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Bringing Politics to the Analysis of Performance Measurement Programs: Case and Comparative Studies in Health Policy

Title of the paper

The politics of implementing a performance measurement program (PMAQ) at the front line of primary health care in Goiania, Brazil: a qualitative political analysis

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ABSTRACT

We develop a political policy analysis to understand how front line health workers in Goiania evaluate the Brazilian "National Program for Improving Access and Quality of Primary Care" (PMAQ). We interviewed 25 front liners, including doctors, nurses, community health agents and local managers. Analysis was based on political themes highlighted by the public policy/implementation and performance measurement political literature. We explored seven key themes: adherence, organizational capacity, participation, alternative logics, feedback, perceived impact and culture of assessment. Results show the need to deconstruct rhetoric/ambiguities on the front line of implementation, by means of fostering organizational capacity, knowledge, participation and policy feedback.

KEYWORDS

INTRODUCTION

From the perspective of politics and public policy, it is widely known that political-realistic-approaches in payment for performance (Bevan and Hood, 2006) (Pollitt, 2013) (Lewis, 2015) and public policy theories/and analyses can be employed to better understand the political, motivational/behavioural and policy themes that characterize the implementation of rational-based programs. Although the Brazilian "National Program for Improving Access and Quality of Primary Care" (PMAQ) has been adopted since 2010, few implementation and qualitative analyses have been developed so far regarding this payment for performance

program. This is due to the prevalence of a quantitative type analysis of the PMAQ in Brazil, that either overemphasizes the results of performance indicators, or uses those results in a descriptive way in order to develop further studies (CEBES, 2014) (Macinko, Harris, Rocha, 2017) (Saddi, 2017). Therefore, little is known about what/how political-realistic issues have characterized PMAQ implementation in Brazil in diverse cities. Moreover, public policy concerns such as organizational capacity, front line participation and policy feedback have not yet or have been little taken into consideration in these analyses. The policy/implementation nexus or links existent between design and implementation have not been explored either. Contributions from political studies on payment for performance have also been ignored by most studies (Saddi, 2017).

Recent research developed by us, together with a few other studies, have been distinctive in this Brazilian context (Saddi, Harris, Pego, 2017) (Saddi and Harris et al., 2016b). We have applied semi-structured questionnaires to front line health professionals (doctors, nurses, community health agents, and local managers) in Goiania. They have revealed that nurses are the main professionals participating in PMAQ, followed by local managers and community health agents (CHWs). Most doctors are not involved. The challenging organizational context affects health worker involvement in and perceptions of PMAQ. The program is mostly perceived as another top-down policy, in which health workers in diverse ways consider (or do not consider) it important to improve the quality of care, given the political/rhetorical and organizational questions that arise in a complex implementation context.

The present paper will further explore those new results related to PMAQ (Saddi and Harris et al., 2016b). Our objective is to understand how front line health workers in Goiania evaluate the Brazilian "National Program for Improving Access and Quality of Primary Care" (PMAQ) as well as to understand it from a political policy perspective. We have interviewed

25 front line health workers – doctors, nurses, community health agents and local managers - so as to verify: 1) if and in what ways front line actors (and which of them) know and value the program, 2) which members of the health team effectively participated in the implementation of PMAQ and how it occurred and 3) if and how PMAQ modified the way in which the professionals assess and plan the working process. The main contents that emerged from the interviews were associated with political themes highlighted by both the public policy/implementation literature and the more realistic-political approach of performance measurement studies. We have also pointed out some similar contributions from health policy and system research, with the aim of highlighting the relevance of that literature to health policy. In the analysis, those themes are explored as factors that can foster or deter (or generate unintended results or alternative logics) the implementation of a performance program.

Primary health care in Goiania presents some contextual and institutional characteristics (Saddi et al., 2016a), which are similar to other primary health care services in middle (Gilson, 2016) and even low-income countries. In Goiania, PC is confronted by inadequate infrastructure for its realization in most of the health units (with mould and leaks, and a lack of rooms to perform procedures), the lack of a pharmacy/or medicines, computers and internet, often with only one doctor and one nurse for most of the teams, and a lack of or high turnover of doctors and lack of community health agents (CHW). Health teams working in PC health units need to cope with complex demands coming from the Municipal Health Secretariat/health districts, local management, other health team colleagues and users/community. A culture of assessment is not part of the systematic routine adopted in most of the units, though they usually meet once a week to plan their work and discuss the main challenges arising during implementation. Front line health workers complain of not taking part in or not being consulted during the drafting or discussion of PC at the

policymaking/Health Secretariat level (Saddi, Harris, Pego, 2016a). New programs are usually elaborated by the Health Minister's Department of Primary Health Care and entail the introduction of new agreements/contracts and transference of funding from the federal government to the municipal level. Once adherence is achieved by the Municipal Health Secretariat, the program is communicated and passed on to health districts. On the front line, new programs are usually introduced by the local managers or district managers to the health teams, and generally do not involve a comprehensive communicative or educational strategy. The new program is implemented together with other demands taking place, following the timing stipulated by superiors.

Defining PMAQ as a quality induced strategy that requires front line worker participation

The Brazilian PMAQ was elaborated with the objective of inducing increased access to and improvement of primary health care quality, guaranteeing a comparable national, regional and local standard of quality, to allow greater transparency and effectiveness of governmental measures directed toward Primary Health Care. Amongst the specific PMAQ objectives, are:

I – To increase the impact of Primary Care (PC) on the population health conditions; II – To provide good practices and organizational standards for Basic Care Units (BCU); III – To promote more BCU adherence to PC principles; IV – To promote quality and innovation in PC management, strengthening Self-Assessment, Monitoring and Assessment, Institutional Support and Permanent Education processes in the three spheres of government; V – To improve the use of Information Systems as a PC management tool; VI – To institutionalize a PC assessment and management culture in the SUS based on the induction and follow-up of processes and results; and VI –To stimulate PC focus on the user, promoting management process transparency. As for the driving PMAQ guidelines, the fact that the program intends to involve, mobilize

and hold responsible all agents of the process should be highlighted (federal, state, and municipal managements, and headquarters, teams and users); develop the culture of negotiation and contracting. (Brasil, 2011).

Therefore, the Brazilian PMAQ may be defined as a program that intends to influence the quality of Basic Health Care, by strengthening assessment and system use practices, to create the institutionalization of an assessment culture, involving and mobilizing the agents that work in primary health care in Brazil. Moreover, if we consider the fact that PMAQ data collection requires the participation of front line health workers, and that the program also aims to evaluate and reward their performance, it is possible to define and understand PMAQ from the viewpoint of front line health workers' evaluations/perceptions and participation during program implementation, in a complex and challenging environment and organizational context.

