

Work process in Low-Cost Health Clinics from the perspective of physicians

Processo de trabalho em Clínicas Populares de Saúde na perspectiva de médicos (resumo: p. 17)

El proceso de trabajo en Clínicas Populares de Salud bajo la perspectiva de médicos (resumen: p. 17)

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The objective of the study was to understand the perspective of doctors regarding the work process in Low-cost Health Clinics. To this end, we conducted qualitative research interviewing 8 young specialist doctors who work in these business firms in São Luís, Maranhão. We identified precarious working conditions, although presenting little resistance from the doctors, considering that these businesses are seen as spaces of projection in the local job market. Due to the limitations of the complaint-driven model of care, the interviewees activate an informal network, and the users of the Low-Cost Health Clinics are referred to the Brazilian National Health System (SUS). Thus, the physician's work process is challenged by this fragmented care model, which blurs the boundaries in the public-private interfaces leading to a naturalized double gateway to the SUS.

Keywords: Health professional. Health workforce. Medical office buildings. Medical sociology.



Introduction

The economic and political crises underway in Brazil, especially since the second half of the last decade have produced significant budget cuts in public spending on health and a growing increase in unemployment rates and informal ties¹. This overlapping of crises is consistent with a pendulum movement of the State that invested in strengthening Primary Health Care (PHC), as in the implementation of the *Mais Médicos* Program in 2013, and then, after the impeachment in 2016, favoring proposals to open the market to private initiative in the health sector, through deregulation strategies and the creation of cheaper insurance and health plans with limited coverage².

These actions fostered a scenario for commercial entities that portray the market as a solution to crises. The “salvation” via the market was an argument that gave support to the fiscal austerity measures adopted by the State, especially those resulting from the neoliberal deepening of the Temer government (2016-2018) and have wide repercussions in the world of work weakening the social protection of professionals in general, including those in health care³.

The impacts of these events have been object of studies in Collective Health^{2,4} regarding the different responses and adjustments in public-private relations^{2,4}, in the transformations in the medical labor market, and in the expansion of the so-called Low-Cost Health Clinics in some Brazilian capitals⁴.

Low-Cost Health Clinics are commercial firms that offer consultations with specialists and low and medium complexity diagnostic exams at allegedly ‘low’ prices^{5,6}. These are the commercial bets and the characteristics that mark their specificities in local health care markets.

The scientific production about these businesses⁵⁻¹⁰ confirms that there is a centrality in their organization and operation of the medical workforce. However, these studies do not focus on the perspective of these professionals about the working conditions and relationships in these facilities.

The health work process is understood here as a complex field of subjectivation, especially in the labor-worker relationship, since it modulates the subject at the same time that it is modulated by the subject¹¹. The social organization of space, the dynamics of the service, and the means of work are taken as the material conditions through which this process of subjectivation takes shape. Moreover, the organization of the work process in health is based on the State’s public policy, not exempt from market pressures, positioning it in constant interaction with the health scenario, civil society, and consumer relations^{12,13}.

The objective of this study was to understand the physicians’ perspective about the work process to which they are submitted, and the ways they characterize these establishments in São Luís, Maranhão.



We seek to contribute to the debate about the working conditions of health professionals. In parallel, we intend to understand the meaning of the actions undertaken by doctors in the production of care in services that follow a market logic, such as the Low-Cost Health Clinics.

Methodology

Physicians working in Low-Cost Health Clinics in the city of São Luís, Maranhão, Brazil, participated in this qualitative research.

We included professionals who, at the time of the interview, worked or had worked in these clinics in the last 6 months, period considered satisfactory for the detailed description of the physical-organizational structure and of the work process.

The fieldwork took place between the months of May and July 2021. The Covid-19 pandemic imposed limitations on us, so all fieldwork was carried out online, by digital means.

A key informant provided the connection between us and the potential interviewees. This mediator helped in getting the agreement of the physicians to participate in the research. The snowball technique was used, a strategy in which an interviewee indicates others, and from the indications, chains of reference¹⁴ are created based on the affinity between these subjects.

