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The contracting policy of teaching hospitals: what did actually change?

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Abstract *The Teaching Hospital Restructuring Program was introduced as a strategy to fight the crisis in this sector. It brings to new funding, management and relationship standards between teaching hospitals and health system. This study presents the results obtained from a multiple case study involving four teaching hospitals whose contracts were executed in 2004. In 2010, a number of 32 interviews were conducted with both hospital and SUS managers, in addition to managers connected with the Federal Government Departments involved in the contracting system. By using elements from the micropolicy of health organizations as theoretical reference, the database was revisited with the goal of analyzing possible changes derived from such governmental policy applied in the daily life of teaching hospitals, in an attempt to explain the position taken by the diverse institutional actors as well as the main role played by the managers and the difficulties encountered in its introduction. Despite the improvements in the financial situation, the changes observed in teaching hospitals were not significant. An analysis of the contracting policy leads to an understanding of how a consistent and idealized project can reproduce the usual conservative behavior found in public management.*

Key words *Health policy, Health management, Hospital management, Teaching hospitals*

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Introduction

In 2003, the federal government conceived a Program for the Restructuring of Teaching Hospitals (TH) that included a significant transfer of financial resources to SUS managers to promote profound changes in TH, starting from the contractual relationship and public financing of these establishments. This program was formulated in a context of a (chronic) crisis of TH and resulted from a consensus that gave viability to the policy, including the capture of new financial resources disputed intensely among other governmental priorities[1].

Inserted in the policy that intended the reform of the Brazilian hospital system, the program sought to reestablish commitments of SUS and TH managers in four dimensions: care and the insertion of TH in the SUS; management of TH; research, teaching and training of health workers; and evaluation and technological incorporation[2].

In 2004, Ordinance No. 1,000/MS/MEC instituted the TH certification process, the first step towards the restructuring program. The following step was the establishment of specific ordinances standardizing the contracting of university hospitals linked to the Brazilian Ministry of Education and other TH[3], which defined contracting as:

the means, by which the parties, the TH legal representative and the local manager of the SUS, would establish quantitative and qualitative goals of the process of health care, teaching and research and hospital management that should be monitored and attested by the Institution's Management Board or the Permanent Contract Monitoring Committee[4].

The contracting was intended to indicate obligations and responsibilities of each actor involved; implement quantitative and qualitative goals; define criteria and instruments for monitoring and evaluating results; develop permanent education (PE) activities for the network; strengthen social participation mechanisms; redefine the insertion of TH in the health network; and promote the regulation of the health system as a whole. It was also intended to induce SUS priority policies, such as the National Humanization Policy (NHP)[5] and the participation of TH in emergency systems[6]. Similarly, it was expected the adoption of multi-annual and participatory strategic planning and information systems for decision-making based on a management performance evaluation system.

The management contract, with targets set in an annual operational plan, should indicate costs and efficiency/effectiveness of the services provided. The TH would be subject to result regulation, control and evaluation, and the contract clauses are expected to be revised or even suspended (temporary or definitive), if necessary.

The financing model has been modified. Until then, the payment was based only on the production of services. The new model provided for a mixed overall budget: partly by budgeting and another by efficiency/efficacy-inducing mechanisms. Only high complexity procedures would continue to be paid per production. The budgeted, transferred regularly and monthly to TH, included medium complexity procedures and other resources (FIDEPS and INTEGRASUS), and the amount corresponding to the new incentive to contracting. After meeting the targets, the TH could use surplus resources according to its needs.

Between 2004 and 2008, 151 hospitals were certified and 119 signed the contract with their manager, generating an annual impact equivalent to R$ 345 million.

This standardization was complemented by the publication of Ordinance No. 3,390/2013, which instituted the National Hospital Care Policy (PNHOSP), later replaced by the MM/MH Consolidation Ordinance No. 2, 2017, which reaffirm the hospital as part of the care network and that its care design responds to the needs of the SUS[7].

Our study object is the policy forerunner of the norms implemented during this decade for the contracting of hospitals and, in particular, for teaching hospitals.

Our article aims to evaluate a government policy – the contracting of THs – emphasizing the changes that have been produced in its strategic dimensions. It seeks to characterize the positioning of the different institutional actors and the role of local Managers of the SUS in their implementation, as well as the difficulties in the implementation of contracting instruments. Thus, it seeks to expand the capacity to understand the current dilemmas for the management and contracting of TH, adding theoretical-conceptual elements to the current debate.

