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ORIGINAL ARTICLE

Municipal managers' perceptions of the PMAQ: Experience in the Crato Health Region, Ceará, Brazil

Compreensão de gestores municipais sobre o PMAQ: experiência na Região de Saúde do Crato

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ABSTRACT The institutionalization of evaluation processes as a central mechanism for improving primary care is a challenge for universal health systems. The National Program for Improving Access and Quality of Primary Care established a performance-based evaluation framework, assessing the implementation and development of elements aligned with defined quality standards. This study analyzed the understanding of the program from the perspective of municipal health managers in the Crato Health Region, Ceará, in northeastern Brazil. Participants were municipal health secretaries and primary health care coordinators. Data were collected through semi-structured interviews in June 2020, and the analysis was based on the principles of content analysis. Three empirical categories were identified: (1) Understanding PMAQ as a policy for improving the work environment and incentives; (2) Scope of the program in managing primary care: contributions and challenges; and (3) The role of managers: commitment and integration. The findings highlighted the program's difficulties in institutionalizing evaluation and team management processes. Divergent perceptions were observed regarding its capacity to reorganize work in primary care management and the impact of competitive processes, overburdening workers, and causing psychological strain.

KEYWORDS Primary Health Care. Health evaluation. National health programs.

RESUMO *A institucionalização dos processos avaliativos como eixo central de melhoria da atenção primária é um desafio para os sistemas de saúde universais. O Programa Nacional de Melhoria do Acesso e da Qualidade instituiu um processo de avaliação baseado no desempenho alcançado na implantação e no desenvolvimento de elementos associados a um padrão de qualidade. Este estudo analisou a compreensão do programa sob a perspectiva dos gestores municipais de saúde na Região de Saúde do Crato, Ceará, Nordeste do Brasil. Os participantes foram secretários municipais de saúde e coordenadores da Atenção Primária à Saúde. Os dados foram coletados por meio de entrevistas semiestruturadas em junho de 2020, e a análise tomou como base os preceitos da análise de conteúdo. Três categorias empíricas foram identificadas: (1) A compreensão do PMAQ como política indutora de ambiência e gratificação; (2) Amplitude do programa na gestão da atenção básica: contribuições e desafios; e (3) O papel dos gestores: comprometimento e integração. Os achados evidenciaram dificuldades do programa em institucionalizar processos de avaliação e gestão das equipes. Foram observadas percepções divergentes sobre a capacidade de reorganizar o trabalho na gestão da atenção primária e sobre o impacto dos processos competitivos, sobrecarregando trabalhadores e causando desgastes psíquicos.*

PALAVRAS-CHAVE *Atenção Primária à Saúde. Avaliação em saúde. Programas nacionais de saúde.*

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Introduction

Health evaluation is a key tool for strengthening policies, programs, and services, particularly in Primary Health Care (PHC), as it allows assessment of value and informs evidence-based decision-making[1]. Frameworks such as Donabedian's[2], which organize evaluation around structure, process, and outcomes, are widely used to examine the multiple dimensions of healthcare quality, including available resources, work organization, and impacts on care and patient satisfaction[3].

In Brazil, the Family Health Strategy (ESF) expanded PHC coverage, yet challenges remain regarding comprehensiveness, financing, and managerial capacity within the Unified Health System (SUS)[4]. To address these gaps, the Ministry of Health launched, in 2011, the National Program for Improving Access and Quality in Primary Care (PMAQ-AB), establishing systematic performance-based evaluation and certification mechanisms that directly influence resource allocation and drive changes in work processes[5].

The PMAQ-AB is based on external evaluation, indicator-based contracting, and financial incentives linked to quality standards, aiming to foster an evaluative culture and continuous improvement in PHC[5,6] services. Studies indicate that structural and organizational advances are underway, yet challenges persist in embedding evaluation into municipal management routines and in the effective use of results for local governance[7,8].

This study aims to understand how managers perceive, interpret, and implement PMAQ-AB at the municipal level, highlighting its limitations, potentialities, and challenges. The study is justified in examining how national evaluation policies are implemented at the local level, as this helps improve strategies for managing primary health care within the SUS.

