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PROGRAM FOR ACCESS AND QUALITY IMPROVEMENT IN PRIMARY CARE FROM A MEDICAL PERSPECTIVE

PROGRAMA DE MELHORIA DO ACESSO E DA QUALIDADE DA ATENÇÃO BÁSICA SOB A ÓTICA MÉDICA

PROGRAMA DE MEJORA DEL ACCESO Y LA CALIDAD DE LA ATENCIÓN BÁSICA BAJO LA ÓPTICA MÉDICA

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ABSTRACT

Objective: To understand the meaning of the program for access and quality improvement in primary care from a medical perspective working in family health teams. **Methods**: Qualitative research, performed with 14 physicians through interviews with a semi-structured script. Data were analyzed using the content analysis technique. **Results**: Three thematic categories were elaborated: The medical conception of PMAQ-AB: opposing views; the positive face of PMAQ-AB; PMAQ-AB and the difficulties experienced by doctors. **Conclusion**: Permanent education programs are necessary in relation to health policies in order to incorporate them with greater effectiveness aiming at quality in health services practices.

Descriptors: Quality Management; Primary Health Care; Evaluation of Health Services.

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RESUMO
Objetivo: compreender a concepção sobre o Programa de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB) sob a ótica dos médicos atuantes nas equipes de Saúde da Família. **Método**: Pesquisa qualitativa, realizada com 14 médicos através de entrevistas com roteiro semiestruturado. Os dados foram analisados utilizando-se a técnica de análise de conteúdo. **Resultados**: Elaboraram-se três categorias temáticas: A concepção médica sobre o PMAQ-AB: visões que se contrapõem; A face positiva do PMAQ-AB; PMAQ-AB e as dificuldades vivenciadas pelos médicos. **Conclusão**: Fazem-se necessários programas de educação permanente no tocante às políticas de saúde de forma a incorporá-las com maior efetividade visando à qualidade nas práticas dos serviços de saúde. Ressalta-se a necessidade de investimentos na estrutura física e recursos materiais que são apontados como aspectos limitadores para a atuação dos profissionais.
Descritores: Gestão da Qualidade; Atenção Primária à Saúde; Avaliação dos Serviços de Saúde.

RESUMEN
Objetivo: Entender el significado del programa para mejorar el acceso y la calidad de la atención primaria desde la perspectiva de los médicos que trabajan en equipos de salud familiar. **Métodos**: Investigación cualitativa, realizada con 14 médicos a través de entrevistas con un guión semiestructurado. Los datos se analizaron utilizando la técnica de análisis de contenido. **Resultados**: Se elaboraron tres categorías temáticas: La concepción médica de PMAQ-AB: puntos de vista opuestos; La cara positiva de PMAQ-AB; PMAQ-AB y las dificultades experimentadas por los médicos. **Conclusión**: Los programas de educación permanente son necesarios en relación con las políticas de salud con el fin de incorporarlos con mayor eficacia con el objetivo de la calidad en las prácticas de servicios de salud.
Descriptores: Gestión de la Calidad; Atención Primaria a la Salud; Evaluación de los servicios de Salud.

INTRODUCTION

Public health policies in Brazil have always been strongly related to the historical-political moment in force at the time. The hegemonic medical health care model has historically been marked by a care approach centered on individualism, mechanism, biologicalism, curativism and hospital care. With the implementation of the Unified Health System (UHS), in 1988, the need for new practices in services arose, and thus the incorporation of the principles of equity, universality, integrality and decentralization.[1]

Then, in 1994, the Family Health Program (FHP) was established, emerging in view of the need to restructure the country's health system, seeking to overcome the old model of health care. Later, in 2006, the FHP ceased to be a program and was consolidated as the priority strategy for offering Primary Care (PC) services in Brazil, and became the Family Health Strategy (FHS).[1]

This new care strategy, since its conception, articulates actions to prevent diseases, promote, recover, rehabilitate and maintain health. Its dynamics also provides

the bond between user and team, considerably reducing the gap previously formed by the biological model.[1]

However, health services need means to consolidate the quality of their actions, with a view to offering services that respond to the population's needs, systematically organizing themselves within predetermined standards that denote acceptable characteristics of execution.

