

Physicians in the external assessment process of the National Program for Access and Quality Improvement in Primary Care, cycles I and II – Brazil

O médico no processo de avaliação externa do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica, ciclos I e II

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ABSTRACT Evaluative research that examined aspects of work management and education of physicians who participated in the National Program for Access and Quality Improvement in Primary Care, cycles I and II, in Brazil. Secondary data obtained from public databases revealed that in cycles I and II medical representation among respondents of Module II was 5.77% and 5.66% respectively; the majority were in practice for less than two years (51% and 53%); had public administration as hiring agency (60.73% and 61.80%); were civil servants (37.26% and 35.41%); were hired through public service entrance exams (41.61% and 41.40%); and had no right for a career plan (67.47% and 70.23%). The conclusion is that medical education should also include political education to favor physicians' active participation in decision-making and work processes in Primary Health Care teams.

KEYWORDS Primary Health Care. Health personnel. Health evaluation.

RESUMO Pesquisa avaliativa que analisou aspectos da gestão do trabalho e da formação dos médicos que participaram do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica, ciclos I e II. Dados secundários, obtidos em bancos públicos, revelaram que nos ciclos I e II, respectivamente, a representação médica entre os respondentes do Módulo II foi de 5,77% e 5,66%; em sua maioria, atua há menos de dois anos (51% e 53%); possui administração direta como agente contratante (60,73% e 61,80%); é de servidores públicos estatutários (37,26% e 35,41%); ingressou por meio de concurso público (41,61% e 41,40%); e não possui plano de carreira (67,47% e 70,23%). Conclui-se que a formação médica deve contemplar, também, formação política para favorecer a participação mais ativa dos médicos nos processos decisórios e de trabalho das equipes de Atenção Primária à Saúde.

PALAVRAS-CHAVE Atenção Primária à Saúde. Profissional de saúde. Avaliação em saúde.

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Introduction

According to the Brazilian National Council of Health Secretaries (Conass), physicians have been pointed as being a critical node for the consolidation of the Family Health Strategy (FHS) due to high turnover and, in some cases, low level of training/preparing for the work in Primary Health Care (PHC) (CONASS, 2011).

PHC requires physicians to be integrated in the health teamwork process, performing counter-hegemonic actions in face of the specialized, curative model of care. In order to resolve most health problems of the population in the coverage area (by means of individual and collective actions), physicians should have a generalist education, engage in peoples' care, create bonds with the population, know the local reality, work on the social determinants of the health-illness process, and participate in the planning and monitoring of actions and outcomes assessment (BRASIL, 2000).

Vicenzi, Girardi and Lucas (2010) carried out a study aiming to identify leaderships in PHC health teams based on the opinion of professionals in the teams. They identified the Community Health Worker (CHW) as a leader due to the knowledge about the population; and nurses due to management/coordination positions often held by them. There was no register of leadership being attributed to a physician or a dentist. Physicians argued that the leader must engage in bureaucratic responsibilities and they make the option for clinical care. In a study by Saar e Trevizan (2007), teams consider physicians as coordinators responsible for guidance and supervision of all team members' work; however, physicians are identified as biased professionals resisting to teamwork and centralizing decision-making.

Several programs have been proposed and implemented by the federal government aiming to qualify PHC and improve medical professionals' work in this level

of care. Prominent programs are: More Doctors (Mais Médicos), Program for the Enhancement of Basic Care Professionals (Programa de Valorização do Profissional da Atenção Básica – ProVab), and National Program for Access and Quality Improvement in Primary Care (PMAQ-AB). The PMAQ-AB was launched in 2011 aiming to increase PHC access and quality improvement to reach nationally, regionally, and locally equivalent pattern (BRASIL, 2015). Two complete cycles of PMAQ-AB have been achieved: cycle I in 2011/2012; and cycle II in 2013/2014. The third cycle is planned for 2017.

PMAQ-AB is organized in three phases and one Strategic Transverse Axis of Development. Phase 1: Adhesion and Agreement – when municipal managers and teams agree on commitments and indicators; Phase 2: Certification – local verification of access and quality patterns (external assessment); certification of teams; and provision of information for managers' and teams' actions; and Phase 3: Re-agreement – with increase of quality patterns and indicators. The Strategic Transverse Axis of Development comprises: self-assessment; monitoring; continuing education; institutional support; and horizontal co-operation (BRASIL, 2015).

