


Reflections of physicians on work in the Family Health Strategy under the management of Social Organizations

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This article presents and analyzes testimonies of physicians who worked in the Family Health Strategy about the work they developed under the management of different Social Organizations (SO) in the city of São Paulo, state of São Paulo, Brazil. The results are discussed in light of the distortions that can emerge from the application of performance indicators (targets) to health services. It was concluded that the simple comparison of services' performance regarding the achievement of targets is not sufficient to determine which service best fulfills its role in the health network, according to the guidelines of the Brazilian National Health System (SUS) and the Federal Constitution. Although the study does not allow to determine the extent to which the reported distortions affect the work carried out under SO management, it points to the importance of further research on the subject.

Keywords: Brazilian National Health System. Health management. Privatization.

Introduction

When we analyze the current situation of the workers of the Brazilian National Health System (SUS), it is necessary to understand the economic context in which the health system itself is inserted and its relationship to the Brazilian State.

The quarter of century that followed the end of the Second World War was marked by policies that established an international regulation for the movement of capital, the State's massive investment and intervention in the economy, and the construction of social welfare systems (mainly in the area of health and retirement)^{1,2}.

These policies were implemented during a period of almost thirty years of worldwide economic growth, very low unemployment rates and reduced inflation¹. However, from the 1970s onwards, the model was threatened by falling profit rates, increased inflation and low economic growth. This explains the strong pressure for the liberalization of financial markets and for the deregulation of capital markets that followed¹, as well as the strengthening of liberal thought and policies².

From this period onwards, the discourse of controlling public spending (reducing social welfare networks) to reach fiscal balance and control inflation, of privatizing State companies, and of eliminating the rules that instituted the State's control over the market started to become increasingly hegemonic.

The relationship between the international economic dynamics and the structuring of public health systems in Brazil and in other Latin American countries materialized through the recommendations of international bodies. The World Bank and the International Monetary Fund were involved in the negotiation of the external debt and in the establishment of targets that, as a rule, restricted public investment in social spending^{3,4}. In addition, they proposed assistance policies that assertively specified, to the governments, which programs they should implement and who should be included, in order to avoid the creation of "rights"⁵.

The government of Fernando Collor de Melo, elected in 1989, was heavily influenced by the advance of neoliberal thought⁶. Submitted to vetoes, the Organic Health Law (8080/90), complemented by Law 8142/90, was an advance in the regulation of SUS. But the balance at the end of Collor's government was worrisome: at the same time that one third of the Brazilian population was incorporated into the new system, the resources allocated to health were reduced by half. Furthermore, there was the increasing demobilization of sectors that had struggled for the Brazilian Healthcare Reform⁷.

In continuity with the neoliberal policies, one of the main priorities of the government of Fernando Henrique Cardoso, known as FHC, in the period 1995-2002, was the macroeconomic adjustment and the State Reform, in consonance with the recommendations of the World Bank and other international bodies linked to neoliberal policies. The Master Plan for the State Apparatus Reform (PDRAE) shows the type of change intended by FHC's government:

[...] to limit the State's action to those functions that are specific to it, reserving, in principle, non-exclusive services for the non-state public property, and the production of goods and services to the market for private initiative; [...] to increase, in this way, the efficiency and quality of the services, better assisting the citizen-customer for a lower cost⁸. (p. 45-7)

FHC's government changed the legislation, enabling the expansion of the private sector in the management of health services⁹, initially with the Social Organizations (SOs), which were created by Law 9637/1998¹⁰. The management of health services, understood then as “non-exclusive”, was, from the end of the 1990s onwards, progressively transferred to “non-state” entities.

Other forms of transfer of public services management to private law entities were subsequently proposed in the governments of Luiz Inácio Lula da Silva and Dilma Rousseff. In spite of their differences, all these “new modalities” of management are consonant with the strategy of counter-reform of the State, notably the flexibilization of public management and work relationships controls¹¹.

Despite the justification that such change was effected to increase the services' efficiency and quality, some studies and reports question if these objectives can, indeed, be fulfilled in this way. The theme remains controversial in the academic sphere, as some researches show advantages while others criticize the model¹²⁻¹⁹.