Public Policy and Implementation literature

The political literature on public policy and implementation, that privileges the study of street level bureaucrats and organizational capacity (Hupe and Hill, 2015) (May and Winter, 2007) (Meyers and Nielsen, 2012), from a bottom-up perspective, but also establishes links between implementation and policy design (Hupe, 2015) (Saetren, 2014) (Howlett et al., 2014) (May, 2012), can be used to shed new light on the implementation of pay for performance programs. This literature offers us relevant analytical instruments to better understand the main drivers of or contradictory conditions that influence implementation, as well as to understand policymaking-implementation connections.

We know both from public policy and implementation theory (May, 2012) (Howlett, Ramesh and Perl, 2013), as well as from health policy and system research (Peters at al., 2009) (Gilson, 2016), that well designed policies involving rational choices of instruments and goals are not sufficient to realize, strengthen or improve implementation on the ground.

Regarding the third (Saetren, 2014) and even the proposed fourth generation of implementation or the policy/politics nexus approach of implementation theory (Hupe, 2014) (May and Winter, 2007), that values the interrelations between policy design and implementation, we also know that implementation takes place in a complex and demanding context, depending greatly on the knowledge/values, interests and actions (or decisions) of front line actors, as well on the organizational capacity of the institution to roll it out (May and Winter, 2009) (Meyers and Nielsen, 2012) (Hupe and Hill, 2015).

Since the publishing of the first edition of Michael Lipsky's (1980) classic work, it has been widely known that street level bureaucrats – a form of conceptualizing front line workers – tend to act with : (1) relatively high degrees of caution; and (2) a relative autonomy from organizational authority (Lipsky, 1980). More recently, Peter Hupe and Michael Hill (2007) have called attention to three types of competing/conflicting forms of accountability that can influence the actions/decisions of front line workers: public, administrative, professional and participatory.

> This means that street-level bureaucrats are held accountable in various relations: bottom-up as well as top-down, but also 'sideways '. Those forms of accountability refer to actions related to the system, organizational and individual scales… Within the web of these multiple accountabilities which produce possibly contradictory action imperatives, street-level bureaucrats constantly weigh how to act." (Hupe and Hill, 2007p. 296).

In a complementary way, Peter May and Soren Winter (2007) present four sets of influences that tend to influence street-level bureaucratic actions during implementation:

> "One set is the signals from political and administrative superiors about the content and importance of the policy… A second set of influences is the organizational implementation machinery… A third set of considerations is the knowledge and

attitudes of the street-level bureaucrats concerning relevant tasks, their work situation, and clients. A fourth set is the contextual factors concerning workloads, client mix, and other external pressures… (and) the role of knowledge and policy perceptions of street-level bureaucrats along with contextual factors." (May and Winter, year, pp; 454-455).

Those authors (May and Winter, 2007) also emphasise that most street-level bureaucrats are more prone to adhere to and implement policy goals when they understand the policy in question. It means that knowledge is a factor that directly influences the level of adherence and decisions related to policy goals. In the conclusion of their work, the authors state the following:

The signalling of policy goals by municipal elected officials and managerial actions of employment services managers are relevant, but these factors seem to have a limited influence. More important are the understanding of the national policy by street-level bureaucrats and their knowledge of the rules under the reform (May and Winter, 2007, 470).

Therefore, although the translation of policy goals into street-level measures depends on diverse factors, from the perspective of public policy theoretical literature, they can be understood according to issues such as the organizational capacity of the bureaucracy, the conflicting forms of accountability (administrative, professional and participatory) which take place at the front line, the perspectives and involvement/re-actions of front line workers, and the pressures and other issues stemming from work processes at the front line. These concerns have also been emphasized by the public health policy and system research literature in low and middle income countries (LMIC). A group of systematic reviews of strategies to strengthen health services in LMIC edited by David H. Peters and colleagues (Peters et al., 2009) has brought new knowledge to the field. One of these reviews has shown that

involvement and engagement of stakeholders including front line actors is necessary for effective implementation (Ovretveit et al., 2009). Another review has also stressed certain institutional factors to explain health policy delivery in LMIC, such as:

"The degree and breadth of commitment to the stated objectives of the strategy or intervention, rules about how critical stakeholders are involved, and the incentives to make them work, incentives and disincentives for health workers (and ultimately organizations) to perform well" (Bloom, Standing and Joshi, 2009, p. 203).

In terms of policymaking-implementation connections, the public policy literature calls attention to the need to study and understand implementation beyond the analysis of policy goals (May, 2012). Michael Howlett and colleagues (Howlett, Ramesh and Perl, 2013), for instance, call attention to the need to focus on implementation as implementation of tools and of considering policymaking as learning and feedback. In a similar way, both public policy and public health policy highlight that the possibilities for strengthening and/or improving implementation or provoking system changes are related to policymakers' capacity to learn and receive feedback from front line actors, perspectives and context (May, 2012) (Howlett, Ramesh and Perl, 2013) (Gilson, 2016).

In relation to policy feedback specifically, it is considered to be a complex, contested and contingent question, and needs to be studied not only from the perspective of positive feedback, but negative feedback as well. Strong positive feedback is constructed when distinct interests, identities and coalitions unite in enduring and creative ways, and is usually a driver for stability. Negative feedback, on the other hand, is considered a powerful driver for change (Jacobs and Weaver, 2010). According to Patashnik and Zelizer (2009), "There are three reasons for weak policy feedback: weak policy design, inadequate or conflicting institutional support, and poor timing" (Patashnik and Zelizer, p.33, 2009). Weak policy design can be attributed to low per-capita resources, information problems and negative social construction.

Conflicting institutional support is associated with absent state functions, multiple conflicting networks and conflicting governance structures. Poor timing can be explained by "incompatibility of policy with the governing norms of the day" (Patashnik and Zelizer, 2009). The integration of these two types of policy feedback – positive and negative - can help us identify the need for either incremental or drastic policy changes (Jacobs and Weaver, 2010). Additionally, "The absence of feedback can be the result of accident or bad luck, but it can also be a product of strategy or design" (Patashnik and Zelizer, 2009).

