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Between a rock and a hard place: dilemmas in human resource management in primary care

Entre a cruz e a espada: dilemas na gestão de recursos humanos da atenção primária

Entre la cruz y la espada: dilemas en la gestión de los recursos humanos de atención primaria

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Abstract:
Objective: to investigate the challenges faced in human resource management in primary health care. **Methods:** a descriptive, exploratory, and qualitative study conducted in 2019. Semi-structured interviews were conducted with primary care coordinators from municipalities in the interior of the state of Piauí, Brazil. Thematic analysis was performed using MAXQDA software. **Results:** 28 managers participated, and 52 speech segments were identified, coded into eight subcategories, which formed the two thematic categories: *Professional profile in conflict with the needs of primary health care* and *Tensions over pay and working hours*, with emphasis on the dilemma of making professionals' working hours more flexible, their motivations, and impacts. **Conclusion:** issues related to human resource management, especially remuneration and working hours, drive managers to make difficult decisions in the search for solutions for the operational maintenance of primary care, sometimes confronting regulations and ethical issues.
Keywords: Personnel Management; Primary Health Care; Decision Making.

Resumo:
Objetivo: investigar os desafios enfrentados na gestão de recursos humanos da atenção primária à saúde. **Método:** estudo descritivo, exploratório e de abordagem qualitativa, realizada em 2019. Utilizou-se entrevistas semiestruturadas com coordenadores de atenção primária de municípios do interior do Piauí. A análise temática foi realizada com auxílio do software MAXQDA. **Resultados:** participaram 28 gestores, e foram identificados 52 segmentos de falas, codificados em oito subcategorias, que conformaram as duas categorias temáticas: *Perfil profissional desalinhado com as necessidades da atenção primária* e *Tensões sobre remuneração e jornada de trabalho*, com destaque para o foco no dilema da flexibilização da jornada de trabalho dos profissionais, suas motivações e impactos. **Conclusão:** questões relacionadas ao gerenciamento de recursos humanos e em especial à remuneração e jornada de trabalho impulsionam gestores à difíceis tomadas de decisão na busca de soluções para a manutenção operacional da atenção primária, afrontando por vezes, normativas e questões éticas.
Palavras-chave: Gestão de Recursos Humanos; Atenção Primária à Saúde; Tomada de Decisões.

Resúmen:
Objetivo: Investigar los retos a los que se enfrenta la gestión de los recursos humanos en la atención primaria de salud. **Método:** Estudio descriptivo, exploratorio, con enfoque cualitativo, realizado en 2019. Se utilizaron entrevistas semiestructuradas con coordinadores de atención primaria de municipios del interior de Piauí, Brasil. El análisis temático se realizó con el programa MAXQDA. **Resultados:** Participaron 28 gestores y se identificaron 52 segmentos de discurso, codificados en ocho subcategorías, que formaron las dos categorías temáticas: *Perfil profesional no alineado con las necesidades de la atención primaria* y *Tensiones sobre la remuneración y la jornada laboral,* con especial atención al dilema del horario flexible para los profesionales, sus motivaciones e impactos. **Conclusión:** Las cuestiones relacionadas con la gestión de los recursos humanos, especialmente la retribución y la jornada laboral, llevan a los gestores a tomar decisiones difíciles en la búsqueda de soluciones para mantener operativa la atención primaria, a veces enfrentándose a normativas y cuestiones éticas.
Palabras-clave: Administración de Personal; Atención Primaria de Salud; Toma de Decisiones.

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INTRODUCTION

In the complex realm of public health management, managers often find themselves in challenging decision-making scenarios, in which they are placed 'between a rock and a hard place'. This expression, originating from Homer's *The Odyssey*, illustrates the difficulty of choosing between two equally undesirable options, akin to navigating between the monster Scylla (the rock) and Charybdis (the hard place). Managers frequently encounter such dilemmas, where any choice made could have adverse consequences.

One of the key challenges faces by managers in the Unified Health System (*Sistema Único de Saúde* - SUS) involves the careful allocation of limited resources while balancing the supply and demand for services. These challenges are even more pronounced in municipalities with scarce resources, particularly in remote areas with low socioeconomic development, which focus primarily on providing primary health care (PHC) services[1].