Methodology

This is a qualitative investigation, of the multiple case study type, in four hospitals contracted as

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TH, randomly chosen. Located in three distinct states: two belonged to federal universities, one was a state public, managed by a Social Organization (SO) linked to the state university, and another to a philanthropic institution.

Chart 1 shows 28 interviews conducted with managers responsible for the implementation and monitoring of the policy and with members of the senior management of the THs. Four others were held in Brasilia, with leaders of the Ministry of Health (MH), the Ministry of Planning, Budget and Management (MPBM) and the Ministry of Education (ME), who worked directly in the coordination of the policy. The questions of the interview were based on the guidelines and legal instruments that make up the policy of contracting of the THs, based on its four priority axes (management, assistance, teaching and technological evaluation).

The field research was conducted in 2010 and the transcriptions of the interviews compose the primary empirical material revisited by the researchers in search of theoretical elements that would allow us to understand the policy of contracting of THs still in force. The systematization and analysis of the collected material was performed based on the four thematic axes of the contracting of THs.

A policy that is part of the same context as others, based on ethical-political principles committed to the SUS, guided by careful discussion with strategic actors, but which assume other contours when operationalized by concrete actors and in complex contexts, are apprehended and rework at the local level in a peculiar way and, in the process, assume new intentions and conformations[1]. After all, the actors have values, projects, interests and dispute meanings for health work, a field marked by disputes, agreements and compositions, coalitions and affections, crossed and constituted by power relations; whose micropolitics has a "rational" and a "irrational," vectors of change, but is also much conservative[8].

Our study, conducted with funding from the Fundação de Amparo à Pesquisa de São Paulo (FAPESP), was approved by the Ethics Committee of Unifesp/HSP.

Results and discussion

Health care

One of the TH policy guidelines was the demobilization of primary care actions still provided in the TH, constituting new teaching-learning scenarios in the primary network[9]. The impact of this strategy was unimpressive. The TH continued to offer such care, claiming to guarantee patients for the teaching of primary health care to

Chart 1. Managers interviewed for the research, by field and position/function.

Field	Position/Function
HE_1	Superintendent; Managing Director; Development and information manager; Medical Coordinator of the Outpatient Clinics; Nursing Director
HE_2	Managing Director; Assistant Director; Administrative Director; Nursing Manager; Coordinator of the Center for Teaching and Research, of the Public Health Center and the Quality Commission
HE_1 e HE_2	Manager responsible for the policy of contracting of THs under the state health department
HE_3	Director-General and Administrative; Technical and Clinical Director; Academic Director; Nursing Supervisor; Coordinator of the Health Services Regulation Management of security, environment and health; Physician responsible for the Relationship Center with security, environment and health Providers
HE_4	General Manager; Administrative Director; Technical Director; Director of Nursing; Clinical Director; Finance Manager; SO Manager; Rector Advisor; University's Former Rector; Municipal Secretary of Health
Ministry of Health.	Coord. General Hospital Care Dep. Basic Care System (BAS)/MH Specialized Care; Technical Consultant of the General Hospital Coordination /Directory of specialized attention (DAS)/ BAS/MH; Coordinator of Strategic Actions of the Dep. Education and Labor Management of the Secretariat of Health Work Management and Education
ME	Coord. General of Health Residences, Of the Board of University Hospitals and Health Residencies
MPBM	Project Manager of the MPBM Management Secretariat

Source: Elaborated by the authors.

students and residents, even when the manager expressed willingness and ability to assume them. The debate around new scenarios that conceive the SUS as a school network[10] has not yet resulted in considerable changes in medical schools. Even after the reformulations of the curricular guidelines undertaken by the Federal Law that created the *Programa Mais Médicos* (More Doctors Program) and determined that 30% of the internship had emphasis on basic care, the TH continues as the training center, keeping different primary care actions in its service[11].

A considerable portion of the basic demand continues to access the TH by the emergency services, and its leaders, in general, claim difficulty in counter-referring users due to the deficiencies of the basic network. The model of care centered on the doctor and procedures is reinforced in the TH, and the users, protagonists in the construction of their care maps, do not seem to wish to replace established bonds and prefer to be treated in the TH[12,13]. The existence of users with rare diseases followed-up in outpatient clinics is another argument used to justify basic care in THs. These findings reinforce a study on the multiple logics of regulation of access to health, which showed that users, in their lay action, seek to enter and fix themselves to the TH, which is now recognized as a central and stable point in their care service maps[14].