The political-realistic literature in payment for performance

The realistic-political approach concerning performance measurement presents some similarities, as well as singularities in relation to public policy/implementation literature. Jenny Lewis (2015) "reminds us that organizations/bureaucracies involved in the construction and implementation of measurements are not (only) rational instruments" (Lewis, 2015, p.9). This is why concerns based on who is involved in its elaboration and implementation, as well as on where/how those processes have been accomplished, have recently contributed to enhancing the importance of taking the politics (Lewis, 2015), the cognitive/subjective ("alternative logics") (Pollitt, 2013) and work task and organizational aspects (Peckham, 2007) (Harris, 2012) of performance measurement programs into account. They have also contributed to better understanding and unfolding of some dynamics and regularities that go beyond rational-based concerns. This literature also emphasizes aspects such organizational capacity, participation of the team in the implementation, and appropriateness of the design. In a more distinctive way, they have highlighted the possibilities of gaming and cheating and symbolic uses during the implementation of p4p programs (Bevan and Hood, 2006) (Pollitt, 2013). Also, concerns and consequences regarding performance measurement programs have been categorized for example as "performance alternative logics" (Pollitt, 2013), or "politics of performance" (Lewis, 2015).

Christopher Pollitt (2013) has highlighted some factors which encourage or deter gaming and/or cheating in performance management systems, and classified them in terms of background factors, task factors and features of PM systems (PMS). They refer to themes/factors such as organizational culture (background factor); observability of outputs & outcomes (task factor), participation in policy design, data collection and validation (features of PMS). With regards to observability of outputs & outcomes, the author says that "Gaming and cheating may become more prevalent the less appropriate a PMS design is for the task, e.g. a hard, tightly coupled PMS imposed on a coping organization". From the perspective of participation of staff in PM design, "PMS is more likely to be seen as 'fair' if staff are involved – therefore less gaming". Concerning the collection and validation of data, "If those being assessed collect the data there is a temptation to game or cheat, especially if there is no independent validation" (Pollitt, 2013, pp. 359). The author also stresses that "alternative logics are closely related to the basic features of PMSs, and deserve to be considered more openly, and extensively" (Pollitt, 2013, p. 360).

Jenny Lewis (2015) uncovers a political aim/logic that is behind the adoption of PM programs in the public sector, which is the objetive to exert political control over the policy. She has also enphasised that PM needs to be understood as a chain of actors, ideas and interests and institutions involved in the policy process.

In diverse ways, political-realistic approaches in payment for performance complement the literature on public policy, as presented in Table 1. The main challenges of performance measurement or payment for performance programs are those related to organizational changes as well as to changes in front liner knowledge/ perceptions and the need to promote closer ties between policymaking and implementation. Among the more distinctive features of the literature on performance measurement, in relation to public policy, are perhaps: 1) the focus on alternative political (contradictory) logics surrounding the

implementation and 2) the study of PM as a chain related to is policy process, attached to the analyses or characterization of possible unintended results or unintended consequences of rational based programs that aim to strengthen/create a culture of evaluation at the front line – especially in LMIC (Table 1).

Table 1 – Themes coming from public policy/ implementation and PM literature

Themes	Public policy/implementation literature	PM literature
ADHE - Adhesion to the policy/implementation	Street level actors' conflicting types of accountability Organizational capacity	Front liner motivational/behavioral reasons Organizational capacity
ORGA - Organizational capacity	As a condition that influences the implementation of programs at the street level	As a background factor influencing implementation.
PART - Participation in the implementation	Street level actors' conflicting types of accountability in a complex context	Front liners diverse motivational/behavioral reasons Participation in the design might increase levels of participation during implementation
FEED - Feedback and use of results	Absence of feedback: not included in the design Poor feedback due to: weak policy design, inadequate or conflicting institutional support, and poor timing Strong feedback: policy design, institutional support	Generates demotivation at the front line
LOGI - Alternative logics and ambiguous rhetoric.	Misconnections between policymaking and implementation: Weak knowledge and understanding about the program by street level actors. Regarded as either implementation failure or failure in design – from policymaking-implementation perspective.	Occurrence of Symbolic uses Cheating/gaming and ambiguities related to the program – generating unintended results. Generated by background factors, task factors and features of PM systems (PMS).
IMPA - Perceived impact of the policy	Influenced by knowledge and participation	Associated with organizational capacity, diverse types of motivations
ASSE - Culture of assessment/monitoring		A policy goal of p4p and pbf programs in LMIC – aim to inaugurate or strength a culture of evaluation

METHODS

Sampling and data collection

We have followed a purposive strategy in the selection of interviewers. They were chosen from three distinct health districts in the city – Northeast, Southeast and East -, in the health units where we had previously applied the semi-structured questionnaires. When selecting informants to take part in the interviews in the present research, attention was given to ensure that we had a balanced representation of informants from those health districts, as

well as a balanced representation from all health team members – doctors, nurses and community health workers - and local managers. We also needed to select informants who had taken part in the previous research, who were not on vacation, and who were still working in primary health care units. We interviewed 25 informants, finalising them after reaching thematic saturation.

During the interviews, we adopted an open-ended approach enabling informants to explore the questions. Interviews were recorded on audio and lasted around 20-30 minutes. They were realised in September and October 2016 in the primary health care units where the informant worked. The same researcher (FS) conducted all of the interviews. All informants signed the term of consent, with the right to withdraw their consent at any time if they wished. The audios were listened to, transcribed and checked by two researchers (FS and FP). We gave a code to each informant to guarantee information confidentiality. The research was approved by the Research Ethics Committee of the Federal University of Goias, authorization number 26584514.3.0000.5083.

Analysis

Our three main questions - related to front liner knowledge/valorization, participation and evaluation regarding the implementation of PMAQ - were responded to and associated with specific themes highlighted by the public policy/implementation literature and the more realistic-political approach of performance measurement studies (Table 1). The coding process was first done manually with half of the texts as we read and reread them searching for patterns, narrative threads, tensions, and themes and sub-themes that shape qualitative texts into research texts. The seven codes, as well as new sub-themes were added line-by-line by two researchers (FS and FP), who compared results between them. Results were afterwards shared with another researcher (MH). After this pre-organization/definition of codes in a manual form, all interview texts were imported into Atlas.ti, and analysis was performed by

two researchers (FS and FP) and shared with the other researches. We began to search for themes and sub-themes, linking selected texts to the seven codes and their sub-themes. No new themes or sub-themes appeared in the analysis performed with all texts in the software. A more comprehensive analytical process occurred by means of using reports generated by Atlas.ti, as well as memos and annotations registered during the process. It was at this point that we made associations between the main questions (dimensions of implementation) and themes, as reveled by participants.