In the external assessment process, an interview is carried out with a member of the health team holding a higher education degree, to obtain information on the teamwork process and the organization of care in the Primary Health Unit (PHU). For this purpose, a form named Module II is filled in by an external interviewer. In a document forwarded to the units by the Ministry of Health to guide the selection process of the professional who will be the respondent, it is stated that:

The professional who will respond to the interview should be the one, among physicians, nurses, and dentists, who has more

knowledge on the teamwork process and shall be previously chosen by the group of professionals. It is important that the respondent holds a meeting with the other team members in order to be prepared to answer the questions posed by the Quality Appraiser. (BRASIL, 2012, P. 62).

In the first cycle of PMAQ-AB, 17.202 teams adhered to the program in the entire national territory; this was therefore the amount of professionals holding a higher education degree who responded to Module II in the external assessment process. Among those, there were 15.876 nurses (92.30%), 993 physicians (5.77%) and 333 dentists (1.93%). In the second cycle, 29,778 teams adhered to the program, with the participation 27,822 nurses (93.43%), 1,686 physicians (5.66%) and 270 dentists (0.91%) (BRASIL, 2016).

These data indicate that, in most teams, physicians do not appear as leaders, nor seem to hold more knowledge than other members about the work process in PHU. Even so, it is interesting to identify those physicians who placed themselves as leaders and what were their working conditions. In this sense, this research aimed to analyze aspects of work management and education of physicians who took part in PMAQ-AB, in cycles I (2011/2012) and II (2013/2014), in all states of Brazil.

Material and methods

It is an evaluative research using databases of PMAQ-AB, cycles I and II, carried out respectively in 2011/2012 and 2013/2014, made available first to universities participating in data collection in the external assessment process. Presently, the databases are made openly available at the Ministry of Health website.

Initially, data were selected referring to places/units in which the respondents were

physicians. Subsequently, drawing on the PMAQ-AB dictionary of variables, data were selected referring to place and length of time working in the PHU, hiring agency, existence of Career and Salary Plan (CSP), and education/training of the 993 physicians taking part in cycle I, as well as 1,686 physicians taking part in cycle II, who responded to Module II of PMAQ-AB representing their teams in the external assessment process of the program.

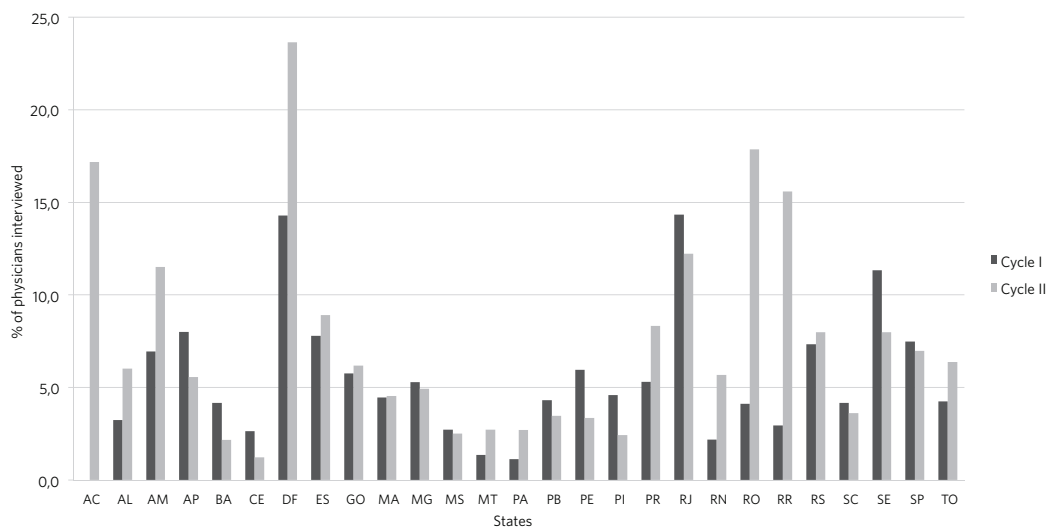
Data were systematized in Excel worksheets and represented in graphs and tables. The results were organized according to two themes: aspects of the work management and professional education. The descriptive analysis was enhanced with discussions based on literature on the theme.

The research project was approved by the Ethics Committee for Research with Human Beings of the Sergio Arouca National School of Public Health/Oswaldo Cruz Foundation (Fiocruz), under nr. 32.012.

