DOI: 10.1590/1413-81232021265.04432021

Medical hiring formats in the Family Health Strategy and the performance of their core attributes

Antonio Leonel de Lima Júnior (https://orcid.org/0000-0003-1267-2181) [1]
Ivana Cristina de Holanda Cunha Barreto (https://orcid.org/0000-0001-8447-3654) [2]
Roberto Ribeiro Maranhão (https://orcid.org/0000-0001-6114-9982) [1]
Sharmênia de Araújo Soares Nuto (https://orcid.org/0000-0002-4763-6773) [2]
Bruno Souza Benevides (https://orcid.org/0000-0002-1697-3427) [1]
Maria Vieira de Lima Saintrain (https://orcid.org/0000-0003-1514-3218) [3]
Anya Pimentel Gomes Fernandes Vieira-Meyer (https://orcid.org/0000-0003-4237-8995) [2]

Abstract *The study aimed to investigate the perception of doctors about the different hiring methods and their influence on the performance of the PHC essential attributes to analyze the formats that best contribute to its implementation and strengthening. This is a quantitative, cross-sectional research using a semi-structured form with 268 doctors from the ESF in Fortaleza, Ceará, Brazil. A unique sociodemographic profile was identified for each group evaluated, influencing the work process and opinions about hiring formats. The development of the essential PHC attributes was positively evaluated, but different perceptions were observed by professional hiring method assessed. The work performed by doctors in the ESF is influenced by how they are hired (p<0.001). Better performance of the statutory (4.4) was noted, followed by scholarship holders of the Mais Médicos Program/Primary Care Valorization Program (3.7), Consolidated Labor Laws (3.5), and, finally, those working with Self-Employed Payment Receipt (RPA) (2.4). We analyzed that hiring through the Brazilian Statutory Regime and RPA are, respectively, the best (85%) and the worst (96.6%) hiring formats.*

Key words *Family Health Strategy, Primary Health Care, Workforce, Unified Health System*

[1] Secretaria Municipal de Saúde de Fortaleza. R. Barão do Rio Branco 910, Centro. 60310-330 Fortaleza CE Brasil. antleonel@hotmail.com
[2] Fundação Oswaldo Cruz (Fiocruz Ceará). Eusébio CE Brasil.
[3] Universidade de Fortaleza. Fortaleza CE Brasil.

Introduction

In Brazil, a transition from the social protection model in health centered on the Bismarckian-based social insurance mechanism, through the National Social Security Institute for Medical Care (INAMPS), to a Beveridgian-based social security model was observed with the 1988 Federal Constitution and the guaranteed right to health. This new standard is supported in the health sector by the Unified Health System (SUS)[1].

Several universal health systems and or systems with universal coverage[2] are found globally, emphasizing the Brazilian, French, English, Canadian, and German systems, which have different financing and professional contracting formats. In England's National Health System (NHS), the general practitioner can have two relationships with the health system: 1. Independent doctors are responsible for running their clinics as businesses (alone or in partnership); 2. Salaried doctors who are employees of independent contracted practices or directly employed by PHC organizations. In Brazil, the professional relationship between the medical professional and the health system is direct or indirect, while in Germany, the service offering is made by public and private providers accredited to the Social Disease Insurance (GKV) at all levels[3].

Brown[4] argues that the conflict between policymakers (ministries of health and finance) and providers over payment terms and levels is a persistent issue of political life in Canada, France, England, and Germany. Providers negotiate with the state, health insurance institutions, or both within public budgets and fiscal limits. In Great Britain and Canada, organizations of doctors and individual hospitals bargain directly with government agencies. In Germany, associations of sickness fund doctors and individual hospitals negotiate with GKV funds. In France, doctors' unions negotiate separately with sickness funds. These questions can affect how the health system works and influence them on different conceptions of universality in health (universal systems versus universal health coverage)[2].

In the SUS implementation process, permanent tension between constructing a national health service with universal access and a system directed to the poorest with selective programs was observed, a conflict located at the core of the public field proposals and the privatizing proposals[5]. Therefore, several difficulties are highlighted in implementing this new system, such as the perennial scarcity of financial and human resources, especially in Primary Health Care (PHC)[6].

Noteworthy is that the shortage of doctors in the Family Health Strategy (ESF) in Brazil is greater than that of other health professionals[7,8]. Thus, the municipalities sought alternative employment relationship types (e.g., Statutory, CLT, scholarship holders, temporary workers) when hiring such professionals to solve this problem[9]. The federal government also created measures with several incentives, emphasizing the employment relationship of doctors with the Ministries of Health or Education, as in the case of medical residencies, the PHC Valorization Program (PROVAB) and the More Doctors for Brazil Program (PMMB)[10-12]. This hodgepodge of professional employment formats occurs despite the guidelines of the SUS Human Resources Policy (PNRH-SUS)[13,14].

It is also relevant to point out that the use of different formats of hiring medical professionals for the ESF teams is a subject of significant interest for the continuity of the PHC work processes and should be addressed as a priority in State policy[15,16]. It is important to have doctors following life cycles, taking responsibility for the health of the community over time, guiding their actions in humanized relationships, having a long-term relationship with their employers[17-19] and developing their activities based on the essential PHC attributes, namely, first contact, longitudinality, comprehensiveness, and care coordination[20].

In this scenario, the diverse connections between doctors and the ESF may influence their work process and the full implementation of the strategy, with its doctrines, principles, and attributes. It is also known that the hiring of health professionals in the SUS must follow the dictates of the National Policy for Human Resources of the SUS, while the work of professionals in primary care must follow the premises of the National Policy for Primary Care (PNAB). However, the literature is not clear about which doctors' hiring format allows the best development of the essential attributes of PHC and assumptions of the PNAB.