Low impact was observed in regulating the opening of new services in TH that should be agreed with the SUS manager, another policy guideline. Managers do not assume the leading role of the health system, they do not question the power arrangements and autonomy of physicians/professors, who continue to create services in absentia of the TH and university management.

This point requires two considerations. The first concerns federal government funding for TH. Prior agreement with SUS managers is not required when funds are raised via parliamentary amendments, agreements or other local initiatives for the expansion or opening of new services. Hospital managers complain that SUS managers do not pay for the new services provided. The second aspect concerns the organization and management of the SUS at the local level, since little is considered to qualify the regulation, redefine the care profile of the TH, change the way of offering health care, monitor and evaluate the use of public resources involved in the contracting relationship.

The contracting policy did not contribute to the creation of integrated care networks with the organic participation of TH in the health system, reorienting its care profile and role, as it intended to. We could, however, identify important advances in the regulation of access and in the use by bed regulation centers, consultations and outpatient procedures offered by THs to the SUS, which is another policy guideline.

However, the guideline that would subject the entire offer of TH to SUS Regulation was effectively not complied with, replaced by internal regulatory mechanisms such as maintaining quotas for teaching and research, which indicated that access is still strongly defined and mediated by the interests of the medical corporation/professors in most THs.

To expedite hospitalization or procedures, the judicial route and the "urgencialization" of the elective patient were used, microregulatory devices that are composed with the logic of lay regulation, described by Cecílio et al.[14], based on the life stories of users considered great users of the system. In the emergency department, doctors act as keys to access different points in the system. They and other TH employees use their network of relationships for small favors, which oversteps regulatory controls**.** This sector is also the place where teachers, residents, students and researchers choose cases with academic interest.

The proposal to integrate TH into the health system generated resistance on the part of physicians/teachers and was seen as a betrayal of the origin of the institution. According to a TH's clinical director: "They're selling the hospital to SUS!". Or, in the view of another clinical director: "The manager is taking from doctors and teachers the power over the hospital that belongs to them!".

The policy would have to face the power of the professor/physician, change the medical institution, disorganize the controls and spaces of power instituted until then. The TH, however, stressed by the demand that escapes the regulatory mechanisms, and due to the complexity of the relationships and interests expressed in the micropolitics, resists offering care regulated by SUS managers. The concept of contracting adopted works with a strong dose of idealization of SUS actors, in particular, state and municipal managers. Part of everyday problems are solved by a complex network of non-formal relationships, operated outside traditional organizational contexts. However, the regulatory agenda was incorporated into the daily life of THs, reinforced by the contracting policy, even with an intense and permanent dispute.

Regarding the changes in the quality of care provided by THs, advances related to the NHP

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were present in all THs studied, although seen as something prior to contracting. According to the interviewees, the policy strengthened and gave more visibility to the NHP, but it was not decisive.

Risk classification systems in emergency services, creation of ombudsman offices, preparation of care protocols, guidelines, among other tools aimed at the qualification of care were actions that were also already being adopted, in collaboration with other government policies, following trends in hospital management that were intensified in the years following the collection of empirical data from this investigation. The creation of ethics committees, medical records, investigation of deaths, among others, pointed out as evidence of the qualification of care, were either already present or induced by the certification process. The lack of monitoring processes, however, prevented the evaluation of the actual functioning and impact on the qualification of care[15].

We could not observe consistent changes desired in the care model, based on lines of care, a theme that still lacked interest in the discussions and negotiations at the time of contracting.

TH Management

The most significant impacts in the years following the contracting of THs were the expansion of the contribution of resources and the change in the financing model. Although perceived differently by managers and directors of the THs, and more positively among those of the federal THs, they were always pointed as the more visible and important changes in the policy, perception corroborated by another study[16], which showed an increase in the financial contribution of the federal THs contracted by 51% between 2003 and 2006, providing the sanitation of the severe crisis, stability and better capacity for planning and management. According to the superintendent of a TH studied:

The new funding method has greatly improved the situation of the hospital. [...] 100% of financial indicators have reversed. The growth of liabilities began to have a downward curve. [...] the hospital debt was negotiated. [...] The objective and clear answer is that it has improved a lot.

