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Vulnerabilities that push away and challenges for the establishment of doctors in Family Health Strategy*

Fragilidades que afastam e desafios para fixação dos médicos da Estratégia de Saúde da Família

Debilidades que alejan y retos para la fijación de médicos de la Estrategia de Salud de la Familia

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This study aims to understand which aspects contribute to distance doctors from the Family Health Strategy. It is a descriptive, exploratory, qualitative study based on the Grounded Theory. Collection between January and July of 2016, with semi-structured interviews. The participants were 10 doctors who work in the Family Health Strategy, in municipalities in the southwest region of the state of Bahia. The process of systematic analysis of data allowed the construction of a theoretical interpretive model of the phenomenon of the study, entitled: Vulnerabilities that push away and challenges for the establishment of doctors in Family Health Strategy and compromise assistance, supported by three categories: Deficits in medical training and lack of incentive to work in FHS, representing conditions that compromise the doctor's establishment in FHS; Political party influence and Comfort for action in the FHS, which highlights actions and interactions that weaken the system; and Turnover and losses in assistance, pointing out the consequences of the deficit in the operationalization of the system. Training failures, absence of a career plan and operational deficits keep doctors away from Family Health Strategy, compromising the population's right to health.
Descriptors: Family Health Strategy; Primary health care; Physicians, family; Personnel turnover.

O objetivo deste estudo é compreender quais aspectos contribuem para afastar os médicos da Estratégia Saúde da Família. Estudo descritivo, exploratório de cunho qualitativo com aporte na Teoria Fundamentada nos Dados. A coleta de dados foi feita entre janeiro e julho de 2016, com entrevistas semiestruturadas. Participaram 10 médicos que atuam na Estratégia da Saúde da Família, em municípios do sudoeste baiano. O processo de análise sistemática dos dados permitiu construir um modelo teórico interpretativo do fenômeno do estudo, intitulado: *Fragilidades que afastam e desafios para a fixação dos médicos da Estratégia Saúde da Família e comprometem a assistência*, sustentado por três categorias: *Déficits na formação médica e falta de incentivo para atuação na APS, representando condições que comprometem a fixação do médico na ESF*; *Influência político-partidária e Comodidades para atuação na ESF, que destaca ações e interações que fragilizam o sistema*; e, *Rotatividade e prejuízos na assistência, apontando as consequências do déficit na operacionalização do sistema.* Falhas na formação, ausência de um plano de carreira e déficits operacionais afastam os médicos da Estratégia de Saúde da Família, comprometendo o direito da população à saúde.
Descritores: Estratégia Saúde da Família; Atenção primária à saúde; Médicos de família; Reorganização de recursos humanos.

El objetivo de este estudio es comprender qué aspectos contribuyen a alejar a los médicos de la Estrategia de Salud de la Familia. Estudio descriptivo, exploratorio y de carácter cualitativo con contribución a la Teoría Basada en Datos. Los datos se recogieron entre enero y julio de 2016, con entrevistas semiestructuradas. Participaron 10 médicos que trabajan en la Estrategia de Salud de la Familia, en municipios del sudoeste de Bahía. El proceso de análisis sistemático de los datos permitió la construcción de un modelo teórico para interpretar el fenómeno del estudio, titulado: *Debilidades que alejan y retos para la fijación de médicos de la Estrategia de Salud de la Familia y comprometen la asistencia*, sustentado en tres categorías: *Déficit de formación médica y falta de incentivo para trabajar en la APS, representando condiciones que comprometen la fijación del médico en la ESF; Influencia político-partidaria y Comodidades para trabajar en la ESF, que destaca acciones e interacciones que debilitan el sistema;* y, *Rotatividad y pérdidas en la asistencia, señalando las consecuencias del déficit en la operacionalización del sistema.* Los fallos en la formación, la falta de un plan de carrera y los déficits operativos alejan a los médicos de la Estrategia de Salud de la Familia, comprometiendo el derecho de la población a la salud.
Descriptores: Estrategia de Salud Familiar; Atención primaria de salud; Médicos de familia; Reorganización del personal.