Based on this observation, this study investigates the perception of doctors about the different hiring formats and their influence on the performance of the essential PHC attributes to analyze the professional relationships that best contribute to its implementation and strengthening, also considering the dictates of PNAB and PNRH-SUS.

Ciência & Saúde Coletiva, 26(5):1657-1668, 2021

Methods

This is a cross-sectional, quantitative, descriptive field study. Data were collected from April to November 2018. A semi-structured form was applied to doctors at the ESF in Fortaleza. The 343 doctors in the municipality at the time had different professional relationships: 171 were scholarship holders through the *Mais Médicos para o Brasil* (More Doctors for Brazil) Program (PMMB) and the Primary Care Valorization Program (PROVAB); 127 were Statutory; 13 were hired under the Consolidated Labor Laws (CLT) regime; 13 were under temporary contracts, through a Self-Employed Payment Receipt (RPA); and 19 doctors were in Medical Residency in Family and Community Health and were included in the study because they are duly qualified professionals and very much incorporated into the daily care of the Family Health Strategy[21]. The inclusion criterion was to be a doctor with effective practice in the municipality's ESF for more than six months. The exclusion criterion was being on leave, sick leave, or away from work at the ESF at the time of collection.

We attempted to apply the questionnaire to everyone regarding the sample composition for relationships with 20 or fewer professionals (CLT, RPA, and medical residency). A simple random sample calculation was used for the finite population for the other groups (PMMB/PROVAB scholarship holders and statutory) due to the difficulties inherent in data collection amid an intense and dynamic care environment, with a 95% confidence interval (CI), P=50%, Q=50%, and sampling error of 5%. The sampling was defined at 96 for the Statutory and 119 for the PMMB/PROVAB, with the expected final sample of 260 professionals. At the end of the collection, the final sample consisted of 268 professionals (123 PMMB/PROVAB scholarship holders; 100 statutory, 13 working under the CLT regime, 13 RPA, and 19 Family Health Residents). As a result, a census was carried out for professionals with a CLT, RPA, or residency relationship, while the simple sample calculation was used for statutory and PMMB/PROVAB scholarship relationships. Chart 1 shows the total number of professionals per job and their respective samples.

A questionnaire was used with inquiries about sociodemographic data (age, gender, marital status, household income, religion, year of graduation), professional training, seniority in the ESF, hiring formats, and perception of the development of the essential PHC attributes (first contact, longitudinality, comprehensiveness, and care coordination) according to the recruitment formats. The PHC attributes were briefly described in the questionnaire. The interviewed professionals evaluated the attributes for all the relationship formats (PMMB/PROVAB scholarship holders, statutory, CLT, RPA, and medical residency). Thus, their opinion was obtained not only regarding their hiring format but also the other.

Data were collected in all Primary Health Care Units (UAPS) in Fortaleza, with visiting moments previously agreed with the unit's coordination and the respective professional. Regarding the location of the study, it is the fifth capital of the country and second in the Northeast in the number of inhabitants. In 2018, the study period, according to data from the Ministry of Health[21], the estimated population coverage of family health teams was below 50%. The municipality currently has 113 health units, distributed among the six regional health administrative offices' units.

The questionnaires were applied as interviews, face-to-face or via telephone, prioritizing the former and using the latter only to complement interviews paused due to the service's issues. When professionals refused to participate in the research, they were replaced by other professionals from the same health unit with the same employment relationship. When there was no other professional with these characteristics in the health unit, a professional from another health unit, but from the same regional health administrative office unit, was interviewed to replace the sample.

Besides the collection of primary data, a documentary analysis was carried out on the characteristics related to the formats of hiring doctors for ESF in UAPS in Fortaleza, based on the principles of the Unified Health System (SUS), the National PHC Policy (PNAB) and the National Policy for Human Resources of the SUS (PNRH-SUS), through a detailed evaluation of documents in the field related to the theme (e.g., public policies, ordinances, standards, technical opinions, and reports).

This research is nested in the master's dissertation entitled "The perception of doctors concerning the impact of hiring formats in the work of the Family Health Strategy" (ISGH Ethics Committee). The data were described by their frequencies. The responses of the variables related to the PHC attributes (first contact, longitudinality, comprehensiveness, and care co-

Chart 1. Number of professionals linked to the Family Health Strategy of the Municipality of Fortaleza by hiring and sampling method used to collect data from this research.

Professional relationship	Universe	Number of professionals scheduled for an interview	Number of professionals interviewed	Sampling method
Statutory Regime	127	96	100	Simple random sample calculation
Scholarship PMMB/ PROVAB	171	119	123	Simple random sample calculation
Consolidated Labor Laws (CLT)	13	13	13	Census
Self-employed payment receipt (RPA)	13	13	13	Census
Family Health Residency	19	19	19	Census

Source: Data analysis from the semi-structured interview.

ordination) were transformed into continuous variables (excellent, good, fair, poor, and very poor, transformed into 5, 4, 3, 2, and 1). Continuous variables were described by the mean and standard deviation of descriptive statistics. The One-Way ANOVA test was used to compare the respondents' mean scores to the variables related to the PHC attributes for the four hiring formats analyzed (CLT, statutory, More Doctors program, and self-employed). The normality of the quantitative variables was verified using the Shapiro-Wilk test. A significance of $p \leq 0.05$ was used. Software packages EpiData 3.1 and STATA 14 (StataCorp. STATA Statistical Software. V 13.0. Release 9.0 ed. CollegeStation, Texas 77845 USA: Stat Corporation: 2007) were used for organizing and analyzing the data. The ethical-legal aspects of Resolution No. 466/2012 were observed.

Results

The survey included 268 doctors working in the ESF teams in Fortaleza, subdivided by professional relationship (123 PMMB/PROVAB scholarship holders; 100 statutory, 13 working under the CLT regime, 13 through Self-employed Payment Receipt, and 19 Family Health Residents).