Aiming to contribute more elements to the debate and to clarify the impact of these management models on the health services, this article presents and analyzes the testimonies of physicians who work in primary care in the city of São Paulo. The interviewees report on their experience concerning the work they develop in the Family Health Strategy, under the management of different SOs.

Method

In the study that originated the present article, we developed an approach based on the qualitative perspective of investigation²⁰, as its object is the perception of physicians regarding forms of management and the daily routine of their work.

Given the insufficiency of studies showing the perception about the theme of outsourced physicians working in SUS, we decided to perform a bibliographic research and to access directly the actors involved, asking them to produce oral reports in semi-structured interviews.

The criteria to include subjects in the research were physicians who work, or worked, in the Family Health Strategy, hired by Social Organizations in the city of São Paulo. The subjects were accessed by means of the snowball sampling technique²¹⁻²³. In this technique, the interviewees, who belong to an initial group of subjects that meet the prerequisites of the research, indicate new subjects with the same characteristics to contribute to the research. The process must be successively repeated until the proposed objective is fulfilled. The snowball sampling technique was adopted because we consider that outsourced workers constitute a segment that is hard to access to conduct research, in spite of the public nature of the system. Concerning this aspect, it is relevant to mention, here, the comment of one of the interviewees, before the recording was started. When she was thanked for accepting to participate, she said: “Not at all; now that I'm retired, I don't have anything to lose anymore. Now I can tell everything”.

In 2015, five physicians (three men and two women) who had professional experiences in three regions, seven districts of the city of São Paulo, and five different SOs were interviewed. Four of them attended specialization courses in Family Health or Family and Community Medicine. All of them had a history of

multiple employment relationships, the majority including simultaneous public and private employment relationships. Only two worked as public servants. Despite the heterogeneity of the employment relationships, all of them had the largest part of the working period inserted in primary care. To preserve confidentiality, the interviewees received fictitious names, as well as their employing SOs.

To analyze the transcriptions of the interviews, we used the content analysis theoretical framework proposed by Bardin²⁴ and by Gomes and Minayo²⁵.

The content of the interviews was interpreted through the identification of units of meaning, condensed units of meaning, categories and dimensions, according to an adaptation of Graneheim and Lundman's proposal²⁶.

In this article, the focus is on the interviewees' reports on work organization in the Family Health Strategy and their opinions about the forms of assessment of the actions they develop. In the discussion, the content of the interviews was also related to the categories described by Goddard et al.²⁷ and Mannion and Braithwaite²⁸ in studies that described distortions that can emerge from the application of performance indicators (targets) to health services.

The research that originated this article was approved by the Research Ethics Committee of Universidade Federal de São Paulo, through Opinion number 698.095 on 06/25/2014.

Results and discussion

It is important to highlight that the city of São Paulo has had an extensive services network since before the creation of SUS. The city's accreditation as full management of healthcare was not free of problems, with a lower amount of funds being transferred from the state level than what was expected^{29,30} and the perpetuation of a fragmented model of care in the city. The consolidation and expansion of the network in all governments since 2001 has largely occurred through partnerships with private entities, mainly through Social Organizations³⁰.

Based on the municipal government of São Paulo's accounting data, in 2006, funds transferred to SOs totaled approximately 338 million reais concerning only the primary care item³¹; in 2010, 470 million³²; in 2014, regarding primary care items and specialized care together, approximately 1 billion and 300 million reais were transferred to the eleven hired SOs³³, responsible for managing 279 health units³⁴. In 2016, according to data provided by São Paulo's municipal health department, 43 thousand workers were under the management of SOs, while adding servants under direct administration to those under indirect administration - municipal government hospital agency -, the total did not exceed 33 thousand. Obviously, these data in isolation do not explain much about the financing and the management dynamics of SUS via SO in the city, but they translate, although in a superficial way, the dimension of this management model. These are some aspects of the scenario in which approximately eighty thousand workers³⁴ act in the municipal health services of São Paulo, and in which this research is inserted.