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INTRODUCTION

The Brazilian health system presents a mismatch between the Primary Health Care (PHC) project and its implementation, which result mainly from the centralizing process that does not consider the heterogeneity and diversity of the municipalities[1]. The national economic and political landscape, at the same time, imposes serious threats to the Unified Health System (SUS) and PHC, with the establishment of a ceiling for primary expenses and an extensive cut in SUS financing[1,2].

The challenge of ensuring the replacement of more than eight thousand doctors who left the country in November of 2018, persists in the obstacle for the assistance of millions of Brazilians, especially residents in regions of difficult access[3,4]. In view of this, the Brazilian Association of Collective Health proposed to the government and the Ministry of Health (MS) the adoption of measures to prevent damage to health care, among them, to trigger the process of public call for doctors to fill idle vacancies[5].

Data from the medical demography survey in Brazil indicate that the country has 2.18 doctors per thousand inhabitants, lower than the international average of 3.4. As for medical specialties, Family and Community Medicine is the first option for only 1.5% of recent graduates. The option for FHS reached 32.1% in the Northern region against 17.5% in the Southeast region. For 84% of graduates, working conditions are the main determinant for settling in an institution or city[5]. The Brazilian average of 4.1 consultations with doctors per inhabitant per year is also below the average of the countries of the Organization for Economic Cooperation and Development (OECD), which is 6.6[6].

The educational model and public policies play an important role in structuring trained, motivated and supported human resources that work in line with proposals for equitable health development[7]. Brazil has advanced a lot in health care, but still has great challenges, such as the need to update the syllabus of professional training courses, with an emphasis on comprehensive care, health promotion, prevention, human rights and cultural diversity. There is also an urgent need to promote professional development actions[8].

In 2019, the Federal Government approved Law No. 13,958 that institutes the Médicos Pelo Brasil Program (MBP)[9], as well as Law No. 12,871/2013 of the Mais Médicos Program (MMP)[10], which aim to provide doctors in regions with difficult access, foster the training of specialists in Family and Community Health.

The MBP presents changes in the way of hiring staff with flexible scholarships and greater freedom for relations with the private sector, that is, the new law shows new arrangements for management contracts, to be carried out by the *Agência para o Desenvolvimento da Atenção Primária* - ADAP (Agency for the Development of Primary Care)[9]. This new body will be responsible for managing contracts with public or private entities, even allowing outsourcing of the service.

The proposed loopholes refer to contracts commonly signed through legal entities such as municipalities. The projection is that these contracts end up undermining any possibility for doctors to receive for labor rights. As the "pejorativation" of workers becomes more and more common. This fact accentuates the critical dilemma of the precariousness of bonds, presented in the health services of the municipalities[11].

Despite the legislation, the problem of providing and keeping doctors in the FHS is still an obstacle to universal access to health. The doctor is an essential part of the composition of the family health team and its establishment is essential to establish efficient care management practices in the service and establish the principles of PHC.

Even with the constant changes in PHC policy and legislation, there are issues that prevent its reach. The organization of the work process and the devaluation of workers can be one of the main obstacles. The Brazilian health service has a disconnect between the quality of the service and those who provide assistance. It is impossible to produce quality public health without considering who produces it.

This work seeks to expand the scope of information on the work dynamics of doctors working in the FHS, so that it is possible to understand their difficulties at work, the service routine, the experiences in health care and the factors that interfere in the stay in that service. Thus, the objective of this study is to understand which aspects contribute to distance doctors from the Family Health Strategy.

METHOD

This is a descriptive, exploratory, qualitative study based on Grounded Theory (GT). GT uses systematic guidelines to understand social phenomena, generating theoretical processes that allow the understanding of human behavior[12]. The data that emerge from the cyclical process of collection and analysis, carried out through rigorous and systematized steps, allows to identify patterns of behavior, to name and compare codes, with the purpose of understanding human experiences and elaborating a representative theoretical explanation[12].