Analytical associations constructed during the textual analysis

Our three main questions referred to specific dimensions or phases regarding the implementation process (Figure 1). During the analysis we have associated the answers to each question/dimension with themes coming from the literature (Figure 1) (Table 1), as well as including new sub-themes revealed by front line health workers (Table 3, 4 and 5). We tried to detect how diverse themes were expressed in a priority and related manner. Themes were classified as first order/priority themes and as recurrent/background themes (Table 2). First order/priority themes are those revealed at the beginning of the narrative and more emphasized by respondents. Recurrent/background themes refer to factors that characterize the background/context of the narrative or that aggregate subsequent inter-related information that explains the first order/priority themes.

We explored what/how themes appeared in the informant's narrative regarding each dimension of implementation and in the implementation process as a whole. In the analysis of each dimension, we tried to detect not only what policy themes were more prioritized or relevant for informants in each dimension of the implementation process, but also how informants construct their prioritization of themes/factors in the narrative, by means of establishing relations or making references to other inter-related theme(s). Regarding the policy process analysis, we tried to detect some regularities related to all three dimensions of

14

the implementation process, paying specific attention to how the repetition of similar themes/factors shaped and gave meaning to the policy implementation process.

Figure 1 – Main questions as dimensions of the implementation process
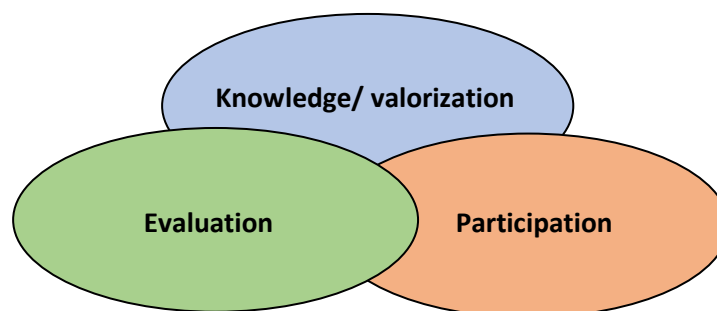
3. RESULTS

3.1. IN WHAT WAYS FRONT LINE ACTORS (AND WHICH OF THEM) KNOW AND VALUE THE PROGRAM? [Knowledge and valorization dimension]

When asked about their knowledge and valorization of the PMAQ, the themes of adherence and organizational capacity were the main first order/priority themes used by informants to construct their narratives about this aspect. Alternative logics and gaming, as well as negative feedback appeared as recurrent/background themes. (Table 2 and 3).

Table 2 - Associations between dimensions of implementation (types of question) and themes (first order and recurrent themes) as revealed by front line health workers in Goiania

Questions as dimensions of the implementation process	First order/priority themes	Recurrent/background themes
Knowledge and valorization	ADHE - Adhesion to the policy/implementation	LOGI, FEED
	ORGA - Organizational capacity	
Participation in the implementation	PART - Participation in the implementation	ORGA, FEED, ADHE
	LOGI - Alternative logics and ambiguous rhetoric.	
Evaluation/policy changing	FEED - Feedback and uses of results	ORGA, LOGI, ADHE, PART
	IMPA - Perceived impact of the policy	
	ASSE - Culture of assessment/monitoring	

Reasons for adhering to PMAQ (ADHE)

Front liners adhesion to PMAQ occurs within tensions between the necessity to adhere to the Health Secretariat/Health District's demands and their perception of the need to improve care. Adhesion is much influenced by conflicting logics experienced by them in the presentation or introductory phase of the current cycle of PMAQ, as well as derived from the previous cycle (Table 3).

Few informants, and mainly half of the managers and few nurses, revealed a high level of knowledge and understanding regarding the program. Half of managers fully adhere to the program, as well as holds high levels of knowledge regarding it, because they used to hold positions in the Health District or Secretariat, and are responsible for the program presentation stage together with Health District's managers. On the other hand, most of front line health professionals expressed that their knowledge about PMAQ were based on presentations given by the Health District, and that their adherence is negatively influenced by the absence of policy feedback from the previous cycle. Although their adherence is associated with quality improvement, they also express other logics operating at the background context related to PMAQ. They emphasize the tension character of adherence, and discussed additional recurrent background factors that accompany the adherence process. They understand that District's pressures regarding adhesion is due to the Municipal Government's need to obtain financial resources (funds). Two nurses revealed that situations of refusal to adherence were followed by pressures and gaming. Many still perceive this demand as an obligation, and recognize that it refers to the usual top-down style of adherence to public policies in PC. Therefore, health workers' adhesion does not tend to be followed by full understanding nor engagement (Table 3). Notes were also made regarding low organizational capacity, and complex process of work at the front line. Those issues will be better explored in the next item related to the dimension of knowledge and valorization.

The narratives and experiences of those health professionals (Table 3) regarding adhesion reveal that PMAQ is embedded in a system of work characterized by tensions, by work overload and the lack of organizational capacity, where front liners already hold a negative evaluation about PMAQ due to the absence of policy feedback in the previous cycle. It can be said, thus, that PMAQ presents a pragmatic (top-down) political orientation adherence style, characterized by conflicting logics, some negative perceptions and low level of understanding regarding PMAQ (Table 3).

Organizational capacity (ORGA)

Most front liners stated that PMAQ is implemented in units with low organizational capacity, with deficits of health professionals (mainly CHW and doctors), with low medicine, supplies availability and insufficient computers. They recognize that this low organizational capacity lives with the introduction of a new culture of "**pressure for numbers (for production)**", and of front line professionals' dissatisfaction regarding the future of primary health care. Half of CHWs claimed that they do not accomplish their primordial function in order to accomplish other tasks due to reduced staff and workload, what has contributed to undermine the existing bond between CHWs and families. Two doctors who have been working in PC for almost 8 years stressed that they are now pressured to obtain a higher number of consultations, and observed that PC is becoming consultation ambulatories, with little or no promotion activity. Despite the pressure for numbers, the professionals report also that there are insufficient computers for the system to be daily or periodically updated (Table 3). In sum, PMAQ's low level of valorization at the front line (and by health professionals in particular) is associated with the low organizational capacity, be it regarding the availability of professionals to discuss and plan according to the program, be it regarding the utilized resources for the accomplishment of these actions. These facts, due to the environment of

pressures and instability, contribute to professionals' skepticism or demotivation about PMAQ.

RESULT 1 – Most front line health workers have a low level understanding of the PMAQ and tend not to value the program. It is seen as another top-down policy with absence of feedback, in a context where reluctance in terms of adherence can generate gaming and cheating between superiors and front liners. Everyday constraints attributed to low levels of organizational capacity also contribute to undermining front line health workers perceptions/valorization regarding the PMAQ. Half of the local managers are an exception, given their previous and present link to the Secretariat/District.