Two studies^{35,36} have analyzed, in the state sphere, services managed by SOs and pointed to an efficiency gain of these services when compared to services directly administered by the State. These studies, funded by the World Bank, have shown

advantages in terms of average occupation rate and average rate of permanence per bed, presenting lower costs and a lower general mortality rate. These studies may seem, at first sight, inescapable evidence of the better performance of the SOs, but it is necessary to analyze these processes more carefully here.

Studies like those of Goddard et al²⁷ and Mannion and Braithwaite²⁸ describe, based on the experience of the English National Health Service, some distortions that may emerge from the application of performance indicators (targets) to health services:

The impact of a performance measurement scheme will depend on the rewards, punishments and incentives implicit in its design. At one extreme, if no appropriate incentives are put in place, the data produced may be largely ignored and produce no meaningful action. At the other extreme, the livelihood of managers and health care professionals may depend crucially on reported measures, leading to the potential for excessive attention to reported performance (as opposed to patient outcome) and misrepresentation²⁷. (p. 158)

To Mannion and Braithwaite²⁸, the “collateral effects” resulting from the application of financial incentives or punishments can be grouped into four categories: poor measurement, misplaced incentives and sanctions, breach of trust, and politicization of performance systems.

We will briefly describe some of the distortions related to “poor measurement” and “breach of trust” that are relevant to our discussion. We will begin by highlighting some distortions related to the measurement of indicators:

- measurement fixation: occurs when there is an emphasis on meeting the target rather than on what motivated it;
- tunnel vision: in which incentives for the service to perform some tasks better can displace other important but unmeasured aspects of performance;
- myopia: in which excessive concentration on immediate and short-term targets may have a negative repercussion in the long run;
- ossification: in which focusing on performance indicators may result in organizational paralysis;
- quantification privileging:

[...] concerns the preoccupation with reducing complex social phenomena to numbers, and the attendant loss of the appreciation of qualitative or softer aspects of healthcare that may be missed or downplayed in assessments. Many important factors affecting performance are qualitative, such as culture, staff morale and patients’ experiences. These are not readily quantifiable [...] ²⁸ (p. 571)

In addition to distortions related to the measurement of indicators, we highlight below some situations related to “breach of trust”, described by Mannion and Braithwaite²⁸:

- misrepresentation: is the deliberate manipulation of data by staff (workers and managers), in situations ranging from creative accounting to fraud;



- reduced staff morale: occurs when workers feel unfairly misjudged in assessments. Their morale decreases and they lose belief in the organization, which negatively affects their future performance;

- bullying: occurs when pressure concerning targets end up causing harassment and intimidation.

It was possible to identify, in the interviews, elements that are aligned with this categorization of possible distortions of an assessment model centered on quantitative targets.

Chart 1. Content analysis of physicians' opinions about the working process

Unit of meaning	Condensed unit of meaning	Category	Dimension
"If we look at the targets every month (...) There isn't any care quality indicator there. There are numbers that don't tell much. That number, for example, doesn't show the work that is done in the team: what I do, what the nurse does, what the community health agents do, what the whole unit does. It doesn't. I've never seen any discussion about changing that perspective."	Targets do not have any care quality indicator Numbers do not show the work done by the team	Emphasis on quantitative targets	Working process
"But it has always been based on numbers. The focus has never been on quality. [...] I agree that you must have the number of assistances, but you must also have professionals for this".	Based on numbers. Never on quality You must have numbers You must have professionals for this	Emphasis on quantitative targets	Working process
"So, we must fulfill for [example the] issue of number of consultations, of time per hour, we can't escape from it. With these courses [clinical meetings], I think it will become more and more limited. [...] because they say the physicians don't want to come, but I'm sure they do. I'm sure it's because of this damn production that they don't want to send the physicians [to clinical meetings]"	We must fulfill the number of consultations They say the physicians don't want to come to the clinical meetings I'm sure it's because of the production that they don't want to send the physicians	Emphasis on quantitative targets	Working process

Source: the authors' own work, adapted from Graneheim and Lundman²⁶.