The study was carried out in Family Health Units (FHU), located in three cities in the Southwest of Bahia, belonging to the Micro-Regional Health Center of Guanambí. The municipalities were: Ibiassucê, Lagoa Real and Rio do Antônio, which have 100% FHS coverage, this is, therefore, the main access to the health service. The population is between 10,062 to 14,815 inhabitants, the region is located 796 km from Salvador-BA, Brazil[13], far from the large urban centers in the country. The three selected municipalities have geographic and population similarities and there is proximity between them, which facilitated the access to the interviewees.

Doctors who worked at the FHS were interviewed. Inclusion criteria: doctors who worked in the FHS and were enrolled in the National Register of Health Facilities, of the FHS of the selected municipality. Exclusion criteria: professionals who worked in the FHS for less than six months and foreign doctors. These criteria were applied because they considered that these professionals could have little experience about the studied reality.

Data collection took place between January and July of 2016, using semi-structured interviews. A first contact was made with the doctors, in a team meeting with the primary care coordinator. In this stage, the free and informed consent process was sought, which constituted the explanations about the research and invitation. Those who agreed signed the Free and Informed Consent Form and the day and place of the interview was scheduled.

The data collection instrument consisted of questions of social and professional characterization, and a script of triggering questions about the experience of doctors in the FHS and aspects that contribute to removing them from the FHS. A field diary was used to record the researcher's observations and impressions about informal conversations obtained during the process of approaching the collection field and the moments that preceded or followed the interview.

Only one meeting was held with each participant. The interviews took place in a reserved and quiet place, chosen by the participants, most of whom opted for the health unit in which they worked. The interviews lasted approximately 40 minutes, were recorded on digital media and transcribed in full to proceed with the analysis.

The stages of data collection, analysis and categorization occurred simultaneously through constant comparative analysis, according to the GT[12]. The interviews were heard, transcribed and data analysis and initial coding were carried out. At this stage, the interviews were examined thoroughly, line by line, to identify the incidents, the stretches that deserved to be highlighted and that, later, gave rise to the codes.

In the next step, the codes were compared with each other and were grouped by similarities to form the categories. During the codification process, the records of ideas and perceptions were used and led to de creation of memos, which were constituted through the records of observations, insight and interpretations of the researchers. The memo allows the adjustment of the continuity of data collection and direct the next interviews, in addition to

gathering relevant information to assist in the other stages of collection, data analysis and preparation of the final text.

From the beginning of the collection until the writing of the text, there was an exhaustive and cyclical process of analyzing and comparing incidents, codes, re-reading interviews, redefining codes, drafting memos, building categories, grouping categories and subcategories, identifying and defining central categories and interpretative data analysis (theoretical model). Several diagrams were built and modified several times, in an attempt to identify the best design that represented the categories of the theoretical model.

The project was approved by the Ethics and Research Committee of the Pontífice Universidade Católica de Goiás (opinion No. 1,107,155). After receiving favorable opinion for the study, the participants were invited and informed about the objectives, the proposed methodology and the risks and benefits of the research.

Prior to data collection, participants signed the Free and Informed Consent Form. The anonymity of the participants was guaranteed, replacing their name with the letter D for doctor and a number that corresponded to the order of the interview. All procedures were performed in accordance with the ethical guidelines for research with human beings, established by Resolution 466/12, of the National Health Council.