In this context, in 2011, the Ministry of Health (MH) built proposals for restructuring PC focused on expanding and qualifying the services provided. Thus, several strategies began to integrate the new National Primary Care Policy (PNAB), including the National Program for Improving Access and Quality of Primary Care (PMAQ-AB).[2]

The PMAQ-AB emerged in the midst of this process, considering that the attempts to improve quality through self-assessment of services had not reached the desired effect and could not collectively contemplate the existing care models.[2] This program consists of four phases: compliance and contractualization; development; external evaluation and recontractualization. It defines several situations/problems/powers through its quality standards and encourages the actors to recognize them, problematize them and define the priorities according to their reality.[2]

It is also worth mentioning the uniqueness presented by this evaluation strategy concerning the adherence, since the plan is voluntary in nature and registration occurs individually between the teams, thus allowing their autonomy. In short, the main objective of PMAQ-AB is to induce the expansion of access and improvement of the quality of PC, ensuring a comparable quality standard nationally, regionally and locally, in order to allow greater transparency and effectiveness of government actions.[3]

Based on the importance of the quality of care provided by all professionals involved in the FHS, the question is: what is the conception of physicians in the Family Health teams about the PMAQ-AB? A literature review was conducted in order to improve the knowledge about the medical conception about the PMAQ-AB and their performance as a member of the team, which found the existence of few studies on this theme.

Based on the above, the study aims to understand the conception of PMAQ-AB from the perspective of physicians in Family Health teams in a municipality in Zona da Mata, Minas Gerais, Brazil.

METHODS

This is a descriptive research of a qualitative nature. The qualitative research

allows the researcher to approach the individual's reality of life, in addition to identifying the context in which he/she is inserted.[4]

To understand the meaning of PMAQ-AB, the chosen scenario was a municipality that has 17 Family Health units, located in the Zona da Mata, Minas Gerais. Data collection was performed between April and December 2016, through interviews with a semi-structured guide. The inclusion criteria were: medical professionals, who worked in the Family Health teams of the municipality in question, who were not absent for any reason.

Of the 17 physicians active in the municipality, three refused to participate in the research, totaling 14 participants. The time of the interviews was previously scheduled with each participant and the interviews were recorded and fully transcribed. As a form of identification in the research, the physicians were coded by the letter "P", followed by numbers indicating the order of the interviews.

The qualitative analysis of the results was performed through content analysis, comprising three phases: pre-analysis, exploration of the material and interpretation of the contents.[5] Thus, initially, a floating and exhaustive reading of the questions of the interviews was performed, in order to be familiar with the text and obtain an understanding of what the subject sought to transmit. Then, the thematic selection occurred, which consisted of identifying the meaning cores, or semantically similar elements, for later categorization. Subsequently, the data were interpreted according to the literature relevant to the theme.

The research was submitted to the Human Research Ethics Committee, being approved under opinion n. 1.146.811.

RESULTS AND DISCUSSION

Of the 14 physicians participating in the study, nine were aged ≤30 years, two were between 31 and 40 years old, and three were over 50 years. Nine professionals were female. Regarding the time since graduation, six had below one year of profession, five between 1 and 10 years and three over 10 years. Twelve physicians had been working in Family Health teams for four years or less and only two for over 10 years. The workload exercised by two interviewees hired by the "*Mais Médicos*" Program was 32 hours per week and the rest had a workload of 40 hours per week. It is also worth mentioning that six professionals had already attended specialization in areas related to Family Health.

After analyzing the interviews, the following categories emerged: The medical conception of PMAQ-AB: opposing views;

The positive side of PMAQ-AB; PMAQ-AB and the difficulties experienced by physicians.

The medical conception of PMAQ-AB: opposing views

In this category, the conceptions about the program from the perspective of physicians will be addressed. Knowing the medical conception about PMAQ-AB allows understanding how the program has been implemented and developed, which may reflect the reality of other teams in Brazil.

Some participants were able to identify essential elements that govern the program, without, however, specifying them. The following statements illustrate the above:

It is the Program for Improving Access and Quality in Primary Care, since it was launched, the goal I realize is to stimulate teams to improve as much as possible the access to services, also improving the access of the quality of this service, with the evaluation of some indicators [...] (P2)

The PMAQ is a program for improvement, to improve both access and quality of primary care in the public network. (P3)

By understanding the guidelines proposed by the PMAQ-AB, there will be a greater mobilization to incorporate them into their care practice. Moreover, actions emerge to expand access to and quality of health services in the scope of Family Health, increasing the provision of qualified care and implementing the problem-solving characteristic of the FHS.

