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Articles

The Brazilian National Program for Improving Access and Quality of Primary Care: a disciplinary apparatus in the management

Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica: dispositivo disciplinar na gestão (resumo: p. 14)

Programa Nacional de Mejora del Acceso y de la Calidad de la Atención Básica: dispositivo disciplinario en la gestión (resumen: p. 14)

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The Brazilian National Program for Improving Primary Care Access and Quality envisaged improvements in the management process of primary care through strategies that involve performance assessment, expansion of funding and improvements in teamwork. This article analyzes the discourses of municipal managers regarding the program to (re) think about the management of primary care based on Michel Foucault's theoretical framework. By viewing the program as an apparatus, we identified components present in the construction of the macro-politics and in its development in baselines, in the cities, that favored the exercise of disciplinary power in the management of contemporary public health. In this context, managers use program strategies to control behaviors and working practices in Primary Care through mechanisms such as normalization and surveillance.

Keywords: Primary health care. Power relations. Managerial decision-making. Foucault.

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Introduction

Enhancements to the quality of services and their high costs have led managers to adopt increasingly rationalist strategies with the purpose of associating cost reduction with increase in productivity and competitiveness in the health services, as a form of adaptation to periods of austerity and to the dimensions of the current capitalism.

This logic has been present in the ideas of the Brazilian people for some time, driven by the strong request for improvements in the provision of essential services like primary care. In 2011, the federal government instituted the National Program for Improving Primary Care Access and Quality (PMAQ-AB) as a response to public pressure and to problems in the management of the Brazilian National Health System (SUS), related to exhaustion of the bureaucratic management model, budgetary constraints and managerial difficulties, aggravated by the fragility of work relationships, poor professional qualification, and even by the (lack of) institutional vocation of the health services[1].

PMAQ-AB was presented as a proposal for expanding the funding of primary care through a complex evaluation mechanism of primary care teams that was called Access and Quality Improvement Cycle. The stages of each cycle underwent modifications during the implementation of the program, but its general principles and objectives were preserved, targeted at access expansion and improvement in services quality through results evaluation and financial incentives, stimulating greater transparency and effectiveness of governmental actions[2,3].

At the end of its third cycle, the program presented many results, especially connected with volume of resources, normative aspects and production of information in its evaluations. These are knowledge and truths that are disseminated and construct narratives pervaded by subjectivities, important to the understanding of health management processes that view quality as the horizon of the health services. Understood in its complexity, management cannot be seen solely as institutional exercise; it is also a governing practice composed of instituted and instituting elements and permeated by formal and informal aspects - practice that produces spaces for the exercise of micro-powers, disputes and tensions pertaining to the relational aspect in which it is constituted[4].

In the sphere of public administration, it is necessary to refer to the studies developed by Michel Foucault about power and its developments, in which the author breaks with the legal-discursive view by presenting power in the perspective of a correlation of forces structured in social relations. In his work, the author shed light on the different forms of exercise of power existing in Western society in distinct times, referring to historical aspects to build a genealogical analysis. He highlighted the main power machineries: sovereignty, disciplinary power, biopower, and the techniques to govern the population. He analyzed different apparatuses present in the society of his time not only to explain them in light of historical events, but also to trigger understandings, reflections and displacements in modern thought[5].

Foucault used the term "apparatus" to delimit a network formed by the interaction of the set of elements that constitute it: discourses, organizations, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions. "In short, the said as much as the unsaid are the elements of the apparatus"[6] (p. 364).

Thus, considering that the apparatus operates in force relations, inscribed in a given play of power constructed by its actors, settings and contexts, we present here an analysis of PMAQ-AB, situating it as an apparatus interwoven in the power relations present in the field of health services management.

Methodological aspects

This study has an essentially qualitative nature and its methodological presuppositions are grounded on Foucault's genealogical framework[6,7]. The research that originated this analysis was carried out with health managers (municipal secretaries and primary care coordinators) from a health region of the state of Piauí, northeastern Brazil. The project was approved by the Research Ethics Committee of the Federal University of Piauí, opinion nº. 2746788.

Overall, 28 semi-structured interviews were performed with managers from cities of a health region in Piauí. The majority of the cities are small and health services are offered almost exclusively in primary care, a profile that predominates in the state's cities.