RESULTS

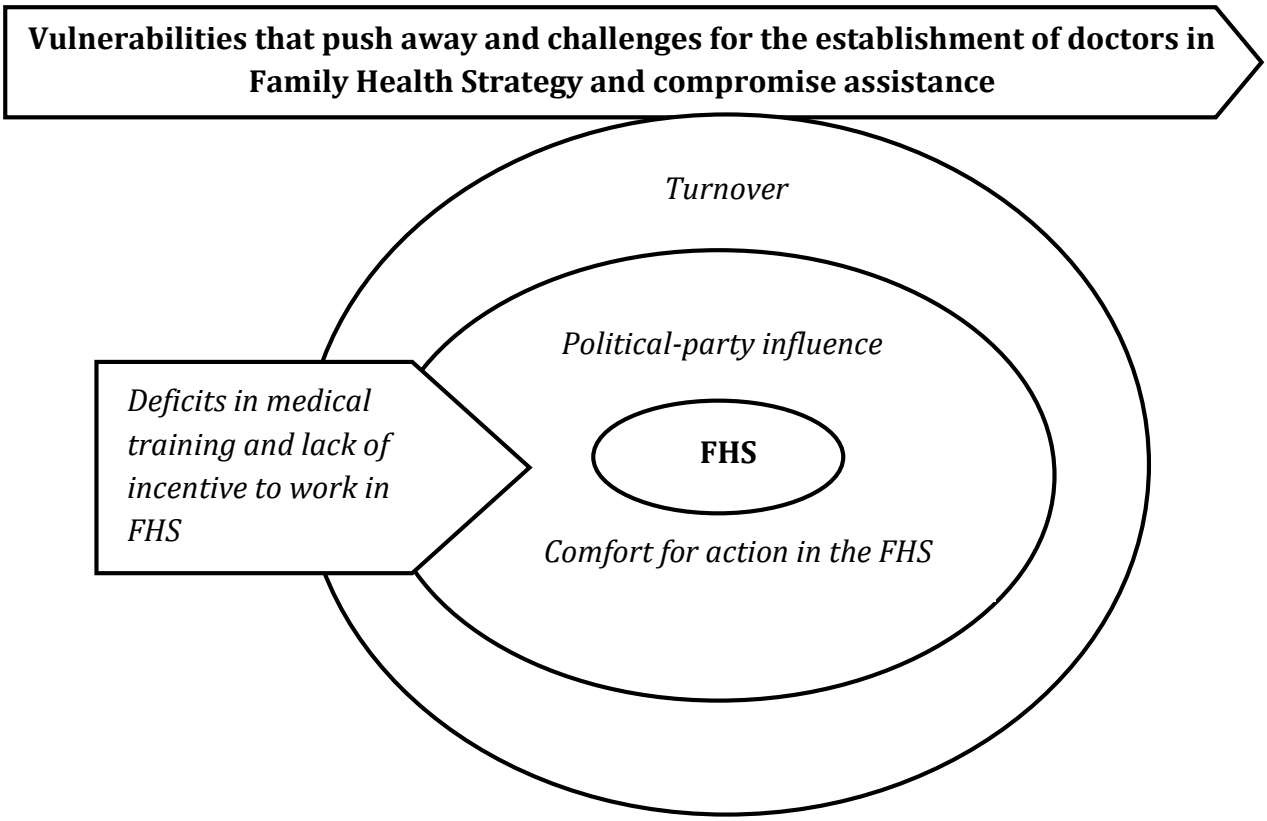
The theoretical sample of this study was composed of ten doctors, nine men and one woman. The youngest was 25 years old, the oldest 60 years old and the average age of the participants is 31.5. The doctors had provisional contracts with the municipalities. Hiring was direct, that is, without the intermediation of organizations, cooperatives such as Social Organizations (SO) or Civil Society Organizations of Public Interest (CSOPI).

The contracts lasted from six months to one year and were not guaranteed labor rights (vacation, Christmas bonus, and others). They were at the beginning (8 D) or the end of their career (1 D), only one mentioned that he is in the FHS as a career option, he was the only one with specialization in the area, but also another specialty in which he divides his time. The length of experience in the FHS ranged from six months to 13 years (1 D).

All of them had another job in addition to working at the FHS, only three lived in the municipality where they worked. The others lived in nearby cities, where they had some family ties or cities that had better options for the family (school, work and leisure). Of the ten, only two stated their intention to remain in the FHS. Seven said they intend to pursue another career and one still has doubts about the professional future.

