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TRENDS IN LABOR CONTRACTING IN THE FAMILY HEALTH PROGRAM IN BRAZIL: A TELEPHONE SURVEY

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Résumé
Introduction

The Family Health Program (PSF) is an important governmental intervention implemented in Brazil to improve primary health care by providing a comprehensive range of preventive and curative health care services delivered by a team composed of a physician, a nurse, a nurse assistant, and six community health workers. In addition, there is an oral health team composed of a dentist, a dental assistant, and a dental hygienist. Each team is responsible for the care of at least 1,000 families in a specific geographic area, usually consisting of about 3,000 to 4,500 people. The PSF has been developed as a strategy for the reorganization of the primary care system.

The PSF proposal was intended to have the teams take on responsibility for following up a given number of families who live in a specific area by promoting prevention, recovery, rehabilitation from the most frequent diseases and other illnesses, and health care in the given community. It is supported by principles such as integrality and quality of care, equality of access and community participation.

The PSF was started in 1994 with 328 teams introduced in 55 municipalities. Today, PSF is up and running in more than 5,100 of 5,564 municipalities across the country, with over 27,140 teams covering about 90 million people (47% of the Brazilian population). It is estimated that almost 400,000 health professional jobs are directly involved in the delivery of the program. In 2006, the Brazilian federal government invested about U$ 1.63 billion in this family health policy.

The program is mostly financed by the federal government with the participation of states and municipalities. The program management, including hiring, recruiting, and payment of the labor force, is the municipalities' responsibility.

From its inception through today, the PSF has found many potentialities and challenges in Brazil. The potentialities have to do with the strategies aimed at dealing with the main problems in the health care model, which has strong access barriers and clear inequalities in the delivery of care. The program has had a major impact on the availability of primary health care. There have also been positive results such as an increase in both employment offers and workers' incomes. The challenges include overcoming the spread of labor "precariousness" and hidden problems related to the contracting out of public health services.

From the perspective of the public labor unions, outsourcing and flexibility of employment relationships by the nation's municipalities primarily take aim at evading labor rights and obligations, leading to instability and lack of protection for workers. Some segments of public management consider this type of contract to have a negative impact on the quality and continuity of health care. It makes the retention of qualified health workers difficult considering that legal aspects, labor courts, and public audit bodies have contested the legality of contracting out labor for the PSF. Contracts with public administration, which are not preceded by recruitment based on merit, have no legal and constitutional support. Besides, they also violate labor rights and obligations.

This paper analyzes contracting out and the kinds of labor relationships between the PSF and its workers in order to identify the main changes in the labor market for the

program over the past five years. This period coincides with the first term of the present Brazilian federal government.

Methodology

This paper presents analysis of the data from two national surveys conducted in Brazilian municipalities in 2001 and 2006.

In 2001, the data were collected in a randomized sample of 759 of the 3,225 municipalities where the program was already working and stratified the geographical location and size. A total of 696 municipalities answered the questionnaire, representing 91.3% response rate. The 2006 telephone survey was applied to a sample of 855 of the 4,884 municipalities that had implemented the PSF in 2005, and stratified the population and geographical location. A total of 795 municipalities answered the telephone survey, representing a 93% response rate. In the 2006, a survey of the municipalities was selected based on the 2001 survey to allow comparison of the data (187 municipalities were added at random to complete the sample).

The survey data were collected through computer-assisted telephone interviews (CATI) with local government managers, human resource managers, or their equivalents, and conducted by the NESCON Center for Survey Research at the Federal University of Minas Gerais, upon the request of the Ministry of Health.

The data collected by the surveys analyzed in this paper were types of contracts (directly by the local government or contracted out through private or autonomous public organizations) and kinds of labor relationships and salaries.

The professional categories surveyed were physicians, nurses, dentists, nurse assistants and technicians, and community health agents (ACS) who work in the PSF, which constitutes its core team.

Results

Direct Contracts

Tables 1 and 2 report the patterns of contracting adopted by the municipalities in 2001 and 2006, including the direct contracting by the municipal government and contracting out. Contracting out occurs when a local government contracts professionals through private organizations, profit or not-for-profit, and autonomous or decentralized public organizations.