PHC acts as the foundational core of the health care network at the municipal level, primarily through the Family Health Strategy (*Estratégia Saúde da Família* - ESF), delivered by multidisciplinary teams. This strategy emphasizes preventive actions and health promotion while maintaining essential care services[2].

As municipalities grow and socioeconomic conditions increase, PHC coverage often diminishes. On the other hand, smaller municipalities with worse socioeconomic indicators and less health structure have shown greater process efficiency, despite being less effective in achieving results[3,4].

Among the Brazilian states, Piauí stands out for its high ESF coverage, reaching an impressive rate of 90% in 2019, an increase of over 10% since 2013, while Brazil reached only 62% in the same year[5]. The state maintained its leadership position in 2022, with more than 95% coverage[6]. Despite this high coverage, Piauí presented an average result in the evaluation of user satisfaction through the Net Promoter Score (NPS), a crucial indicator of user satisfaction with the services provided, verified in the Brazilian National Household Sample Survey (*Pesquisa Nacional por Amostras de Domicílio* - PNAD)[7].

While some states have achieves NPS scores above 6.0, Piauí, along with states such as Rondônia, Amazonas, Goiás, and Maranhão, presented lower scores, showing possible service gaps. Time series analyses of strategic PHC indicators also reveal concerning results, such as high infant mortality rate[8], and hospitalizations of children[9] or the general population[10] for conditions sensitive to PHC.

This scenario brings the need for investments and specific actions to improve both the quality and effectiveness of PHC in the state, since mere numerical expansion is insufficient for

ensuring effective service delivery. This reality poses a direct challenge to managers, whose role is crucial in developing and implementing strategies to improve services. In the context of local management, improving services is imperative, requiring managers to have strategic skills and make careful decisions to face unique challenges in different scenarios intertwined by different interests. Thus, this study aims to explore the challenges faced in human resource management in primary health care.

METHODS

This is a descriptive, exploratory, and qualitative study focusing on the challenges experienced in management within primary care in municipalities in the interior of the state of Piauí. This is an excerpt from a study conducted with health managers, including municipal secretaries and primary care coordinators, in a microregion of Piauí, Brazil, on the implementation of a performance evaluation program in PHC.

Interviews were conducted with primary care coordinators to understanding the challenges related to human resources. The managers considered for the study are primarily mid-level management, encompassing administrative, managerial, and technical-assistance aspects.

To conduct the interviews, the participants were contacted in advance via telephone or email. After giving their consent, meetings were arranged based on their availability and location preference. The interviews took place in 2019, and were recorded with the participants' permission and, then, transcribed in full and anonymized, forming the corpus of analysis of the research.