The dominant age group among the respondents was 31-40 years (47.7%). A slight female predominance (50.6%) was determined by the PMMB scholarship holders (56.9%), while the number of men is higher (55% statutory, 61.5% CLT, and 53.8% RPA) in the other subcategories. Most respondents were married (59%). PMMB scholarship holders stand out as the group with the most significant number of members with completed *lato sensu* specialization (86.9%), followed by statutory (84%), where just under half of the courses are in the Family Health field (46.6%). Just over a third of the statutory (37%) completed Medical Residency in Family and Community Medicine, lower than the number of statutory who reported completing medical residencies in other areas (39%). There is low adherence to the title test by the Brazilian Society of Family and Community Medicine (38% statutory; 23% CLT; 23% RPA; and 13% PMMB/PROVAB). Among those who declared household income, the highest incomes are with statutory and scholarship holders (5% and 1.6% above 31 minimum wages). Table 1 shows the sociodemographic data by hiring method, excluding residents, as they are non-contractual relationships.

The findings show that hiring through the Statutory Regime and autonomously were assessed as the best (by 85% of respondents) and the worst (96.6% of respondents) ways of hiring ESF doctors. These formats protect antagonistic positions regarding stability, labor rights, relationships, remuneration, regular payments, care continuity, security, possible incentives, access to

Ciência & Saúde Coletiva, 26(5):1657-1668, 2021

Table 1. Sociodemographic profile of doctors working in the ESF in Fortaleza.

	CLT 13	STATUTORY 100	PMMB/ PROVAB 123	RPA 13
	n (%)	n (%)	n (%)	n (%)
Age				
Up to 30 years	3(23.0)	0 (0.0)	39 (31.5)	3 (23.0)
31-40 years	9 (69.2)	34 (34.0)	70 (56.7)	6 (46.1)
41-50 years	1 (7.6)	41 (41.0)	7 (5.6)	1 (7.6)
51-60 years	0 (0.0)	20 (20.0)	2 (1.6)	0 (0.0)
>61 years	0 (0.0)	5 (5.0)	5 (4.0)	3 (23.0)
Gender				
Male	8 (61.5)	55 (55.0)	53 (43.0)	7 (53.8)
Female	5 (38.4)	45 (45.0)	70 (56.9)	6 (46.1)
Marital status				
Single	8 (61.5)	12 (12.0)	59 (47.9)	7 (53.8)
Married	5 (38.4)	78 (78.0)	58 (47.1)	6 (46.1)
Divorced	0 (0.0)	10 (10.0)	6 (4.8)	0 (0.0)
Lato sensu specialization (concluded)				
Yes	7 (53.8)	84 (84.0)	107 (86.9)	04 (30.7)
Specialization type				
Family Health	3 (23.0)	42 (42.0)	77 (62.6)	3 (23.0)
Public Health	0 (0.0)	2 (2.0)	2 (1.6)	0 (0.0)
Medical Auditing	1 (7.6)	2 (2.0)	2 (1.6)	0 (0.0)
Occupational Medicine	1 (7.6)	9 (9.0)	7 (5.6)	1 (7.6)
Other	2 (15.3)	29 (29.0)	19 (15.4)	0 (0.0)
Completed medical residency				
Yes, in Family and Community Medicine	2 (15.3)	37 (37.0)	13 (10.5)	1 (7.6)
Yes, in another field	2 (15.3)	39 (39.0)	11 (8.9)	1 (7.6)
No	9 (69.2)	24 (24.0)	99 (80.4)	11 (84.6)
Specialist title by the Brazilian Society of Family and Community Medicine				
Yes	3 (23.0)	38 (38.0)	16 (13.0)	03 (23.0)
Household income in minimum wages				
Up to 10 minimum wages	5 (38.4)	9 (9.0)	7 (5.6)	6 (46.1)
11-20 minimum wages	3 (23.0)	44 (44.0)	64 (52.0)	3 (23.0)
21-30 minimum wages	0 (0.0)	14 (14.0)	14 (11.3)	0 (0.0)
>31 minimum wages	0 (0.0)	5 (5.0)	2 (1.6)	0 (0.0)
Preferred not to declare	5 (38.4)	28 (28.0)	36 (29.2)	4 (30.7)

Source: Data analysis from the semi-structured interview.

improvements, reducibility of salaries, longitudinal monitoring, and turnover of professionals, as shown in Table 2.

Most doctors had experience with some previous contract types (70.8%). The possibility of changes in satisfaction in exercising their activities with the hiring format is reported by the respondents (58.5%), who refer to exercising their activities differently according to the hiring format (88.4%). Stability (53.7%), increased employment (23.5%), labor rights (22.3%), security (13.8%), retirement (4.8%), and lower turnover (3.7 %) were cited as items that would provide changes in satisfaction; while dedication (20.8%), continuing education (20.1%) and long-term planning (20.1%) appear as the central claims for changes in the exercise of their work according to the hiring format.

Table 2. Opinion of medical professionals working in Fortaleza on their employment relationship and the impact of the employment relationship on professional performance. Fortaleza-CE, 2018.

