

Contextual dimensions of work: the vision of executive directors from the unimed in Minas Gerais*

Dimensões contextuais do trabalho: a visão de diretores executivos de uma unimed de Minas Gerais

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ABSTRACT

This article aimed to analyze the macro-environment (supplemental health), the work environment (UNIMED-Beta), and the context of work (cooperated manager) under the point of view of Executive Directors from Unimed in Minas Gerais. This was a research with a qualitative approach and descriptive character, conducted as a case study. The subjects were four executive medical directors in the organization. The data were collected in 2011, through interviews using a semi-structured script, and analyzed by the technique of content analysis. In the view of the respondents, the macro-environment and the environment and work context are dimensions of performance space for the Executive Director that present significant challenges, among them, the dual function performed in the medical work cooperative stands out, i.e., as Executive Director (owner) and as a doctor (assistance service provider).

Key words: Health Management; Health Manpower; Supplemental Health; Prepaid Health Plans; Private Sector.

RESUMO

O presente artigo teve como objetivo analisar o macroambiente (saúde suplementar), o ambiente de trabalho (UNIMED-Beta) e contexto do trabalho (cooperado gestor) na perspectiva de diretores executivos de uma Unimed de Minas Gerais. Trata-se de pesquisa com abordagem qualitativa, de caráter descritivo, tendo sido realizado estudo de caso. Os sujeitos foram quatro médicos diretores executivos da organização. Os dados foram coletados por meio de entrevista com roteiro semiestruturado, em 2011, e analisados pela técnica de análise de conteúdo. Na visão dos entrevistados, o macroambiente, o ambiente e o contexto do trabalho são dimensões do espaço de atuação do diretor executivo que apresentam significativos desafios, entre eles destaca-se a dupla função ocupada na cooperativa de trabalho médico, isto é, como diretor executivo (dono) e como médico (prestador de serviços na assistência).

Palavras-chave: Gestão em Saúde; Recursos Humanos em Saúde; Saúde Suplementar; Planos de Pré-Pagamento em Saúde; Setor Privado.

INTRODUCTION

The UNIMED cooperatives integrate a set of Brazilian health providers that together with the group medicine, specialized health insurance, self-management, and philanthropy provide assistance to 46 634 765 million Brazilian people¹ correspond to one quarter of the country population linked to the segment of supplementary health.

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Medical cooperatives are a modality highlighted in this macro context because through 335 cooperatives, 29.61% of health providers; they assist 16 981 220 clients. The set of UNIMED cooperatives is responsible for 36.40% of the population assisted by the segment with supplementary health assistance in the country.^{1,2}

Medical cooperatives emerged in Brazil in 1967 with the creation of the Medical Union from Santos-UNIMED-Santos as a way of opposition to the group medicine. The Unimed cooperative system grew and in 2011 was already the largest network of medical assistance in the country. UNIMED centers are located in more than 83% of the national territory reflecting its capillarity and especially its capacity to generate employment and income for more than 108 thousand associated doctors.³ Despite of the variables such as the strength of the UNIMED brand used throughout the system, inter-cooperation was crucial to enable the service to clients of this health provider modality, as well as to boost the expansion of medical cooperatives.⁴

Associated doctors have performed the management of these cooperatives, which has been defined as an important challenge related to several factors. In this regard, the global environment transformation and the national reality, issues relating to medical training, labor market, and regulation of the supplementary health segment in 1998 increasing competitiveness in the private health sector, and finally, the specificities of cooperative management need to be highlighted. All associated factors have created a complex scenario of performance for those who have been in the Executive Boards of UNIMEDS.^{4,5}

Because the management of cooperative societies is a complex activity with its specific characteristics, the management of UNIMED cooperatives in the segment of supplementary health in Brazil added variables that made the work of directors even more challenging. In this perspective, it is essential to know these variables, as well as their influences on these managers' works. According to Cheetham and Chivers⁶, the labor environment involves the physical, cultural, and social conditions around the individual at work. Bearing in mind the specificity and complexity of work in a medical cooperative in the segment of supplementary health, the work environment was considered in two dimensions in this study: the macro environment dimension about supplementary health and the work environment dimension, contemplating UNIMED, which is the study scenario. The work dimension context refers to, "the particular situation re-

quired for a professional to act"^{6,273} and, in this case, the role of the associated executive director.