The process of systematic analysis of the data allowed the construction of a theoretical interpretive model of the phenomenon of the study, entitled: *Vulnerabilities that push away and challenges for the establishment of doctors in Family Health Strategy and compromise assistance*. This model is represented by a diagram (Figure 1), supported by three categories, which are: a) *Deficits in medical training and lack of incentive to work in FHS*, representing conditions that compromise the doctor's establishment in FHS; b) *Political party influence and Comfort for action in the FHS*, which highlights actions and interactions that weaken the system; and c) *Turnover and losses in assistance*, pointing out the consequences of the deficit in the operationalization of the system

Figure 1. Theoretical model: *Vulnerabilities that push away and challenges for the establishment of doctors in Family Health Strategy and compromise assistance*. Interior of Bahia, 2016.



In the category '***Deficits in medical training and lack of incentive to work in FHS***', in general, participants describe medical training with syllabus that did not prepare them to meet the needs of the public health care system. For them, the training is fragmented, curative and directed to hospital specialties. They consider that the specialty 'family and community medicine' receives little prominence and is not sought ou because it is not considered prestigious, does not guarantee stability and the financial return is not very attractive. They also emphasize that the unpreparedness to act in primary care compromises assistance, making it have an immediate, curative and low resolution characteristic:

Speaking very sincerely to you, training today in the vast majority of medical courses was supposed to be training doctors to work in primary care, but it is not. [...] *How do they do it? They do the following: they don't know what it is - so they ask for an exam* [...] *doctors are being trained without autonomy, without absolute security, they are there to prescribe medications for the flu, for dengue, for throat infection, pain muscle and renew prescription of controlled medication, that's what I see.* (D4)

The people who go to college now end up building this culture of going back more to the healing part, I realize this, there are people there who think the FHS does not work, I think there is a certain incentive there in the Southeast to work more in the healing part . [...] *We realize that residencies still have vacancy in primary care, because there is this culture of going back to the tertiary part and because from the moment you make a specialty in another area, you have a way to perform your service in a broader and financial way maybe making up for what you earn in the PSF. If I do an area of orthopedics, I can assist in several segments, private public in more than one place... in primary care it is not possible, if I work here in the FHP, I have to fulfill that workload.* (D8)

Four doctors reported that they had training built on problem-based learning. However, they consider that the "new learning models" are not attractive, they emphasize that medical students and the population prefer the traditional biomedical model:

[...] *they went go my university or state universities and ended up leaving because they thought that that method would not be ideal, because they believed that that method would only train general practitioners or family health professionals.* (D1)

As much as we make a waiting room, groups and say that prevention is important [...] *the population still seeks us in the same way as before, medicalization of health.* (D5)

Respondents do not see the FHS as a promising career for the doctor and emphasize that the performance in primary care does not allow professional growth, does not add prestige, is devalued by the medical profession itself, by the population, by managers and is a target of prejudice. Emphasize the need to raise awareness about the role and importance of preventive activities and health education, which are underrated:

I'm sure it will be like this, when I arrive at a graduation meeting, 10 years old, there is a cardiologist, a neurologist, there is a pediatrician and you go there and say: - I did family health. The first thing they will think about you, is that you didn't want to study anymore, you just wanted to rest. The prejudice is huge. (D1)

I do not know if the manager does not want to invest in the area or if he does not want to see the benefits, just as many doctors do not want to see [...] *a good part of managers do not see preventive medicine as something productive in the long term.* (D2)

I think that the population lacks awareness of what the FHP is, it turns out that you work more as an emergency doctor than as the FHP [...] They don't have the habit of prevention [...] *they don't understand and it ends up that you lose one little of the FHP characteristic.* (D9)

In the category '***Political party influence and Comfort for action in the FHS***', the interviewees describe facilities that attract doctors to the FHS and recognize two specific moments in the lives of doctors when they choose to work in the FHS - the beginning and end of their careers. At the beginning of the career, the lack of experience and specialization do not represent an obstacle to entering the FHS. In addition, the "flexibility" of schedules allows you to reconcile other jobs, expanding sources of income and wages. With this it is possible to have financial conditions to plan the future elsewhere. The FHS becomes a "bridge" to the specialty in other areas of greater prestige or a way of entering the political career:

We end up seeing 'family health' as the beginning or the end. For a doctor who is just starting their career and needs to work and maybe it is the easiest way to enter the job market or that doctor who is already at the end of their career, who is finishing it, who no longer wants to be on duty, who thinks hospital routine is very intense [...] *FHS is even more peaceful.* (D1)

The perspective is to become health secretary, mayor, they want a political mechanism [...] *it is more political than a career itself. It would be a spectacular area, if there was a career path.* (D3)

For the participants, doctors who seek FHS at the end of their career want a "quiet place", they are professionals who have developed curative work throughout their careers and who will not develop preventive and health promotion actions:

Doctors go to the FHS to do what they have always done, health post, it also does not change your mind, no matter how much you try to make it change, it never changes. (D5)

In part, what we find is the following, that FHP is for those old, tired doctors, retiring, unfortunately it still is, it still is. (D6)

Doctors lament the negative impact of political influence on municipal health administration. On the other hand, they highlighted amenities that make it possible to "circumvent the system", such as flexible hours and the possibility of not meeting the workload. Doctors and managers make informal agreements, made to get access to work and compensate for the lack of structure, professional stability and wage gap. They are frustrated by the imposition of political interests by compromising assistance to the population:

The way we doctors and managers find to be able to circumvent this gap (salary) *a little is in relation to the workload. So, I don't do it at 40 hours a week.* (D4)

What discourages us a little is the fact that we work a lot like the SUS, we are constantly frustrated by the lack of equipment, often by the political influence that we have in the service, to go ahead, something like that... There is some interference external, so it also ends up bothering me. (D7)

Working directly with the municipality is complicated [...] *the mayor changes, the other mayor already has someone interested in that vacancy, so they will take you away.* (D1)

In the "***Turnover***" category, all doctors cite the short time spent in the FHS as an obstacle to achieving comprehensive medical practice and guaranteeing the quality of care. They point out that the frequent exchange of professionals affects the bond and the bond of trust between the professional and the population.

Turnover is driven by the fragility of employment contracts (which do not guarantee labor rights), political party interference and precarious working conditions. Doctors emphasize the need for a career path (which allows for stability, good salaries and the possibility of professional growth), investment in physical and material conditions and in continuing

education. Several difficulties related to the lack of structure to guarantee the operationalization of work have been described. They demand conditions for referral to assistance of medium and high complexity and regret the low resolution of the population's problems:

The main devaluation of those who want to work in public health is something that is called lack of connection. [...] *There is no career plan, there is no security* [...] *what I think discourages people is this lack of connection.* [...] *it is very bad, the doctor loses, the service and the population lose.* (D5)

I think the first thing, stability, job security, working conditions, both in the physical part, physical structuring and everything, you know that there is a municipality that is well structured, but there are others that you will attend in a rural area that you don't have a place to sit to attend [...]. (D8)

Here it is quite different from the theory. Especially in this unit that we are in, there is a lack of structure to function as a family health program [...] *we cannot follow up on the programs as required by the ordinance.* (D2)

DISCUSSION

The doctors' reports reveal that several aspects work together and contribute to turnover. The knowledge built allows to broaden the understanding about the weaknesses of the system that keep doctors away from the FHS and compromises longitudinality and quality of care.

The theoretical model developed reveals weaknesses that distance doctors from the FHS and compromise health care for the population. Doctors do not feel prepared and are unmotivated to work in primary care. Investments in teaching Family Medicine are unable to overcome cultural, economic and social barriers that encourage the hospital-centered and specialist model.

Although undergraduate medicine courses have included innovative methodologies, there is no integrative action of content, theory and practice in the teaching-learning process. Prevailing the traditional model centered on disciplines and little interaction with the services of the primary health care network[14].

Other research indicates that the curricular reformulations failed to keep up with the needs inherent to the expansion of PHC in SUS and point to the need for advancement in professional qualification, with the implementation of permanent education strategies[1,15-16] in addition to this, there is a historically constructed model in the valorization of medical specialties, in the curative practice and which has no tradition of developing an empathic profile for students in the FHS. Accordingly, medical specialties that focus on family health medicine receive little demand and do not add prestige.