In these fragments of Chart 1, it is possible to identify some distortions that were listed above, like measure fixation and quantification privileging. The fragments "But it has always been based on numbers. The focus has never been on quality" and "I'm sure it's because of this damn production that they don't want to send the physicians [to clinical meetings]" are an indication that too much attention is paid to meeting quantitative targets, showing that other aspects, like professionals' permanent education, come second. The fragment "That number, for example, doesn't show the work that is done in the team" also draws attention to the fact that a considerable part of work in primary care is more complex than what can be measured quantitatively. Both fragments draw attention to the risk of neglecting this complexity (tunnel vision) and failing to value the permanent education of professionals who work in primary care, focusing only on short-term targets (myopia).

Chart 2. Content analysis of physicians' opinions about the working process

Unit of meaning	Condensed unit of meaning	Category	Dimension
"To do clinic management at the unit, we use our targets, our parameters: control lists, absence lists, control of time between health demand and consultation, or between health demand and health response. These are things we quantify because we wanted to, locally. This has a much greater impact on the population's health than controlling if I delivered 400 consultations and 40 home visits."	To do clinic management at the unit we use our targets We quantify these data because we wanted to Controlling these data has a much greater impact on the population's health than the amount of consultations and home visits	Emphasis on quantitative targets	Working process

Source: the authors' own work, adapted from Graneheim and Lundman²⁶.

In the fragment above (Chart 2), the physician reports on the internal creation of criteria to assess his own work and that of his Family Health Team, as he considers the quantitative targets established by the management contract between the municipal government and the SO insufficient to assess his work and the impact on the health of the population he assists. Furthermore, he believes the targets are insufficient to guide internal clinic management and care coordination actions. This can be seen as a kind of resistance against measurement fixation.

Chart 3. Content analysis of physicians' opinions about the working process

Unit of meaning	Condensed unit of meaning	Category	Dimension
"The administration was performed by the SO. The unit's manager was appointed by the SO and the whole mode of functioning, the whole working process, the unit's organization, were determined by the SO. [...] The agenda was determined by the SO. [...] The form of organization of user embracement was also determined by the SO. [...] The times of team meetings were determined by the SO and we were obliged to hold team meetings everyday, we couldn't hold a longer team meeting during the week. We tried to change it, but the manager's answer was that we couldn't do it because the Yellow SO decided it would be in that way [...] And, even so, the majority of the things were barred with this argument: 'No, this is the rule, this is the contract, the contract between the SO and the municipal government, between the SO and you. This is the company's rule'"	The whole mode of functioning was determined by the SO. We tried to change some things but it wasn't possible because the SO decided it would be in a certain way. The majority of the things were barred with this argument: 'No, this is the rule, this is the contract, the contract between the SO and the municipal government, between the SO and you. This is the company's rule'.	Work organization	Working process

Source: the authors' own work, adapted from Graneheim and Lundman²⁶.

In the fragment above (Chart 3), it is possible to observe an excessively rigid organization concerning the working process, supposedly legitimated by the Management Contract, which prevents teams from searching for better solutions to problems found in the daily routine (ossification). The same physician continues her description:

Chart 4. Content analysis of physicians' opinions about the working process

Unit of meaning	Condensed unit of meaning	Category	Dimension
"To solve their problem, patients have to go 4 or 5 times to the unit, because they will get in people's production 4 or 5 times. In this way, you exceed the target. With the same problem, not doing things and leaving them to the next day. For example: you come today because your prescription will expire. Today, I heard you saying that your prescription will expire. I keep your prescription and ask you to come back in a few days. I write in the production that I heard you. Then, on the next day, in the team meeting, I make your prescription and you get in the production again, because I made your prescription. On the third day, when you come to pick up your prescription, you get in the production again. People do this on purpose and it is stimulated by the unit's manager."	To solve their problem, patients have to go 4 or 5 times to the unit, because they will get in people's production 4 or 5 times. It is like this that the target is exceeded: with the same problem, not solving it on that day, leaving it to the next day. People do this on purpose and it is stimulated by the unit's manager.	Emphasis on quantitative targets	Working process

Source: the authors' own work, adapted from Graneheim and Lundman²⁶.