Therefore, the present study aimed to analyze the macro environment (supplementary health), work environment (UNIMED-Beta), and the context of work (associated manager) within the vision of executive directors at a UNIMED in Minas Gerais.

METHODOLOGICAL COURSE

The nature of the problem and details of the analyzed phenomenon led to the choice of a qualitative approach.⁷ A case study of the descriptive nature was chosen because it aims to describe in depth the characteristics of a given phenomenon.⁸

The scenario of the study was a medical work cooperative from UNIMED located in Minas Gerais, named as UNIMED-Beta for the purposes of this study. The subjects of the research were four medical executive directors at UNIMED-Beta.

The research was structured based on primary and secondary data collection. The data collection was in 2011 using a semi-structured interview script as an instrument. The interviews were recorded in order to ensure data reliability and promote interaction between the researcher and interviewees, and incorporation of its production.⁹ The research was approved by the Ethics Committee in Research from UFMG and the interviewees signed a Volunteer and Informed Term of Consent (VITC) in compliance with Resolution 196/96.¹⁰ Data were transcribed in full and analyzed through analysis of content,¹¹ which covers the clarification of initiatives, systematization, and expression of message contents.

The documentary research was conducted based on internal sources (reports, bylaws, rules, organization charts) and external sources (newspapers, magazines, newsletters) enabling the rescue of relevant information about the history of the organization and its transformations.

RESULTS

The UNIMED-Beta cooperative has a prominent position in Minas Gerais with regard to its number of clients. It was created in 1980, and it has overcome challenges in the macro context of supplementary health such as competitiveness in the segment and

ANS demands, adapting, surviving, and growing. In the ANS¹² evaluation from 2010, it reached the general Index of Performance in Supplementary Health (IDSS) of 0.40 and 0.59, meaning a median result in the evaluated perspective: health care, economic-financial, structural and operational, and client satisfaction.

To achieve such results, the UNIMED-Beta had four associated doctors as directors, with three of them occupying cooperative management functions for 12 years or more. As stated in the UNIMED-Beta bylaws, it is up to the executive directors, within the limits of the law, to deliberate at the General and Board of Directors Assemblies, as well within its own bylaws, to manage, execute, control, and standardize. Such work, performed by the president director, superintendent director, medical-social director, and market and associative relations director contemplates activities beyond those specific to the basic formation of a doctor, which becomes an important challenge for them.

In the view of the executive directors, the work performed in the direction of the UNIMED-Beta shows specific characteristics. In regards to the macro-environmental dimension, the distance between private organizations providing assistance in the area and the global planning of health actions in Brazil were expressed. The directors understand that rules, legislation, and accounting, among other macro-environmental factors, bring difficulties for the management of the UNIMED-Beta.

Today the companies, health institutions, are isolated from the political context, the proper governmental programming, or better, from each function. I think it is more or less each one for themselves. I think the rules, laws, accounting, legislation, revenue, the rules of the country, they are, many of them, exaggerated and confusing. There is not one person who has the knowledge over this. (INTERVIEWEE 4)

The testimony of interviewee 4 expressed the need of knowledge over rules, laws, and accounting requiring knowledge that extrapolates the curricular contents and that, in practice, are required by medical managers working in cooperative health providers. This report indicates the fact that the exercise of executive direction demands the mobilization of competences and skills concerning the contextual knowledge, i.e., “knowledge of general fund specific to one industry sector, organization, etc.”^{6,13,14}

With regard to the working environment of the executive directors such as physical, cultural, and so-

cial conditions in the UNIMED-Beta, aspects related to three evolutionary moments were highlighted: the foundation; the significant growth after the creation and commercialization of the co-participative health plan in 1990 with an increase and diversification in the number of clients and expansion of cooperative members; and the transformations that occurred after the post-regulation, more specifically from 1998 to 2011.