The operationalization of the research started with the identification of the participants, who were contacted by telephone or e-mail. After explanations were provided and the managers accepted to participate in the study, meetings were scheduled according to their availability and place of preference. The interviews occurred from June 2018 to March 2019, based on a previously developed script containing general questions related to challenges of primary care management and to the aspects of motivation, implementation and development of PMAQ, triggering open dialogs in this context. The subjects authorized the researchers to record and transcribe their discourses, and this ensured the register of the details of each discourse. After being fully transcribed, the discourses were coded to ensure participants' anonymity and then composed the corpus of analysis of this study.

To perform the analysis, the researchers read the entire material to identify the real conditions of the emergence of certain discourses within the conflicts and webs of power that permeate the management process of primary care in the interweaving of PMAQ-AB as an apparatus. It is important to highlight that this investigation presents a reflective perspective between investigators and investigated subjects, given the researchers' experience in the sphere of management. Such process (reflectiveness) facilitated both the conduction of the interviews and the process of analysis.

The adoption of the Foucauldian framework as the method of analysis opens a range of possibilities for the exploration of the apparatus, especially when the construction of the research respects the object's specificity. Therefore, if the method is the path that must be walked to reach the researched object, we can say that the "apparatus" is the map of this path, but also the very point of arrival[8].

Thus, taking discourse as a series of elements that operate within power relations, we attempted to attribute meaning to the managers' discourses in the context that conditions, legitimates and puts them in the order of truthfulness[9]. In this perspective, our analysis focused on what was said, on what was visible, with no attempt to find veiled intentions, presenting a discursive synthesis in groupings of meaning, exemplified and discussed from the elucidation of elements of the apparatus and of its disciplinary machinery.

Results and discussion

Health management practices, especially in small cities - the majority among the Brazilian cities -, usually occur in unfavorable technical and structural conditions[10] and consolidate their actions within the traditional conception: rigid, disciplinary and permeated by the exercise of power legitimated by truths and knowledge constituted in the sphere of relationships between managers, workers and users, many of them captured by hegemonic forces.

These practices are potentialized by governing apparatuses like PMAQ-AB and, as such, configure lines of visibility and enunciation, of strength, of escape, of subjectification, of fissure or fracture, and of rupture[11], in a complex power-knowledge play that is intrinsic to the management field. Essentially strategic, every apparatus is configured as a rational intervention organized to manipulate force relations in a previously established direction through practices that govern conducts (of the self and of others), imbricated in the production of power-knowledge[6].

We identified some of these components both in the trajectory of macro-political construction of the program and in its implementation in the cities, by crossing the managers' discourses about the challenges, interests and motivations that surround its implementation and interfere in the micro-political processes of the performance of management.

It is important to explain that the apparatus is not configured in a rigid way; rather, it can reconfigure itself in terms of its elements and the way in which they relate to one another, and this is the characteristic that enables it to act in processes that produce subjectivities or specific modes of existence of each subject[4]. However, we aimed to identify characteristic elements of the apparatus analyzed here.

Elements of the apparatus

Three decades after the creation of SUS, there are still countless challenges to its consolidation as a public policy. Beyond problems attributed to the magnitude and scope of a universal system in a country with continental dimensions, challenges related to organizational difficulties and fragmentation of health policies and programs remain, especially when it comes to programs based on convenience to the detriment of evidence. Furthermore, problems deriving from insufficient funding and from the very qualification of management and social control have not been solved either – and social control becomes less significant and more disjointed as time goes by[12].

Despite countless advances, problems that emerged a long time ago still affect SUS and have become larger in view of new obstacles, like threats to reduce the system's funding, restrictions on infrastructure investments, and absence of an effective work management, which increasingly limit the consolidation of SUS as a public health policy in the perspective of social security, the perspective within which it was constituted. These challenges are confirmed in the discourse of the municipal managers as characteristics rooted in the public sector and in SUS, in such a way that it is impossible to separate them.