Despite this, TH leaders pointed out problematic aspects. First, the lack of periodic realignment of the values of incentive to contracting and the non-incorporation of new resources to expand services to the SUS beyond the contracted, often demanded by the manager. Moreover, the retention by managers of resources made available to THs by the Brazilian Ministry of Health, based on changes in the *Fundo de Ações Estratégicas e Compensação* (Strategic Actions and Compensation Fund - FAEC), incorporated into the medium and high complexity procedures. In a TH studied, administered by SOs, even the values of the incentive to contracting were not passed on by the state manager, who claimed that he already had a global contract with the TH.

The most critical aspect was the maintenance of the billing logic by the SUS table, which made the THs resented in negotiating changes in the profile of assistance and service offer, generating restriction of emergency supply and medium complexity, since increasing the high complexity would result in greater mobilization of SUS resources to the THs.

Another aspect was the non-implementation of mixed global financing, with part of the fixed resources and part received by the fulfillment of contracted targets, which should increase annually and progressively until they make up 50% of the total amount to be received by the TH. The payment of high complexity procedures would be maintained by production, so as not to discourage the provision of services to the SUS. Some local managers "packaged" all the resources and made the fixed global payment, without managing the contracted goals. There was, therefore, a distortion of the original logic.

Another point of conflict concerns the dispute between MH and ME regarding the cost of federal THs, unresolved tensioning that resulted in the implementation of the Brazilian Hospital Service Company (EBSERH) and in the change in the standardization of the policy of THs linked to the federated institutions of higher education, among other things.

The policy provided for a period of up to four years for the public TH to make 100% of their offer available to the SUS. This point, which dealt directly with the public-private relationship, remains unimplemented.

Coping with the financial crisis, the THs opened new perspectives, expanding the governability of their leaders, who began to use the balance achieved as a validation device for the projects desired. For the implementation of actions defined as strategic for TH, its leaders did not hesitate to insert them between the goals of the contract and to strain the other actors internal to TH to comply with them, pointing out the risk of decreased financial resources if they were

not implemented, even if they were not charged.

Moreover, it can be empirically apprehended that the chosen goals were under governability of the leaders and each sector of the TH, avoiding those that required confrontation with the academic or medical institution, corporate interests or changes in the work process.

The arrangements of participation and control idealized by the policy, strongly inspired by the production of authors that emphasize the need for the constitution of collective subjects, horizontalization and democratization of relations between workers, users and managers[17], failed to produce a new management logic, more visible and transparent.

The fragility of the mechanisms for monitoring and democratizing management, the absence of initiatives by local managers to implement the contract, provoke changes, negotiate and monitor indicators, goals and commitments were one of the most critical points of the contracting policy. The Contract Monitoring Committees, which should involve, in addition to managers, representatives of users of health councils and the internal community, were either not implemented or assumed a markedly formalist profile, with a purely homologatory character and composition, sometimes manipulated. The same occurred regarding the institution of Management Councils, which worked according to the protocol, reproducing practices identified in other instances of social participation provided for in the SUS[18,19].

The perception that SUS managers presented technical weaknesses in the conduct of policy and that the TH was not properly monitored prevailed among TH leaders. According to one manager interviewed: "We were much more prepared than what we were charged. I'm under the impression that this would help. The charge could be more rigid".

The managers of the SUS attributed a secondary character to the management of the contract, once the resources were originally from the federal sphere. It should be considered, however, that they recognize that HE is a place of high concentration of power, and that they depend on it to guarantee the supply of services in their network. The managers interviewed consider TH a complicated provider, difficult to control.

Complacency is a concept that characterizes the attitude of managers regarding the monitoring of goals. It results from the (non) training of the manager and the fragility of the public structure responsible for regulation, how essential the TH is for locoregional assistance, making any more radical attitude of cutting resources impossible, and frequent "agreements of gentlemen" among the actors that go out of instances and formal control procedures proposed. Due to many local reasons, an agenda of indulgence is established among the actors[20] that permanently discredits contracting instruments, causing them to lose their power. This may be considered an indication of how much the contractual logic of the State business process[21] may not have the expected power of control, because it is full of formalism and false transparency, which hinder the effective monitoring, by the State, of the performance of the contracted entities.