Contrary to some expectations, the data show that the level of contracting out by the local governments decreased throughout the country. Between 2001 and 2006, it fell from 17.1% to 13.4% for physicians, from 14.6% to 11.4% for nurses, from 10.9% to 10.5% for dentists, from 13.9% to 10.4% for nurse assistants, and from 25.8% to 21.7% for ACS. The most significant levels of decrease were reported by the cities with more than 500,000 inhabitants. In these regions, contracting out of physicians and nurses decreased from 55% to 10%.

In 2001, direct labor contracting by local governments was predominant in all categories and regions, except for municipalities with more than 500,000 inhabitants. In

2006, direct contracting was also predominant in these places. In 2006, direct contracting measured 86.6% for physicians, 88.6% for nurses, 89.5% for dentists, 89.6% for nurse assistants, and 78.3% for ACS.

In general terms, we concluded that for the country as a whole, contracting out has a relatively low rate, although contracting out for ACS is more common. There are, however, significant variations when the regions and the sizes of municipalities are considered. Therefore, the levels of contracting out increased significantly in the country's most developed regions (South and Southeast) and in bigger cities (with more than 100,000 inhabitants).

In 2006, the South and Southeast regions registered the highest levels of contracting out with 23.5% and 23.1%, respectively, for ACS, and 21.1% and 22.2%, respectively, for physicians. For the municipalities with between 100,000 and 500,000 inhabitants, the levels of contracting out reported were 28.6% for physicians, 23.8% for nurses, 21.6% for dentists, 23.8% for nurse assistants, and 40.5% for ACS.

It is interesting to note that, as expected, the organizations most used for contracting out by the government were the not-for-profit, private ones, which hold more than 90% of contracts carried out by the municipalities in 2001 and 2006. Around 10% of the local governments simultaneously used direct contracting and outsourcing (Girardi et al., 2007).

Labor Regimes

Tables 3 and 4 show the labor regimes employed in direct contracting by the local governments. The criteria used to classify the kinds of jobs were based on the existence of social protection, legal support, and long-term job contracts. Therefore, the category "protected jobs" consists of a statutory regime that corresponds to the standard employment relationship between civil servants and the public administration, and "CLT workers" -- Brazilian civil labor law. Both have, as common traits, legal support and social protection, which includes labor and social rights. On the other hand, the "unprotected jobs" category includes temporary contracts with the public administration, contracts with independent professionals, and other informal relationships. Unprotected jobs share the fragility of the work relationship, the absence of standard labor and social rights, and the instability of the job.
In spite of the low rates of contracting out labor, the data showed high levels of utilization of employment relationships characterized as unprotected jobs. This occurred in all professional categories, all regions, and in municipalities of different sizes. The utilization of employment relationships characterized as unprotected jobs is higher concerning physicians, reported by 72.4% of the municipalities. The percentages are lower with nurse assistants and ACS, with 42.4% and 57.4%, respectively.

Between 2001 and 2006, there was a significant decrease in the utilization of employment relationships characterized as unprotected jobs in all regions and in municipalities of different sizes. In fact, it was observed that the smaller the municipality, the bigger the existence of unprotected jobs. This was especially true among the graduate professionals such as physicians, nurses, and dentists. With physicians, for instance, about 80% of the municipalities with only 20,000 inhabitants

utilized this kind of employment relationship. This percentage did not include the 25% of municipalities with more than 500,000 inhabitants.

Salaries

The monthly national salary averages found in 2006 were as follows: about U$ 2,600 for physicians, U$ 1,100 for nurses and dentists, U$ 270 for nurse assistants, and U$ 180 for ACS. The data show an increase in the salaries for all categories between 2001 and 2006, with the most significant increase for ACS. Between 2001 and 2006 salaries increased 34% for physicians, 26.3% for nurses, 36.7% for dentists, 42.6% for nurse assistants, and 79.6% for ACS (Table 5). The national minimum wage increase during the same period was 94.4%, while the inflation rate was 45.2%.

In broad terms, PSF pays higher wages for physicians than the private market (considering a week of 40 hours for salaried positions), but for the other health professionals, the private market salary is higher (RAIS, 2005).