Results and discussion

On *graph 1* it can be observed that only a reduced number of states presented an important difference in cycles I and II regarding physicians' participation as respondents to Module II of PMAQ-AB, with the following highlights: Federal District, that raised from 4 (14%) professionals in cycle I to 26 (24%) in cycle II; Rondônia, from 4 (4.12%) to 45 (18%); Roraima, from 1 (12%) to 12 (16%); and Acre, with no physician respondent in cycle I and 17 (17%) in cycle II. The state with the highest amount of physicians interviewed, both in cycles I and II, was Rio de Janeiro, with 150 physicians in cycle I and 230 in cycle II. A reduction is observed, in relative numbers, of physician respondents in cycle II in 12 states, with highlights to Pernambuco (3%), Piauí (2%), Bahia (2%), and Ceará (1%).

Graph 1. Relative frequency of physicians participating in the external assessment process of PMAQ-AB, cycle I and cycle II, according to states. Brazil, 2015

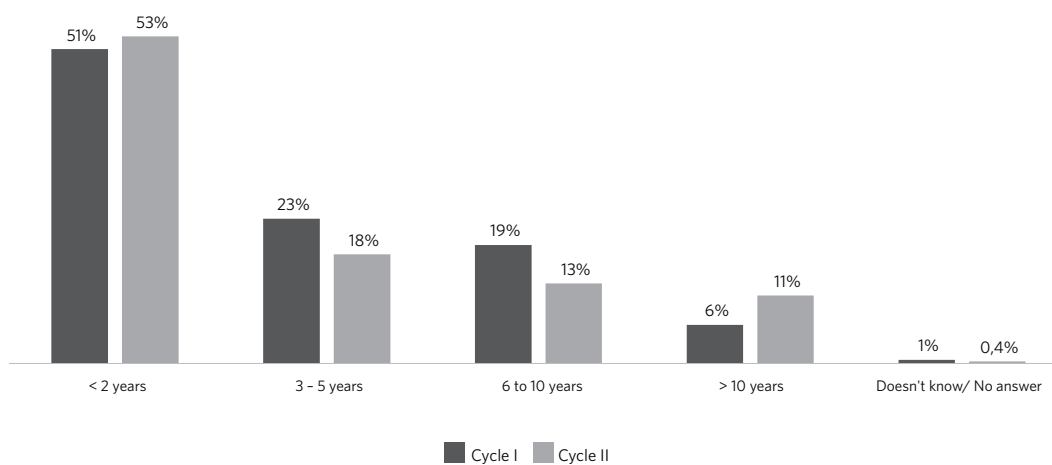


Source: Databank, cycle I (2011/2012) and cycle II (2013/2014) of PMAQ-AB.

Most physicians who responded to Module II of PMAQ-AB, both in cycle I (51%) and cycle II (53%), had been working in the team for two years or less, with a slight increase from the first to the second

cycle (*graph 2*). This stresses the high turnover of physicians in PHC, a fact that has been reported in other studies (MEDEIROS *ET AL.*, 2010; RODRIGUES; SILVA; ROCHA, 2010; MACHADO, 2003; CAMPOS, 2005).

Graph 2. Relative frequency of physicians participating in the external assessment process of PMAQ-AB, cycle I and cycle II, according to length of time working in PHC. Brazil, 2015



Source: Databank, cycle I (2011/2012) and cycle II (2013/2014), of PMAQ-AB.

The term turnover can be defined as staff entering and leaving the job, either voluntarily or involuntarily. Every institution has some degree of staff turnover and it can be considered as positive when non-essential employees leave the job; but it is negative when it causes ruptures and when it happens with personnel considered as strategic (ROBBINS, 2002).

The option to remain or not in a job may be considered as an individual choice. In the health area, especially in the PHC, professional turnover hinders the team's work, the establishment of bonds with users, and the knowledge of the population's health problems. With the implementation of FHS, it was expected that PHC would be re-organized with the creation of multi-professional teams working in defined territorial areas, with their population linked by means of programmed actions' delivery and having the family as the nucleus of care. However, one of the greatest challenges of FHS implementation consists in involving the professionals in this health care re-orientation process (MENESES E ROCHA, 2005).