This strategy created conditions for the acceptance of the interview, since our contact was preceded by the contact of a colleague, someone known with whom the potential interviewee had a certain close relationship. This also allowed for the transference of the trust that was present among the medical colleagues to the interviewers. This situation made the field work feasible, allowing the participants to feel at ease to share information about their professional trajectory, their daily work at the Low-Cost Health Clinics, their reflections about the assistance and the future of their careers.

Upon interest in participating in the study, an informal invitation was made via WhatsApp. This invitation was formalized by e-mail with date and time of the interview previously agreed upon, informed consent form (ICF) and a Google Form to characterize the interviewees: age, gender, race/color, place and period of training, medical specialty, and the Low-Cost Health Clinics in which they worked.

Each of the participants was interviewed individually, based on a semi-structured script that addressed situations related to everyday medical work, which included the conditions and work relations in the space of the interactions between managers and professionals, and of these with the clientele. All interviews were conducted using the Google Meet platform, audio and video recorded, and being later transcribed in full.

The fieldwork was terminated when we noticed that the snowball technique no longer allowed us to expand the heterogeneity of the interviewees' profile. Although this is a limitation of the technique, the similarity among the participants reflected the configuration of a relational field, if not personal, at least professional, among them and, consequently, during the field research, made more detailed interviews possible.



We analyzed the accounts based on the articulation of different theoretical approaches, combining the often-Marxist analysis of the labor process with concepts and authors from other fields of knowledge, such as anthropology and sociology¹³. This theoretical-methodological choice¹³ enabled us to describe the medical work process in its materiality (organization, dynamics, instruments), as well as to understand the perspectives of these professionals about the work in Low-Cost Health Clinics, namely: the relational dimensions that take shape in the micropolitics of care production^{13,15,16}.

We understand micropolitics^{15,16} as the activities of care production that are not formalized by the norms and limitations of health services. These actions are represented by the agents as being based on values acquired in professional training and, at the same time, the result of practical and strategic creativity incorporated in the professional habitus, at the core of the daily interactions among health workers and between them and their patients¹⁵⁻¹⁷.

This study is a development of the research entitled: “*Como a atual crise reconfigura o sistema de saúde no Brasil? Um estudo sobre serviços e força de trabalho em saúde nos estados de São Paulo e Maranhão*”, approved by the Research Ethics Committee of the Federal University of Maranhão, under certificate number of presentation of ethical appreciation (CAAE) 00761118.2.0000.5087. Following all the recommendations of the resolution n° 510 of April 2016 of the National Research Ethics Council.

Participants were named using the prefix ‘MED’ plus a number, for example ‘MED5’. To preserve the anonymity of the respondents, we suppressed specific social properties such as gender, race/skin color, place of training, and medical specialty that could somehow identify them.

Results and discussion

The fieldwork and methodological choices produced eight interviews. These participants were young physicians, in the age range between 25 and 35 years, graduated from medical school in the past decade. As for professional characteristics, newly graduated specialists were interviewed, with residency completion from the year 2020. Moreover, all interviewees had links with up to three Low-cost Health Clinics, and five of them also worked in the Brazilian National Health System (SUS).

There was a concentration of specialists in Women’s Health, given that our key informant works in this area of knowledge, directing indications of colleagues with the same expertise.

The results and discussions are concentrated in three sections. “Medical work in Low-cost Health Clinics” presents the contracting model, the organization of the work process in health, and the routine in these companies. “Micropolitics of medical work in Low-cost Health Clinics” analyzes the production of care, considering the informal norms and rearrangements in the daily work routine. “Making a name and training the hand” talks about the meanings, potentialities, and limitations to care in these companies.

Medical work in Low-cost Health Clinics

We present here elements that configure the objectivity of the medical work process in Low-cost Health Clinics, considering the working conditions and remuneration of labor practices and how these conditions were subjected to processes of precarization as a result of the recent political and economic context.