On average, the municipalities located in the North region are the ones that better remunerate the PSF graduated professionals. For nurse assistants, the municipalities in the South region pay the highest salaries, and for ACS, the highest salaries are paid by the municipalities located in the Center-West region. The municipalities with more than 500,000 inhabitants offer the best salaries to all PSF professionals, except for physicians, who are better remunerated in the municipalities with up to 10,000 inhabitants. Most of the municipalities reported that there were no compensation incentives to the PSF professionals.

In general, salaries were a little higher in municipalities that used contracting out compared to the municipalities that used direct contracting. The data showed that nurses had equivalent salaries in both cases. This was true for all regions and municipalities of different sizes with few exceptions. In municipalities with more than 500,000 inhabitants, the salaries paid to all categories of professionals when contracting out were higher than with direct contracting. However, in the same municipalities, ACS salaries were higher when they were directly contracted (Tables 6 and 7).

Discussion and Conclusions

With the PSF program, it can be seen that contracting out and unprotected jobs decreased in the country's municipalities between 2001 and 2006. This fact can partly be attributed to the Brazilian Federal and State Courts of Accounts – TCU and TCE. The present situation can also be attributed to federal government policies and the federal government's positive agenda concerning employment relationships. Brazilian Public Health System (SUS), through its permanent body for labor negotiations (Mesas de Negociação Permanente do SUS) and the National Inter-institutional Committee for employment relationships protection (Comitê Nacional Interinstitucional de Desprecarização do Trabalho no SUS), has implemented a national program to prevent the spread of labor precariousness on a national basis. During the forums, it was primarily the major national civil servant unions that strongly objected to the utilization of contracting out and non-standard employment.

From the research, it was seen that the types of municipalities that used labor from contracting out were not the same types (i.e., size, region) as those that used direct contracting relationships characterized as unprotected jobs. Contracting out practices were predominant in the bigger and more developed municipalities (those in the South and the Southeast, and the ones with more than 100,000 inhabitants). In contrast, municipalities with fewer inhabitants in the other regions of the country were more likely to contract directly for unprotected jobs.

Analysis of the data suggested, then, that the reasons why the government (when acting as employer) used externalized work arrangements involving labor market intermediaries were different than the reasons why it contracted directly for unprotected jobs.

As the literature pointed out, there is no single reason for contracting out for labor (Hachen, 2004; Kalleberg, 2000). Economic, external, institutional, and flexibility factors (numeric or functional) are at stake in determining decision making related to contracting out labor and using unprotected labor relationships. PSF data from our research confirmed the presence of this diversity of factors in Brazil, although not conclusively.

Indeed, numeric and functional flexibility -- to be able to dismiss, hire, and manage the workforce – was cited as a reason to use unprotected labor relationships by about 40% of the study interviewees.

Economic factors, such as saving on indirect costs of protected jobs or the possibility to offer physicians higher salaries, were stated by 20% of the municipalities as determinants of the utilization of non-standard employment relationships and contracting autonomous and independent workers.

Thirty percent (30%) of the municipalities considered external factors as some of the main reasons for contracting out. These factors related to the existence of legal or judicial rules constraining the employers' behavior and the presence of strong labor unions acting in opposition to contracting out. The Brazilian Law of Fiscal Responsibility prohibits municipalities' payroll to be higher than 60% of their revenue.

Issues related to the financing capacity were reported by around 15% of the municipalities. These issues stand out more in smaller municipalities and in the ones in poorer regions with lower revenue.

Finally, around 34% of the municipalities reported difficulty of recruitment based on merit (Brazilian Constitution Law) as a reason for employment relationships for unprotected jobs.

PSF professionals, with the exception of physicians, earned lower salaries when compared to the market. However, retention rates for physicians were low. More than 30% of physicians did not keep their PSF jobs for more than 12 months. Job precariousness and relatively low salaries for working 40 hours weekly as well as workplace conditions accounted for this high turn over.

The survey research concluded that there is still a high level of poorly paid jobs as well as non-compliance with legal requirements when it comes to hiring health professionals, even though, when compared to the results of the 2001 survey, one can find trends moving in different directions in this situation.