Job stability of FHS workers is essential for the construction of a model of care that includes among its actions elements such as integrality of care and bonds with the population (MEDEIROS ET AL., 2010). Taking into consideration that physicians play a prominent role in the organization of PHC attributes – especially longitudinality, with the need for regular, continuous care and long term relationship between team and population – the attraction and retention of those professionals constitute necessities to be provided by managers of the Brazilian Unified Health System (Sistema Único de Saúde – SUS) (RODRIGUES; DA SILVA; ROCHA, 2010).

The increase in job offers resulting from the expansion of FHS is an attraction factor, but it is not a factor of physicians' retention. Yet, satisfaction with the work and the feeling of gratification are indeed factors of attraction and retention (BARBOSA; RODRIGUES,

2009). Several authors report that the salary is an important attractive for health professionals, but it is not a factor that increases retention. On the contrary, it increases the probability of higher turnover, because it generates competitiveness between municipalities (MEDEIROS ET AL., 2010; RODRIGUES; DA SILVA; ROCHA, 2010; MACHADO, 2003; CAMPOS, 2005).

Furthermore, teams' work overload and structural hindrances, such as lack of materials and absence of referral to other levels of care, associated to physicians' insecurity for doing the generalist practice required by PHC are factors that cause turnover increase (CAMPOS; MALIK, 2008). Mendonça *et al.* (2010) add that the 40-hours working week associated to the exclusivity basis required by some municipalities are factors that hinder physicians' retention.

Rodrigues, da Silva and Rocha (2010), based on literature review, have classified professionals' attraction and retention factors as: (1) individual: related to the professional's personal characteristics, background and trajectory; (2) culture and identity: related to the professional's satisfaction, valorization and recognition; (3) work organization: related to work characteristics at FHS; (4) management: related to municipal management and the specific health unit management; (5) context: related to the specific health team's work.

In the same direction, Campos (2005) proposes the division of factors that lead to physicians' non-retention in three categories: types of employment contract, profile of FHS's physician, and working conditions. Regarding the profile of FHS's physician, it is expected that the professional is prepared to provide integral care to individuals of various age groups incorporating emotional, family, social, curative and preventive aspects, and to participate in teamwork organization, requiring for this purpose that the physician has a generalist medical education and some knowledge on other areas. Yet, what can be observed is a large number of professionals

with many attributions but low qualification (MENDONÇA ET AL., 2010).

Regarding working conditions, a research conducted by Capozzolo (2003) showed that physicians' practice was marked by daily work overload, centered on the delivery of individual medical care, with a great number of short duration consultations directed to patients' complaints; and the reduced length of time available for group activities, home visits, and team meetings. Besides, skills were considered inadequate in face of the diversity of demands (MENDONÇA ET AL., 2010).

Regarding work management, the majority of the physicians interviewed, both in cycle I (60.73%) and cycle II (61.80%), had an employment contract with the public administration. However, it was also observed that many workers were hired by Social Organizations (SO), Civil Society Organizations of Public Interest (Oscip), and cooperatives, among other types of employment contracts (*table 1*).

In cycle I, in the states of Alagoas, Amapá, Maranhão, Rondônia, and Roraima had 100% of physicians hired by the public administration; this fact was not repeated in cycle II. In contrast, in both cycles Rio de Janeiro maintained its position as the state that had the lowest rate (8% and 12%) of employment contracts by the public administration. (Data are not in the tables).

In relation to the type of employment

relationship, the civil servant contract prevailed with 37.26% of cases in cycle I and 35.41% in cycle II. The second most frequent type was the contract ruled by the Brazilian labor legislation known as Consolidated Labor Laws (Consolidação das Leis do Trabalho - CLT), with 31.72% of professionals in cycle I and 23.61% in cycle II. In this aspect, a reduction was observed in stable employment relationship, whereas there was an increase in the precarious relationship, such as the temporary contract for services rendered, which raised from 9.77% in cycle I to 12.34% in cycle II; and the temporary contract by public administration ruled by special legislation, which raised from 11.08% in cycle I to 14.59% in cycle II. The types of relationship 'freelance', 'other', and 'doesn't know' increased from 3.02% in cycle I to 6.64% in cycle II (*table 1*).

In cycle I, regarding the type of relationship, the Federal District had 100% of respondents as civil servants and in cycle II this rate decreased to 88%. Amapá, Maranhão, and Roraima had no physicians with this type of employment relationship in cycle I – and in Roraima 100% of physicians had temporary contracts; in cycle II these states had respectively 0%, 20% and 8% of physicians as civil servants, and 86%, 59% and 78% remained with temporary contracts. (Data are not in the tables).