	Total 268	CLT 13	EST 100	PMMB/ PROVAB 123	RES 19	RPA 13
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Main reason to be in the current employment relationship						
Stability	69 (25.7)	3 (23.0)	43 (43.0)	21 (17.0)	0 (0.0)	2 (15.3)
Identification	129 (48.1)	7(53.8)	51 (51.0)	52 (42.2)	14 (73.6)	5 (38.4)
Transient situation	59 (22.0)	3 (23.0)	0 (0.0)	47 (38.2)	4 (21.0)	5 (38.4)
Lack of options	3 (1.1)	0 (0.0)	2 (2.0)	0 (0.0)	0 (0.0)	1 (7.6)
Other	8 (2.9)	0 (0.0)	4 (4.0)	3 (2.4)	1 (5.2)	0 (0.0)
Previous contract in PHC						
Yes	190 (70.8)	11 (84.6)	83 (83.0)	76 (61.7)	15 (78.9)	5 (38.4)
No	78 (29.1)	2 (15.3)	17 (17.0)	47 (38.2)	4 (21.0)	8 (61.5)
Changes in satisfaction with the change in the hiring format						
Yes	157 (58.5)	12 (92.3)	57 (57.0)	67 (54.4)	16 (84.2)	5 (38.4)
No	111 (41.4)	1 (7.6)	43 (43.0)	56 (45.5)	3 (15.7)	8 (61.5)
How changes in the hiring format change the satisfaction in exercising your work						
Stability	144 (53.7)	6 (46.1)	62 (62.0)	58 (47.1)	8 (42.10)	10 (76.92)
Strengthened employment relationship	63 (23.5)	2 (15.3)	38 (38.0)	10 (8.1)	9 (47.36)	4 (30.76)
Employment relationship / Labor rights	60 (22.3)	4 (30.7)	26 (26.0)	18 (14.6)	6 (31.57)	6 (46.15)
Security	37 (13.8)	3 (23.0)	14 (14.0)	17 (13.8)	2 (10.59)	1 (7.62)
Retirement pension	13 (4.8)	0 (0.0)	11 (11.0)	2 (1.6)	0 (0.0)	0 (0.0)
Lower turnover	10 (3.7)	2 (15.3)	0 (0.0)	5 (4.0)	1 (5.2)	2 (15.3)
Changes in the way of working according to the hiring format						
Yes	237 (88.4)	12 (92.3)	91 (91.0)	103 (83.7)	18 (94.7)	13 (100.0)
No	31 (11.5)	1 (7.6)	9 (9.0)	20 (16.2)	1 (5.2)	0 (0.0)
How changes in the hiring format cause changes in the way you perform your work						
Dedication	56 (20.8)	0 (0.0)	23 (23.0)	18 (14.6)	11 (57.8)	4 (30.7)
Continuing education	54 (20.1)	3 (23.0)	12 (12.0)	27 (21.9)	9 (46.3)	3 (23.0)
Long-term planning and actions	54 (20.1)	2 (15.3)	18 (18.0)	17 (13.8)	13 (68.4)	4 (30.7)
Motivation	46 (17.1)	7 (53.8)	14 (14.0)	11 (8.9)	8 (42.1)	6 (46.1)
Strengthened employment relationship	31 (11.5)	2 (15.3)	16 (16.0)	8 (6.5)	3 (15.7)	2 (15.3)
Stability	17 (6.3)	1 (7.6)	8 (8.0)	6 (4.8)	2 (10.5)	0 (0.0)
Labor rights	15 (5.5)	0 (0.0)	5 (5.0)	8 (6.5)	2 (10.5)	0 (0.0)

it continues

Assessing the fulfillment of PHC attributes when evaluating the first contact (4.4 statutory; 4.0 PMMB/PROVAB; 3.8 CLT; 3.0 RPA), longitudinality (4.5 statutory; 3.5 PMMB/PROVAB; 3.2 CLT; 2.0 RPA), comprehensiveness (4.4 statutory; 3.7 PMMB/PROVAB; 3.6 CLT; 2.5 RPA) and care coordination (4.4 statutory; 3.6 PMMB/PROVAB; 3.5 CLT; 2.3 RPA), the respondents consid-

Ciência & Saúde Coletiva, 26(5):1657-1668, 2021

Table 2. Opinion of medical professionals working in Fortaleza on their employment relationship and the impact of the employment relationship on professional performance. Fortaleza-CE, 2018.

	Total 268	CLT 13	EST 100	PMMB/ PROVAB 123	RES 19	RPA 13
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Best hiring format						
CLT	8 (2.9)	0 (0.0)	0 (0.0)	5 (4.0)	3 (15.7)	0 (0.0)
Statutory	228 (85.0)	13 (100.0)	98 (98.0)	90 (73.1)	14 (73.6)	13 (100.0)
Mais Médicos para o Brasil (More Doctors for Brazil) Program	26 (9.7)	0 (0.0)	2 (2.0)	24 (19.5)	0 (0.0)	0 (0.0)
Temporary	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Other	6 (2.2)	0 (0.0)	0 (0.0)	4 (3.2)	2 (10.5)	0 (0.0)
Reason for considering the best hiring format						
Stability	141 (52.6)	8 (61.5)	55 (55.0)	61 (49.5)	8 (42.1)	9 (69.2)
Employment relationship	68 (25.3)	4 (30.7)	28 (28.0)	28 (22.7)	4 (21.0)	4 (30.7)
Longitudinal monitoring	67 (25.0)	3 (23.0)	29 (29.0)	29 (23.5)	4 (21.0)	2 (15.3)
Labor rights	53 (19.7)	7 (53.8)	10 (10.0)	23 (18.7)	5 (26.3)	8 (61.5)
Social security rights	16 (5.9)	1 (7.6)	4 (4.0)	6 (4.8)	3 (15.7)	2 (15.2)
Incentives for improvement	13 (4.8)	1 (7.6)	1 (1.0)	6 (4.8)	5 (26.3)	0 (0.0)
Security	18 (6.7)	1 (7.6)	8 (8.0)	7 (5.6)	1 (5.2)	1 (7.6)
Irreducible wages	5 (1.8)	1 (7.6)	1 (1.0)	2 (1.6)	1 (5.2)	0 (0.0)
Worst hiring format						
CLT	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Statutory	2 (0.7)	0 (0.0)	2 (2.0)	0 (0.0)	0 (0.0)	0 (0.0)
Mais Médicos para o Brasil (More Doctors for Brazil) Program	5 (1.8)	0 (0.0)	2 (2.0)	3 (2.4)	0 (0.0)	0 (0.0)
Residency	-	-	-	-	-	-
Temporary	259 (96.6)	13 (100.0)	95 (95.0)	120 (97.5)	18 (94.7)	13 (100.0)
Other	2 (0.7)	0 (0.0)	1 (1.0)	0 (0.0)	1 (5.2)	0 (0.0)
Reason for considering the worst hiring format						
Instability	95 (35.4)	4 (30.7)	38 (38.0)	36 (29.2)	8 (42.1)	5 (38.4)
Lack of labor rights	93 (34.7)	10 (76.9)	31 (31.0)	33 (26.8)	8 (42.1)	11 (84.6)
No employment relationship	85 (31.7)	4 (30.7)	32 (32.0)	38 (30.8)	6 (31.5)	5 (38.4)
Wage arrears	54 (20.1)	7 (53.8)	15 (15.0)	27 (21.9)	4 (21.0)	1 (7.6)
Low remuneration	38 (14.1)	1 (7.6)	11 (11.0)	21 (17.0)	3 (15.7)	2 (15.3)
Discontinued care	37 (13.8)	0 (0.0)	12 (12.0)	16 (13.0)	4 (21.0)	5 (38.4)
Insecurity	28 (10.4)	3 (23.0)	15 (15.0)	7 (5.6)	1 (5.2)	2 (15.3)
High turnover	21 (7.8)	0 (0.0)	8 (8.0)	13 (10.5)	0 (0.0)	0 (0.0)
Finds current hiring format disadvantageous						
Yes	165 (61.5)	12 (92.3)	51 (51.0)	79 (64.2)	10 (52.6)	13 (100.0)
No	103 (38.4)	1 (7.6)	49 (49.0)	44 (35.7)	9 (47.3)	0 (0.0)