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Table 1. Percent of Direct Contracting and Contracting Out of PSF Professionals in Brazilian Municipalities by Region, 2001 and 2006

Categories	***Region***	***Direct Contracting***		***Contracting Out***	
		2001	2006	2001	2006
Physicians	Center West	96.2	93.8	3.8	6.2
	North	91.2	93.9	8.8	6.1
	Northeast	95.0	94.9	5.0	5.1
	South	62.1	78.9	37.9	21.1
	Southeast	74.2	77.8	25.8	22.2
	Brazil	82.9	86.6	17.1	13.4
Nurses	Center West	97.4	93.8	2.6	6.2
	North	93.0	95.5	7.0	4.5
	Northeast	95.4	95.3	4.6	4.7
	South	67.2	83.7	32.8	16.3
	Southeast	78.6	80.5	21.4	19.5
	Brazil	85.4	88.6	14.6	11.4
Dentists	Center West	98.5	94.9	1.5	5.1
	North	87.1	93.8	12.9	6.3
	Northeast	92.1	96.1	7.9	3.9
	South	76.2	82.1	23.8	17.9
	Southeast	85.5	82.8	14.5	17.2
	Brazil	89.1	89.5	10.9	10.5
Nurse Assistants	Center West	96.1	96.3	3.9	3.7
	North	93.1	93.9	6.9	6.1
	Northeast	94.7	94.6	5.3	5.4
	South	72.8	85.5	27.2	14.5
	Southeast	78.6	83.3	21.4	16.7
	Brazil	85.4	89.6	14.6	10.4
ACS	Center West	88.5	86.4	11.5	13.6
	North	86.0	83.3	14.0	16.7
	Northeast	77.0	76.7	23.0	23.3
	South	53.6	76.5	46.4	23.5
	Southeast	74.6	76.9	25.4	23.1
	Brazil	74.2	78.3	25.8	21.7

Table 2. Percent of Direct Contracting and Contracting Out of PSF Professionals in Brazilian Municipalities by Population Size, 2001 and 2006

Categories	***Size***	***Direct Contracting***		***Contracting Out***	
		2001	2006	2001	2006
Physicians	Até 10 mil	84.3	90.7	15.7	9.3
	10 a 20 mil	89.0	86.2	11.0	13.8
	20 a 50 mil	80.6	81.3	19.4	18.7
	50 a 100 mil	80.9	85.4	19.1	14.6
	100 a 500 mil	84.2	71.4	15.8	28.6
	Mais de 500 mil	45.5	89.5	54.5	10.5
	Brasil	82.9	86.6	17.1	13.4
Nurses	Até 10 mil	87.7	92.9	12.3	7.1
	10 a 20 mil	86.1	88.9	13.9	11.1
	20 a 50 mil	84.0	81.3	16.0	18.7
	50 a 100 mil	82.6	87.5	17.4	12.5
	100 a 500 mil	81.8	76.2	18.2	23.8
	Mais de 500 mil	45.5	89.5	54.5	10.5
	Brasil	85.4	88.6	14.6	11.4
Dentists	Até 10 mil	88.4	92.3	11.6	7.7
	10 a 20 mil	90.9	90.8	9.1	9.2
	20 a 50 mil	90.6	83.5	9.4	16.5
	50 a 100 mil	84.8	93.5	15.2	6.5
	100 a 500 mil	93.3	78.4	6.7	21.6
	Mais de 500 mil	75.0	84.2	25.0	15.8
	Brasil	89.1	89.5	10.9	10.5
Nurse Assistants	Até 10 mil	89.2	92.9	10.8	7.1
	10 a 20 mil	83.4	92.1	16.6	7.9
	20 a 50 mil	86.2	83.5	13.8	16.5
	50 a 100 mil	83.0	91.7	17.0	8.3
	100 a 500 mil	84.8	76.2	15.2	23.8
	Mais de 500 mil	50.0	73.7	50.0	26.3
	Brasil	86.1	89.6	13.9	10.4
ACS	Até 10 mil	78.7	83.6	21.3	16.4
	10 a 20 mil	74.3	82	25.7	18
	20 a 50 mil	69.3	69.8	30.7	30.2
	50 a 100 mil	70.2	70.8	29.8	29.2
	100 a 500 mil	61.8	59.5	38.2	40.5
	Mais de 500 mil	44.4	63.2	55.6	36.8
	Brasil	74.2	78.3	25.8	21.7