The fragment presented on Chart 4 exemplifies a process of organizational paralysis due to the focus on performance indicators (ossification). In addition, it reveals the emphasis on "exceeding the target" - a term commonly used in the workers' daily routine - to the detriment of ensuring medical care (measurement fixation and quantification privileging), being stimulated by the unit's manager herself. By considering any interaction with the user a "consultation" in the production, she perpetuates a kind of "creative accounting" (misrepresentation).

Chart 5. Content analysis of physicians' opinions about the working process

Unit of meaning	Condensed unit of meaning	Category	Dimension
"At the Blue SO, the target was considered very important, both of home visits and consultations. (...) It was always easy to exceed the consultation target. But not the home visit target. What did we do? You have four weeks. You did it in the first week, when you listed your priorities; in the other three weeks, if you had to return to some patient's home you returned there, otherwise you simulated a demand - you delivered a normal exam, you made registrations with a community health agent - to exceed the home visit target."	The target was considered very important, both of home visits and consultations. What did we do to exceed the home visit target? In the first week, you listed your priorities. If you had to return to some patient's home you returned there, otherwise you simulated a demand: you delivered a normal exam, you made registrations with a community health agent	Emphasis on quantitative targets	Working process

Source: the authors' own work, adapted from Graneheim and Lundman²⁶.

In this fragment of Chart 5, we have another example of "creative accounting" (misrepresentation), in which, to "exceed the target", a physician from the Family Health Strategy used his home visit time to deliver a normal exam at the patients' home or to make registrations with the community health agent, clearly characterizing a distortion of the physician's role. The physician opts for actions that, although unnecessary from the point of view of care (or even delaying the resolution of the catchment population's demand), aim to meet the quantitative target of home visits (quantification privileging).

Chart 6. Content analysis of physicians' opinions about the working process

Unit of meaning	Condensed unit of meaning	Category	Dimension
<p>"Now they call it management contract. The management contract between the SO and the municipal government has changed. So, I know that now everything is based on numbers. [...] It was said in a threatening tone. To the physicians nobody said anything, and we don't have a physician there at the moment, so we can't exceed the target anyway. [...] The meeting in which the supervisor was. Someone says this comes from the municipal government, the municipal government says it comes from the Yellow SO. The Yellow SO must deliver what the municipal government requires; otherwise, its contract is terminated. It must demand it of the manager and the manager must demand it of us, so that everybody keeps their jobs; it was like a threat. But I couldn't care less"</p>	<p>The management contract between the SO and the municipal government has changed, now everything is based on numbers. It was said in a threatening tone. The SO must deliver what the municipal government requires; otherwise, its contract is terminated. It must demand it of the manager and the manager must demand it of us, so that everybody keeps their jobs; it was like a threat. But I couldn't care less</p>	Management characteristic	Working process
<p>"So, sometimes, when we hear the supervisor of the Yellow SO saying like 'so, you must think that if we don't meet the target... why does one person meets it and the other doesn't? Why could it be? Well, we can replace this professional.' To me, this is moral harassment, coercion and something else. I tell the girls, the community health agents of my team, 'do you know all the targets? You work well, don't worry about that. You've always met the target, you don't need to be nervous, you'll get sick and then the situation will get worse. But I think that saying that is bad. So many professionals being absent from work, so many good people. "(...) "So, the professionals get sick (...) stress makes everything worse."</p>	<p>When we hear the supervisor of the Yellow SO saying like 'so, you must think that if we don't meet the target... why does one person meets it and the other doesn't? Why could it be? Well, we can replace this professional.' To me, this is moral harassment, coercion. I tell the community health agents of my team, 'You've always met the target, you don't need to be nervous, you'll get sick and then the situation will get worse'. So, the professionals get sick. Stress makes everything worse."</p>	Management characteristic	Working process
<p>"The discourse is the following: we'll meet the targets, if people start complaining about the targets, that everything must be justified all the time, that quantity doesn't measure quality... The manager used to say 'if you don't prove it's necessary, that you're meeting the targets, if you say: downward, perhaps the government thinks this unit is not necessary... Let's close this unit, let's invest in another one, let's reduce the teams, and so on.' There was a lot of terrorism."</p>	<p>The discourse is: we'll meet the targets, if people start complaining about the targets, the manager used to say 'if you don't prove it's necessary, perhaps the government thinks this unit is not necessary... Let's close this unit, reduce the teams'. There was a lot of terrorism.</p>	Management characteristic	Working process

Source: the authors' own work, adapted from Graneheim and Lundman²⁶.