According to the directors, cooperativism was little known when the UNIMED-Beta was created. However, reports about other medical cooperatives founded in the State of São Paulo indicated this strategy as an alternative to confront the reality of that time by creating better job opportunities for doctors and avoiding the labor market dominance by health insurances and other medical services.

At the time, we had news from several UNIMEDS operating in São Paulo, in Santos, in other cities in São Paulo. The system was growing and we thought to also do the same and try to build something that would be ours, a cooperative of doctors, avoiding even the influence and dominance of medical insurance companies in the medical field. We knew little about UNIMED. The UNIMED here was just the UNIMED of Belo Horizonte and we had little idea about what UNIMED was, what was medical cooperativism, however, UNIMEDs were sprouting in big cities, therefore, we opted to accept the foundation and see what would happen. (INTERVIEWEE 2)

We saw medical cooperativism being born as an alternative to other health insurance options, other health insurance services. (INTERVIEWEE 1)

One of the difficulties identified in the management of medical cooperatives is related to the assistance model in the country. On the doctors' side, the complete autonomy to decide on the use of resources linked to remuneration per procedure – fee for service – and on the user' side, the free access to health service providers created the proper environment to confuse necessity and interest. The lack of “protocols” to organize the use of diagnostic and therapeutic resources available and, therefore, limiting the misuse were cited as a failure in the current assistance model.

Today we have a lot to work on this necessity and interest issue. Sometimes the user, the doctor wants to do a lot for their interests not by the science, but by their needs. One day we

are going to register this, referring, changing the model a little bit. Our model today is also a flawed model. Our model today is too much based on assistance, the doctor has significant autonomy, he does what he wants, not everyone, since most of them are coherent; and the user also does what he wants. This is our model today, the more you do, the more you earn; I do whatever I want. Our model will have to have a scientific protocol [...] to model in this sense. (INTERVIEWEE 4)

The board of directors in the UNIMED-Beta created a co-participative plan as an alternative to “promote responsible use”^{15:125} of diagnostic and therapeutic resources by the clients. The desired goals and results achieved by the cooperative with the release of this type of health insurance can be found in the following report.

The staff liked it, and the companies liked it because the interesting about this plan is that it controls the user’s own spending. When a person has a consultation, an examination, he thinks a little more because he will participate in the expenses; he does not get everything for free, you know? It means it is not a prepaid plan; it is a more or less postpaid plan. Then he participates in what is his, so he thinks twice. (INTERVIEWEE 2)

The supplementary health macro-environment enforces relations between the cooperative executive direction and the Judiciary Power and consumer defense organizations. These are contacts arising from the conflicts between the cooperative and clients, particularly after the regulation of the segment. Such conflicts arise, among other things, from issues related to health insurance contracts signed before the law 9656/98, which does not cover all procedures in regulated contracts but that are required in court by the user, and often ordered by judges.

Users were adapting to the new plan [regulated] according to the norm, and this has decreased the possibility of problems, which still persist to this day. We have sought to do everything in the best possible way to avoid problems because of legal issues. Today even having a contract, saying that you [UNIMED-Beta] have the right, judges no longer understand this way. So, it does not help at all. We have had these problems, then you are losing, losing in court. If a judge order comes, we have to give in, let’s say, to what is not contemplated in the contract because those plans that had not been adapted are still valid. (INTERVIEWEE 1)

The difficulties are of all kinds. So, health plans today, you have also the user’s requirements, the Judiciary is not understanding, it does not understand. The Judiciary sometimes arbitrates a treatment. I think that, are you going to perform the treatment if this treatment is scientifically incoherent, if the user is going to be harmed with it, will [the Judiciary] assume the costs and outcomes? (INTERVIEWEE 4)

Besides the macro-environmental issues and those related to work environment, aspects about the scenario of work have also been mentioned by the interviewees, that is, the cooperative manager. In the point of view of the UNIMED-Beta directors, being an associated doctor is the result of a demand from doctors because of the expansion in the number of companies in the segment of supplementary health. It is a type of organization in which the doctor is the “owner”, therefore directing, deciding, and transforming what is understood as peace of mind because the UNIMED cooperative allows the defense and struggle for the profession.