Table 3 – In what ways front line actors (and which of them) know and value the program? – Adhesion and organizational capacity *[Knowledge and valorization dimension]*

FIRST ORDER THEMES/SUB-THEMES	Recurrent background themes	EXAMPLES
Reasons for Adhering to PMAQ (ADHE)		
Program Presentation	*FEED*	*The District came, presented and followed up. Everything they asked was done'. (Nurses, Health Unit 8). 'They came, presented and went away. We sent everything. They did not come back. (Nurse, Health Unit 5)*
Improvement of care plus obligation	LOGI	*'We adhered because we **wanted to improve care**, but we were all obliged ... Goiânia's City Hall ... is saying a lot but not doing much. So, everything works around **money**. That is, things have been done **quickly**' (Nurse, Health Unit 6 – August 2016)*
Obligation followed by conflicts with administration/ gaming	LOGI (gaming)	*'Adherence was not mandatory on paper. But I put down that I was signing because I was obliged. The Health District at the time said **"if you don't sign, because you don't want to, you can leave"**'. (Nurse, Health Unit 4 – August 2016)*
Organizational Capacity (ORGA)		
Reduced staff and work overload	LOGI, FEED (negative : lack of support, timing)	*'The main difficulties to execute PMAQ were due to **reduced staff**. At the time there were not enough CHW and doctors, and today there are still not enough CHW'. (Manager, Health Unit 8).* *'But we need to check how to do it, if it will be the **full staff of not** with PMAQ. Because in this logic, doctors **don't have time** for other things'. (Doctor, Health Unit 2).* *'We didn't have a receptionist for a year. We work a lot at the front desk. We also substitute the technician. **We cover holes**. If there's PMAQ, we also participate. This way, it took us three months to go back to the same house'. (CHW, Health Unit 7)*
Lack of materials and safety, poor infrastructure, with increased demand	LOGI, FEED (negative)	*'I have no consulting office, or even a room for myself ... So, what's the main problem? **Physical structure**.... There are no **working conditions**. **Lack of materials**. And in our area the demand is too high. Just one doctor isn't enough to attend'. (Nurse, Health Unit 4)* *'It happens that with PMAQ my work condition **didn't change**; They could invest in infrastructure and give better work conditions, I have no computer, I need to use paper. We don't have an ultrasound, pressure measuring equipment, injecting drugs. The job is very unstable and the demand only grows. (Doctor, Health Unit 6)*

3.2. WHICH/HOW MEMBERS OF THE HEALTH TEAM EFFECTIVELY PARTICIPATED IN THE IMPLEMENTATION OF PMAQ? [Participation dimension]

Front liner participation in the implementation of the PMAQ was influenced by the way they acted/participated in response to contradictory demands/forms of accountably as well as due to alternative logics and ambiguities related to the PMAQ. Policy feedback, organizational capacity, and adherence (knowledge) appeared as recurrent/background themes. (Table 2 and 4).

Participation in the implementation of PMAQ (PART)

Interviews confirmed that overall the nurses (and local managers) had higher participation in PMAQ, followed by CHWs and doctors in last (Table 4). And in general, the doctor participates sporadically (or more in the beginning), when he/she participates. The exception was verified more in units of the Health District East, where participants said everybody's participation occurred in PMAQ's discussions and planning. Even here, some doctors claimed they only participated when required. This is because nurses are more accountable to the administration, and most doctors are much less accountable to the public administration, as they hold provisory positions in PC. Absence of feedback from the previous cycle, low levels of understanding and low organizational capacity were the main recurrent background factors discussed by front health workers when talking about their participation during PMAQ. Informants declared that the environment of demotivation and distrust about the intentions or possibilities of PMAQ's concrete accomplishment end up creating an enabling environment or even risks of gaming and cheating during the data collection (table 4).

Two sub-themes related to alternative logics were revealed by front line health workers: fund not received/nor invested and gaming and cheating. Most front line health professionals widely consider PMAQ as an ambiguous policy in terms of the uses of funding

and transference of its financial benefit/reward (Table 4). They thought the program's fund would be invested in infrastructure and used to increment the organizational capacity of PC, but it did not happen. The fact that the fund has not been invested nor transferred to them in form of reward, make them see PMAQ as an ambiguous policy and attached to gaming.

Table 4 - Which/how members of the health team effectively participated in the implementation of PMAQ? – Participation and alternative logics [Participation dimension]

THEMES/SUB-THEMES	Recurrent background themes	EXAMPLES
Participation in the implementation of PMAQ (PART)		
Mainly nurses	*FEED*	'There were actions and plans. Who answered those books *was the nurse*. (CHW, Health Unit 3) 'It was me and the CHW who discussed the questions and filled out the data. **We didn't hear about it after that. It was also like that in the other PMAQ**' (Nurse, Health Unit 5)
CHW participated but needs to be further included	LOGI ORGA	'CHW and I talked for PMAQ. It was good for us to think. When a doctor was needed, we talked to him'. (Nurse, Health Unit 11) '**We CHWs helped** in the part that asked what to do to make improvements. And we programed trying to answer within that question. That's it. Our part involved discussing, promoting, an action and putting it to the test. Just a few were actually approved. **Because the staff was always reduced here. So some things weren't even done**'. (CHW, Health Unit 3)
Doctors' low level of participation	ADHE	'To be honest, I didn't get involved and **I don't know much about the program**. I know it's an assessment program. **The nurse can talk more about it**. My work is focused on attending'. (Doctor Health Unit 12) 'We've always had problems with doctors. Before the adoption of 'More Doctors Program', no doctor would linger here. **In PMAQ there was no doctor**'. (Nurses, Health Unit 8) 'Our staff's interest was absent. **It needed to include CHW and the doctor**. (Manager, Health Unit 3)
Ambiguous rhetoric/ unclear policy (LOGI)		
Fund not received/nor invested	ORGA, FEED	'We thought that with PMAQ it would be solved, the fund, **money, would come to improve the structure, some materials, supplies, we thought** that all this would get better, but nothing improved, things only got worse. If at that time there was a little, today there's nothing. We thought it would help'. (CHW, Health Unit 7) 'It was said that there would be a transfer to the doctor, the dentist, CHW. But here in Goiás we **didn't even hear about this fund**'. (CHW, Health Unit 3)
Cheating/gaming (ambiguities on what is PMAQ)	ORGA, FEED	'We did the discussion part, but **I filled out the same way the other nurse did in the other PMAQ**, I'm not too good at filling out'. (Nurse, Health Unit 4) 'The way they did it, pressuring us to do it quickly, it **was a mask**'. (Doctor, Health Unit 11) 'We though and planned good things, it was thoroughly planned. But accomplishing was never possible. It frustrates you as a professional. Because the **nurse leaves, the doctor leaves** and you always stay. And the actions are never continued .... So **PMAQ is not the reality**. To be honest with you, I don't even know how to fill this in here. Because we didn't accomplish it, I will answer something that is not real'. (CHW, Health Unit 3)**.** 'Later we had access to the grade, which we didn't get it, but why? Because **we don't have the structure here, it lacks, it lacks...** If there were Tele Medicine, then the team would be in contact with the Tele Medicine to solve matters, that's improvement, right? So, we had flaws at the implementation of PMAQ, when it is really implemented then we will have this assessment. **Tele Medicine was together with PMAQ**, but it was not implemented in this unit, because I don't have internet access. **I've already asked for internet access several times**'. (Manager, in Health Unit 12) 'Exactly. Because who's on top [in management/elaboration] doesn't know what's happening here. Normally, who's on top [Ministry] never set a foot on the health care unit. They step inside to visit, where they will visit, just like the mayor will visit, **they clean, paint and it's all beautiful. That's what happens when they come. They put some makeup on PMAQ, because it needs to respond well**. Otherwise the City Hall doesn't get the money'. (Nurse, Health Unit 4)