Initially, we were struck by the way the doctors reported their recruitment made by these companies. They were hired when they were still post-graduate students, at the end of their residencies. The invitation to work was mediated by a physician colleague who already worked in the contracting company, that is, the mode of capturing the work force occurred mostly by informal means, “by referral”, based on personal relationships. The participants explained that the companies contacted them, presented the working conditions and the forms of remuneration, but that they only accepted the proposal after getting to know the physical and managerial structure of the clinic.

As for the physical structure, the clinics located in the central part of the city are located in older houses and small buildings adapted to the new function. Those located in neighborhoods outside the central region are more recent and use new, corporate buildings. In both models, the clinics have a reception desk and waiting room for clients, generally small consulting rooms, a procedure room, a room for the collection and analysis of biological materials, and their own laboratory. For the employees, there is an administration room and a pantry.

According to the reports, there is a set of criteria, considered minimum, required by professionals to work in the Low-Cost Health Clinics. Participant MED1, in a tone of indignation during the interview, told us why he did not work in a larger number of clinics and clarified these criteria:

[...] I arrived at yet a third clinic to work, also by indication of medical colleagues [...] Only then, when I got there, I saw that the profile of the clinic was a production [factory] profile. It had a bad structure, the room was unhealthy, minimal, tiny, a little dirty looking. There was material, but it was stored in a bad way. I also only went one afternoon and then I didn't go anymore. (MED1)

With respect to the work dynamics, the ‘flexibility’ of the shifts allows for conciliation with other jobs, since the consultations are organized in a schedule prepared by the clinic itself, with the consent of each professional. The interviewed doctors see an average of 8 to 20 patients per shift, in appointments lasting from 15 to 40 minutes, depending on the complexity of the case. In case of return appointments, their duration decreases to about 5 minutes.



Regarding the available work means and instruments, basic supplies such as gloves, masks, alcohol gel, gases and office supplies were always available and easily replaced, according to the interviewees. Resources such as stretcher, gynecological table, screen, sphygmomanometer, scales and other instruments needed for clinical activity were cited as available by the participants.

According to the interviewees, the model of care is the complaint-driven model, that is, the professional attends the client in his specialty, with no referrals to other specialists and even less discussion of cases in a multiprofessional perspective. Furthermore, the doctors' relationships are limited to the interaction with managers and other employees that support the routine demands of the doctors to schedule and make possible the administrative management of the services, such as call center operators, receptionists, security guards, and cleaning professionals.

The companies develop strategies to attract and maintain the loyalty of their clients. There are health insurance cards that aim to attract clients with a payment proposal of a fixed monthly amount that gives access to consultations and exams at promotional prices. In the places where MED2 and MED3 work, the value of the transfer from consultations with health insurance cards is lower. Although this loyalty strategy has the proposal of offering advantages to customers, in practice it produces a differentiation between users, considering that doctors can choose whether or not to see patients who use these cards.

The interviewees criticize several aspects as: exam combos, sets of procedures/exams purchased for a promotional value, usually allusive to medical specialties such as the "Women's combo". The companies adopt the vocabulary of national health promotion campaigns, presenting them and representing themselves as if there were a relationship of continuity between the public and private systems, an elective affinity, such as the "Pink- October combo".

[...] I have had clinics where I worked before that used to have Pink October combo, Blue November combo and, for example, women who were not even indicated for mammograms were having mammograms or, what I thought was even more serious, women's health combo, Pink October combo. There were transvaginal ultrasounds, breast ultrasounds and Pap smear and no mammogram. So, the main screening exam for breast cancer is not the ultrasound, it is the mammogram for women who are in the defined age group. Then the woman has that false feeling that she is protected. (MED3)

The way to remunerate the doctors is the so-called 60/40 system, that is, 60% of the amount received for the consultations is passed on to the professionals and the rest to the clinic. Some companies work with a 70/30 system, with the largest part going to the doctors and the smallest to the companies, but this is not the most usual system. There is also a system called coworking, in which the doctor pays a monthly rent for the use of the office room and pays a percentage of each consultation performed.