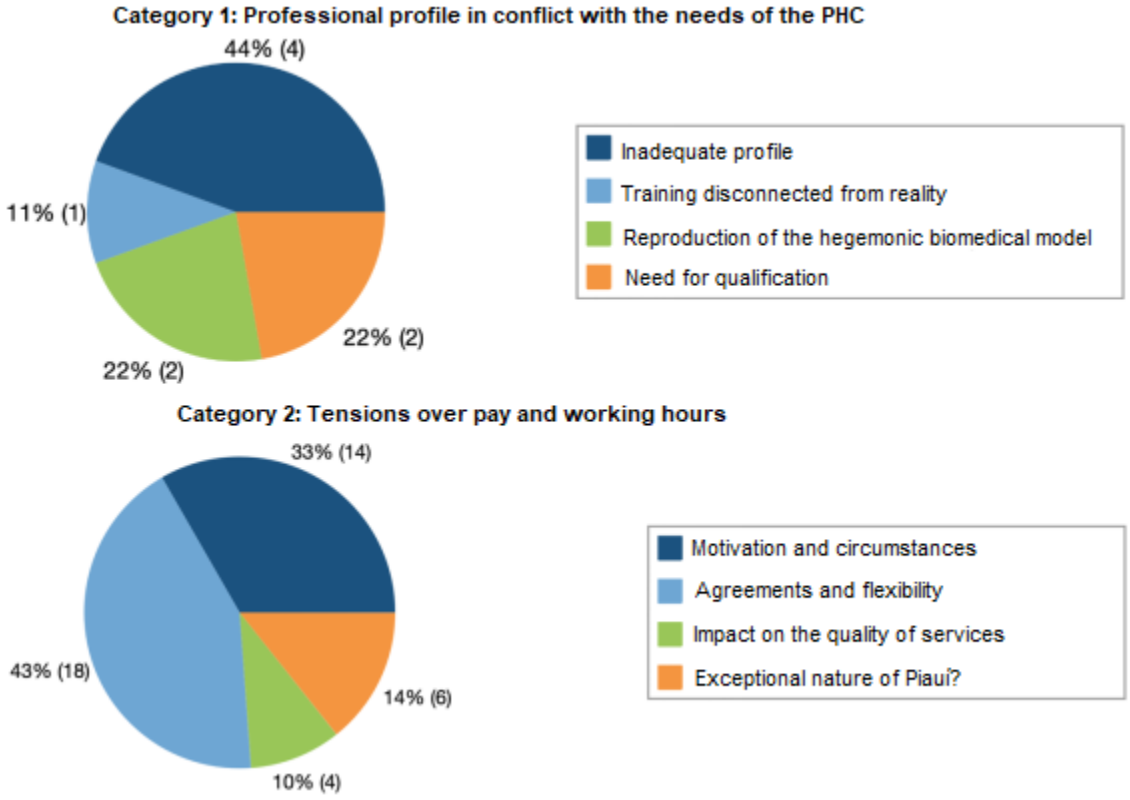
The thematic qualitative analysis was conducted using MAXQDA 2024, following the method proposed by Braun and Clarke[11,12]. This process began with familiriazing oneself with the interview content to identify primary ideas, followed by the creation of preliminary codes/categories. A more detailed coding was then performed to explore patterns and relationships between the codes. Emerging themes were identified through grouping codes and reflecting significant patterns in the data. After a thorough review and refinement, the results were described and analyzed according to thematic categories, with interpretation based on existing literature. The research project that gave rise to this study was approved by the Ethics Committee of the Universidade Federal do Piauí, Brazil, under opinion No. 2,746,788.

RESULTS

A total of twenty-eight interviews were analyzed, resulting in the identification of 52 segments of the coordinators' statements relevant to the study's theme. These segments were coded into eight subcategories and organized into two main thematic categories.

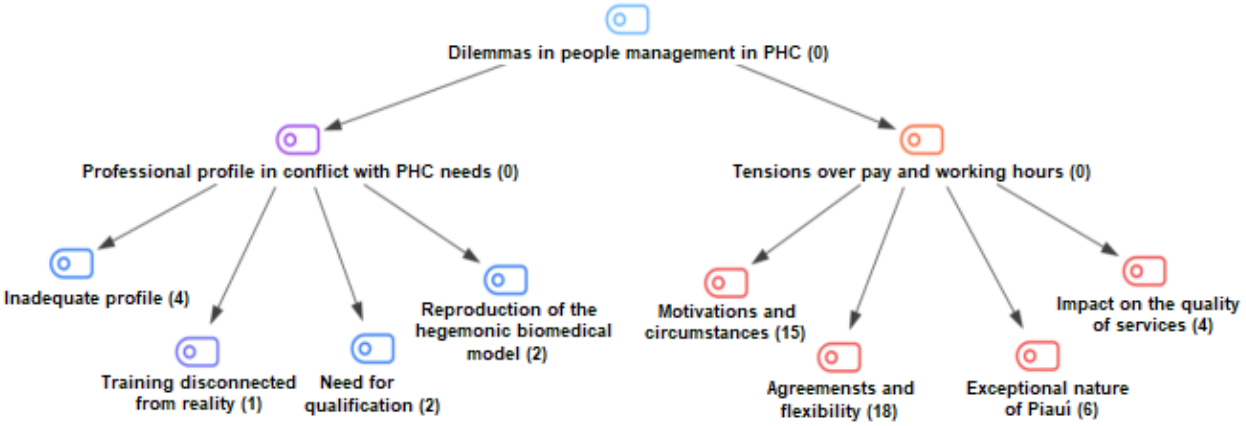
The distribution of the segments across subcategories was uneven. The second thematic category, which focused on issues such as remuneration and working hours, accounted for 82% of the segments. Within this category, the subcategories of motivations and circunstances (35%) and flexibility agreements (45%) were particularly prominent, as shown in Figure 1.