Table 3. Percent of Protected and Unprotected Jobs of PSF Professionals in Brazilian Municipalities by Region, 2001 and 2006

Categories	***Region***	***Protected Jobs***		***Unprotected Jobs***	
		2001	2006	2001	2006
Physicians	Center West	9.8	13.2	90.2	86.8
	North	14.8	27.4	85.2	72.6
	Northeast	5.9	24.2	94.1	75.8
	South	39.4	45	60.6	55
	Southeast	23.7	25.6	76.3	74.4
	Brazil	16.8	27.6	83.2	72.4
Nurses	Center West	15.5	21.1	84.5	78.9
	North	23.7	38.7	76.3	61.3
	Northeast	10.4	30.7	89.6	69.3
	South	48.3	61.1	51.7	38.9
	Southeast	30	27.3	70	72.7
	Brazil	22.9	35.3	77.1	64.7
Dentists	Center West	11.7	21.3	88.3	78.7
	North	30	43.5	70	56.5
	Northeast	12.7	27.9	87.3	72.1
	South	57.2	63.8	42.8	36.2
	Southeast	41.8	37.3	58.2	62.7
	Brazil	24.2	37.7	75.8	62.3
Nurse Assistants	Center West	38	53.2	62	46.8
	North	41	66.1	59	33.9
	Northeast	37.7	50.6	62.3	49.4
	South	70.9	77.5	29.1	22.5
	Southeast	45	50.5	55	49.5
	Brazil	44.6	57.6	55.4	42.4
ACS	Center West	12	20	88	80
	North	21.1	54.5	78.9	45.5
	Northeast	23.2	47.7	76.8	52.3
	South	46.5	52.8	53.5	47.2
	Southeast	30.5	34.7	69.5	65.3
	Brazil	26.7	42.6	73.3	57.4

Table 4. Percent of Protected and Unprotected Jobs of PSF Professionals in Brazilian Municipalities by Population Size, 2001 and 2006

Categories	***Size***	***Protected Jobs***		***Unprotected Jobs***	
		2001	2006	2001	2006
Physicians	Até 10 mil	13.5	19.9	86.5	80.1
	10 a 20 mil	11.6	22.1	88.4	77.9
	20 a 50 mil	15.1	32.7	84.9	67.3
	50 a 100 mil	29.6	53.7	70.4	46.3
	100 a 500 mil	40	56.7	60	43.3
	Mais de 500 mil	85.7	76.5	14.3	23.5
	Brasil	16.8	27.6	83.2	72.4
Nurses	Até 10 mil	21.3	30.4	78.7	69.6
	10 a 20 mil	15.4	32.1	84.6	67.9
	20 a 50 mil	23.5	40.7	76.5	59.3
	50 a 100 mil	34.8	52.4	65.2	47.6
	100 a 500 mil	43.4	62.5	56.6	37.5
	Mais de 500 mil	85.7	88.2	14.3	11.8
	Brasil	22.9	36.7	77.1	63.3
Dentists	Até 10 mil	22	31.8	78	68.2
	10 a 20 mil	19.6	35.8	80.4	64.2
	20 a 50 mil	24.9	37.7	75.1	62.3
	50 a 100 mil	30	53.5	70	46.5
	100 a 500 mil	46.6	65.5	53.4	34.5
	Mais de 500 mil	75	75	25	25
	Brasil	24.2	37.7	75.8	62.3
Nurse Assistants	Até 10 mil	44.6	56.5	55.4	43.5
	10 a 20 mil	39.3	54.6	60.7	45.4
	20 a 50 mil	43.9	56	56.1	44
	50 a 100 mil	53.7	65.9	46.3	34.1
	100 a 500 mil	57.6	71.9	42.4	28.1
	Mais de 500 mil	71.4	73.3	28.6	26.7
	Brasil	44.6	57.6	55.4	42.4
ACS	Até 10 mil	27.2	40.5	72.8	59.5
	10 a 20 mil	25.9	45.2	74.1	54.8
	20 a 50 mil	22.2	41.2	77.8	58.8
	50 a 100 mil	34.3	44.1	65.7	55.9
	100 a 500 mil	33.2	48	66.8	52
	Mais de 500 mil	20	58.3	80	41.7
	Brasil	26.7	42.6	73.3	57.4