UNIMEDS grew, and we are here. Being an associated doctor today is almost a necessity because of the system in operation in the entire country, through several health plans, many health insurance companies, and several health plan companies. So, the cooperative was a necessity. It is a company, but it is our company, we are the owners, we are managing, solving things, changing; so, we work on it, I think it is a tranquility that we have to defend ourselves and to fight for the profession. (INTERVIEWEE 2)

Being an associated doctor is also seen as something modern, widespread in first world countries. It is understood as a much better combination between cooperation and professionalism because everyone works, and the result is proportional to productivity. In the point of view of directors, the associated doctors feel satisfied with the UNIMED-Beta.

Associated doctor is a modern thing today. If we could, everyone would be associated, in Europe and in first world countries cooperatives are much larger than in Brazil. The idea of cooperation and professionalism is much better. In Germany, I think that 70% of the population is associated. I am talking about more or less data; in Brazil 5% of the population is associated. So, in the cooperation, if everybody works and shares, there is fair share among doctors, those who work hard earn a lot, and those who work less

earn less. It is a very good thing that tends to be more homogeneous. And the doctors are satisfied with the UNIMED here. (INTERVIEWEE 3)

According to testimonies, being a director at UNIMED means to have a participatory and cooperative spirit, as well as to understand the cooperative as a different possibility of work from that offered by other health insurance companies or health services.

I have this more participatory spirit, more cooperative. So, although I think I have a different point of view from other colleagues, working in this medical and healthcare trajectory, we saw medical cooperativism emerging as an alternative to other health insurance plans. (INTERVIEWEE 1)

DISCUSSION

According to the UNIMED-Beta bylaws, the cooperative members are organized in the following structure: General Assembly, Board of Directors, Technical and Ethical Council, and Fiscal Board. The duties of the executive board, within the limits of the law, bylaws, and resolutions of the General Assembly and Board of Directors is management, execution, control, and normative. These assignments show that the UNIMED-Beta opted for a management strategy through a Board of Directors consisting of the Executive Board and assembly members. This definition reveals that the function of management strategy of the organization is under the responsibility of the executive board members.¹⁶

According to the interviewees, in the UNIMED-Beta trajectory, challenges and difficulties were faced and overcome, highlighting: the initial ignorance about cooperativism and the need for learning about this type of society; the creation of the co-participative plan in the 1990 decade, a product that enabled the growth of the cooperative and creation of work for doctors; and the marketing of this product before the regulation set in 1998 favoring the reduction of conflicts with users and the Judiciary because it was well accepted by companies and inhibited the excessive use by customers, and thus reduced costs.

In this perspective, the distance between private organizations that provide supplementary assistance, via the supplementary segment, and the global planning of health actions in Brazil mentioned by the directors, could be analyzed based on Albuquerque et al.¹⁷. According to the authors, "the market of private health insurance plans in Brazil is still little known

and considered in the planning of the health system in the country"^{17:1429} The participation of organizations, as well as clients, in the discussions of topics of interest to those who are directly involved is under construction because of the fact that the action of the State over the segment is through a regulatory agency, which according to Sato¹⁸, assumes independence.

To address the lack of a single person who dominates the legislation as well as other factors related to the management of health providers, and understanding that these factors arise from actions of the State through the ANS, difficulties concerning the function of the UNIMED-Beta direction were cited. Managing the segment of supplementary health organizations, after regulation, has been a challenge considering the need for qualification in managers to adequate the providers' procedures to changes required by the legislation.^{19,20}

The standard history of remuneration of health professionals, especially doctors, is a challenge for the health system in Brazil. It is about the way of hiring and remuneration of medical services, specially the common practice of receiving fees for services provided (fee-for-service), inherited from the social security system.²¹ At least theoretically, this could increase the doctor's earnings in proportion to the volume of services provided, inducing the misuse of services and compromising the economic results of the organization. It is proposed that "in the absence of ethical and moral constraints and external managerial regulations, doctors would tend to produce more services than necessary."^{22:55}

By mentioning that "the doctor has a lot of autonomy, doing what he wants", one of the interviewees addresses one type of cooperative behavior that, in addition to other ethical aspects, would endanger the economic stability of the cooperative. Such conflict generated by the necessity of control of activities of professional colleagues is a space for mobilization of skills of political nature from this work environment.