Figure 1. Segments by subcategories and thematic categories. Picos/Piauí, Brazil, 2024.



The thematic analysis of this study culminated in the structure presented in Figure 2.

Figure 2. Thematic categories and subcategories coded in the analysis. Picos/Piauí, Brazil, 2024.



The analysis subcategories are briefly described, accompanied by the segments that best represent them:

Category 1: *Professional profile in conflict with PHC needs* (18%)

Inadequate profile: challenges related to the profile of professionals working in PHC, which result in difficulties in performing activities:

One of the biggest challenges is the issue of the profile of the professionals, many do not have the profile to work in primary care and sometimes this makes it a little difficult to perform primary care activities, to provide assistance... [C8]

The professionals do not want to, do not contribute, they complain a lot, they do not want to, do not contribute to our work. [C12]

Training disconnected from reality: a gap between academic training and the practical reality of PHC services:

And I think that what is lacking at the University itself, when training professionals, it must bring them come back to reality. There are many things that Nurses, when they arrive at Primary Care, have never seen at University, so they are not prepared. [C1]

Reproduction of the hegemonic biomedical model: challenge of incorporating a comprehensive understanding of PHC:

The main challenge is to make professionals understand what the real role of primary care is. Because until now [...] *the idea that only consultations, only the care part, remains, and I see that it leaves a lot to be desired in the preventive part, it works more on the healing care and the preventive part leaves a lot to be desired.* [C11]

The professional needs to understand that primary care is not just that kind of service, right?! Whether it's punctual or according to a schedule that's already set in stone, right?! Primary care services are much broader. [C18]

Needs for qualification: portrays continuing education as a tool to overcome challenges in improving work processes:

We do need to work hard on continuing education. Because there are several situations that professionals don't know how to handle, and they come to the coordination to conduct and guide. [C11]

We carry out continuing education activities, but the professionals don't go, they don't recognize the importance of always studying, updating themselves, especially doctors. [C1]

Category 2: *Tensions of pay and working hours* (82%)

Motivations and circumstances: reflects salary pressures, shortage of qualified professionals and additional costs associated with full compliance with the workload in PHC:

Higher education professionals, who work fewer hours, have other jobs, two or three jobs, and then they split up so they don't miss work either here or there [...] *but if the pay was good, they wouldn't need to have other jobs, it would be possible to work on just one.* [C3]

The big difficulty in working with medical professionals is that they are professionals we are still short of and we don't have a professional who works 40 hours. [C6]

If they had a much higher salary, it would be easier for us to find professionals to work 40 hours, morning and afternoon. [C14]

We play this game because either we have a doctor on the team for at least three days or we don't have a doctor at all, because we can't guarantee a salary that the Mais Médicos program pays, right?! [C18]

Unfortunately, we have to be flexible, especially because we are in the middle of a hotbed of municipalities offering better benefits. [C24]

As electronic timekeeping is not yet a reality for all municipalities, they have the option of going to a municipality that does not have a continuous schedule. What was agreed upon was a new meeting with the public prosecutor's office and they said they could work 3 days, as long as they worked the hours. [C23]

It is not in the manager's best interest because if they are there 40 hours, they spend more on supplies, more printing, more medication, electricity, so it generates all the costs and the professionals will charge more, so it is kind of a constraint [...] *and the managers are very concerned with this and it ends up becoming an agreement.* [C4]

Agreements and flexibility: points out the models of agreements related to non-compliance with full-time working hours:

They work full-time. It should be 40 hours, but they are working like this: the nurse and dentist work three days a week, the doctor works two or three shifts, sometimes a day and a half. [C11]