Table 1. Number and percentage of physicians participating in the external assessment process of PMAQ-AB, cycle I and cycle II, according to hiring agency, type of relationship and way of entrance. Brazil, 2015

Variable	Category	PMAQ-AB CYCLE I		PMAQ-AB CYCLE II	
		AF*	%	AF*	%
Hiring Agency	Public Administration	603	60,73	1042	61,80
	Public law inter-municipal consortium	17	1,71	26	1,54
	Private law inter-municipal consortium	4	0,40	4	0,24
	Public law public foundation	40	4,03	87	5,16
	Private law public foundation	17	1,71	33	1,96
	Social Organization (SO)	154	15,51	184	10,91
	Civil Society Organization of Public Interest (Oscip)	44	4,43	4	0,24
	Philanthropic Organization	27	2,72	41	2,43
	Non-Governmental Organization (NGO)	5	0,50	11	0,65
	Private company	25	2,52	43	2,55
	Cooperative	7	0,70	14	0,83
	Other	42	4,23	185	10,97
	Doesn't know/No answer	8	0,81	12	0,71
	Total		993	100	1686
Type of employment relationship	Civil servant	370	37,26	597	35,41
	Commissioned post	11	1,11	20	1,19
	Temporary contract with public administration, ruled by special legislation (municipal/state/federal)	110	11,08	246	14,59
	Temporary contract for services rendered	97	9,77	208	12,34
	Public employee (CLT)	60	6,04	105	6,23
	Contract (CLT)	315	31,72	398	23,61
	Freelancer	9	0,91	15	0,89
	Other	16	1,61	89	5,28
	Doesn't know/No answer	5	0,50	8	0,47
Total		993	100,00	1686	100,00
Way of Entrance	Public service entrance examination	414	41,69	698	41,40
	Public selection	263	26,49	449	26,63
	Indication	312	31,42	214	12,69
	Other	4	0,40	325	19,28
Total		993	100	1686	100

Source: Databank, cycle I (2011/2012) and cycle II (2013/2014), of PMAQ-AB.

*AF - Absolute Frequency.

Rodrigues, da Silva and Rocha (2010) found relations between retention and type of contract, coordination, and settling. The authors highlighted that employment resulting from entrance examination increases the permanence of professionals, whereas contracts with or without legal labor guarantees made no difference in the retention of professionals. Coordination may produce conflicts in the relationship between professionals and managers, generating dissatisfaction and stimulating non-settling. The authors verified that the second main motive to move the working place from one municipality to another was the political shift in the municipal administration.

In the same direction, Machado (2003) highlighted that physicians feel more satisfied and motivated when they observe administrative coherence, leadership, clear definition of the role of each team member, and the possibility to participate in the decision-making process.

Also regarding human resources management, employment resulting from entrance examinations with more stable labor guarantees has positive impact and helps professionals' settling, although it is not sufficient to keep them in the locality (MENDONÇA ET AL., 2010). It is believed that an important factor for professionals' settling would be the establishment of a national career plan for health workers.

The third aspect of work management of medical professionals who responded to Module II of PMAQ-AB regards the way of entrance. In both cycles, the majority of respondents entered by public examination (41.69% and 41.40%) or public selection (26.49% and 26.63%); these two ways totalize 68% in both cycles. One situation that stands out is the entrance in cycle I of 31.42% of professionals by ways that are not publicized, like the indication. It is noteworthy that although the rate of this modality has decreased to 12.69% in cycle II, there was an increase of 19.28% of 'other' way of entrance.

These two modalities totalize 31.97%, i.e., the practice of non-publicized entrance remains unchanged in both cycles (table 1).

Regarding the existence of CSP in the services where respondents worked, 67.47% of participants in cycle I stated that there was none, whereas for 30.51% the answer was affirmative. In cycle II, the rate of professionals without CSP increased to 70.23%. (Data are not in the tables).

Eberhardt, Carvalho and Murofuse (2015), in a study about health workforce in the macro-region of Western Paraná, identified that from the total of 28,239 work relationships, 36.46% were precarious; the majority (85.28%) was related to higher education degree professionals, and among physicians it represented 78.88%.

Nunes *et al.* (2015), when studying the workforce in PHC in 49 small municipalities, identified that the majority of professionals (77.2%) had formal employment relationship. Among non-formal relationship, 4.1% were temporary contracts, 2.3% commissioned posts, and 12.4% were outsourced.