The federal government has not made its part. Despite the amount of resources involved in the policy and the set of bets involved, the federal managers interviewed acknowledged that they were unable to implement policy monitoring mechanisms. The only effective strategy was certification for framing the set of policy regulations, which did not objectively confront the TH fundamental issues, particularly those within the scope of the academic institution and the medical institution. Thus, the formal and precarious functioning of contract evaluation committees was not an isolated finding and is an important evaluative element. The difficulties in the contracting of THs remain present, although few advances have been produced beyond the formal contractual relationship[15,22].

The non-capillarization of the targets inside the hospital was one of the most important problems observed. Knowledge of the terms contracted among workers was very low. Contracting also did not resulted in the TH horizontalization of management and participatory planning. Most of the THs had master plans that were not elaborated with the participation of workers or, at least, of the intermediate managements. If there was any impact on the qualification of planning, it was attributed to ongoing accreditation processes, inserted in the broader management restructuring movement established throughout the country[23,24].

One of the most relevant aspects of contracting was the intense use of information as a management tool that sometimes assumed a fetish character. In all spheres of government and within the THs studied, there was a certain expectation that the adoption of an efficient information system could expand control over TH complex life, giving it the necessary visibility and predictability.

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Computerization emerged as the main technological basis of the new organizational rationality desired paradoxically marked by strong elements of irrationality, including the existence of multiple disarticulated or redundant systems, letting the irrational within the rationale show. On the one hand, TH's leaders, reacting with discomfort to the different systems, fed to fulfill formalities required by managers that, in turn, believed that they would qualify monitoring with new computerized tools.

Management instruments thought as powerful to induce transformations in organizational life *per se* become simulacrums or mere formalities when implemented, without producing new configurations of power relations in hospital life. Contracting involves several actors that dispute their projects in action in the TH micropolitics; however, if allowed to strengthen senior management, it could not include new actors and substantially transform organizational dynamics. This was not due to lack of training, management instruments or policy "maturation time", as advocated by the prevalent functionalist conception, but because of the limitations of conception and formulation of the TH's own contracting policy.

TH leaders and federal managers attributed significant weight to the lack of training of local SUS managers to explain deficiencies and failures of the contracting policy. As a corrective measure, they recommended more training courses for managers, who also assume a fetish character, similar to information systems.

Training and Permanent Education

The influence of this guideline was not significant. Changes in health education that use new teaching scenarios outside the hospital environment were treated as isolated initiatives. However, significant improvements in teaching infrastructure in THs (spaces for classes and meetings, laboratories, libraries and internet access) were emphasized, attributed to the induction triggered by the certification, because they were observable requirements in the qualification of the establishment as TH.

The participation of THs in the training of SUS professionals was insignificant. For the managers of the THs, the managers did not demand training processes and CE, and the offers in courses and other activities did not have the support of the network professionals. The goals presented in this axis were not met and the TH was not penalized only because the Contract Monitoring Committees worked only formally. The managers claimed that the THs are far from the needs of the SUS, without using the goal contract to present their demands. In practice, the relationship with TH remains restricted to the care dimension. It is difficult to identify the extent to which this situation can be explained by the disinterest or fragility of SUS managers or by the type of training proposal and PE that the TH can provide.

Another relevant aspect concerns the investment in permanent education in THs. The recommendation for the problems was the mass training of employees and the training of hospital managers to apply management techniques and tools. Powerful information systems and strong investment in management training ended up being conducted in a very simplified way, with the expectation of being strategies to face the complex web of relationships that cross and constitute organizational life.

It was also observed that there is a conceptual confusion regarding training, continued education and PE, treated as synonyms. The EP foresees long-term processes, with strong participation and leadership of managers and/or workers, based on their daily problems, with the intention of going beyond the formal training processes related to permanent education, with more punctual approaches and less power to transform practices[10,25]. The discourse contained in the proposal of PE, conceived by the Ministry of Health, was guided by a well-defined ethical-political-emancipatory sense, but ended up being translated into the daily life of THs and local management as permanent education, with emphasis on training, which is another element that points to the distance between discourse and practice.

Knowledge production and technological incorporation based on the needs of the SUS

There is a widespread perception that policies has not had enough power to trigger changes in this axis. SUS managers did not introduce these themes into their agendas. Even educational establishments pointed out by federal leaders as reference experiences in the implementation of the policy presented recognized inexpressive results.