Source: Data analysis from the semi-structured interview.

ered the performance (on average) of the statutory in realizing these attributes to be the best, always with higher evaluations than the others, changing the percentage differences according to each essential attribute evaluated (where 1 is very poor and 5 indicates excellent performance), as shown in Table 3.

The documentary analysis found different features between the medical relationships with the ESF. The differences were evident regarding

the contractors, the policies for retaining the professional, the assurance of labor and social security rights, and career and training opportunities. The employment relationship can be divided into two groups: with employment relationship (CLT and statutory) and without employment relationship (PMMB scholarship holders and self-employed). Concerning the institutional link, three direct links can be determined with the Municipal Health Secretariat (SMS) (CLT, statutory, and self-employed) and a relationship mediated by the Ministry of Health (PMMB scholarship holders); concerning contract's length, they can be classified into temporary (CLT, PMMB scholarship holders, and self-employed) and permanent (statutory); same division for the group without Career Progression Plan (PCCS) (CLT, PMMB scholarship holders, and self-employed) and with PCCS (statutory). Assessing opportunities for continuing education, we identified a group with a mandatory training process (PMMB scholarship holders), a group with potential opportunities (CLTs and statutory), and a group with few opportunities (self-employed).

Table 3. Evaluation of PHC attributes by ESF doctors, according to the employment relationship. Fortaleza-CE, 2018.

	CLT	STATUTORY	PMMB/ PROVAB	RPA	p-value**
	Média (DP)*	Média (DP)*	Média (DP)*	Média (DP)*	
First contact	3.8 (0.8)	4.4 (0.7)	4.0 (0.8)	3.0 (1.3)	p<0.001
Excellent n (%)	48 (17.9%)	140 (52.2%)	86 (32.0%)	42 (15.6%)	
Good n (%)	127 (47.3%)	88 (32.8%)	119 (44.4%)	60 (22.3%)	
Fair n (%)	50 (18.6%)	17 (6.3%)	49 (39.8%)	63 (23.5%)	
Poor n (%)	14 (5.2%)	6 (2.2%)	4 (1.4%)	47 (17.5%)	
Very poor n (%)	4 (1.4%)	1 (0.3%)	3 (1.1%)	40 (14.9%)	
Don't know/Did not answer n (%)	25 (9.3%)	16 (5.9%)	7 (2.6%)	16 (5.9%)	
Longitudinality	3.2 (0.9)	4.5 (0.6)	3.5 (0.9)	2.0 (0.9)	p<0.001
Excellent n (%)	11 (4.1%)	165 (61.5%)	40 (14.9%)	3 (1.1%)	
Good n (%)	96 (35.8%)	76 (28.3%)	108 (40.3%)	16 (5.9%)	
Fair n (%)	90 (33.5%)	9 (3.3%)	82 (30.6%)	65 (24.2%)	
Poor n (%)	34 (12.6%)	4 (1.4%)	23 (8.5%)	80 (29.8%)	
Very poor n (%)	16 (5.9%)	1 (0.3%)	11 (4.1%)	91 (33.9%)	
Don't know/Did not answer n (%)	21 (7.8%)	13 (4.8%)	4 (1.4%)	13 (4.8%)	
Comprehensiveness	3.6 (0.8)	4.4 (0.7)	3.7 (0.9)	2.5 (1.1)	p<0.001
Excellent n (%)	20 (7.4%)	150 (55.9%)	56 (20.9%)	11 (4.1%)	
Good n (%)	137 (51.1%)	84 (31.3%)	123 (45.8%)	38 (14.1%)	
Fair n (%)	63 (23.5%)	13 (4.8%)	66 (24.6%)	78 (29.1%)	
Poor n (%)	24 (8.9%)	5 (1.8%)	14 (5.2%)	73 (27.2%)	
Very poor n (%)	2 (0.7%)	2 (0.7%)	6 (2.2%)	56 (20.9%)	
Don't know/Did not answer n (%)	22 (8.2%)	14 (5.2%)	3 (1.1%)	12 (4.4%)	
Cara coordination	3.5 (0.8)	4.4 (0.7)	3.6 (0.9)	2.3 (1.0)	p<0.001
Excellent n (%)	19 (7.0%)	145 (54.1%)	50 (18.6%)	6 (2.2%)	
Good n (%)	120 (44.7%)	85 (31.7%)	109 (40.6%)	30 (11.1%)	
Fair n (%)	78 (29.1%)	18 (6.7%)	78 (29.1%)	77 (28.7%)	
Poor n (%)	24 (8.9%)	6 (2.2%)	22 (8.2%)	84 (31.3%)	
Very poor n (%)	5 (1.8%)	0 (0.0%)	4 (1.4%)	58 (21.6%)	
Don't know/Did not answer n (%)	22 (8.2%)	14 (5.2%)	5 (1.8%)	13 (4.8%)	