For most of front line health workers, PMAQ is also taken as another program full of rhetoric due to the gap existent between policymakers and front liner actors, or due to the fact that some of the goals/tools that comprise the program were actually not implemented in Goiania, such as the Tele Medicine, as declared by a local manager. A good number of them claimed that formulators do not fully understand the reality of the unity. One informant revealed having repeated the same information given in the previous cycle of PMAQ, as he/she does not agree with the type of indicators and the way the program has been implemented. Another informant declared having organized the room to perform a « planning section about PMAQ » when receiving a visit from managers holding position at the Municial Health Secretariat (Table 4).

RESULT 2 – Front line health worker participation was influenced by contractidtory demands as well as characterized by certain sorts of gaming and cheating. Factors such as a low level of organizational capacity and knowledge and absance of feedback explains their partial participation or engagement in the implementation of the PMAQ.

3.3. IF/HOW PMAQ MODIFIED THE WAY IN WHICH THE PROFESSIONALS ASSESS AND PLAN THE WORK PROCESS?

Priority themes explaining how front liners evaluate policy changes realized due to PMAQ are associated with themes/factors such as policy feedback, perceived impact and adoption of an assessment culture. The recurrent background themes/factors, ORGA, LOGI, ADHE and PART, aggregate additional information regarding this dimension of implementation (Table 5).

Policy feedback from policymakers to front line professional (FEE)

In general, the participants complain about the lack of feedback on the work accomplished with PMAQ, including that concerning the lack of access or the unawareness

on the results. Absence of feedback is expressed in terms of lack of continuation/ weak policy design and inadeqaute/lacking of support. Few informants reveal that it also hapenned in the previous cycle of PMAQ, demonstrating the absance of feedback is associated to design. Also, absance of feddback leads some respondents to make comments regading the non-transference of funds to front liners. Negative feedback as poor timing is another factor explaining policy feedback. Some nurses expressed that they had to fill in PMAQ data in an urgent manner, due to pressures/demands. They mention that district managers used to pay unexpected visits to collect the results, and that pressures were made without respecting their agenda, nor offering alterative planned strategy (table 5).

Perceived impact of PMAQ (IMP)

Absence of impact or null impact

Three informants considered that PMAQ did not actually impact the FHS. One of them attributed it to the fact that problems related to the lack or organizational capacity remained during the implementation of PMAQ, and no complementary strategy/support was offered. Few other explained it due to the lack of support and absence of feedback. Another one expressed this happened because the planning remained on paper and was not implemented nor monitored afterwards (Table 5).

Positive perceptions lives with questionings about PMAQ

A large number of informants emphasized that PMAQ positively impacted on some organizational aspects of health care management in PC, but this more positive perception lives with questionings about PMAQ. Positive impacts consists the adoption of groups for hypertensive, diabetic and pregnant women, as well as the organization of the area map locating morbidities of patients with colored pins. However, those positive aspects were also associate with conflicting issues or negative impacts (Table 5).

Those who mentioned the adoption of groups, also made references to negative impacts related to organizational capacity and alternative logics. One informant claimed that the planning required by PMAQ helped them to organize and visualize their work better, but timing was very strict. Another informant mentioned that planning and organization of work was indeed made, but remained in the paper, and he/she thinks this may be associated to the fact that the incentive has not been delivered. Another informant, though asserting positive points regarding PMAQ, complained about lack of support during its implementation. Another informant revealed that PMAQ has brought a reflection at the front line, but she/he wondered if it had provoked the same at the management level. This means that health workers consider the impact of PMAQ in an integrated form and its impact is associated not only to absence of actions regarding planning and changes made in their routine of work, but to low organizational capacity, low level of knowledge and ambiguities regarding the program.

Uncertainties regarded the impact of PMAQ

Some informants do not know exactly in which aspects PMAQ impacted care. Their narrative are strongly associated with alternative logics. They associate it to the lack of continuation or even related to the lack of feedback or advertisement of the program's results within the professional of the unit. This means that those informants hold low level of knowledge regarding the PMAQ, and more specifically regarding the demands/problems that the program aimed to target, therefore he/she was unable to talk about changes caused by PMAQ. One informant is more direct in relation to this aspect, claiming that there was only two conversations about PMAQ, therefore he/she couldn't say what had really changed.

Establishing a new assessment and monitoring culture? (ASS)

The main sub-themes related to the adoption of a new culture of assessment are: culture of assessment not established, interest in continuing with PMAQ/developing and a

culture of assessment that masks the real process. These expressions were associated with organizational capacity, forms of adherence and low participation of some members of the health team.

Culture of assessment not established

According to all respondents, the implementation of PMAQ did not contribute to the generation of a routine assessment practice in the units. It was about focused actions aiming at obtaining the required data by PMAQ instruments.

Interest in continuing with PMAQ/developing a culture of assessment

Respondents show interest in making this assessment practice more institutionalized. Some of them further associate this to the need of implementing a countinuous assessment initiative. Few of them also understand that PMAQ was not implemented in its totality, as described in the documents, once it did not manage to go beyond data collection and required registers. One responded repeated and kept on mentioning that Tele Medicine constituted a tool to support the implementation of PMAQ. However, it was not possible use this tool during PMA, because internet was not available in the unities in Goiania.