Some authors also describe that the PMAQ-AB enables the management of health resources, provides improvements in the performance of the work process, reflecting on health indicators, so that they are not only conditioned to the program, but to a daily practice that has a considerable impact on the flow of services.[6]

The following statements evidence the erroneous conceptions that characterize the medical unawareness of the real meaning of the program:

You know I am so out of PMAQ?! I do not have the vaguest idea, I mean; people come and talk. Isn't the PMAQ responsible for assessing and comes every year and evaluates doctors and stuff like that? (P1)

[...] I mean, I lost it, so I do not really know what it is anymore. (P5)

That is what I told you, I did not know until you invited me to the interview, but I tried to know, it is a program of the federal government that seeks to improve care, management, but nothing about health, but so far I had no idea about the program. (P11)

The frail understanding of what PMAQ-AB is restricts its importance, creating a barrier that can limit its development, minimizing its role as a potentiating tool for improving quality and access to public health services. Thus, the

unawareness of the actors involved limits the program to a bureaucratic mechanism, with direct implications in the proposed objectives. This, in turn, interferes in the recognition of the FHS as the gateway to health services, concealing the problem-solving character of PHC.[7]

The involvement of physicians in the process of program support is questioned, because according to the statements, it is assumed that the PMAQ-AB was a strategy introduced vertically in the researched scenario. In this sense, its insertion was carried out without sensitization regarding the real need for its implementation, without presentation of its potentialities or the need to adapt to health actions aimed at strengthening care practices, without implying work overload.

A study conducted in the Federal District showed that some physicians were not in favor of implementing the program, associating the necessary reformulations with the increase in workload.[8]

Another important aspect evidenced in this research concerns professional preparation, including the search for postgraduate courses, in which only six professionals interviewed reported having already attended specialization in areas related to Family Health. This datum is relevant since, in an economic, political and social context of major changes regarding health scenarios and practices, it is expected that all the actors involved are engaged in improving the quality of care. Thus, training in the area of activity can influence the satisfactory performance of the activities, besides reflecting positively on the motivation of the professionals.[9]

The positive side of PMAQ-AB

In view of the reflections developed on the medical conception about the PMAQ-AB, this category will address the potentialities of the program, identified by the study participants. Among them, its recognition prevails as a self-evaluating instrument:

I think the main benefit [of the program] is exactly the self-assessment for teams, so they can look a little at the daily work and identify weaknesses and strengths [...] identification of deficiencies, identification of areas where access needs to be improved... (P2)

I think exactly this [benefit] of making each professional look at the own job a little more critically, trying to identify weaknesses of their performance as a professional, I think the PMAQ makes the team stop to look at their own work [...] (P4)

The perception of the need for a self-assessment tool allows the construction of objectives based on the reality in which they operate, providing the reformulation of the practices performed. Thus, the whole process will lead to a replanning of actions aimed at coordinating care, benefiting users of the service. Thus, it is important to highlight

the need to create a culture of quality in PHC, where self-assessment results in changes and adjustments, in which the actors involved are not only restricted to meeting goals, but focus on the individual and collectivities.[10]

Physicians also recognize that the program's premise is to facilitate access, as described in the following statements:

[...] The goal that I perceive is to encourage teams to improve a little the access to services by improving the quality access of this service [...] (P2)

[...] The program is for improvement, to improve both access and quality of primary care in the public network. (P3)

[...] The access to improved access, active search that is unquestionable [...] (P4)

It is important to understand access as a form of health promotion, not only restricting itself to structural and geographical issues, but also allowing resolution of the existing demands in the service, whether scheduled or spontaneous. Thus, accessibility or access appear as one of the aspects of the provision of services related to the ability to produce services and respond to the health needs of a given population.[11]

In this context, the physicians reported that the PMAQ-AB had the potential to implement the embracement in the units:

[...] in the end everyone has to work on everything from patient embracement to treatment [...] (P3)

[...] but for now the benefit was only the knowledge of embracement [...] (P14)

Primary Care must establish mechanisms that ensure the embracement, thus, a logic of organization and functioning of the health service is presupposed, which assumes that the health unit should receive and listen to all people who seek its services, in a universal way and without exclusionary differentiations.[3]

However, challenges still need to be overcome, with the need to have professionals prepared, motivated and with specific training to work in primary care, with the ability to respond to the needs of individuals.[12]

The participants' statements also revealed the importance of PMAQ-AB investments in permanent education, allowing the updating of professionals regarding new scientific evidence. The following statements represent the above:

Many benefits... Many benefits [PMAQ took to PC]... Because what happens, we have to train more, we have to learn more, treat more, while quality of care understands, so that the patient receives at the end a good quality product, that is, a good quality care [...] (P10)

[...] so when training was done for me that was already normal, it was already my routine, cough up two weeks, but now it is all protocol. (P3)

Permanent education is understood as a strategy for transforming health practices, as it allows professionals to

acquire increasingly more practical experiences, aiming to improve their actions before daily problems and feasible solutions, where management support favors their consolidation.[13] Organizations need to invest in workers generating opportunities for continuous learning. Thus, permanent education provides support to the discussion of the work process and appreciation of the experiences of the entire health team, in the sense of the refined construction of a care product.[14]

One study expressed the view of managers about the participation of physicians in permanent education programs, and it revealed that the participation of physicians was related to the adequacy of the physical space for the performance of educational activities and the multidisciplinary approach.[13]

Moreover, some challenges need to be overcome, since many family health teams located in rural areas do not have permanent education in their daily lives.[15] According to data from DATASUS[16], in 2016, Brazil had 64.0% FHS coverage, of which 20.04% were located in rural areas. It is suggested to encourage professional qualification to acquire skills and abilities in PC, and permanent education is a fundamental means for building quality standards that respond to emerging demands in services.