Captions: SD: Standard Deviation. *Mean was calculated based on the scores given by the respondents for each of the attributes in the different professional relationship formats (levels from 1=very poor to 5=excellent performance); **One-way ANOVA.

Source: Data analysis from the semi-structured interview.

Ciência & Saúde Coletiva, 26(5):1657-1668, 2021

Discussion

This study was carried out in a large municipality with mixed hiring formats, which allowed the development of a robust assessment on the subject. The results are relevant for understanding the influence of the hiring formats in the work processes of the Family Health Strategy doctor and subsidizing the improvement of human resources policies for the SUS focused on the quality of service[16].

The different hiring formats found among doctors in Fortaleza confirm the consequences of the neoliberal reform that allowed more flexible relationships and contracts with simplified selection processes and the effects of informal reforms, which led to the use of temporary contracts and hiring permanent staff through grants and wage compensation[22].

There was a unique sociodemographic profile for each of the groups of doctors working in the ESF, according to their hiring format, diverging from one another by age group, predominant gender, religion, marital status, training time, academic qualifications, and household. While it was not possible to assess these aspects, they can influence the work process of ESF doctors and the assessment of essential attributes. The literature reports that gender, marital status, training, number of employment relationships, seniority in the service, and the employment method influence the development of the essential attribute of longitudinality of ESF professionals[23].

Rodrigues et al.[24] show that a high percentage of professionals working in the ESF do not receive training to work in PHC, which has been observed in this study, as less than half of the professionals had a specialization in family health (46.6% in general) and only 19.9% in the residency modality). It is essential to mention that training was already one of the challenges identified by the Ministry of Health for the success of the ESF since its early days. Consequently, incentives for academic PHC-oriented training both for new doctors and doctors already working are essential to qualify care[25].

Discrepancies were evidenced in evaluating professionals about the different relationship formats, which led to greater dissatisfaction by those evaluated, notably more significant among professionals with an RPA relationship (with 100% of the professionals demarcating their bond as disadvantageous; 51% among statutory). As for the disadvantageous points in their hiring compared to other groups, it was noted that 84.6% of the RPAs pointed out the lack of labor rights and 38.4% of them the lack of a relationship. It is worth noting that more than one item in this variable could be selected, which means that the sum of these can reach values above 100%.

This dissatisfaction can negatively influence doctors' work activities in their workplaces, affecting the quality of health care developed in the ESF. Thus, professional valorization is an essential aspect of workers' satisfaction and is linked to service quality. Identifying inequalities may influence the perceived professional appreciation. In the respondents' view, the uniformity of rights is seen as a determining condition in improving the performance of multidisciplinary work.

The topic of remuneration has always held a relevant space for health system managers[26]. Poli Neto et al.[27] states that the best results in the care management of the assisted population stem from a combination of different remuneration formats, usually with a higher fixed amount and a variable amount. In Brazil, Curitiba and Rio de Janeiro led mixed remuneration actions – with fixed and variable sums, also found in Portugal[27]. According to the author, the managers of these locations felt the need to reward financially achieved goals. Thus, an incentive policy aimed at professionals could improve the population's health indicators.

Another debatable point is the relevance of the stability offered by each employment relationship of medical professionals in the ESF. The statutory relationship was by far characterized as the best hiring format (85%), with more than half (52.6%) of the respondents highlighting stability as a critical factor for such an assessment. However, new processes for the inclusion of professionals through this format are scarce, with the immediate financial issue possibly emerging as one of the relevant points in this equation, the economy with earnings by the federative entity. However, there seems to be an oversight by not considering the financial impact of a resolute PHC, reducing referrals to other levels of care, and providing more concrete actions to promote and prevent diseases, affecting costs[20]. Nevertheless, it is necessary to know that, as described by Piola et al.[28], salaries attract professionals but do not retain them. In the opinion of Brito et al.[29], a powerful way of retaining SUS human resources is creating an attractive policy for workers, combining financial and training aspects and the possibility of advancing in a state career.

Thus, organizational aspects can be related to hiring formats, which may hinder or facilitate

access over time to obtain an appointment, type of appointment, continuity of treatment, or service shifts[30]. The socio-cultural and economic aspects of accessibility related to the hiring formats include the professionals' ability to perceive the understanding of the assisted people, assimilation of the risk of severity, knowledge about their bodies and the provision of health services, fear of diagnosis, beliefs, habits, and communication difficulties with the health team, credit given to the health system, education levels, employment, income, and social security[31].

Most respondents assessed the PHC attributes positively. However, this assessment was not uniform concerning the group that was assessed. The first contact is characterized by accessibility and the use of services for each new problem or new episode of a problem for which health care is sought[20] and must be considered regarding geographic, organizational, socio-cultural, and economic aspects. Positive but different evaluations were observed for the first contact performance, with the statutory and RPA receiving, respectively, the best (52.2% rate it as excellent) and the worst rating (32.4% rate it as poor or very poor). The availability of a doctor in the health units (if present, the first contact is well evaluated) may have influenced the respondents' assessment of the first contact.