Mora and Rizzotto (2015), in a research on work management in hospitals in the 9th Health Region of Paraná, identified that 39.7% of higher education degree professionals had precarious work relationship, the majority of them being freelance workers (30.88%). In this study, 100% of physicians presented legally unprotected work relationship.

Data in the present research show that in PHC physicians' condition is slightly better in terms of legally protected work relationships when compared to hospital level; but it is still far from an ideal condition, considering that greater precariousness was observed regarding the work of physicians in cycle II, when compared to cycle I, which could indicate a negative tendency.

Regarding medical practice, it can be stated that the scientific revolutions have produced great changes; knowledge and professional practice have become continuously

more complex, leading to technical division of work. In the medical field, specialization became one of the characteristics of the new work organization, with the rise of new specialties and subspecialties. This characteristic has led to the fragmentation of knowledge and medical practice (MACHADO, 1997).

A research conducted by Scheffer *et al.* (2015) showed that from the total number of active physicians in Brazil in 2015 (159.341) only 41% did not have a specialty degree. Furthermore, there was an increase in the number of physicians with more than two specialties. The Southern region had the greatest proportion of specialists in relation to generalists: 2.11 specialists for each generalist. When considering age, in the group from 31 to 60 years old, specialists are the majority with 70.2%; in the group of younger than 30 years of age 73.7% are generalists, which can be explained by the fact that the younger are still in the process of specialization.

Scheffer *et al.* (2015) also found changes in the picture of the four specialties with higher rates of specialists, as follows: medical clinic (10.6%), pediatrics (10.5%), general surgery (8.8%), and gynecology and obstetrics (8.6%). Family and Community Medicine, despite its increase in absolute numbers to 4,022, still represents 1.2% of the totality of specialists; and Preventive and Social Medicine, with 1,790 doctors, represents 0.5% of the totality.

Regarding complementary education/specialization, it is observed that both in cycle I (81%) and cycle II (78%) most professionals report having concluded some sort of specialization. But the majority of the specializations have not been concluded in areas that favor the work in PHC, which would be Family and Community Medicine, Family Health, or Public Health/Collective Health (table 2).

Table 2. Number and percentage of physicians participating in the external assessment process of PMAQ-AB, cycle I and cycle II, according to type of specialization. Brazil, 2015

Specialization	Categories of answers	PMAQ-AB CYCLE I		PMAQ-AB CYCLE II	
		AF*	%	AF*	%
Specialization in Family and Community Medicine	No specialization	563	56,70	958	56,82
	Concluded	191	19,23	288	17,08
	Ongoing	42	4,23	63	3,74
	Not applicable	193	19,44	377	22,36
	No answer	4	0,40	-----	-----
	Total	993	100	1686	100
Specialization in Family Health	No specialization	532	53,58	864	51,25
	Concluded	185	18,63	334	19,81
	Ongoing	79	7,96	111	6,58
	Not applicable	193	19,44	377	22,36
	No answer	4	0,40	-----	-----
	Total	993	100	1686	100

Table 2. (cont.)

Specialization in Public Health/ Collective Health	No specialization	696	70,09	1157	68,62
	Concluded	86	8,66	127	7,53
	Ongoing	14	1,41	25	1,48
	Not applicable	193	19,44	377	22,36
	No answer	4	0,40	-----	-----
Total		993	100	1686	100
Has another specialization?	Yes	436	43,91	628	37,25
	No	360	36,25	557	33,04
	Ongoing	-----	0	124	7,35
	Not applicable	193	19,44	377	22,36
	No answer	4	0,40	-----	-----
Total		993	100	1686	100

Source: Databank, cycle I (2011/2012) and cycle II (2013/2014), of PMAQ-AB.

*AF - Absolute Frequency.

When analyzing education in medical residencies, it can be observed that a minority among the physicians have achieved complementary education, and it is not necessarily related to PHC (*table 3*). Numbers

are even lower when regarding master's and doctoral degrees: approximately 1% of physicians responding to Module II of PMAQ-AB in both cycles.