> One of the greatest challenges today is the financial aspect. We must focus on what is the priority at the moment, because [funding] still leaves a lot to be desired. (S14)

> [...] we've been struggling with these challenges, both the financial one, related to making the system work, and the challenge of motivating these public servants to perform their functions in the best possible way. (S18)

These discourses sustain assertions about financial scarcity as the main cause of the inadequacies and inefficiency that are present in the health services. In view of the insufficient resources and operational difficulties, the media frequently explores problems of infrastructure and organization of the services network, questions related to employee remuneration and apathy, corruption and (partisan) politicization in management, disseminating that the neoliberal and privatist ideas are the solution that will bring efficiency to SUS[13].

Thus, the media products are a solid trap[5], visibility devices to "make people see what must be seen", like threads weaving the combination between the visible and the enunciable. The media produce truths and knowledge that collaborate to the construction of the ideal space for the genesis of urgent strategies like PMAQ-AB, among others, idealized to guarantee the increase in the funding of primary care actions and to produce results - and truths - about the evaluated context.

The centrality of financialization in the discourses also ratifies the reductionist character in the debate about the management of work that the managers perform. When the discourses focus essentially on cost-effectiveness relations, they move away from issues related to the care model and to the instituted forms of health work production - dilemmas that must be faced nowadays in the field of management. These are escape routes that lead to pragmatism and to the concentration of efforts on solving imminent problems solely by increasing the financial resources. Although the resources - human and financial - are essentially necessary to structure the functioning of the services, they alone are not capable of guaranteeing their quality or suitableness to the necessary care profile[14].

In spite of the shared responsibility for the funding of public health services and actions (tripartite), the organizational design of SUS established that the municipal entity is in charge of executing the majority of health services and actions, especially of primary care, implemented according to local and regional characteristics and peculiarities and subordinated to the rules of the National Primary Care Policy (PNAB), with its

dilemmas and challenges associated with the historical and structural dilemmas of the system itself. This seems to be an important issue for the discussion, especially in view of the incipience and fragility present at the municipal level of health management[15].

In the context of municipal health management, criticisms about governance and the capacity to manage responsibilities in a decentralized way are frequent, and also about difficulties concerning accountability and productivity evaluation - factors that open space for propositions of reforms in the funding systems with the aim of creating robust systems of monitoring and technical and economic evaluation. Other managerial strategies connected with efficiency are currently constituted not only in the analyzed discourses, but also in the macro-political reality of the Brazilian public management[16].

The interferences of neoliberalism and the political and economic changes that, since the creation of the SUS, have submitted it to the alignment with the tendencies of international public policies, associated with the managerialist dynamics, have promoted the adoption of hybrid governmental policies that make the guarantee of social rights converge, even though hypothetically, with financial sustainability[17].

This makes the soil be fertile for the proposition of mechanisms like PMAQ-AB, which associates the allocation of financial resources to primary care by the federal government with variation connected with achievement of results, under the auspices of efficiency and performance assessment as premises for improving services quality and access. Such concepts and perspectives derive from the managerial administration model (or managerialism) and induce the adoption of management practices based on the awarding and/or punishment (financial or not) of managers and workers according to their performances.

Disciplinary apparatus in work management

The motivations that led managers to adhere to PMAQ-AB go beyond the search for qualified services. They are rooted in the opportunity of guaranteeing more financial resources to the city and in the possibility of using the program as an instrument to control the workers, applied to the management of health work through power relations. Such relations confront one another and are determined by the managers' own interests, according to the place each actor occupies in this process.

> One of our motivations to continue wanting the PMAQ-AB, besides the financial aspect, which helps the management to pay the professionals, is that, through it, we can demand that better work is delivered. (S28)

The discourses are rooted in a clear definition of limits and norms for the performance of the work, and are directed to the manifestation of the exercise of disciplinary power, which dictates norms and prescribes routines to the workers. This scenario strengthens the formal and rigid comprehension of the exercise of management, based on normative and inspection implications. This points to the panopticism explored by Foucault[7] to demonstrate the utilization of surveillance to control the conducts of the self and of the others.