Regarding longitudinality, determined by the connection between users and service providers, the interference by hiring format appears more expressively. The highlight of the statutory (61.5% rated it as excellent) in this attribute may be related to the fact that they are a lasting employment relationship with lower turnover[23,32].

Longitudinality is built by the existence of a regular supply of care by the health team and its consistent use over time in an environment of mutual trust and humanization between the health team, individuals, and families[20]. Longitudinality and the relationship with the service were also assessed by Paula et al.[23] when higher scores were attributed to statutory workers and professionals with more than three years of service seniority. The authors believe there is evidence that the time for developing interpersonal relationships interferes favorably in the longitudinality attribute. In this study, 61.5% rated the performance of the attribute as excellent by professionals with a statutory relationship, with 33.9% evaluating it as very poor in the case of RPA.

Comprehensiveness is represented by the provision of a set of services that meet the needs of the population enrolled in the fields of promotion, prevention, cure, care, rehabilitation, and palliative care, unlike the responsibility for not offering services in other health care points and the adequate recognition of the biological, psychological, and social problems that cause diseases on the part of the health teams[20].

Care comprehensiveness depends on the redefinition of practices to create bonds, reception, and autonomy, which values the subjectivities inherent to health work and the individuals' unique needs as starting points for any intervention, building the possibility of care centered on the health system user[30]. In this study, the statutory relationship also has an advantage in the ESF medical professionals' evaluation regarding the performance of this attribute: in this case, 87.2% evaluate it as excellent or good.

Care coordination is determined by the ability to secure care continuity, recognizing problems requiring constant follow-up, and is articulated with the role of the communication center of the Health Care Networks (RAS)[14,20]. In this sense, health needs are complex and, in general, are not adequately addressed by health systems characterized by specialization and isolated professional guidance[31,32]. Inadequacy can result in unmet needs, unnecessary treatments, duplicated actions, and excessive medicalization. However, the professional's ability to coordinate care depends on a strong need for regional knowledge and the RAS, aspects related to professional turnover, and access to training processes in the field, and the last characteristic is better identified among the statutory and PMMB, with 85.8% and 51.7%, respectively, evaluating them as having an excellent or good performance.

Finally, the study's limitations are its cross-sectional design, which does not allow the monitoring of notes related to relationship formats and their implications on the quality of care and the fact that only the doctors' viewpoint was considered. Thus, further studies are suggested, if possible, containing the views of managers, the population, and other actors involved in the ESF.

Conclusion

The development of the essential ESF attributes was positively evaluated. However, it was not uniform by relationship type concerning the group evaluated in Fortaleza. In this capital, doctors' work in the Family Health Strategy is influenced by their professional relationship. Concerning the PHC essential attributes, the doctors inter-

viewed perceived better performance of the statutory workers, followed by the scholarship holders of the Mais Médicos Program/PHC Valuation Program, Consolidated Labor Laws, and, finally, those working under the Self-Employed Receipt regimen (RPA).

The respondents' report points out that job satisfaction and the different ways of conducting activities are stimulated by the hiring configuration, including its stability. From the doctors' perspective, hiring through the statutory regime and via RPA are the best (85%) and the worst (96.6%) hiring formats for developing essential attributes in the ESF. Scientific studies addressing the theme are required to support the federative entity because public policies will profile the health professional valorization. There is an urgent need to implement the SUS Human Resources Policy as a guiding tool for the creation of employment relationships retaining medical professionals in the PHC services but also contribute to the realization of its essential attributes, quality of care, and, consequently, health levels of the Brazilian population.

Collaborations

The authors participated effectively in the preparation of the manuscript. Research idealization: AL Lima Júnior, ICHC Barreto, RR Maranhão, APGF Vieira-Meyer. Data collection: AL Lima Júnior, RR Maranhão. Tabulation, statistical analysis of data, and creation of tables and figures: AL Lima Júnior, ICHC Barreto, RR Maranhão, SAS Nuto, BS Benevides, MVL Saintrain, APGF Vieira-Meyer. Text writing and rule standardizations per the journal: AL Lima Júnior, ICHC Barreto, RR Maranhão, SAS Nuto, BS Benevides, MVL Saintrain, APGF Vieira-Meyer. Review of the text and addition of significant parts: SAS Nuto, MVL Saintrain, APGF Vieira-Meyer.

References

1. Brasil. Constituição da República Federativa do Brasil de 1988. *Diário Oficial da União* 1988; 5 out.
2. Giovanella L, Mendoza-Ruiz A, Pilar ACA, Rosa MC, Martins GB, Santos IS, Silva DB, Vieira JML, Castro VCG, Silva PO, Machado CV. Sistema universal de saúde e cobertura universal: desvendando pressupostos e estratégias. *Cien Saude Colet* 2018; 23(6):1763-1776.
3. National Health Service (NHS) [Internet]. Reino Unido; 2021 [acessado 2021 fev 17]. Disponível em: https://www.healthcareers.nhs.uk/explore-roles/doctors/pay-doctors.
4. Brown LD. Comparing Health Systems in Four Countries: Lessons for the United States. *Am J Public Health* 2003; 93(1):52-56.
5. Pessoto UC, Werneck EA, Guimarães RRBO. O papel do Estado nas políticas públicas de saúde: um panorama sobre o debate do conceito de Estado e o caso brasileiro. *Saude Soc* 2015; 24(1):9-22.
6. Giovanella L. A provisão emergencial de médicos pelo Programa Mais Médicos e a qualidade da estrutura das unidades básicas de saúde. *Cien Saude Colet* 2016; 21(9):2697-2708.