There are also forms of passing on the costs of these companies to the professionals, such as the processing fee of the credit card machines, in consultations paid in credit, which is deducted from the doctor, according to MED2. Another situation concerns the professional work instruments. The company does not provide biopsy equipment but offers and charges for the service. The professional is paid for the consultation and the exam, but the cost of the equipment, its maintenance and wear and tear are charged to him.

The [biopsy] gun is a very expensive piece of equipment. I had a problem with another equipment, and I had to buy another one now, which is very expensive. It is my cost, [...] nobody gives me this damage for an equipment that was broken during treatment. (MED3)

In these businesses there is a physician-centered care model in operation. This model can have a direct impact on the quality of care provided and is one of its main limitations, since the collaborative work of multiple players contributes more effectively to meeting complex health challenges¹⁸.

The interviewed doctors evaluate work flexibility as something advantageous, because it gives them the impression that they control their schedules, a certain individual freedom that overlaps with the fragility of labor bonds, representing this fragility as management availability. The “flexibilization”, in the frameworks analyzed here, would imply in “uniprofessionalization” and, above all, isolation of the medical professional, isolation that is presented - by the companies - and represented - by the doctors - as “margin of autonomy”.

As expressed in the speech of MED1, the interviewees evaluate the minimum conditions for the work practice and hardly mention the influence of the hiring terms in the decision to work in these companies. These physicians behave as self-employed and are hired as individual microbusinesses, a contracting modality called ‘pjotization’ due to the acronym PJ (Juridical Person as opposite to PF physical person).]

The movement of the ‘pjotization’ of medicine in Brazil is based on the arguments of a supposed autonomy and flexibility of the workers and their employment relationships. These physicians provide services as legal entities, without the rights guaranteed by the Consolidation of Labor Laws (CLT)¹⁹, which makes them vulnerable to the transfer of service costs, as elucidated by MD2 and MD3.

However, this movement concomitantly brings a precariousness of labor contracts and conditions, since the employer-employee relationship and the set of guarantees associated with it ceases to exist. This arrangement is seen as advantageous both for doctors, since it allows the accumulation of multiple employment relationships, and for the Low-Cost Health Clinics, which have no tax costs of labor laws to maintain these professionals on their staff.



As any health workforce, medical labor is inserted in the forms of replacement and exploitation by the capital, and although the model of contracting gives them the feeling of autonomous and liberal exercise, these professionals are subjected to the “contractual” conditions of a private service, which deprives them of rights and makes their activities more precarious^{2,20}.

Commercial strategies are some of the results of the mercantilization movement that has gained even more strength with the economic and political crises in progress in the country. Neoliberal actions, which, although announced as directed to control these crises, have caused a strong segmentation of care practices, with an appeal to excessively specialized and individual care^{21,22}, such as the care model offered by the Low-cost Health Clinics. And, as stated by MED3, they cause the false sensation that these patients are protected and that their health needs are satisfactorily met with this service model.

Micropolitics of medical work in Public Health Clinics

This section is the outcome of interrogations about medical autonomy. For this, we rehearsed a dialogue space for the interviewees to present their working conditions and eventually talk about the existence or not of conducts subordinated to the interests of the companies they worked for, especially when they requested exams and made referrals.

We were presented with the subjective dimensions of work and its often-implicit micropolitics. And, as Strathern²³ teaches, relationships are both the object of analysis and the means by which we come to understand how they work. Therefore, the relationships and intersubjective exchanges among physicians and between these and their clientele were taken as the object of study, to understand the rearrangements performed by these professionals in their work routines.

According to our interviewees, the management does not force them to request only the exams available at the company and does not explicitly impose protocols that limit their autonomy and clinical reasoning. However, despite affirming their autonomy regarding their conducts, with some frequency they develop actions without the knowledge of the management/administrators of these clinics. This happens not in terms of a consensual and legitimized autonomy, but as an irregular form of defense of this autonomy, as a way to preserve a clinical criterion of care.

Interviewees MED3 and MED7 referred to the need for a good quality imaging exam to outline appropriate conducts, particularly in cases of breast cancer diagnosis. Therefore, in companies where the quality of the radiography is not good, these specialists recommended other establishments to perform the exam, for the sake of the best care to be provided.