Material and methods

This qualitative, exploratory, and descriptive study was conducted in the Crato health region, located in the municipality of Crato, southern Ceará, Brazil. The region was selected for its role as a regional management hub, its active participation in PMAQ-AB, and its organizational features and challenges typical of the rural Northeast, providing insight into municipal-level dynamics in the implementation of evaluation policies.

The Crato health region comprises 13 municipalities. For this study, all municipal health secretaries and PHC coordinators from each municipality were invited to participate. Three municipalities were excluded due to the unavailability of managers during the data collection period. Consequently, managers from 10 municipalities participated, totaling 10 health secretaries and 10 PHC coordinators. Inclusion criteria were holding the position regularly during data collection and agreeing to participate by signing the Free and Informed Consent Form. Exclusion criteria were legal absence (e.g., vacation or leave) or refusal to participate.

Data were collected in January 2020 through semi-structured interviews conducted by the researcher. Interviews were audio-recorded and transcribed verbatim, a technique that reproduces participants' speech faithfully, preserving their original expressions to ensure the authenticity and richness of the qualitative material[9]. Transcriptions were subsequently reviewed to guarantee the accuracy and reliability of the records.

Information was collected on the participants' sex, professional background, length of experience in management, and age. Data analysis was conducted using the thematic content analysis method as described by Minayo[1], identifying and categorizing emerging themes based on the axes defined by the adopted theoretical framework. The organization of empirical categories linked interview findings to Donabedian's structure, process,

and outcome dimensions, enabling an integrated analysis of municipal managers' experiences with PMAQ-AB.

The study was approved by the Research Ethics Committee of the State University of Ceará (opinion No. 3,344,159; CAAE 08277519.8.0000.5534) on 05/23/2019, and followed the guidelines of National Health Council Resolution No. 466/2012[10].

Results and discussion

Regarding sex, women were predominant, accounting for 80% of municipal health secretaries and all PHC coordinators. In terms of professional background, 50% of the municipal health secretaries and all PHC coordinators were nurses. The remaining secretaries included professionals in administration, pharmacy, biomedicine, and biology. The average time in management was 4.6 years (SD = 5.5) for secretaries and 3.2 years (SD = 2.4) for coordinators. The mean age of managers was 37.4 years (SD = 6.0) for municipal health secretaries and 38.4 years (SD = 5.6) for PHC coordinators. The time in management ranged from 2 to 20 years, while the ages ranged from 28 to 48 years.

Horizontal syntheses were constructed from the meaning units, resulting in the formulation of three empirical categories, as shown in *table 1*. These categories were analyzed and discussed in relation to the study's theoretical framework and guiding assumptions.

Table 1. Breakdown of the empirical categories identified in the research and their key sense-units

Empirical categories	Sense-units
Understanding PMAQ as a policy to improve working conditions and professional incentives	Perceptions of PMAQ's purpose
PMAQ and its scope in PHC management: contributions, weaknesses, and challenges	Impacts on teamwork processes, advances, and contributions
	Challenges and criticisms
	Future perspectives and challenges
The role of managers in PMAQ: commitment and integration	Managerial commitment in PMAQ: experiences and lessons learned
	Managerial alignment and integration

Source: The authors' own elaboration.

Understanding PMAQ as a policy to improve working conditions and professional incentives

In this category, participants' statements reflected their understanding as expressed through their daily routines in their managerial roles. For the municipal health secretaries, emphasis was generally on the program's potential to generate financial resources. All managers interviewed also highlighted the program's link to improvements in health infrastructure units.

> *In short, honestly, what PMAQ has meant in practice for us managers is that it brought structural improvements to our primary care units, providing more resources for this purpose. That has been my main understanding of PMAQ, and we were fortunate that it lasted as long as it did.* (S10).

My only involvement with PMAQ at the health department was to discuss professional incentives and renovations of the units. For this reason, I understand its main purpose today as helping to partially overcome underfunding. (S9).