PMAQ's type of assessment mask the real process

Respondents also recognizes that the type of assessment provided by PMAQ is focused on result collection/presentation rather than change achievement. This logic of result focus was considered by some as a way to mask the real process, once the context and complex process of work is not taken into account.

RESULT 3 – Front line health professionals' diverse negative and contradictory perspctives regarding how PMAQ has impacted their working process is mainly explained by the lack of policy feedback and support, low levels of perceived impact and non-adoption of

an assessment culture. They also explain it in terms of other recurrent and background

factors such as ORGA, LOGI, ADHE and PART.

Table 5 - If/how PMAQ modified the way in which the professionals assess and plan the work process? – Feedback, impact and new assessment culture *[Evaluation/policy changing dimension]*

THEMES/SUB-THEMES	Recurrent background themes	EXAMPLES
Policy Feedback from policymakers to front line professional (FEE)		
Absance of feedback as lack of continuation/ weak policy design	LOGI	'*I want to see results. Wasting hours and hours locked in a room and not seeing anything. It was really only for the record. Only for history, like in the year 2012 there was a study. Only for me to tell my grandchildren that there was a study and I was there. I had a heroic act, I was part of that'. (CHW Health Unit 3)* '*They start but there's no continuation. They never came back. We didn't get a fund. I'd like to have access to the data, to know my grade. We never had access to the publication or the data'. (Doctor, Health Unit 1).*
Absance of feedback as inadeqaute/conflicting support	LOGI	'*I still didn't get the result. They didn't use the incentive to bring improvement'. (Nurse, Health Unit 12).* '*PMAQ brought a lot more work to us. And it remains there, with no support, with no answer. (Manager, Health Unit 6).*
Perceived impact of PMAQ (IMP)		
Positive perception lives with questionings about PMAQ	ORGA, LOGI	'*Thanks to PMAQ the staff now has groups to walk, for the hypertensive and diabetic, and that's what remained, we improved a little. And the rest was not put to the test, all that we discussed and talked about was not put to practice'. (CHW, Health Unit 7)* '*With PMAQ we adopted notebooks again, of hypertensive and pregnant women, which we had stopped using. We made our area's map, locating morbidities of patients with colored pins. But that cost was covered by me, there are no funds for anything'. (Nurse Health, Unit 6)* '*With PMAQ there was an adjustment of the system and sheets'. (Manager, Health Unit 2)* '*Because of PMAQ we started to do research with patients identifying them as asthmatic and overweight. I think the impact was good, but it could be better, but the staff was incomplete'. (Manager, Health Unit 8)* '*At the beginning I had no comprehension of PMAQ's importance. But it caused my staff to self-reflect at that time, towards improving quality. PMAQ brings you a reflection at the time. It should contribute more for management. At the level of the previous management, I'm not sure if they understood very well. Because PMAQ brings reflections to management as well. I don't know if it caused management change. It arrived at the unit at the time of the boom of Dengue, so you can imagine how it was'. (Nurse, Health Unit 5)* '*In the sense that it is put on paper what the situation of your area is, that there's more organization, you visualize the work better, yes, PMAQ was good. I remember we had little time to answer the questions'. (Doctor, Health Unit 10)*
Null impact	FEED, ORG	'*From PMAQ, I didn't really see any change. Nothing, nothing, nothing comes to mind, nothing. Since what I need, for example, here once a month we had the strategic planning meeting. That is, to plan what we need to improve in the unit. All that depended on us to be done has already been done.* ***That's the structure, lack of space, a place to have meetings****. It's not up to my governability. It's not, it's theirs.'. (Nurse, Health Unit 4)* '*As I told you, we answered, we planned.* ***But it was only on paper*** *… I think that the organization was only on paper.* ***But there was no action****, because it required data and the notebooks to organize the work of prevention, reception, forwarding patients, who comes in, who comes out. Administrative data, more for the organization, not for action.* ***It could be the reason we didn't get the fund.*** *Because there was no action. See? This could be one of the explanations'. (CHW, Health Unit 3)* '*PMAQ brought much more work. And it stays there and dies.* ***There's no support. There was no answer****'. (Manager, Health Unit 6).*
Uncertainties regarded the impact of PMAQ	ADHE	'*The program was scored for quality improvement according to the demands, but* ***I can't say exactly what has changed****'. (Nurse Health Unit 11)* '*I think it has improved... but* ***I can't say in which aspect. There were only two conversations****. I'd like it to continue, that it always happened'.(Doctor, Health Unit 1)*
Establishing a new assessment and monitoring culture? (ASS)		
Culture of assessment not established	ORGA, ADHE, PART	'*The discussions didn't continue later, it was really just for PMAQ'. (CHW, Health Unit 9)* '*I believe it's important to assess. But afterwards we weren't able to go on, there's too much work,* ***too many demands****'. (Nurse, Health Unit 8)* '*There were only two conversations. I'd like that to continue, that it always happened, they start and there's no continuation. They never came back. I think it got better, but I can't say in which aspect'. (Doctor, Health Unit 1)*

		'PMAQ is of great importance if it is really implemented because it will assess all these situations ... then I see this, PMAQ will be able to assess service quality. Our staff's interest was absent. Actually, the doctor doesn't have the bond the strategy needs, he only performs the procedures'. (Manager, Health Unit 3)
Interest in continuing with PMAQ/developing a culture of assessment		'It needs to continue. It's different when you have an assessment in which you meet and decide what we have to do. The staff themselves will do it because nobody likes low grades, right?'. (Nurse, Health Unit 6) 'We had that meeting, discussed, read, we need to go back and rescue what was left behind. It was so in the beginning, but there was no continuation'. (CHW, Health Unit 7)
PMAQ's type of assessment mask the real process		'I hope this study can make them review this PMAQ, and how to implement and give the necessary tools to accomplish the actions. And not only be part of the records. Our reality doesn't change, there's only a "mask"'. (CHW, Health Unit 3)

3.4. REGULARITIES RELATED TO ALL THREE DIMENSIONS OF THE IMPLEMENTATION PROCESS

RESULT 4 – Front line health workers evaluate PMAQ implementation in a comprehensive form and as part of a policy process, aggregating more themes to the discussion as the interviews went on, using recurrent/background themes to establish connections between policy dimensions regarding implementation (knowledge, participation and evaluation). When discussing the knowledge/valorisation dimension, for instance, recurrent themes were less prominent than when discussing the dimensions of participation and evaluation. The number of and inter connections between recurrent themes was higher when talking about evaluation. As the interview/discussion process developed, certain themes either gained or regained significance in a comprehensive and integrative fashion, being used and reaffirmed/confirmed to evaluate the policy implementation process. More recurrent themes referred to ORG, ADHE, PART, FEED, LOGI.