[...] in places that I see that the exam is not such a thorough exam I direct to other places. Generally, I make a list of places with more reliable exams. I did this today, even. Sometimes I am a little afraid of what the administration of some clinic [would do] if they knew about this. How would this approach be? But, at the same time, I think that [...] I do it because of the clinical need of this patient to be evaluated in a much more detailed way by a breast radiology specialist. So, I think that the benefit of this outweighs this risk. (MED3)

The limitations presented are characteristic of the very precariousness of the service that, in this case, presents a questionable quality for exams that are primordial in the diagnosis of diseases and critical illnesses. Moreover, the fear about the reaction of the administrative sector reflects the fragility of the employment relationship and the mercantile logic that operates in these establishments.

Once serious diagnostic suspicions are identified, the interviewed physicians stated that they refer patients from the Low-Cost Health Clinics to SUS services. To some extent, it is as if there was an informal network that works according to the specialty of each physician. The professionals with dual links, in these companies and in the public system, referred patients to themselves, in the SUS. The others used to contact medical colleagues of the same specialty who worked in the public health service.

When they couldn't get through this informal network, these professionals instructed the patients on the less time-consuming procedures and ways to get assistance in the city's large public hospitals. According to reports, the companies' clients, once their health needs were met, showed satisfaction and gratitude to the doctors and to these companies for the care provided, even when the health problem had been solved at SUS, through an informal referral.

By treating health as a consumer good, something common in neoliberal societies²⁴, the Low-Cost Clinics cannot ensure the therapeutic quality of their services, considering that it is the doctors themselves who take charge of this task through informal rearrangements.

These informal measures create friction, but at the same time preserve the mercantile rationale of functioning of the Low-Cost Health Clinics, since they potentiate both situations seen as problematic by the doctors, and provoke reflections and attitudes towards cases, for example, like the exams advertised as "solution to health problems", but that present questionable quality. This causes a certain movement, either in the physician-company relationship, or in the physician-patient relationship, and consequently in the production of care^{15,16}.

The rearrangement articulated by physicians is advantageous for the companies, since it contributes to the "resolutivity" of the service offered, satisfying the client's health needs without investing in the quality of the service. Therefore, physicians contribute to the very counterproductive character to the health of these companies without disengaging from them.



An argument present in the literature about Low-Cost Clinics is that these establishments would be an “alternative to SUS”⁵⁻⁹. The offer of consultations with specialists at lower prices, with greater agility, through direct scheduling⁵⁻⁹ is presented in opposition to an “inefficient” and “overcrowded” public health service⁶⁻⁹. This argument has the character of a justification and seems to be part of common sense.

The informal referrals contradict this idea, considering that the access to exams or highly complex procedures of patients from these companies is done at SUS, as in the case of possible cancer diagnosis.

Moreover, it is not possible that the Low-Cost Clinics solve the SUS problem when they effectively cause another one: informal referrals speed up the process of solving the demands of users of these companies, bypassing formal steps and procedures for referring patients to SUS, while slowing down the waiting flow of those who are already waiting for care in the public health system.

Such a strategy enables the creation of niches dependent on - and not alternative to - the SUS structure and simultaneously weakens the impersonal dimension that sustains the forms of organizing access to different levels of care, based on the logic of rationality and integrality of health care.

The demonstration of satisfaction and gratitude to the Low-Cost Health Clinics, even when the health problem was solved in the public health sector, is particularly curious and leads us to reflect that this is due to the way the conception of a “ditched” and “inefficient” SUS is mediated²⁵ and is present in the social imaginary. These representations convey interests of delegitimization/legitimation, considering that it is commercially advantageous the narrative of a SUS said to be “ineffective”, when Primary Health Care, for example, can meet 80% of the population’s health needs²⁶.

The micropolitics, therefore, entangle the work process²⁷ of the interviewed doctors and, particularly, help us understand the complexity of the dilemmas of the medical practice in the search for responding to dichotomous interests: to frame their conducts to the mercantile character of the functioning of the Low-Cost Clinics, while seeking to meet the health needs of patients within this service with a limited care model.