> What led us to adhere to PMAQ-AB was the financial incentive to production, to increase the health professionals' productivity, and the fact that it enhances the quality of the services provided for the population. (S03)

The management of public health services is a hard task not only because of the specificities of the health field or the characteristics of the public sphere, but also because of the remarkable peculiarities of the services sector, which involves production and consumption relations, standardization difficulties, the importance and centrality of the human factor, and problems in the evaluation of costs, processes and results. Managing such a complex system is a challenging mission that requires the adoption of paths grounded on planning in the areas of materials management, quality management, financial management, care management and, especially, people management, which is known as health work management[18], not to mention the understanding of the relational aspect that this entire dynamics has.

In the management spaces of SUS, countless - and tragically reductionist - solutions are presented to the problems, which are no longer seen only as structural or derived from the political-economic conjuncture; rather, they are considered adjustable through a better utilization of the few, not to say minimum, existing resources by skillful and powerful subjects performing the role of managers[19].

> Besides being a very difficult job, the demand is large and the resources are few. There is also the question of the professionals who don't provide a good service and aren't really willing to work. (S23)

> I come from a private company and I have a completely different view. Here I work from Monday to Saturday, in the morning and in the afternoon. I go beyond what is necessary, but within what is required by my job. But the professionals think you just have to come and be available for 2 or 3 hours. There are professionals who have already left when I look for them at 10 in the morning. It's very complicated. (S26)

Considering the dynamics of PMAQ-AB of encouraging the incorporation of practices targeted at improving the quality of the services, gaps in the official norm about resources allocation (whether directed or not to paying rewards to workers) give autonomy to municipal managers in their utilization, prioritizing the fulfilment of the primordial objective of services qualification. In this context, resources become the object of disputes and are used as an instrument to overcome the challenges of the complex relationship between management and workers, enhancing the decision-making power that is present in this relationship.

Especially in the management of health work, greater attention is paid to enforcing the legally instituted determinations, like number of working hours and presentation of realistic results, mathematically accounted, to meet the demands that are created by the health market. This makes the population become increasingly aware of their right to receive high-quality public health, under the executive responsibility of the State. However, the health services cannot be reduced to their material, political and normative aspect, as they are also composed of diverse actors. The organizations are full of symbols,

conflicts and power relations that make them be spaces for the production of care and subjectivities[20]. Therefore, it is not possible to condense them in simplistic or merely technical analyses, even though they are also necessary for the production of relevant knowledge to the process of technical management.

Hiding behind the PMAQ-AB apparatus or using it as a motivation instrument by awarding and/or punishing workers, the managers implement mechanisms to control the work and workers through measures of performance and of bargain. They grant financial rewards and publicity not only as a way of fulfilling the organizational objectives, but also as a way of interfering in the construction of the worker's subjectivity through prescriptive work, duly standardized and controlled.

> We pay the PMAQ-AB (gratification), but we make demands, too! They have to earn it. (S05)

> We have to demand that they work properly, but this would be much more difficult without PMAQ-AB. I'd demand it, but there would be no return... With the incentive, it is different: either they do what needs to be done or they don't receive it. With it, we're in a better position to make demands. (S03)

We highlight that using the resources allocated to the city because of the program to reward the professionals is not mandatory, but the greatest pressures reside precisely here, regarding negotiation of values and the grant of resources to the professionals, which shows the exercise of power in the path of reverse hierarchy. It is possible to notice that the managers act in the context of the pressure put on them to grant financial incentives as a way of justifying benefits to the workers for the service they provide, but when they perceive the high quantity of granted resources and the professionals' low commitment to work, they react and start emphasizing the inspection facet of the program.

The discourses connecting rewards with performance place on the professionals the responsibility for determining their entitlement to the benefits. The managers remove from themselves the duty of leading the workers to use these tools as the necessary motivation to fulfil the institutional objectives, in a movement that is similar to the Foucauldian concept of governmentality - they want to obtain the maximum result with the minimum use of power[6].

These movements go in the opposite way from the purpose instituted by the apparatus in order to externalize the disciplinary aspect of management as a common practice. It is possible to notice that the managers exercise disciplinary practices with their subordinates; in this case, primary care workers. Discipline is nothing but a power technology, a specific manner through which some exercise power over others, in a relationship that is not necessarily unidirectional.