The municipal health secretaries perceived PMAQ as a policy that fosters an appropriate work environment in primary care units, ensuring the infrastructure, facilities, equipment, and supplies necessary for team workflows, in accordance with the program's standards regarding the quality of professional relationships and work bonds[4].

The allocation of financial incentives was left to the discretion of municipal management, with each local administration responsible for defining its own criteria for using these resources[5]. Within the chronic and well-documented context of underfunding in health care, particularly affecting primary health care, these incentives are highly valued by municipal health secretaries, as evidenced in the statements.

As noted by Mangueira[11] and Pinto[12], the implementation of PMAQ resulted in a substantial increase in funding allocated to both teams and primary health care in general, with financial transfers to municipalities rising by approximately 30% due to the introduction of the program's quality component.

The National Council of Health Secretaries (CONASS) stated that from the 1950s to the mid-1980s, the primary concern of municipal health managers was financing, while human resources were considered a secondary issue[13]. It was observed that the effects of this model still appear to influence some of the managers interviewed.

For PHC coordinators, PMAQ was understood more broadly as an evaluative mechanism for improvement—an instrument to guide actions, enhance effectiveness, and strengthen primary health care. It was also seen as capable of prompting reflection on work processes and inducing changes according to predetermined standards.

I see the program as a means to reinforce quality and strengthen services. We placed particular emphasis on Qualifica-APSUS, and together these programs guided our management and supported the improvement of our services. (C3).

*I believe the purpose of PMAQ is to certify municipalities based on their performance in evaluations and provide financial rewards. This is intended to drive change across the health system, or at the very least, to encourage reflection on work processes. (*C10).

The distinction between this group of managers and the municipal health secretaries lies in their perception of PMAQ as operating within a bureaucratic framework, with a strong emphasis on the program's financial incentives, reflecting the predominantly administrative view of the secretary's role. In this regard, as Pinto[12] notes, PMAQ is seen by these managers as bureaucratic, funding-oriented, regulatory, and emphasizing accountability.

There were also reports of managers having little to no understanding of the program's purpose, due to their extensive responsibilities, which limit both direct engagement and involvement, as well as the limited institutional support available. Consequently, PMAQ is often perceived as a minor initiative or as being solely the responsibility of Primary Care Coordination:

Based on my experience, which I believe is similar to that of other secretaries, I have had only isolated and sporadic contact with PMAQ, so I do not know exactly what its purpose is. This is a theoretical question that should be directed to Primary Care Coordination. (S1).

*Just yesterday, I was asking the Coordinator about PMAQ. I think she has halted the actions, and I will request that the important initiatives be resumed to meet the targets, because I do not have time for this, and we receive no external support. (*S6).

According to Gomes[8], managers receive very little guidance and generally have limited experience in public health. Technical unpreparedness, compounded by the high turnover of those assuming managerial roles, directly undermines

their engagement in the various phases of the program, compromising its implementation.

Flores[14] emphasizes that limited knowledge of the program's actions and objectives hinders the secretary's participation, restricting their effective involvement primarily to the initial stage of program participation and creating additional barriers to the proper execution of program activities.

Examining PMAQ from the managers' perspective also provides insights for program improvement. Coordinators, in particular, perceive the program as a driver of change in primary health care, designed to influence the reality of Brazilian health care and consistent with the objectives outlined in institutional documents[5].

However, this understanding contrasts with the majority of statements from the municipal health secretaries regarding the program's guidelines and objectives. For this group of managers, PMAQ's primary purpose is to provide financial support to municipalities, rather than serving as a guiding framework for their management.

Thus, it was observed that municipal secretaries and coordinators displayed varied understandings of PMAQ. While their statements often converged and complemented each other, contradictions also emerged, highlighting perceptions that ranged from active engagement to complete unfamiliarity with the program. Overall, PMAQ was understood as a driver of change, perceived as a vertically structured, funding-oriented, demanding, and complex program, and, in some cases, met with indifference.

PMAQ and its scope in PHC management: contributions, weaknesses, and challenges

Underfunding is a major reality. The municipalities in the region rely almost entirely on the SUS, a context that enhances PMAQ's perceived value as a management tool among local health managers.