4. DISCUSSION *(work in progress)*

Relevant political policy issues arise when the implementation of a pay for performance program is studied from the perspective of front liner perceptions and attitudes in distinct and complex organizational settings and contexts – where front liners face contradictory forms of accountability, needing to make choices between them.

Regarding the implementation of pay for performance programs in health policy in LMIC, researchers have highlighted that organizational capacity needs to be strengthened during the implementation. Organizational capacity has been considered one of the main key factors that either caused the failure of programs - as happened in Uganda (Ssengooba, McPake and Palmer, 2012) - or as a factor associated with the rise of partial effects (Bhatnagar and George, 2016), or even as a factor explaining the main constraints (Olafsdottir et al., 2014) or the low levels of adherence and engagement on the front line by some members of the health team (Saddi and Harris et al., 2016b). Therefore research undertaken in LMIC has shown that, though in diverse ways, those programs need to be accompanied by capacity building strategies and human resource reforms.

Moreover, studies have shown that undesired effects of P4P in health policy are usually a result of low motivation of front line workers (or health workers) (Songstad et al., 2012) (Eijkenaar, 2013). In Tanzania, for instance, workers did not believe the program would result in financial gains, nor did they receive feedback regarding their performance (Songstad et al., 2012). A systematic review that explores front liners' perceptions on p4p in diverse countries revealed that efforts should be made to generate "increasing levels of provider awareness" about p4p, "providing technical and educational support, reducing their burden, developing cooperative relationships with providers … and minimizing the unintended consequences" (Lee et al., 2012). Given the prevalence of low or contradicting forms of motivations, as well as the lack of feedback, the literature has considered it important to actively involve actors in the formulation/design of the program (Lee at al., 2012) (Eijkenaar, 2013). As stated by Eijkenaar, "This increases the likelihood of provider support and alignment with their professional norms and values (Eijkenaar, 2013, p. 140). Therefore, low motivation tends to be associated with low/absence of feedback and non-participation in the design.

In Goiania, in a similar way to other cities in the LMIC, the main factors driving the implementation of financial based programs at the front line are the low organizational capacity of the bureaucracy, low levels of understanding and participation/engagement by front liners and absence of feedback received from policymakers. Poor knowledge/understanding regarding the policy, as well as an absence of feedback, did not encourage the participation/engagement of front line workers during policy implementation. These policy issues occurred in a context of low organizational capacity without the adoption of additional/complementary support during the PMAQ.

The public policy literature and PM political literature (previously discussed), as well as findings from PM programs in other LMIC enable us to assert that those factors driving the implementation of PMAQ might have happened (and are possibly happening) in other parts of Brazil. This might be occurring in PC units experiencing similar organizational constraints, in cities were health Secretariat/Districts managers adopt a more top-down and less communicative/integrative style of relation with front line health workers.

Moreover, the analysis of the case of the PMAQ in Goiania uncovers and brings some relevant political regularities/challenges regarding the implementation of a p4p program, that could be seen as policy assumptions to be comparatively and meaningfully explored/used not only in other cities/units in Brazil, but in other LMIC countries or between distinct LMIC as well. It offers an integrative policy perspective for the analysis of p4p programs, which involves three dimensions of the implementation process (Figure 1), and calls attention to main recurrent themes and sub-themes shaping implementation. Organizational capacity *(in a more anchored/structural/supportive aspect of the policy process),* adherence/knowledge, participation, feedback (as *social construction issues anchored in distinct ORGAs*) and alternative logics (*as unintended consequences/ factors attributed to P4P/PBF*). The three main policy assumptions are:

1) *The greater the **level of knowledge and understanding** of front liners regarding the policy, and the more institutionalized or dynamic the feedback received from the top are, the greater the likelihood of front line health workers effectively adhering and acting in accordance with the policy.*

2) *Poor interaction during the promotion (and formulation) of the policy and increasing or contradictory demands/accountabilities, in a context of low organizational support, can be considered factors prone to limiting **participation/engagement** during implementation.*

3) *In an integrative manner, low levels of knowledge, low levels of participation/engagement, absance of policy feedback, and absance of alternatives to foster organizational capacity, do not favor **sustainable changes to the working process of or the creation of an assessment culture**.*

According to our research findings, based on the public policy literature and PM realistic-political studies, whenever the implementation of a p4p program (and of PMAQ more specifically) focuses mainly or solely on the production of performance indicators/numbers, it is very unlikely that they will contribute to strengthen the public policy, or to quality improvement. From the viewpoint of public policy – and aligned with system strengthening and quality improvement perspectives -, successful implementation requires the adoption of additional/complementary strategies/tools at the front line, to counteract policy failure or the emergence of alternative logics (and gaming/cheating) in p4p programs. Organizational capacity, knowledge/motivation, participation/engagement and policy feedback are the types of strategies to be targeted. Organizational capacity could play a more definite background supportive role, providing the structure needed for the construction of

understanding, participation and feedback. All those factors together can contribute to counteracting the emergence of alternative logics.

5. CONCLUSION

Fundamental lessons to be extracted from the analysis refer to the need of 1) creating a new organizational culture and capacity. This is allied to the need of 2) developing a new politics of adhesion, 3) fostering a participative culture in PC and PMAQ and 4) adopting strategies that would foster more feedback from PMAQ and uses of PMAQ's results. This would enable the deconstruction of ambiguities about PMAQ and construction of identifications with PMAQ at the front line, as well as favor the development of a new culture of assessment/monitoring. There is the need to improve infrastructure, staff hiring and necessary materials supply in the units, which would depend on available resources (ORGA). It is also about challenge lessons that can be adopted through strategies/tools of dialogue (ADHE, PART, FEED), and that, by being faced routinely in PC, and not only related to a single program, would be constructing the necessary participative fundaments and involvement for a perception and understanding change of the front line about the program.

In fact, PMAQ improvement at the front line, would mean the initiation (or revision) of a new organizational culture in the implementation of PC and PMAQ, privileging the front line, with higher possibility of creating a (new) assessment culture and, consequently, guided by a new adhesion, more feedback and uses of PMAQ, making possible to deconstruct rhetorics and ambiguities related to the program, and the construction of a new way of valuing PMAQ program and the policy process related to it.

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