Table 5. Salaries of PSF Professionals in Brazilian Municipalities, 2001 and 2006

Salaries	***2001 (Reais)***	***2006 (Reais)***	***Increase (%)***	***U$ (2006)***
Physician	4079.50	5465.50	34.0	2,603
Nurse	1741.30	2199.10	26.3	1,047
Dentist	1755.80	2400.00	36.7	1,143
Nurse Assistant	401.80	572.90	42.6	273
ACS	213.10	382.70	79.6	182

Table 6. Salaries of PSF Professionals in Brazilian Municipalities by Region and Type of Contract, 2001 and 2006

Categories	***Region***	**Salaries (Reais)**	
		Direct Contracting 2006	**Contracting Out** 2006
Physicians	Center West	5858.80	6366.00
	North	6311.80	7250.00
	Northeast	5086.02	5261.54
	South	5722.87	5440.33
	Southeast	5253.10	5581.26
	Brazil	5444.74	5598.82
Nurses	Center West	2283.16	2266.60
	North	2389.84	2793.33
	Northeast	2382.87	2183.33
	South	1838.61	1978.15
	Southeast	2129.18	2281.98
	Brazil	2199.79	2193.87
Dentists	Center West	2408.64	1975.00
	North	2844.92	2533.33
	Northeast	2317.36	2510.00
	South	2448.00	2619.08
	Southeast	2199.57	2686.21
	Brazil	2378.20	2590.83
Nurse Assistants	Center West	553.03	893.33
	North	580.57	650.00
	Northeast	498.99	533.64
	South	662.31	658.13
	Southeast	551.62	760.14
	Brazil	558.86	696.88
ACS	Center West	391.12	413.00
	North	379.66	374.55
	Northeast	369.59	359.58
	South	383.85	394.38
	Southeast	380.63	444.27
	Brazil	378.90	396.30

Table 7. Salaries of PSF Professionals in Brazilian Municipalities by Population Size and Type of Contract, 2001 and 2006

Categories	Size	Salaries (Reais)	
		Direct Contracting 2006	**Contracting Out** 2006
Physicians	Até 10 mil	5800.44	5837.69
	10 a 20 mil	5216.61	5796.80
	20 a 50 mil	5219.06	5135.36
	50 a 100 mil	5218.75	5559.29
	100 a 500 mil	4767.37	5495.91
	Mais de 500 mil	4358.82	5800.00
	Brasil	5444.74	5598.82
Nurses	Até 10 mil	2137.33	1832.40
	10 a 20 mil	2113.60	2143.29
	20 a 50 mil	2295.52	2199.08
	50 a 100 mil	2376.83	2318.83
	100 a 500 mil	2378.31	2774.00
	Mais de 500 mil	2835.29	3900.00
	Brasil	2199.79	2193.87
Dentists	Até 10 mil	2279.27	2551.73
	10 a 20 mil	2209.09	2094.67
	20 a 50 mil	2460.13	2436.00
	50 a 100 mil	2716.87	3200.00
	100 a 500 mil	3035.03	3311.43
	Mais de 500 mil	3168.75	4100.00
	Brasil	2378.20	2590.83
Nurse Assistants	Até 10 mil	533.82	610.91
	10 a 20 mil	535.92	634.33
	20 a 50 mil	555.01	657.57
	50 a 100 mil	605.24	683.75
	100 a 500 mil	719.63	921.11
	Mais de 500 mil	964.85	1052.00
	Brasil	558.86	696.88
ACS	Até 10 mil	370.18	388.26
	10 a 20 mil	376.72	381.21
	20 a 50 mil	377.10	382.86
	50 a 100 mil	375.21	414.29
	100 a 500 mil	441.75	452.44
	Mais de 500 mil	516.33	449.29
	Brasil	378.90	396.30