Indeed, comparing the infusion of resources into PHC from the program's third cycle reveals a substantial financial boost across the entire health region. Significant variations were observed between cycles, with some municipalities experiencing particularly large increases, such as Altaneira (177%) and Crato (57%). Overall, municipalities in the region saw an average funding increase of 30%[15].

Coordinators viewed the implementation of financial incentives for teams as a form of recognition and appreciation for their work. Their perspectives echo official program documents, which highlight that these financial transfers can boost professional satisfaction and enhance the quality of services delivered to users.

Barreto[16] argues that financial incentives in health act as a powerful motivational tool, effectively promoting targeted interventions and short-term improvements, both of which require ongoing monitoring and regular evaluation. Incentives can influence performance by positively affecting motivation, increasing engagement, and fostering greater commitment to achieving objectives.

Another key point raised by the Secretaries regarding financial transfers was the lack of clear guidelines for allocating these resources. For some, this represented a significant challenge.

> *Having to please everyone—staff and the mayor—I feel like I'm walking a tightrope with this transfer. Drivers and community health agents will complain in the office, council members take up the issue, and I have dozens of serious matters to resolve... This is the program's greatest weakness. There isn't a single secretary who doesn't complain.* (S7).

> *Managing these funds is a real headache. Clear guidance from the Ministry would make things much easier. Every level wants a share—higher-level staff, mid-level staff, Community Health Agents—and trying to divide it fairly often leaves very little for anyone. Negotiations with the union spark conflict and accusations. I support the incentive, but the process needs to be much clearer.* (S10).

The program incorporates principles of negotiation and contractualization, guiding the management of resources based on the results achieved. A central theme emerging from the interviews was the absence of this culture. Secretaries acknowledge the commitment of professionals striving to improve service quality, yet they are candid about their own difficulties in managing or negotiating these payments.

In the participating municipalities of the region, financial transfers occur regularly in 77% of them. However, only 38% distribute the funds among professionals with higher and mid-level qualifications, while 68% allocate them exclusively to professionals with higher qualifications. The criteria and amounts vary across municipalities, reflecting local decisions involving politicians and/or unions. None of the secretaries reported full satisfaction with the distribution model used in their own municipality.

The secretaries highlighted the potential for these financial transfers to be used politically to appease staff, who, in most cases, received the incentive as a supplement to an already insufficient and outdated salary. As a result, little funding remained for improving the infrastructure of the units, triggering a chain reaction in which working conditions were not enhanced, staff were not adequately trained, and, ultimately, the program's objectives were not achieved.

For the coordinators, there is a palpable concern that frontline staff perceive the program as an additional tool for oversight and punishment, with certification being used to justify retaining workers who have weak employment ties. These labor relationships, marked by fear, expose staff to forms of workplace harassment. When managers approach PMAQ in this way, its political use becomes evident.

This discussion underscores that additional compensation for staff must balance productivity gains with the complexity of their work tasks. Achieving a fair allocation of these resources increasingly requires a sophisticated understanding of the program to ensure that funding decisions are equitable.

In an effort to achieve better certification results, some municipalities resorted to a practice locally referred to as *PMAQuiagem* (PMAQ makeup), meaning superficial adjustments for PMAQ compliance, as mentioned by several coordinators, which reflects the program's limitations and challenges. According to them, the preparations for external evaluation visits often involved cosmetic adjustments to reality, such as shifting supplies and materials between facilities or temporarily adopting new work processes and organizational routines solely for the assessment.

> *In the week of the external evaluation, the PMAQuiagem was intense. Many services were introduced in the units solely for that occasion, and supplies and materials would only arrive at the facilities during that week because the mayor had ordered their purchase. We, as coordinators, share responsibility as well. At times, we treated it almost like a competition, a kind of contest with neighboring municipalities and even among ourselves.* (C1).

> *Many of the coordinators with very high scores are, in fact, just putting on a façade. Go and see whether they actually provide patient reception, follow or even know the protocols, schedule appointments, or carry out risk classification, record information in the registries required by PMAQ, or whether their pharmacies are consistently stocked and basic equipment—such as scales, speculums, or autoclaves—are always functional and in proper condition for use...* (C3).