In regards to clients "doing what he wants", it concerns on the use of services in a way that is not controlled externally, which is an existing practice even before the regulation of the sector. Health plans known as pre-paid, with unlimited coverage, allowed services demanded by clients without restrictions within the contracted. This procedure facilitates the practice of use according to the preferences of those who seek the service.

The concepts of necessity and demand were defined in a classic study by Jeffers et al.²³. The need refers to the amount of services and resources that doctors

consider that an individual should use to maintain his health, considering the available knowledge in the scientific field; the demand refers to freedom of choice by the individual, depending on his preferences. Mechanisms could be created to reduce the gaps between need and demand.²³ The UNIMED-Beta decided in 1994 for the implementation of a copayment as one of the mechanisms to control the demand for health services.

With a copayment, the client is responsible for the payment of part of the total cost incurred on the provider, then, a risk sharing occurs. [...] This is already quite common in countries where the secondary sector operates for some time with the addition of moderating factors to health insurance contracts.^{18:59-60}

The co-participative plan created by the UNIMED-Beta was a strategic response from the direction of this cooperative medical work.³ The initiative anticipated the solution to a future problem that it would become evident after the control arising with rules from the ANS from 2000. It is the creation of the future reality of an organization in the perspective of Drucker²⁴.

One of the difficulties with clients faced by the cooperative has been the demands by the carriers of non-regulated health plans. The coexistence of contracts with differentiated rights “can be cited as the greatest source of conflict in the regulatory process: the coexistence of two worlds, with very different contractual rules and regulatory possibilities also different;” it is a situation that causes “everyday confrontation between providers, the Judiciary, and consumer defense organizations.”^{25:1468}

The directors saw the cooperative as a job alternative to doctors, advocated since the creation of the Unimed System in Brazil.²⁶ However, there is a need to “promote cooperative education, that is, the real understanding of cooperation is fundamental to a due recognition and sustainable development of the system.”^{27:216}

Executive directors mix the activities in the direction at the UNIMED-Beta with those of client’s assistance. This dual function includes acting spaces that differ with regard to sociocultural aspects. As providers of the cooperative’s service, there is a tendency to comply with individual interests such as productivity and remuneration; however, as executive directors, there is the responsible for results from the UNIMED-Beta and the tendency would be the benefit of associated members, favoring the manifestation of collective interests such as profits and investments in their own business.

FINAL CONSIDERATIONS

In this study, the vision of the UNIMED-Beta executive directors was presented based on three dimensions of professional space in which they operate, that is, the macro-environment (supplementary health), the work environment (UNIMED-Beta), and the work context (associated manager).

The UNIMED-Beta has four associated doctors as executive directors, three of them practically since its foundation, therefore, acting on management for over 12 years. As a medical cooperative in the segment of supplementary health, the UNIMED-BETA became one of the first in number of clients in Minas Gerais in 2011, with more than 120 thousand, generating employment and income for more than 500 associated doctors.

In the view of the interviewed directors, the macro environment (supplementary health) shows challenging situations for the medical manager such as the distance between providers of global health planning, historic practices of remuneration for services provided (fee for service), and the user’s wide freedom of choice, among others, requiring the repositioning of the organization and thus management capacity to deal with these issues.

As for the work environment (associated manager), the participation and cooperation were cited by the interviewees as important behaviors for the exercise of this position. They understand the medical cooperativism as a much better combination between cooperation and professionalism because everyone works, and the result is proportional to productivity, which has been the motive of satisfaction among UNIMED-Beta doctors.

In the point of view of doctors in the function of executive directors at the UNIMED in Minas Gerais, the macro-environment, work environment, and context of work are dimensions in the professional performance space that present significant challenges. Among them, the dual role occupied in the medical service cooperative is identified, i.e. the work as executive director – owner – and the activities as a doctor, assistance service provider.

The macro-environment, work environment, and context of work are dimensions of professional performance space of the doctor who contributes on relevant variables in the configuration process of identity and mobilization of professional competencies.

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