The challenges of payment for performance under Brazil's PMAQ

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In 2020, the Brazilian Unified Health System (*Sistema Único de Saúde*; SUS) celebrated 30 years. However, adequate government funding allocation to continue supporting SUS's universal health coverage goal remains a challenge to be addressed.[1] Payment for performance (P4P) was the strategy proposed to strengthen primary health care with the implementation of Brazil's National Programme for Improving Primary Care Access and Quality (PMAQ), a federal public policy that started in 2011, with three rounds completed in 2019.[2,3]

In *The Lancet Global* Health, Roxanne Kovacs and colleagues[4] highlight the effort to support and decentralise resources to primary health-care teams, most of them organised through the Family Health Strategy (FHS). This strategy aims to provide preventive and basic health care to approximately 1000 households in a defined area through a multidisciplinary professional team, usually consisting of a physician, a nurse, and about six community health workers.

Through PMAQ, primary health-care performance became a continuous and progressive process directly associated with a federal government incentive policy, based on transfer of financial resources to municipalities by monitoring a selected group of indicators obtained from primary (health-care team self-evaluation and manager and external evaluation) and secondary databases (national health information system).[2] Secondary data have some limitations, such as incomplete information and poor electronic medical records linkage. Therefore, it is important to consider the complexity of the P4P programme rolled out in Brazil during the three PMAQ waves of evaluation organised by researchers from public Brazilian universities in collaboration with local health managers and stakeholders.

Kovacs and colleagues[4] analysed data on the quality of care delivered by family health teams participating in PMAQ over three rounds of implementation. Then, using census data on household income of local areas, the authors examined the PMAQ score by income ventile, the association between PMAQ scores and the income of each local area across implementation rounds, and the geographical variation in PMAQ score. Kovacs and colleagues included 13 934 teams that participated in the three rounds of PMAQ, located in 11 472 census areas and serving approximately 48 million people. In round 1 of PMAQ, the authors observed a positive socioeconomic gradient, with the mean PMAQ score lower in the poorest areas and higher in the richest areas. Between rounds 1 and 3, mean PMAQ performance increased significantly for the poorest group and decreased slightly for the richest group, with the gap between richest and poorest narrowing from 7·5 percentage points (95% CI 6·5–8·5) to −0·4 percentage points over the same period (−1·6 to 0·8). These results show a decrease in socioeconomic inequality between Brazil's geographical regions during the period of PMAQ implementation and cash transfer to the municipalities according to their performance.

An aspect that requires further investigation relates to how the local managers and stakeholders used their financial resources to achieve quality and improve access to health-care centres, as well as which specific interventions and initiatives were done by FHS teams and managers that could explain the health performance level in their territory (census sector) to reduce social inequalities. It is also important to assess how much of their own resources the municipalities have invested in health, considering the shared responsibility between local, state, and federal government to support the SUS.

Measures from PMAQ were important in the assessment of the FHS teams' performance during the three rounds of evaluation and support the decision to decentralise financial resources at the municipality level. However, the FHS teams that participated in the first PMAQ round were in states with better socioeconomic indicators and well organised local health-care systems. Additionally, the decision to have an external audit, which was part of the PMAQ evaluation criteria, was voluntary. Therefore, the presence of selection bias needs to be acknowledged. Furthermore, the performance in the first PMAQ round was associated with the performance from the best primary health-care teams and local managers who believed they would have a good evaluation.

Kovacs and colleagues[4] used a well designed analytical strategy, with their main findings presented on maps that allow a better understanding of the performance level in the different regions of the country. The results showed a reduction in inequalities in primary healthcare performance over the three rounds of PMAQ. However, a PMAQ score corresponds to the performance of a health team, whose coverage area (or territory) does not necessarily correspond to a census sector. This is a local decision based on health and socioeconomic indicators.

The political and geographical contexts have strong influence on the success of P4P programmes,[5] from the implementation process to the way schemes are designed, including overall aims, focus of target setting, and political actors involved in its conception.[6] This way, a universal health coverage can only be achieved through strong investments in primary health care, by use of a family health approach in a defined territory with a registered population.

During the 8 years of the PMAQ, it was possible to verify improvements in infrastructure, medical supplies, medications, and health outcomes.[2] Unfortunately, in 2019, a political decision was made to interrupt the PMAQ by implementing a new financing model for primary health care, with changes to the P4P programme.[7] PMAQ was an effective programme and its interruption represents removal of the opportunity to continue the assessment of the P4P programme's impact on health outcomes and socioeconomic inequalities based on collaborative scientific work among researchers from federal universities and government.

We declare no competing interests.

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