Making a name and training the hand

In this section we present the reasons that led our interviewees to work in Low-Cost Health Clinics, how they characterize these establishments, and what they plan for their careers.

All participants are young doctors, recent graduates in their specialties and in search of their own space in the local job market. Therefore, the main reason enunciated by them for staying in these companies is linked to the professional projection made possible by the Low-Cost Health Clinics, that is, to make their name known:



[...] it let me to make a name and that was the main thing for me, right? In the end, if I could list and choose only one [reason]. So, the main thing was that, right, I could attend, little by little, right, and make myself known as [...] doctor. Today my income is mainly from the shifts [...], but this projection that the Low-Cost Clinic gave me and gives me I consider very important. (MED1)

Mainly companies located in peripheral and populated neighborhoods were seen as those that made doctors known to the public. Other participants also argued that these clinics were their first experience practicing their medical specialties. In these cases, they served as a field for developing expertise in the newly completed specialty, and therefore, as a place to “train their hand” of those who were hired at the end of their residencies.

The financial aspect was also a motivator for maintaining ties with these companies.

One thing that draws a lot of attention from the doctors is the financial issue, whether you like it or not, most of these Low-Cost Clinics pay you on time. So, in other words, you get an immediate return. (MED8)

However, none of the interviewees planned in the future to work as frequently as they did at the time of the interview, that is, they would like to reduce or even stop working in these companies. All of them wanted less exhausting work routines and more stable jobs. They planned to open their own practices, to sit for a public health position examination, or to pursue an academic career.

The way health care is practiced in these establishments was reflected by our interviewees, especially when they talked about the effort that patients from low-income neighborhoods made to pay for consultations. Thus, MED3 started not charging for the punctures of small cysts done during consultations. This procedure, however, was not reported to the administrative sector. MED4, on the other hand, does not charge for return consultations for exams that take longer than 30 days. Even going against institutional practices, the participants ended up legitimizing the discourse of these companies that claim to have a “social function” by supposedly guaranteeing access to health care at lower prices.

The adjective “low-cost”, included in the name of these companies, gives these doctors the impression that they are working in services that contribute to the collectivity, that have an almost philanthropic function. However, it is possible to observe that the one who guarantees “access” and even the continuity of care is the physician himself and his network of personal and professional relationships, entrenched and linked to SUS.



Because of the need to “make a name for themselves” the fragile contracting model and payments have become attractive in the short and medium term, since, when planning for the future, these characteristics give way to the search for stability and rights guaranteed by labor legislation. These future ambitions help us understand that these professionals see the established bond as something temporary or transitory.

These effects in the practice of doctors point to the dimension of what Bourdieu²⁷ calls disinterested interest. According to the author: “behind the pious and virtuous appearance of disinterest, there are subtle, camouflaged interests [...]” (p. 152)²⁸. This concept has proven fruitful, especially in understanding how these professionals are engaged in serving their patients well while seeking to accumulate more symbolic capital.

Symbolic capital is understood here as the knowledge and recognition built by the doctors in the Low-Cost Health Clinics. For the interviewees, these businesses are a field of practical experience of the knowledge acquired in their recently completed residency, a space for building clientele and producing networking. Thus, they will be recognized by patients and peer-competitors²⁹.

The accumulation of symbolic capital is concomitant with the investment in social capital, that is, the set of relationships and spaces for professional socialization²⁹. In this context, we can think of the forms of recruitment and the practical functions performed in the clinics, including accessing the SUS colleague, who is in a position to welcome and provide services and counter services in the public sphere for his clients in the private sphere. The articulation and combination of these kinds of capital is fundamental for doctors with little experience in their specialties and given the characteristics of the distribution of medical labor in São Luís and Maranhão.

Maranhão has the second worst record in distribution of medical labor in the country, there are only 1.08 doctors for every thousand inhabitants. Among all the doctors in the state (7,642), 51% (3,899) are specialists, and most of these professionals are concentrated in the capital, São Luís³⁰. Due to this reason, in the initial years of their practice as specialists, and given the income expectations of these types of capital, they submit themselves to the model of labor relations and work in Low-Cost Health Clinics.