Table 3. Number and percentage of physicians participating in the external assessment process of PMAQ-AB, cycle I and cycle II, according to type of residency. Brazil, 2015

Residency	Categories of answers	PMAQ-AB CYCLE I		PMAQ-AB CYCLE II	
		AF*	%	AF*	%
Residency in Family and Community Medicine	No residency	692	69,69	1165	69,10
	Concluded	90	9,06	121	7,18
	Ongoing	14	1,41	23	1,36
	Not applicable	193	19,44	377	22,36
	No answer	4	0,40	-----	-----
Total		993	100	1686	100
Residency in Family Health	No residency	765	77,04	1263	74,91
	Concluded	24	2,42	39	2,31
	Ongoing	7	0,70	7	0,42
	Not applicable	193	19,44	377	22,36
	No answer	4	0,40	-----	-----
Total		993	100	1686	100

Table 3. (cont.)

Residency in Public Health/ Collective Health	No residency	782	78,75	1206	71,53
	Concluded	10	1,01	12	0,71
	Ongoing	4	0,40	1	0,06
	Not applicable	193	19,44	377	22,36
	No answer	4	0,40	-----	-----
Total	993	100	1686	100	
Has another residency?	Yes	196	19,74	369	21,89
	No	600	60,42	940	55,75
	Not applicable	193	19,44	377	22,36
	No answer	4	0,40	-----	-----
Total	993	100	1686	100	

Source: Databank, cycle I (2011/2012) and cycle II (2013/2014), of PMAQ-AB.

*AF - Absolute Frequency.

This study has verified that, in cycle I, the states of Maranhão and Rio Grande do Norte had 100% of physicians with complementary education, whereas Roraima had no physician with this characteristic. In cycle II, the states of Pernambuco, Paraíba, and Rondônia had the highest rate of physicians with complementary education – 90%, 90%, and 89%, respectively –, whereas Goiânia (36%), Ceará (35%), and Paraná (31%) presented the highest rates of physicians without complementary education. (Data are not in the tables).

A study conducted by Campos and Malik (2008), relating education with turnover, showed that there is a correlation between years since graduation and stability in the job, i.e., the longer the period since graduation, the lower the professionals' turnover. A research carried out by Rodrigues, da Silva and Rocha (2010) in the state of Minas Gerais has also shown a positive relation between longer period since graduation and lower turnover. Another interesting relation found by these authors regards post-graduate

education: physicians who have post-graduation in basic clinics or family health stay longer than those with post-graduation in other areas, i.e., education related to PHC favor settling. Yet, the search for training, especially for residency, constitutes a factor of turnover increase.

Mendonça *et al.* (2010), analyzing the theme training, affirm that the Health Secretariat of the city of Florianópolis (state of Santa Catarina – SC) has put into practice the requirement of specialist degree in Family and Community Medicine as a requisite for entrance examinations for civil service. This was evaluated as a positive fact for professionals' adequacy and as motivation and adhesion factor. The authors also highlighted that physicians of all municipalities under study requested technical training that would be directed to them, because they believed it would provide them greater competence and readiness to act more resolutely, thus reducing the number of referrals to specialists and improving diagnoses and therapeutics in PHC.

Final considerations

The reduced number of physicians that responded to Module II of PMAQ-AB, in both cycles (5.77% in cycle I and 5.66% in cycle II), reveals a certain distance of those professionals from the discussions about the health policy implemented on the local level and about the work process organization of the health teams in which they work. Among the respondents, the majority does not have specialization and/or residency in areas of the collective health field, which prepare and enable professionals to work in the complex reality of PHC.

The reduction of direct employment contracts, public entrance examinations, and existence of CSP, and the increase of precarious work relationship among physicians participating in the external assessment process of PMAQ-AB, cycles I and II, are negative data that may contribute to the increase of those professionals' turnover, which is already high in relation to the other professionals in the teams and may jeopardize the work in PHC.

It was also possible to verify an increase of medical work precariousness, despite the fact that the reality in PHC still offers higher protection than in hospital settings.

The short length of time working in the PHC – less than two years (51% in cycle I and 53% in cycle II) – may indicate, besides high turnover, a change in the profile of PHC professionals; this is verified from the fact that younger professionals have been choosing to have the first job in FHS teams, stimulated by public policies such as Provacab and More Doctors.

It is understood that the involvement of physicians in discussions on public policies in general, and those put into practice on the local level in particular, is a decisive factor for the change in the model of care and the very consolidation of FHS. In this sense, further in-depth studies are recommended to analyze the medical education process; besides good clinical education, physicians need political education to enable more active participation in decision-making and work processes of PHC teams.

Collaborators

All the authors have actively participated in the design and planning of this study and also in the analysis and interpretation of data. ■

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