The difficulties increase when considering the context of the region that housed this study, Southwest Bahia, which is a region with few attractions for doctors to settle. A study on medical turnover in Brazil highlights that it varies according to geopolitical characteristics, as it is higher in smaller municipalities, with up to one hundred thousand inhabitants, and with low economic indicators. In these municipalities, opportunities for personal and professional growth are limited. The higher turnover in the Southeast and South regions, may be the result of the more competitive labor market and incentive to stay[17].

The poor distribution and shortage of doctors, especially in remote areas and with few attractions, are recognized internationally as a barrier to the efficient development of health systems. The theme motivates national and international cooperation efforts and strategies to improve training, establish doctors and improve the quality and resolvability of PHC[7-8,18].

Previously, the Mais Médicos Program (MMP), influenced the reformulation of the curricula of medical courses, with an increase in the workload in PHC, financial incentives and education for the performance and establishment of professionals in the SUS. These programs represented advances that had an impact on the increase of jobs and the expansion of PHC coverage. However, in practice, the challenges persist and represent obstacles for SUS. CSOPI reports draw attention to the need for measures to reduce inequalities in access and ensure the quality of public health care services[19].

Devaluation before professional colleagues, the population and managers contributes to the demotivation of doctors with work in PHC. According to them, there is prejudice and lack of prestige. Among strategies pointed out by the participants as important for valuing work is health education with a focus on prevention strategies, creation of a career plan and conditions that guarantee better operationalization of services and resolution of problems.

Job satisfaction in PHC is related to several aspects, among them good working conditions, fair remuneration, job stability, support for the different levels of complexity of the health system[16], liking what you do, user satisfaction with the assistance received, team cooperation, link between professionals and users[20]. On the other hand, dissatisfactions are influenced by inadequate physical structure, lack of material resources, wage deficit, lack of appreciation of work, management problems, excessive working hours, lack of team qualification and deficiency in work organization, overload of work excess demand and bureaucracy[21]. Doctors also point out the devaluation before colleagues and public opinion, the high number of consultations and the limitation of autonomy[22].

A qualitative approach survey carried out with 51 doctors from five regions of Brazil, in order to learn about attraction and retention factors in remote areas, highlighted the salary as the most mentioned, but draws attention to the need to combine financial and non-financial incentives. Among the non-financial ones are flexibility and slack at work, the infrastructure of the health unit, training/updating opportunities and leisure options in the municipality[23].

The flexibilization of the workload was described, by doctors, as a result of political agreements. The Ministry of Health has known for some time the practice of easing and reducing the workload of doctors in the FHS and has launched measures for its legal recognition[17]. Flexibilization is a claim by doctors and municipal secretaries, justified by the difficulty of reconciling other bonds, expanding income, and of obtaining provision and fixing professionals.

In an analysis of the incentive actions for work in municipalities with difficulty in attracting or retaining doctors, it is evident that flexibilization can have an impact on the fragmentation of work, discontinuity of care and fragility of bonds (between team members and between the team and the population)[24]. The losses can be increased with the reformulation of the *Política Nacional de Cuidados Primários* - PNAB (National Policy of Primary Care) of 2017, which allows, the relativization of universal coverage and adopts measures that can contribute to greater flexibility of the doctors' hours, fragmentation of the work process and less bond between the health team and the population[2, 25-26].

In addition to making the workload more flexible, the interviewees described how municipal managers use political-party influence and personal interests to distribute positions, boosting the turnover and discontinuity of assistance. These practices are not new and are certainly not restricted to the municipality that housed this research. They represent a serious ethical and moral deviation, compromise the quality of care and do not consider the principles of universality, integrality and equity of SUS.

A study on the provision and fixation of FHS doctors in the state of Bahia, portrays the creation of an intermunicipal career as a solution through the *Fundação Estatal da Saúde da Família* - FESF (State Foundation for Family Health). However, the proposal was not well accepted by the municipalities[27]. The high values of the contracts offered by the foundation do not match the budget made available by the three instances (federal, state and municipal) to finance the FHS.