In the following fragments of Chart 6: the first one, "the manager must demand it of us, so that everybody keeps their jobs, it was like a threat"; the second fragment, in which the physician says, "to me, this is moral harassment"; and the third fragment, "perhaps the government thinks this unit is not necessary... Let's close this unit, let's invest in another one", it is possible to identify indications of exacerbated demands (measure fixation), which end up causing situations of intimidation and harassment (bullying).

The fragments "but I couldn't care less", "the professionals get sick (...) stress makes everything worse", and "There was a lot of terrorism" present indications that the demands are not viewed as fair by these professionals. Added to the perception of situations of intimidation and harassment reported above, they may affect the workers' belief in the organization. Workers may get sick due to these situations, and this may discourage good performance (reduced staff morale).

Blanch and Stecher³⁷, analyzing perceptions of workers from universities and hospitals whose management was reorganized under the corporate paradigm, investigated the workers' subjectification of organizational capitalism. They found that both the education and health workers valued more the aspects of their organizations related to the "culture of services" compared to those related to the "culture of business". Even so, they were moderately satisfied with their organization, relatively adapted to it, and considerably distant from managerialism values. Nevertheless, one perception that stood out was related to excessive work and lack of time to develop their work adequately. These workers' experience is lived as generating "stress", "anxiety", "preoccupation", "impotence", "frustration", and "uneasiness", and the workers attribute them to "management style", "privatization", "lack of human resources", characteristic of the "increasingly complex" demand. This Ibero-American study is brought to discussion here because it enables a dialog with the data produced in this research: narratives of physicians dealing with management forms that, in their perceptions, assess their performance and that of family health teams only through quantitative targets of the SOs. It is important to mention the difficulty in finding data in the literature about this theme in SUS.

Conclusion

According to Hood, distinct key characteristics of the managerialism of the public sector originate from the view developed by Jeremy Bentham about public administration in the 18th and beginning of the 19th centuries³⁸. Many supposedly contemporary ideas were already present in Bentham's work: payment according to performance, provision of public services by private entities, emphasis on individual responsibility, and the notion that more effective public services could be obtained by the application of ideas pertaining to the management of the private sector.

An important aspect of the discussion about the Brazilian State, the managerial reforms discussed here become particularly relevant in the analysis of public healthcare services. Different models have been applied worldwide and, in the case of Brazil, according to Contreiras³⁹, privatization and the concession of commercial public services advanced much quicker in the 1990s when compared to the delegation of social public services, whose expansion happened from the beginning of the 21st century onwards. Inspired in the so-called "Washington Consensus" and, many times, financed by the World Bank itself⁵, these transfers were marked by the execution of management contracts based on the application and meeting of performance targets. Particularly in the city of São Paulo, the implementation of SOs prospered as a promise of "efficiency, transparency and publicization" of the social health policy³⁹. Through the analysis of testimonies of physicians who worked in the Family Health Strategy of the city of São Paulo, and with the support of the national and international literature about the theme, it was possible to see that this management model has a potential for generating distortions and conducting these services to different directions from those that had been initially planned. Although it was possible to identify, in these interviews, distortions previously described in other studies about the theme^{27,28}, we recognize that the study that originated this article does not allow to determine to what extent the reported distortions affect the work performed under the management of

SOs. It is not possible to determine if, at one extreme, they are isolated cases that do not represent the work performed under the management of SOs, or if, at the other extreme, they affect, in a systematic way, the entire services network. Even so, based on the highlighted situations and reports, it is possible to conclude that the simple comparison of the services' performance in the achievement of targets is not sufficient to determine which service best fulfills its role in the health network, according to the guidelines of the Brazilian National Health System (SUS) and the Federal Constitution.

In this sense, the article brings elements that point to the importance of further investigations about the theme, in the growing segment of primary care in SUS under private management.

Author's contributions

All the authors participated actively in all the stages of the preparation of the manuscript.

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