They don't work 40 hours in care, but they do preventive measures, they work on educational aspects. [...] *when they travel to rural areas, we let them work full-time*. [C14]

They work six shifts and are divided into different shifts during the week [Monday, Tuesday and Wednesday], *except for one shift when they go provide care in rural areas and another shift when they return to the city where they finish their workload here. The other doctor who comes on Thursday and Friday works a shift in rural areas and returns to provide support to the people in the city.* [C28]

Since they don't follow the ministry's 40-hour standard, we end up, the management ends up arranging some days to work, two and a half days, three days. [C22]

We are working with a continuous schedule from Monday to Thursday. The electronic timekeeping was set up and we are even required by the Federal Public Ministry, but this suggestion was made to work continuous hours and we justify it on Fridays with training, mainly online. [C23]

What we made here was an agreement with the manager, so that we would only work three days a week and the other two days would be used to resolve this bureaucratic issue. [C27]

Impact on the quality of services: portrays losses in the efficiency of services and in the continuity and integrality of practices:

It's a real hassle, because they can't handle everything and a lot of things end up being left for the coordination team to deal with, whether it's an administrative issue in the unit itself or a healthcare problem, because a lot of patients still come to me for care. [C11]

The professional can't work the whole week, so often, for example, a childcare activity that should be carried out every week can't be followed in that sequence because they already have other activities to work on, and since there are only a few days of work, some of them end up being lacking. [C17]

Exceptional nature of Piauí? reveals a widespread culture among health professionals that appears to affect the entire state, manifested by widespread non-compliance with working hours in PHC:

I wonder whether it works for other states, why it doesn't work only in Piauí [...] *because the issue of forty hours is really a challenge for Piauí. In other states, forty hours is already stipulated, so why was there such a struggle in Piauí?* [C9]

You can see, excluding the doctors from the Mais Médicos program, you won't find any other doctors working 4 days in a municipality. [C13]

Even though they are permanent, there is the issue of the culture of professionals, such as doctors, nurses and dentists, in terms of not complying with the forty-hour workload. [C19]

DISCUSSION

Human resource management in primary care plays a vital role in the effectiveness of health services. Analyzing the discourses of managers reveal two issues: first, the mismatch between the professional profiles of staff and the demands of primary care, and second, concerns related to remuneration and the flexibility of working hours. These challenges, while notable in Piauí, are not unique to the state. They reflect broader obstacles faced by public health managers at the municipal level across Brazil, highlighting the pressing need to enhance employment relationships, implement robust career development plans, and promote continuous professional training and qualification.

Professional profile in conflict with needs of PHC

The evolution of primary health care (PHC) in Brazil has been remarkable in recent years, but challenges persist, particularly in aligning professionals to meet service goals. Key issues include lack of preparation of professionals to deal with the complexity of services and the disconnect between their academic training and the practical reality of PHC.

Health professionals, the pillars of PHC, often come with a professional profile shaped by outdated training models that focus on curative approaches and the role of the physician.

This misalignment hinders their ability to address the comprehensive and integrative demands of PHC. Coordinators have highlighted that this misalignment obstructs activity performance and team integration (C8, C12) and is further exacerbated by the dominance of the hegemonic biomedical model, which limits the comprehensive understanding of PHC and its performance, which limits the effectiveness of PHC in promoting health (C11, C18). Although the Family Health Strategy (*Estratégia Saúde da Família* - ESF) was once an effective solution for the SUS, it now faces challenges in breaking away from the traditional biomedical mode. This shift was more efficient in the past, but recent changes indicate obstacles in fully realizing the reorientation of the health model[14].

These difficulties are aggravated by the changes in the National Primary Care Policy, which have weakened the community and preventive focus of the ESF[15]. The presence of professionals with profiles that diverge from the needs of PHC contributes to the persistence of the biomedical model, with many prioritizing disease treatment over preventive measures. This inclination stems from both professional training and external pressures influencing contemporary health practices, which must be addressed by health managers. The diverse profiles of PHC professionals reflect the varying needs of their work environments, making effective service provision challenging, especially in small municipalities and remote rural locations. The struggle of attract and retain qualified professionals in remote areas is not only due to the low supply of professionals in the market, more specifically doctors, but is also exacerbated by the lack of adequate infrastructure and precarious working conditions[16].