In financial terms, it is more advantageous for the municipalities to adhere to the PMB. However, despite guaranteeing the provision of medical services, the law does not solve the problem of labor rights. This fact perpetuates the FHS as a temporary job for doctors, as mentioned by the interviewees. The measures for fixing professionals in the FHS must be planned in the long term, not only with an emergency and transitory nature. The consequences of the measures presented by the current PMB law go against the principles of PHC and

configure paths for a possible commercialization of one of the most relevant and public interest services of the SUS network[11].

In addition, changes in funding further aggravate the situation for PHC resources. The progressive reduction in funding imposed by the health spending ceiling may cause limits on the universality of access to services[28]. In relation to medical work, budget restrictions and underfunding aggravate the maintenance of service expenses, especially with regard to the costs of labor charges for professionals.

In addition to the crisis and adversities that have occurred in PHC in recent years, there is still another worrying factor. The Ministry of Health expressed support for the creation of low coverage plans that will start offering family health services also in supplementary health. This new, more flexible, private sector job undermines efforts made with MMP to provide, secure and reduce the shortage of doctors in remote regions. The new plans will be another precarious alternative. It represents alternative jobs that can attract both workers and the population. However, it can further weaken the bonds that the FHS needs[29].

The scenario that is being observed refers to an uncertain future. The progress made in PHC since the creation of the FHS is seriously threatened. The new legal arrangements open loopholes for the commercialization of the medical service, which resumes the format of the selectist and curative PHC. Previously associated with the idea of a “poor program for the poor”. The lack of professionals and/or lack of links with the program and with the population compromises work with an emphasis on family and community, focused on comprehensive care.

In view of all the aforementioned weaknesses, it must be considered that promoting the fixation of the doctor in the FHS is a great challenge. How to change the vision of the professional who seeks a place of "*easy job*", with conditions that allow "to circumvent the system"? How to combat political party influence? How to avoid turnover due to poor working conditions? How to solve the serious problem of precarious employment relationships? How can PHC become the organizer of the Health Care Network and guarantee the population's right to health?

It is impossible to think of a magic formula for so many weaknesses. The national policy must be structured considering the need for services and the population, who are entitled to receive free and quality assistance. It is essential to invest in the training of managers, involving locoregional services and, above all, to think about training and professional development that takes into account local health specificities, which in addition to the hegemonic medical model invests in new ways of producing care and promoting life[30].

CONCLUSION

This study reveals the urgency of reformulations in medical education, in addition to policies that ensure effective and efficient financing and management that addresses PHC problems in SUS. The human right to quality health is threatened, ethical aspects are neglected and it is shocking to realize how self-interest is valued at the expense of collective interest and good health care practices.

There is also a need to formulate a career plan that guarantees working conditions, fair remuneration, stability, labor rights and possibilities for professional advancement; availability of resources (financial, physical, operational); ethical strategies (and not political arrangements) and measures that allow health professionals to stay in poorly developed regions.

The data reveal gaps between the theory and practice of working in PHC. They report for the search for solutions to serious issues, which in some cases have repercussions as a complaint, and deeply compromise public health. In summary, the solution to the problems identified depends on a comprehensive state policy, with appropriate financing, qualified

management, planning, monitoring and evaluation that must be shared between all levels (municipal, state and federal).

It is not possible to have an effective health care system without a supply of qualified, motivated and sufficient professionals. The workforce is decisive for changing the care model, in order to implement SUS precepts, guaranteeing broad access to health services.

It is worth mentioning that the study presents as a limitation the sampling restricted to a region of the state of Bahia. New studies should be carried out in other regions of the state and also in the country, allowing an analysis of different health territories to support the solutions and challenges in the work of the FHS. Despite this, this picture refers to the possible reality of many regions of the country, which need to be further explored for the maintenance of doctors in the territories.

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Vera Gardênia Alves Viana contributed to the study design, data collection and analysis, writing and review. **Maysa Ferreira Martins Ribeiro** participated in the study design, writing and review.

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