PMAQ-AB and the difficulties experienced by physicians

This category will discuss the weaknesses experienced by the participants that hinder the achievement of the goals proposed by the program. The professionals interviewed reported the inadequate physical structure of the units, which mostly work in rented houses and consequently imply unfavorable working conditions, making care difficult. Those issues can be noted in the following statements:

[...] Here it is more goodwill and stuff, each one shares the place with the other, the conditions are very bad, the human material conditions are very good, but physical unit, structure, are very bad (P3)

[...] But I think they have more money and that they could be investing it in the health unit. Mainly because our structure here is very bad, it is a rented house, they say they cannot keep investing in a rented house [...] (P2)

[...] so to do a health program, any kind of health program, first you have to have a structure created. (P10)

To guide the teams that joined the PMAQ-AB, the MH developed a handbook that listed the greatest challenges related to the implementation of the program, and the precarious conditions related to the physical structure of the units are pointed out as a complicating factor. However, no proposal or reflection about those determinants is presented and/or

contextualized.[3,17] Added to this is the fact that an unfavorable work environment results in the demotivation of professionals who work in those scenarios.[18]

In this sense, to consolidate the implementation of the FHS throughout the national territory, it is necessary to overcome elements that constitute obstacles to its implementation, highlighting the physical structure of health services. Therefore, it is necessary to support managers at all levels of management who should focus on the results generated in the PMAQ-AB cycles and develop proposals aimed at solving such weaknesses.[3,19]

Another difficulty experienced by physicians is the lack of material resources to provide quality care. There is a report of lack of essential materials for the operation of the units, as observed in the following report:

[...] There is lack of material, sheet and we are missing different things we end up buying, we replace one thing, and the other is missing, so it is difficult to work this way... I already bought stapler, pen... I even brought paper from home [...] (P1)

The lack of material resources limits care practices, preventing PC from offering resolution to the demands existing in the services. This compromises the development of activities that are part of this scenario, restricting the principle of integrality, which is one of the central axes of the UHS.[19]

Studies reaffirm the aspect of health work management in PC, highlighting that municipalities are unable to make up health teams and cover care demands when the sector is underfunded. It is also punctuated that there is a lack of incentives in actions aimed at evaluating the care outcomes.[19] Therefore, it is evident the importance of a greater articulation between the spheres of government, allowing the concreteness of the proposals of the PMAQ-AB.

Moreover, the statements also pointed to the medical perception in relation to the contractualization phase in the PMAQ-AB, understanding it as a vertical-oriented policy, where a direct agreement between municipal management and the MH prevails, decharacterizing the voluntary participation of the PMAQ-AB, as seen in the excerpts below:

I am, aren't I?! You know they signed me up for PMAQ? (P1)

I have been since I came in. The PMAQ is the one of the city hall, right?! As soon as I came in they already signed me up, it was not by my will. (P8)

Only if the city hall signed me up. I do not know how it actually works. (P11)

It is emphasized that the program's support should be carried out voluntarily and its success depends on the motivation and proactivity of all professionals in the

multidisciplinary team.[3] Thus, the unawareness of the principles of the PMAQ-AB results in obstacles to the implementation of the program, decharacterizing its inducing profile to improve access and quality of services provided by PC.[20]

A study states that the challenges related during the implementation process of the PMAQ-AB allow professionals to understand the program as something imposed by municipal managers, who use it as a form of punishment or financial compensation. In view of this scenario, managers need to allow all stages of the program to be executed correctly so that professionals feel motivated and participants in this process.[20]

CONCLUSION

The study revealed that some physicians were unaware of the meaning of PMAQ-AB. On the other hand, some participants identified the potentialities of the program as a tool for self-assessment and improvement in the access of the population, characterized by embracement. Another positive aspect of PMAQ-AB is the implementation of permanent education in health services.

The professionals also identified weaknesses related to the development of the PMAQ-AB, such as inadequate physical structure, hindering the work process, also allied to the lack of material input, and finally vertical-oriented contracts.

It is suggested to advance in research related to the performance of physicians in the PMAQ-AB, in order to develop it adequately, resulting in a comparable health standard nationally, regionally and locally.

One limitation found was the low number of studies available to support the discussion and comparison of the results.

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