The lack of engagement and motivation among professionals can undermine the quality of services, work environment, and team effectiveness, leading to reduced collaboration. PHC is often viewed as having low intentionality for professional practice[17]. Some studies[18,19] have identified factors that influence professional retention in primary care, including personal like empathy and the opportunity for continuous service improvement. Furthermore, adequate infrastructure, organizational climate, and competitive salaries are crucial for retaining professionals and achieving significant improvements in healthcare and management.

Regarding issues discrepancies with the SUS reality (C1), proposals for curricular changes in undergraduate programs, as noted by Machado[20], have been encouraged by the government to align the training of professionals with the needs of PHC, prioritizing a more holistic approach, centered on the needs of the patient and carried out using the SUS itself as a practice setting. However, these changes only have an impact in the long term.

Addressing the culture of curative and biomedical assistance in PHC requires a joint effort by healthcare professionals and managers on multiple fronts. Continuing education

programs are essential for updating professionals' knowledge and skills[20], fostering a shift towards more preventive and patient-centered care that considers social determinants of health and individual patient context.

Throughout the SUS's implementation, there have been both advances and setbacks regarding Work and Education Management Policies in Health. These range from periods of neglect and devaluation of health workers, with increasing precarious work, to the implementation of policies and programs aimed at improving PHC worker provision, retention, and qualification, such as the National Policy for Continuing Education in Health; AprenderSUS; Projeto Vivências e Estágios na Realidade do SUS (VER-SUS); Pró-Saúde; PET Saúde; Telessaúde; UNASUS, PROVABand Mais Médicos[16].

Current efforts to reactivate and expand specialization courses, residencies, master's and professional doctorates through networks like PROFSAÚDE and RENASF are aimed at advancing professional development in family health[16]. While these initiatives have been effective in mitigating shortages and improving the distribution of doctors in PHC, they have not fully resolved the ossue.

Significant work remains to ensure a trained and engaged workforce capable of addressing PHC challenges and promoting population health and well-being[22]. This involves local managers effectively mobilizing financial, technical, and human resources in alignment with SUS and PHC principles. A study[23] indicates that health secretaries face substantial challenges in managing municipal health departments due to resistance to change and lack of commitment from health professionals. The reluctance to adopt new behaviors and engage in training (C7) underscores the need for a more comprehensive approach to human resources management in PHC, fostering an organizational culture that values ongoing education and evidence-based practices. This requires enhancing the skills and capabilities of both health professionals and managers to address complex, multifaceted issues such as professional demotivation.

Tensions over pay and working hours

The wage gap in primary care significantly impacts the relationship between managers and workers, particularly as they navigate the challenges of low financial and human resources. uman resource costs in primary care often account for up to 90% of the total service costs, with doctors' salaries being a major component[24].

This financial burden is exacerbated by the practice of professionals taking additional jobs to compensate for low salaries, as mentioned in the statements [C3]. Managers face the

dilemma of needing to offer more attractive salaries to retain full-time professionals while also grappling with a limited supply of medical professionals willing to work in PHC.

Financial constraints, coupled with limited human resources and geographical challenges, compel managers to adopt strategies to address professional dissatisfaction. In this context, the statements point to flexibility in working hours by professionals as one of the strategies commonly employed, linked to a culture already established in condensed or on-demand services.

Given the scarcity of human resources, financial limitations and the varied demands of the communities served, managers become hostages of the situation. The choice often comes down to making professionals' working hours more flexible or facing the lack of professionals in sufficient numbers to ensure minimally adequate service provision. In this context, flexibility becomes not only an option, but a necessary measure to ensure the continued operation of health services offered to the population.

In PHC, managers and health professionals have diverse backgrounds and training, reflecting a wide range of experiences. Exploring their trajectories involves understanding the values that guide their lives, revealing motivations and perspectives influenced by individual factors and broader social contexts, such as the structure of health services in the community[25].

