use. It's a notebook, I do not know how many questions, but unnecessary questions because they are not able evaluate my work and what has improved in my work* (Nurse-P2).

Due to its normative nature, the Program allows professionals to respond only to objective questions in a punctual manner and verify some documents which are often prepared only for the moment of evaluation, without need for compromising with the subjectivities and conducting the care practice. This evaluation process leads some professionals to affirm that this is a utopian activity, as expressed in the following statements: *Today I had a patient of mine who needed to do food reeducation, but we do not have it here. The only thing is a food reeducation poster there at the reception room. I told her "where did you see that, because I am not aware of this stuff?". Yesterday, the community agents said: "No, this is there only because of the National Program for Improving Access and Quality of Primary Care, to pretend that we are doing it, for us to gain something"* (CHA--P14). *For me, it only causes discomfort, because once you turn your back you have another year to do nothing and in the last month we start running to prove that we do something that we actually don't! Then you have to multitask, come up with a folder, and say that you do that. Because they are academics, they do not even ask* (Nurse-P4).

Another aspect considered a flaw in this evaluation process was the aspect of financing, which was even pointed out by some participants as a benefit. *Now it comes the critical aspect: money. This is what irritates me, that people are only interested in money, that's what irritates me most in my job. And what about their duties? Because, this money corresponds to the fourteenth salary and much more; their fifteenth salary in the year. This wasn't supposed to be this way* (Manager-P34). *Today, everyone questions the Program. From it comes an incentive that should be 100.0% for the professionals, but we only receive 25.0%, where is the other 75.0%? If I am the one here in the corner, it's me! And from my point of view, there should be a difference, because nurses work much more than others and yet they get the same of community health agents. So, these situations end up discouraging* (Nurse--P4). Hence, funding was also mentioned as a point of contention by professionals and managers, who considered it insufficient within this context.

Discussion

One of the limitations of the study was the fact that it did not involve all the categories of health professionals involved in the primary care network or service users, who could reveal perceptions about the distinct benefits and shortcoming of those listed above, according to the reality experienced.

The health professionals who make up the Primary Care service pointed out benefits and flaws in the National Program for Improving Access and Quality of Primary Care. The benefits included aspects that brought improvements related to the pillars of the Unified Health System, such as quality, accessibility, longitudinality, comprehensive care and social control. Beneficial changes in the care practice mentioned by the participants also included the improvement in the performance of community health agents in their tasks developed to meet the goals established by the Program. However, this aspect was related to the financial incentive.

Studies show that it is important for municipalities to adopt a financial distribution of values of the quality component to the Primary Care workers evaluated because they say that these social actors are central to the evaluation and important transforming agents of the local reality[8-9]. Moreover, the Program foresees the transfer of funds, i.e. from the National Health Fund to the Municipal fund, allowing the resource to go to the whole of the municipal health budget and to be used for financing of Primary Care[1,10].

The stimulus promoted by the financial reward,

that is, the incentive to achieve a good score to continue receiving the grant, causes this commitment to start to rule the work in Primary Care. Some professionals said that, they better organized their care practices after the result of the evaluation process. This was therefore a positive response to the Program, which is the ultimate goal of any evaluation process of health services. As a Program that aims to support decision-making processes in the area of Primary Care, it is an important evaluation that guides the planning of future actions for this level of care[1].

With regard to the shortcomings of the National Program for Improving Access and Quality of Primary Care pointed out by health professionals, it is important to note that not all the professionals of the Family Health team are involved in the evaluation process and with its results. In this case, the evaluation does not contribute to changes and improvements in the quality of care.

In the evaluation processes of health services, the discussion of the obtained results should guide processes of monitoring and continuous education[6]. In ultimate case, the results are expected to pose issues and challenges for both the staff and the various levels of management. The appropriation of the results by all these segments is an essential part of the evaluation cycle. When this does not happen, the process is incomplete[11-12].

Criticism was expressed as to the way in which the evaluation is carried out. This is because the evaluation is a normative evaluation process, based on a quantitative, punctual and closed evaluation. There is no involvement of the subjectivity of the social actors or of the daily dynamics of care; data regarding the structure, processes and results are evaluated in a directive way. It is emphasized that the subjectivity, values, feelings and desires present in social actors are essential aspects to be researched in the evaluation of health programs and services. Quantitative researches are unable to go deep in the phenomena of intersubjectivity, experiences, understandings, and interpretations shared by these actors[6,13].

As evidenced in the results of this study, this type of evaluation opens possibilities for some information to be manipulated by health professionals. For example, the preparation of bureaucratic material such as folders and minutes to be evaluated in a punctual manner, without observing how the daily care practice works, but rather focusing on what is said and shown in the documents, which is not always part of the daily work of the professionals in Family Health Care teams.

However, among the principles for assessing the quality of health care services is the ethical commitment and the responsibility of the institution evaluated before its users regarding the quality of care offered[14-15]. Therefore, an evaluation cannot seek a single cause and a single effect; it must be open to investigate the multiple contradictions and dimensions that exist in the investigated phenomenon[13]. It must resort to methodological innovations that promote the participation of all actors involved in the scenario investigated[16].

Situations such as those identified in this study allow us to reflect on the institutionalization of the National Program for Improving Access and Quality of Primary Care, which is something to be analyzed at various levels of management. The literature points out that evaluation processes with a view to improving quality should preferably be voluntary, continuous and systematic, carried out by professionals in their daily life and in the workplace in order to establish a culture of evaluation based on facts, stimulating the participation and understanding in services, promoting the accountability of individuals to improve services[4,17].

However, instituting an evaluative culture in the social actors involved in the care practice and management takes time and requires a good deal of effort to understand the importance and benefits of this process as a tool for change[13,18]. This is because the evaluative practice consists in a complex pro-

cess, which requires several approaches that pervade the acceptance of services by the subjects involved, as well as the fulfillment of technical criteria, which must take into account the subjectivities involved in the context[19].

While the evaluative culture does not become part of the work process of Brazilian health professionals, the evaluators who are in the leadership of the National Program for Improving Access and Quality of Primary Care should rethink the methodologies employed in order to enable them to adopt more comprehensive techniques that allow the survey of information and a more thorough reading of the assessed reality.

In order for the National Program for Improving Access and Quality of Primary Care[1] to reduce the shortcomings pointed out in this study, as an evaluation program, it is necessary to adopt other research methodologies in the evaluation process, so as to help in the reading of reality with greater accuracy with respect to the real events of everyday practice. For the evaluators involved in the evaluation process, the use of qualitative methodologies is recommended, in view of the inadequacies pointed out in this research, resulting from a quantitative and punctual evaluation.

Conclusion

In the view of health professionals and managers of the Family Health Strategy, the National Program for Improving Access and Quality of Primary Care has promoted positive experiences, which culminated in the reorganization of some aspects of care that were not valued or developed by the professionals in former times. However, some important shortcomings of this program were pointed out by the interviewees. They are related to the normative nature of the evaluation, which makes it difficult to make a subjective analysis of the reality of the service.

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Collaborations

Salci MA, Meirelles BHS and Silva DMVG contributed in the conception and design, analysis and interpretation of data and article writing. Paiano M, Radovanovic CAT and Carreira L contributed to the relevant critical review of the intellectual content. All authors collaborated with the final approval of the version to be published.

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