> [...] PMAQ-AB makes demands, so they work as I say! A cycle ends and they immediately begin working to the other [...] perhaps, without this demand, they wouldn't work, right? They wouldn't promote many of the activities they perform in primary care, either. (S04)

In his analysis of power, Foucault found that discipline had become an auspicious form of domination in society, mainly from the 18th century onwards. According to the author, discipline became a meticulous method to control the body based on a docility-utility relation instituted by the constant subjection of its forces[7]. Therefore, it became an instrument for the generation of docile bodies, simultaneously useful and obedient, through the manipulation of gestures and behaviors, creating a *modus operandi* that develops aptitude or ability, but also promotes a relationship of subjection[21]. This docilization is instituted by the PMAQ-AB apparatus in the workers, who react in the way they were shaped by the circumstances of (financial) dependence, fragility (employment relationship), or even of self-esteem and fulfilment (publicization of results).

In the context of primary care, the difficult dialog between managers and professionals is a challenge exacerbated by diffuse and even divergent interests. In addition, the power relations that exist inside the teams underline the presence of a professional hierarchy and create environments whose management is complex[22].

The exercise of power is not a crude fact, rigidly instituted or structured; rather, it is gradually developed, transformed and equipped with procedures to be exercised through relationships[23]. We perceive, in the discourses, the utilization of typical instruments of the training performed by disciplinary power: hierarchical observation, normalizing judgment and examination, inserted in PMAQ-AB and potentialized by local strategies.

Foucault[7] presents surveillance as a silent and discreet watching game that enables to observe, inspect and control individuals. Its hierarchic perspective emphasizes the manifestation of unidirectional control, exercised by the managers, as representatives of the organization, over those who allow to be controlled, who submit themselves to health work.

> I really watch them! For example, yesterday I was at the primary care unit, because sometimes a professional does not show up for work and we're not informed about it; when I find out, it has already happened. And I demand that they follow the rules! I cut, suspend, delay the payment and normalize it only after everything goes back to normal. (S25)

The act of "conduction" differs from and, at the same time, is confused with the exacerbation and extremism manifested by "coercion". It becomes a way of behaving in a field more or less open to possibilities, where power shapes conducts in a space where the subject naturally needs to feel free, moving away from resistance to the practices of the apparatus.

The penalties are similar to the normalizing judgment, nurtured by micro-penalties that are disseminated as useful and necessary mechanisms in the midst of the gaps left by the laws, or even ratified by them, punishing any failure to comply with previously determined rules, in order to achieve the "normalization" of the individuals. In the sphere of health work, this aspect tends to limit the freedom to construct humanized practices, distant from machine algorithms. This configures clear lines of control, normalization and framing of individuals. Through their mechanisms, they aim to maintain order and prevent what is considered inadequate in the instituted context; in this case, rigid, accounted and, above all, depersonified work.

> I even commented that it would be good if the evaluators came here every month, because I think the employees would only perform their duties if there were an evaluation. Then I'd say, look, PMAQ-AB will come here this month and if things aren't right, the resource will be discontinued and you won't receive the gratification. (S01)

It is possible to note the conception that it is necessary to implement the examination, the submission of work and worker to the assessment and measurement of performance as a way of constructing knowledge that is directly related to the exercise of power. According to Foucault[7], "the examination that places individuals in a field of surveillance also situates them in a network of writing; it engages them in a whole mass of documents that capture and fix them" (p. 181).

In PMAQ-AB, the external evaluation is a good example of this perspective, as it awakes the actors of the process to the conception of inspection, to the detriment of what it proposes to be: a naturalized and voluntarily requested evaluation. It moves away from its premises to become a disciplinary instrument that is not only collective, due to the evaluation of the team, but also individualized by its own strategies of surveillance and monitoring of the achievement of goals and of measurement of professional performance. These instruments, when documented, make the individual become a 'case', an object for knowledge, control and exercise of power.

The power present in relationships enables knowledge production not only through surveillance and discipline, but also through workers' resistance. Foucault warns us that, if power were only repressive, it would not have the force of production (of things, knowledge, discourses and pleasures) that it has. "Disciplinary power does not destroy the individual; on the contrary, it constructs them. The individual is not the other of power, an external reality annulled by it; the individual is one of its most important effects"[6] (p. 25).