The shortage of professionals in certain regions, combined with the need to travel between poorly located health units, underscores the importance of flexible working hours. Many doctors are willing to work in PHC, but are deterred by the demands of a full-time schedule and distant locations[26].

Thus, flexible working hours emerge as a strategic response to the complexities of the health system and ensure the minimum supply of primary care services, in an approach that is sensitive to the needs of professionals and communities; an adaptive response to the unique demands of the local reality.

The managers' decision encompass more than just technical issues, as they are influenced both by internal pressures from workers and external political and social demands The population expects managers to ensure that Basic Health Units are staffed by professionals, and the political implications of retaining a manager in their role must not be overlooked, given the position’s discretionary nature. As one manager (C28) pointed out, the absence of family health professionals on certain days necessitates both technical and possibly creative solutions to ensure community care. Strategies such as continuous schedules and reduced working days are adopted, as illustrated in the statements, where professionals concentrate their work on a few days of the week. Although these arrangements are not formally established, they are based

on the availability of medical professionals to work in basic units, focusing care into two or three days a week to allow for work in other municipalities or services, particularly in areas far from large centers where doctor availability remain low.

Despite an increase in medical courses and professional residency programs, the regional distribution of doctors is still very uneven, highlighted by the lack of provision of PHC in the most remote locations[27]. It is important to emphasize that, even in municipalities with enough health teams, their distribution throughout the territory may favor urban or nearby areas over rural and remote ones.

However, the agreements extends beyond doctors to other higher education professions, such as nurses and dentists, often due to demands for equitable treatment across professions. This situation can lead to tensions regarding remuneration, work conditions, and benefits, as professionals across these categories work three-day shifts or continuous schedules.

Wage equity is also a critical factor in these negotiations. Disparities in remuneration between doctors, employees, contractors or those linked to the Mais Médicos program (C18), as well as between these and other professional categories, impact decisions about working hours. This disparity can foster cultural resistance, as noted by the coordinators (C9, C13, C19), who highlight the persistence of a deep-rooted culture of reduced working hours.

Flexible working hours can generate imbalances in work distribution, leading to some professionals shouldering a heavier workload than others. This can lead to feelings of injustice and resentment within the team, undermining team collaboration and cohesion, which naturally affects the well-being of professionals and consequently the quality of services provided.

Some statements attempt to justify the absence of employees on certain days and shifts by citing their engagement in training or bureaucratic tasks. While these activities are part of the primary care work process, they are sometimes used to rationalize non-compliance with service workloads, either to meet control body demands or to support managerial decisions favoring workers, given low pay and limited service days.

These agreements often lead to increased workload during working hours, as employees must handle both accumulated demand and bureaucratic tasks, which are integral to daily service

A recent study on doctors in remote rural municipalities identified the presence of work schedule agreements related to spontaneous demands[28]. However, it is important to

distinguish between flexible working hours and non-compliance with the recommended or legally established work hours outlined in employment contracts.

The decision to implement flexible working hours contradicts institutional regulations that guide family health services and the professionals' own employment contracts, which require a minimum work week of 40 hours.

The latest update of the National Primary Care Policy (*Política Nacional de Atenção Básica* - PNAB)[2] allows for flexible working hours under two conditions: the possibility of using working hours for professional qualification and continuing education, and the option for medical professionals to work shorter hours of 20 and 30 hours, increasing the required number of team members.

Nonetheless, the study reveals that these exceptions are sometimes used to support agreements of a different nature, driven either by the flexibility granted to medical professionals or by pressures to reduce working hours due to outdated salaries or poor working conditions.

PNAB[2] also outlines penalties for non-compliance with primary care and family health guidelines by teams and municipalities. The text of the policy reinforces that, in the event of irregularities being found, the incentive. It emphasizes that irregularities may lead to the suspension of incentive resources, further impacting managers' ability to pay salaries and maintain services, especially in small municipalities heavily reliant on federal funds.