This study adopts the term '*PMAQuiagem*', already used by other researchers studying the program across Brazil. As noted by Sampaio[17], the term gradually took hold as repeated attempts were made to manipulate or adjust reality solely for PMAQ's external evaluations. According to these authors, such practices stem from managers' perception of PMAQ

as a punitive mechanism, and this manipulation reinforces a mistaken understanding of evaluation as a tool for criticism and sanction—contrary to the program's own guidelines. As a result, the changes attributed to PMAQ may have been only superficial or temporary, with little lasting impact on the teams' work processes, serving primarily to mask reality.

Evidence points to a discontinuity in the implementation of PMAQ-agreed actions in some municipalities within the health region, despite the program's role in fostering initiatives to change work processes and promoting transformations aligned with the institutionalization of evaluation as an ongoing cycle of analysis, reflection, and development of new practices[18]. This raises a critical question: can simply asking, during the external evaluation, whether teams complied with each verification item legitimately be treated as evidence that PMAQ effectively initiated and sustained these processes over the long term?

In this category of analysis, regional managers raised issues offering a critical perspective on key aspects of this comprehensive policy. These include perceptions of changes in work processes, patient care, and health resource management; professional motivation and financial incentives; and the induction of competitive dynamics among teams, increased workloads, and the resulting psychological strain on staff.

Thus, PMAQ encompasses a wide range of initiatives in an innovative format that fundamentally relies on inducing change and improving management processes, and it needs to be understood as such by those responsible for its administration.

The role of managers in PMAQ: commitment and integration

It is evident that, for some municipal secretaries, PHC and the PMAQ are regarded as matters of secondary importance, and managing the program is not always recognized as part of their responsibilities. Their daily concerns and actions tend to focus instead on the provision of medium- and high-complexity health services at the local and regional levels. When efforts are made to overcome this limited engagement with the program, they often occur in a fragmented manner and are rarely used to redesign strategies or operational approaches that could strengthen PHC as a permanent priority for managers.

Although weaknesses in managerial commitment—an inherent challenge of health administration—remain evident, progress has been made in how managers understand their role within the program. According to some coordinators, the PMAQ generated extensive documentation and information, promoted a more integrated view of the health system, fostered practical collaboration, and encouraged monitoring and evaluation practices. Several coordinators described and systematized these experiences in detail.

> *I consider it a very valuable experience to serve as a municipal coordinator during the PMAQ evaluation visits, adapting to each requirement while navigating difficult personalities along the way. Over time, I even developed a certain fondness for the program.* (C3).

> *At first, I was skeptical about the PMAQ. To me, it seemed like nothing more than extra work and oversight. But as we began organizing services according to the manual, I saw everyone getting involved, then came the motivation to achieve good certification, the effort to reach a strong score, and, in the end, a positive result. Today, I am deeply committed to the PMAQ and genuinely fear that it might come to an end.* (C10).

According to Flores[14], in the context of the PMAQ, the involvement of municipal secretaries is generally limited to meetings with PHC teams aimed at presenting the program, its phases, and the actions to be undertaken—essentially restricted to the beginning of each cycle. In his study, which examined the perceptions and engagement of municipal

secretaries in the 28th Health Region of Rio Grande do Sul, these managers were found to participate primarily through program oversight, focusing on controlling activities, evaluating teams, and monitoring expected outcomes.

Although this study highlighted the limited integration between secretaries and coordinators—given the scarcity of joint planning and coordination meetings—the PMAQ stood out as the only structured evaluation experience that effectively fostered collaborative work among managers at the municipal level:

> *The positive aspect of PMAQ was that it also brought our management team together. Before PMAQ, we had never all sat down in a single meeting to discuss how to conduct evaluations or even to plan our work. We were always divided by departments, completely disconnected.* (S7).