Although the interviewees recognize that the physician’s labor force is exploited, these companies encounter little resistance from these professionals. On the one hand, this is because the companies have a more subtle “exploitation process”, without abruptly removing the autonomy, the social status, and the feeling of protagonism of these professionals in the health work process²⁰. On the other hand, contradictorily, this exploitation is the possible way to accumulate symbolic capital.



Final considerations

It was possible to understand that there are dilemmas in the performance of doctors in Low-Cost Health Clinics, since when complying with the market logic of these companies they face a limited extension service and, therefore, informally rearrange some actions of the work process to provide a more resolute and ethical care. However, it is these companies that benefit the most from these informal mechanisms, since they receive the “resolutive service” bonus, even when the health needs of their clients have only been resolved through care at the SUS.

By seeking these doctors at the end of the residency, the Low-Cost Clinics open the job market for new specialists, who are very welcome in a context of such unequal distribution of medical labor. Simultaneously, these professionals replicate the narrative that makes these establishments a commercial success and, therefore, also “make the name” of these companies.

The actions that constitute the work process of doctors in Low-Cost Clinics are contextualized in a larger scope: neoliberal policies for crisis control, such as Constitutional Amendment No. 95 of 2016, reducing the opportunity for professional development within the public health system and weaken working conditions in ties with the private sector.

Finally, from this research we did not observe substantiality in the idea that the private service would be more “resolutive” than the public health service, as is preached by business sectors. On the contrary, the naturalized way that the double gateway to the SUS is constructed in an unofficial and insidious manner provides us with tools to problematize the “savior” position in which the market positions itself. Moreover, it contributes to thinking about larger issues, such as public-private relations in health, considering that this context enables the creation of health care niches, such as the Low-Cost Health Clinics, which are strongly dependent on SUS, but benefit from the degradation of its image.



Authors' contribution

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

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Conflict of interest

The authors have no conflict of interest to declare.

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O objetivo deste estudo foi compreender a perspectiva de médicos acerca do processo de trabalho em Clínicas Populares de Saúde. Para isso, realizamos uma pesquisa qualitativa na qual foram entrevistados oito jovens médicos especialistas que atuam nessas empresas em São Luís, Maranhão. Identificamos condições precarizadas de trabalho, mas com pouca resistência por parte dos médicos, considerando que essas empresas são encaradas como espaços de projeção no mercado de trabalho local. Devido às limitações do modelo assistencial do tipo queixa-conduta, os entrevistados acionam uma rede informal e os usuários das Clínicas Populares de Saúde são encaminhados para o Sistema Único de Saúde (SUS). Assim, o processo de trabalho do médico é desafiado por esse modelo assistencial fragmentado, o que faz borrar os limites nas interfaces público-privado na medida em que uma dupla porta de entrada para o SUS é naturalizada.

Palavras-chave: Profissional de saúde. Mão de obra em saúde. Edifícios de consultórios médicos. Sociologia médica.

El objetivo de este estudio fue comprender la perspectiva de médicos sobre el proceso de trabajo en Clínicas Populares de Salud. Para ello, realizamos una investigación cualitativa en la que fueron entrevistados ocho jóvenes médicos especialistas que actúan en esas empresas en São Luís, Maranhão. Identificamos condiciones precarias de trabajo, pero con poca resistencia por parte de los médicos, considerando que esas empresas son consideradas como espacios de proyección en el mercado de trabajo local. Debido a las limitaciones del modelo asistencial del tipo queja-conducta, los entrevistados ponen en acción una red informal y los usuarios de las Clínicas Populares de Salud son derivados para el Sistema Brasileño de Salud (SUS). De tal forma, el proceso de trabajo del médico es desafiado por ese modelo asistencial fragmentado, lo que borra los límites de las interfaces público-privado a medida que se naturaliza una doble puerta de entrada al SUS.

Palabras clave: Profesional de salud. Mano de obra en salud. Edificios de consultorios médicos. Sociología médica.