While flexible working hours represent an attempt to balance complex demands and ensure minimum efficiency of health services amidst funding constraints of the SUS itself, it is crucial to consider the ethical and legal implications and their impact on care quality. Flexible working hours, compensation for travel and continuous working hours can increase access to PHC services. However, these strategies must be be formalized in the working condition ti maintain their intended purposes[28].

Given the constant increase in service demands, non-compliance with workload requirements can lead to professional overload. With the increase in demand and the condensed organization of care, professionals who often already work in several locations, without adequate time to rest, quickly reach exhaustion. This overload can result in an even less satisfactory experience for users, with possible negative impacts on the effectiveness of treatments or even on the resolution of demands.

However, the statements suggest that flexible working arrangements have become culturally established in municipalities across the state. This cultural shift perpetuates itself,

seemingly supported by competent authorities due to the complexity of issues and difficulties in resolution.

In addition to local particularities, health managers are faced with the requirement to comply with established regulations, including the PNAB[2] guidelines, which recommend a 40-hour work week for PHC professionals. This legal demand is added to the need to justify the practices adopted, especially in light of the implementation of electronic timekeeping, as highlighted in some statements (C22, C23), adding an additional layer of complexity to the management of work schedules.

What drives the spread of a culture of non-compliance? What ethical issues arise? Who, through action, omission, or collusion, maintains the status quo? We are not talking about a new problem, but about a culture that perpetuates itself even with advances in the availability of human resources, increased financial resources and reorganization of public policies. The inefficiency of health services is high in several states, and there is evidence that corruption has an inverse relationship with the quality of management[29].

This study presented the difficult situation experienced in the context of work management in primary care by managers who find themselves in the difficult position of complying with the obligation to monitor and control compliance with the working hours of health professionals and meet the demands of the control bodies that point to the legislation or succumbing to pressures from both professionals and the population to guarantee service, even if minimal.

Thus, managers are caught between the rock of putting themselves at the mercy of punishments or even committing acts of administrative impropriety, whether due to agreements made or the lack thereof, and the hard place of pressure from the population, which demands quality service and operation, and from professionals who seek better working conditions and remuneration.

CONCLUSION

The analysis uncovers a series of challenges in managing people in PHC, which directly affects the quality and effectiveness of services provided to the population. Key issues include the inadequacy of the professionals' profiles, gaps between academic and practical training, and the shortage of qualified professionals. These challenges necessitate attention and action from managers and other health system stakeholders. Additionally, tensions related to remuneration and working hours highlight the need for public policies that recognize and support work in

PHC, ensuring suitable conditions for professional practice and maintaining the quality of services.

The challenges identified in people management reveal constant concerns related to the shortage of qualified human resources, inadequate profiles of professionals, the need for training, and a lack of motivation. The situation of non-compliance with working hours by higher-level professionals in PHC appears to be a widespread culture in the state's municipalities, which deserves further exploration and observance, both in order to ensure real compliance with regulations in favor of the adequate functioning of services and qualified provision of primary health care, and in order to deepen the debate on specific and contextualized approaches to address the regional challenges faced by SUS managers and workers.

Despite advances in recent decades in the areas of work management and health education, aspects related to the dilemmas experienced by managers in human resource management in PHC, the lack of planning and sizing of the workforce on a regional basis continues to be a significant challenge for the SUS as a whole. This gap limits the effectiveness of the health system, focusing the confrontation of the problem more on local management than on the comprehensive vision of the system at the regional level. It is therefore crucial that the federal government take a more active role in this regard, providing guidance, funding and strategies for local managers to deal with the complexities of the health workforce, especially in underserved regions.

These findings provide valuable insights to improve the management and functioning of health systems at the municipal level, aiming at significant improvements in the management of work in PHC. Despite the governance and autonomy of local managers, it is up to the federal government, which has the necessary resources and authority, to develop policies and guidelines that address the specific needs of each region in terms of health workforce, with the aim of not only strengthening the capacity of local managers to deal with complex challenges, but also contributing to the construction of a more equitable and integrated health system throughout the country.

It is also important to recognize the potential limitations of the study, including a possibly limited sample and potential response bias from participants. Therefore, the findings should be interpreted with care and in context.

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