7. Feuerwerker L. Modelos tecnoassistenciais, gestão e organização do trabalho em saúde: nada é indiferente no processo de luta para a consolidação do SUS. *Interface (Botucatu)* 2012; 9(18):489-506.
8. Brasil. Lei Complementar nº 101, de 04 de maio de 2000. Estabelece normas de finanças públicas voltadas para a responsabilidade na gestão fiscal e dá outras providências. *Diário Oficial da União*; 2000.
9. Medeiros CRG. A rotatividade de enfermeiros e médicos: um impasse na implementação da Estratégia de Saúde da Família. *Cien Saude Colet* 2014; 15(1):1521-1531.
10. Schraiber LB. Saúde coletiva: um campo vivo. In: *Reforma sanitária brasileira: contribuição para a compreensão e crítica*. 3ª ed. Salvador: Edufba; Rio de Janeiro: Fiocruz; 2016.
11. Girardi SN. Impacto do Programa Mais Médico na redução da escassez de médicos em Atenção Primária à Saúde. *Cien Saude Colet* 2016; 21(9):2675-2684.
12. Servo LM. Financiamento e gasto público de saúde: histórico e tendências. In: *Políticas públicas e financiamento federal do Sistema Único de Saúde*. Brasília: Ipea; 2011.
13. Ney MS, Rodrigues PHA. Fatores críticos para a fixação do médico na Estratégia Saúde da Família. *Physis* 2012; 22(4):1293-1311.
14. Brasil. Ministério da Saúde (MS). *Programa mais médicos – dois anos: mais saúde para os brasileiros*. Brasília: MS; 2015.
15. Medeiros CRG. A rotatividade de enfermeiros e médicos: um impasse na implementação da Estratégia de Saúde da Família. *Cien Saude Colet* 2010; 15(Supl. 1):1521-1531.
16. Carvalho GCM. A saúde pública no Brasil. *Estud Av* 2013; 27(78):7- 26.
17. Araújo HE. *Migração de médicos no Brasil: análise de sua distribuição, aspectos motivacionais e opinião de gestores municipais de saúde*. Brasília: UnB/Ceam/Nesp/ObservaRH; 2012.
18. Brasil. Ministério da Saúde (MS). *HumanizaSUS: política nacional de humanização: documento base para gestores e trabalhadores do SUS*. 2ª ed. Brasília: MS; 2004.
19. Brasil. Lei nº 12.690, de 19 de Julho de 2012. Dispõe sobre a organização e o funcionamento das Cooperativas de Trabalho; institui o Programa Nacional de Fomento às Cooperativas de Trabalho - PRONACOOP; e revoga o parágrafo único do art. 442 da Consolidação das Leis do Trabalho - CLT, aprovada pelo Decreto-Lei nº 5.452, de 1º de maio de 1943. *Diário Oficial da União*; 2012.
20. Starfield B. *Atenção Primária: equilíbrio entre a necessidade de saúde, serviços e tecnologias*. Brasília: UNESCO, MS; 2002
21. Brasil. Ministério da Saúde (MS). *E-Gestor Atenção Básica* [Internet]. 2019 [acessado 2019 jun 14]. Disponível em: https://egestorab.saude.gov.br/paginas/acessoPublico/relatorios/relHistoricoCoberturaAB.xhtml
22. Nogueira RP. Estabilidade e flexibilidade: tensão de base nas novas políticas de recursos humanos em saúde. *Divulg Saude Debate* 1996; (14):18-22.
23. Paula CC, Silva CB, Nazário EG, Ferreira T, Schimith MD, Padoin SM. Fatores que interferem no atributo longitudinalidade da atenção primária à saúde: revisão integrativa. *Rev Eletr Enferm* 2015; 17(4):1-4.
24. Rodrigues IJJAC, Pereira MF, Sabino MMFL. Proposta para adoção de estratégias para diminuir a rotatividade de profissionais da estratégia de saúde da família de Santo Amaro da Imperatriz. *Coleção Gestão Saúde Pública* 2013; 2:65-81.
25. Campos CVA, Malik AM. Satisfação no trabalho e rotatividade dos médicos do Programa de Saúde da Família. *Rev Adm Pública* 2008; 42(2):347-368.
26. Scally G, Donaldson LJ. The NHS's 50 anniversary. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998; 317(7150):61-65.
27. Poli Neto P, Faoro NT, Prado Júnior JC, Pisco LAC. Variable compensation in Primary Healthcare: a report on the experience in Curitiba, Rio de Janeiro, Brazil, and Lisbon, Portugal. *Cien Saude Colet* 2016; 21(5):1377-1388.
28. Piola SF, Paiva AB, Sá EB, Servo LMS. *Financiamento Público da Saúde: Uma História sem Rumo*. Rio de Janeiro: IPEA, 2013.
29. Brito ESV, Oliveira RC, Silva MRF. Análise da continuidade da assistência à saúde de adolescentes portadores de diabetes. *Rev Bras Saude Matern Infant* 2012; 12(4):413-423.
30. Oliveira DC, Sá CP, Santo CCE, Gonçalves TC, Gomes AMT. Memórias e representações sociais dos usuários do SUS acerca dos sistemas públicos de saúde. *Rev Eletr Enf* 2011; 13(1):30-41.
31. Travassos C, Martins M. Uma revisão sobre os conceitos de acesso e utilização de serviços de saúde. *Cad Saude Publica* 2014; 20(Supl. 2):S190-S198.
32. RolimI LB, Monteiro JG, Meyer APGFV, Nuto SAS, Araújo MFM, Freitas RWJF. Evaluation of Primary Health Care attributes of Fortaleza city, Ceará State, Brazil. *Rev Bras Enferm* 2019; 72(1):19-26.

Article submitted 05/08/2020
Approved 24/02/2021
Final version submitted 26/02/2021

Chief Editors: Romeu Gomes, Antônio Augusto Moura da Silva