In the midst of the power relations that exist in the management of work in primary care, we find not only the exercise of a disciplinary mechanism, but also a producer of truths, of objectified realities and spaces that favor training and the perpetuation of capitalist strategies. Such spaces also favor resistance. Resistance not only in the sense of liberation or deactivation of the apparatuses that involve the subjects, but also in the practice and exercise of power in the disputes where each individual refuses, engages, or becomes inexorably involved[4]. This subjectification process conditions and captures workers and managers simultaneously in a synchronous, desiring and involving movement.

Final considerations

By situating PMAQ as an apparatus in the sphere of management, we go beyond the technical understanding of this program and of its characteristics and investigate the aspects that have made it an instrument for the exercise of power in contemporary public health management, guiding working conducts and practices in the Brazilian primary care.

The managers' utilization of the program as a tool for the exercise of disciplinary power converges to the legitimation of instruments capable of responding to pressures of the political and economic context of contemporary capitalism. Such instruments tend to rigidify the working processes and limit workers' freedom through mechanisms like normalization and surveillance.

We noticed that the managers tend to promote the functioning of the health services in different ways, either by mobilizing the workers or by using tactics to awake their motivation to fulfil institutional objectives, although momentarily, through the grant of financial benefits and other rewards that are capable of docilizing and making the space fit for training.

They justify their surveillance and control actions attributing to the hierarchically superior authority the negative responsibility for regulation and imposition of norms, as if they were not free to exercise management under their own conceptions and logics of thought. In practice, they use the freedom they have to operate the governmental machine in favor of their conveniences, presenting pragmatic discourses and instituting increasingly rigid governing practices, boasting about them publicly.

However, between the lines and curves of the PMAQ-AB apparatus, institutional support, permanent education and co-management processes are implicit, as well as collective and machinal intermediation of bodies with potential strength to trigger creative movements in spaces of repetition, resignation and resentment[24], which need to be better understood.

The management of primary care is complex and demands using technical knowledge to make the services function in accordance with the institutionalized norm. Moreover, it requires walking the paths of construction of practices to govern the self and the others, as well as the paths of action over what is possible in different production regimes and disputes, being careful not to exhaust the actors of this relational circle.

Authors' contributions

Both the authors participated actively in all the stages of construction of the manuscript.

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Conflict of interest

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O Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica idealizou melhorias nos processos de gestão da Atenção Básica por meio de estratégias que envolvem avaliação de desempenho, ampliação do financiamento e melhorias no processo de trabalho de equipes. Este artigo analisa os discursos de gestores municipais acerca do programa como dispositivo para (re) pensar a gestão da Atenção Básica a partir do referencial de Michel Foucault. Ao situar o programa como dispositivo, foram identificados componentes presentes na trajetória de construção da macropolítica e em seu desenvolvimento em linhas de base nos municípios, potenciais ao exercício de poder disciplinar na gestão da Saúde Pública contemporânea. Nesse contexto, os gestores utilizam estratégias do programa para avançar no controle de condutas e práticas de trabalho na Atenção Básica por meio de mecanismos como a normalização e a vigilância.

Palavras-chave: Atenção primária em saúde. Relações de poder. Tomada de decisões gerenciais. Foucault.

El Programa Nacional de Mejora del Acceso y de la Calidad de la Atención Básica idealizó mejoras en los procesos de gestión de la atención básica por medio de estrategias que envuelven evaluación de desempeño, ampliación de la financiación y mejoras en el proceso de trabajo de equipos. Este artículo analiza los discursos de gestores municipales sobre el programa como dispositivo para (re) pensar la gestión de la atención básica a partir del referencial de Michel Foucault. Al situar el programa como dispositivo se identificaron componentes presentes en la trayectoria de construcción de la macropolítica y en su desarrollo en líneas de base, en los municipios, potenciales al ejercicio de poder disciplinario en la gestión de la salud pública contemporánea. En este contexto, los gestores utilizan estrategias del programa para avanzar en el control de conductas y prácticas de trabajo en la Atención Básica por medio de mecanismos como la normalización y la vigilancia.

Palabras clave: Atención primaria en salud. Relaciones de poder. Toma de decisiones de gestión. Foucault.