> *In the midst of the constant rush, only the PMAQ actually got me to attend consecutive meetings with managers and coordinators. I also went to the regional meetings, and we replicated everything here. Still, I don't think my presence is strictly necessary—I'm not entirely sure it's my role. I try to do my part, but the bulk of the actions are handled by the coordinators here.* (S5).

Based on these statements, it is possible to reflect that PHC coordinators are overburdened with demands, since sharing responsibilities is uncommon, which hinders the promotion of new actions and activities beyond the scope of the program and limits the response to other demands identified in the local context. Additional unfavorable conditions affecting performance include the nature of employment, which does not provide job stability and generates anxiety and dissatisfaction, as well as the high turnover of coordinators in managerial positions.

Although no qualitative data have been published by the National Council of Municipal Health Secretaries (CONASEMS), Councils of Municipal Health Secretaries (COSEMS), or similar bodies to verify appointment criteria, there is a recurring perception among public management experts and observers that, in many municipalities, appointments to health management positions are based more on political connections, networks of trust, and personal ties than on technical criteria or merit-based evaluation. This suggests that secretaries may become constrained by political dynamics, limiting their willingness to engage with programs, develop managerial competencies, and make evidence-informed decisions.

Through the PMAQ, efforts were made to implement a more horizontal management model, replacing the previous vertical structure in which responsibilities rested solely with the secretary, with one in which all team members assumed an active role. Collective effort and full engagement were intended to directly influence the program's successful certification.

The findings indicate that while most municipal health coordinators are actively engaged with the program, secretaries still need to fully assume responsibility for performance evaluation processes and associated actions. Developing a broader perspective on their managerial role and fostering a culture of capacity-building are essential for effective leadership. Furthermore, coordinated and collaborative action between coordinators and secretaries is critical to address gaps in commitment and engagement, ensuring that program objectives are fully realized and sustained within primary health care management.

When such engagement occurs within municipalities where political and organizational conditions support participatory initiatives and management teams are cohesive, improvements in access and quality are significantly enhanced[17]. Leveraging these favorable conditions increases the likelihood that managers can generate lasting, positive impacts on service delivery and strengthen overall primary health care performance.

Final considerations

The findings of this study suggest that municipal managers and PHC coordinators primarily perceived the PMAQ as a mechanism for financial support and structural improvements in primary health care units, serving mainly to mitigate the chronic underfunding of PHC. While the program's potential to drive the reorganization of work processes and strengthen health planning is acknowledged, in practice, its impact was largely limited to material gains and short-term incentives, without consolidating an evaluation culture in the daily operation of services.

In the context examined, the program functioned primarily as an administrative and financial mechanism, facilitating investments and incentives. However, the introduction of evaluative criteria and certification largely resulted in short-term adaptive responses aimed at compliance during external assessments. These adjustments often came at the expense of systematically incorporating evaluative practices, revealing limitations related both to the managers' limited knowledge of health evaluation and to their low appropriation of the tools provided by the PMAQ.

These findings highlight the persistent challenge of harmonizing perceptions and practices across different managerial groups, emphasizing the need to integrate evaluative tools consistently into the daily routines of teams rather than as isolated, procedural exercises as observed in the region studied. The experience contributes to the national debate on evaluative programs and performance assessment, providing evidence to inform the refinement of strategies in comparable contexts and underscoring the pivotal role of managers in guiding, adopting, and sustaining these tools to strengthen primary health care management.

A key limitation of this study is the time gap between data collection (2019–2020) and the current scenario of municipal management and national evaluation policies, given the regulatory and organizational changes that have occurred since then. The results should therefore be interpreted in the context in which they were produced, acknowledging that some challenges may persist while others may have evolved in response to recent developments. Although the study is limited to a regional sample, it provides valuable insights into the constraints and opportunities of evaluative programs in primary health care, fostering critical discussion and reflection.

Collaborators

Moreira NST (0000-0001-8438-3683)* contributed to the conception and design of the study, data collection and analysis, writing and structuring of the manuscript, and critical review of the content. Gondim APS (0000-0003-4267-2422)* contributed to the review of the content and analysis of the results. Morais APP (0000-0001-6188-7897)* contributed to the study design, data analysis, and critical review of the content. ■

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