The timid changes observed, restricted to the implementation of Ethics Committees, Studies and Research committees and research boards,

indicate that certification also had, in this axis, a more striking inducing character than contracting. Moreover, they served as attempts by THs' senior management to discipline and control the current chaotic situation. The regulation of beds by the manager and the creation of the teaching and research boards in the THs allowed the introduction of regulatory movements of the production of research in institutions, changing the previous standard, markedly dictated by academic interests. It is worth assessing if they would be internal devices to micropolitics with the power to conduct new postures, constituting a more micropolitical path to be followed.

It is worth citing the main limits of the methodological framework adopted in this study. It was not possible to apprehend the evaluation of other organizational actors that act in a strategic position in a TH and, by them, to capture possible resonances of the desired distribution of politics in organizational life. It was not possible to make comparative considerations between the state and municipal management of THs, although they do not point to substantive differences. It was not possible to consider the changes that have occurred in recent years in the management of federal THs since the creation of EBSERH. One selected federal TH has not yet joined EBSERH and the other only established its first contract in May 2018. Finally, it is also necessary to consider the discontinuity – although not formal – in the conduct of policies based on the profound changes that occurred in the Brazilian political scenario, since 2016, which affected several public policies conducted by the MH and ME. If not repealed, they have had compromised implementation rhythms or taken other directions. This, in turn, extends the importance of analyzing a politics undertaken at an odd historical moment.

Final remarks

The contracting policy of THs brought concrete benefits. In the period studied, its most visible face was the economic-financial balance and decreased indebtedness. It also allowed an organizational balance and improvements in the regulation of access of SUS users in all he studied. Other advances seem to be more due to previous interventions required for certification as TH, or resulting from collaboration with other ongoing government policies, results that present marked convergences with other research[26]. Teaching, PE, research and technological incorporation were neglected purposes. Care management and the more micropolitical processes of the organization of the work of the teams were not faced.

The policy forged a consistent project, idealized, full of laudable principles and intentions, which ended up reproducing the conservative behavior that characterizes public management, an instrumental rationality that emphasizes the administrative act and excessive standardization. It was elaborated based on a management concept with structural-functionalist bias, with strong emphasis on process standardization, increased visibility and responsibility of all sectors (and actors) of the hospital, in the incessant search for predictability and regularity, and an increasing capacity for control, through the intensive and increasingly sophisticated use of information technology.

The empirical material presents several clues that the policy ended up being a game of absent actors; that is, how much the projects formulated by the Sanitary Movement, even when generous and bold, conceive idealized actors that never act as expected. It assumed the support of actors capable of operationalizing a policy that did not exist in the desired power or whose performance was not compatible with the assigned responsibilities. There is no public manager of the ideally qualified SUS. The hospital management is still very fragile. The contracting was effective in a field produced by the relations of local forces that also deform the rationalizing vectors proposed by the policy. TH is the field of great disputes, although not necessarily noisy, of both the academic and the medical institution.

The empirical findings of our study provoke a shift of exteriority look that characterized the initial formulation of the study for the interior of the policy itself. The expectation that a new managerial rationality could overcome conflicts and disputes based on a government policy did not materialize without considering the complexity of TH's micropolitics. The set of proposed devices, at most, was appropriated by some directions of hospitals to expand, consolidate or simply legitimize ongoing change projects.

Based on an ethical-political project that aims to build the new TH (democratized, transparent in all dimensions of its management and committed to the construction of the SUS as a public policy), the TH restructuring policy ended up being implemented with elements related to the structural-functionalist framework, reproducing the instituted ones that it proposed to transform.

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Theory – specifically concepts and the world's way of thinking – has a profound influence on our way of acting and thinking about management. There are conceptual-operative elements of the policy that require review.

The policy had the great merit of pointing out a new mode of relationship between the SUS and the THs, if considered the isolation and the current disengagement, as well as its crossing by numerous private interests, from the chair to the medical-industrial complex.

In this sense, the contracting policy represents a milestone in health policy in our country, a fact recognized by almost all interviewees. However, the empirical material is full of indications about how the most ambitious and generous policy guidelines and principles have only touched the surface of this challenging territory that is a TH, so that the study indicates the importance of a critical review of its theoretical-conceptual starting point, thus hoping to contribute to future interventions and studies.

Collaborations

A Chioro and LCO Cecílio worked on the study conception and design, methodology and writing of the article. A Chioro and R Andreazza worked on the final review. The other authors worked on the critical review and approval of the published version.

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