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Research Article

Sociodemographic profile of family and community doctors who work in Brazilian supplementary health

Perfil sociodemográfico de médicos/as de família e comunidade que atuam na saúde suplementar brasileira

Perfil sociodemográfico de los médicos de familia y comunitarios que actúan en la salud suplementaria brasileña

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Abstract

Introduction: Family and Community Medicine is a reference in comprehensive humanized care in the Brazilian Unified Health System, especially in Primary Health Care. Due to the cost-effectiveness of this model, supplementary health has sought to integrate this specialty into its services. **Objective:** To evaluate the sociodemographic profile of family and community doctors who work in Brazilian supplementary health. **Methods:** This is a quantitative-descriptive research, in which an electronic questionnaire was applied between June 2022 and June 2023. A total of 156 valid responses were obtained. After tabulating the responses, relationships between the main variables were observed using Fisher's exact test for 2x2 cross tables. **Results:** We identified a predominant profile of cisgender, heterosexual, white women from the Southeast region, with an average age of 35.7 years, and with a per capita family income greater than 20 minimum wages. We found evidence of wage inequality between sexes, in addition to greater work overload for women due to childcare. However, according to the tests carried out, no significant relationships were found between the variables income, gender identity, and having children. **Conclusions:** The profile of professionals working in family and community medicine of supplementary health is similar to other medical categories.

Keywords: Primary health care; Family practice; Supplemental health.

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Resumo

Introdução: A medicina de família e comunidade é referência no cuidado integral humanizado no Sistema Único de Saúde, sobretudo na Atenção Primária à Saúde. Por causa do custo-efetividade desse modelo, a saúde suplementar tem buscado integrar essa especialidade nos seus serviços. **Objetivo:** Avaliar o perfil sociodemográfico de médicas/os de família e comunidade que atuam na saúde suplementar brasileira. **Métodos:** De natureza quantitativo-descritiva, a pesquisa aplicou um questionário eletrônico entre junho de 2022 e junho de 2023 e obteve 156 respostas válidas. Após as respostas tabuladas, foram vistas relações entre as principais variáveis por meio do teste exato de Fisher para tabelas cruzadas 2 × 2. **Resultados:** Obteve-se um perfil predominante de mulher cisgênero, heterossexual, branca, da Região Sudeste, com média de idade de 35,7 anos e renda *per capita* familiar superior a 20 salários mínimos. Foram encontradas evidências de desigualdade salarial entre os sexos, além de maior sobrecarga de trabalho entre as mulheres em função do cuidado com os filhos. Todavia, não foram encontradas relações significativas entre as variáveis renda, identidade de gênero e filhos, por intermédio dos testes realizados. **Conclusões:** O estudo evidenciou que o perfil de profissionais atuantes na medicina de família e comunidade da saúde suplementar se aproxima do perfil restante da categoria médica.

Palavras-chave: Atenção primária à saúde; Medicina de família e comunidade; Saúde suplementar.

Resumen

Introducción: La Medicina Familiar y Comunitaria es referente en la atención integral humanizada en el Sistema Único de Salud, especialmente en la Atención Primaria. Debido a la rentabilidad de este modelo, la salud suplementaria ha buscado integrar esta especialidad en sus servicios. **Objetivo:** Evaluar el perfil sociodemográfico de los médicos de familia y comunitarios que actúan en la salud suplementaria brasileña. **Métodos:** De carácter cuantitativo-descriptivo, se aplicó un cuestionario electrónico entre junio de 2022 y junio de 2023. Se obtuvieron 156 respuestas válidas, las cuales, luego de tabularlas, se observaron relaciones entre las principales variables mediante la prueba exacta de Fisher para tablas cruzadas de 2x2. **Resultados:** Se obtuvo un perfil predominante de mujeres cisgénero, heterosexuales, blancas, de la región Sudeste, con edad promedio de 35,7 años y con ingreso familiar per cápita superior a 20 salarios mínimos. Se encontraron evidencias de desigualdad salarial entre sexos, además de una mayor sobrecarga laboral para las mujeres por el cuidado de los hijos. Sin embargo, no se encontraron relaciones significativas entre la variable ingreso, identidad de género y tener hijos, a través de las pruebas realizadas. **Conclusiones:** el estudio demostró que el perfil de los profesionales que actúan en la medicina familiar y complementaria en salud comunitaria es cercano al resto de la categoría médica.

Palabras clave: Atención primaria de salud; Medicina familiar y comunitaria; Salud complementaria.

INTRODUCTION

Family and community medicine (FCM) emerged from the need to overcome the biomedical model and establish doctors in primary health care (PHC).[1] In 1976, there were already some experiences of this new model in Brazil: the *Centro de Saúde Escola Murialdo* [Murialdo School Health Center], in Porto Alegre (state of Rio Grande do Sul); the *Projeto Vitória de Santo Antão* [Vitória de Santo Antão Project], in Vitória de Santo Antão (state of Pernambuco); and the Comprehensive Medicine Service of Universidade do Estado do Rio de Janeiro, in Rio de Janeiro (state of Rio de Janeiro). It is worth noting that these residency programs were only formalized in 1981 by the National Commission for Residency Programs, which created the specialty of general and community medicine.[2]

In 2001, the name of the specialty of general and community medicine was changed to FCM. Two years later, the first calls for tender for specialists also began to be published, establishing residency and proof of title as means of specialization.[3] Since then, FCM has substantially contributed to the good development of PHC in Brazil.[2] Hence, the government began to encourage training in FCM focused on PHC and the Family Health Strategy (FHS), strengthening the National Primary Care Policy. In addition, in 2013, the *Mais Médicos* [More Doctors] Program expanded residency vacancies in FCM and sought to establish long-term family and community doctors in family health centers.[4]

Even with the creation of the Brazilian Unified Health System (SUS), the private health network remained strong in the country, becoming recognized as a supplementary network in relation to the public

system, that is, this modality could exist without the SUS depending on it. However, its regulation was only based on the economy, which made the environment conducive to market failures, with unilateral breaches of contracts and abuse of monthly fees.[5] Under the need for public regulation of private supplementary health, the *Agência Nacional de Saúde Suplementar* [National Supplementary Health Agency] was created, an autonomous entity linked to the Brazilian Ministry of Health responsible for regulating health insurance plans and operators, ensuring the quality of care provided by them.[6]

Private health contradicts the principles of FCM, as it is mostly based on medical examinations and referrals, while FCM, implemented in PHC, has high problem-solving capacity with a reduction in unnecessary interventions as a premise.[7] Seeking to reduce costs with interventions, the supplementary network began to attract family and community doctors to work in its services, but differently from public practice, as family and community activity is not prioritized in the private scenario.[8] This may indicate not only ideological cleavage in the name of the specialty, but also the acquisition of FCM only driven by cost savings.[7] This insertion has been configured to weaken the lines of force of FCM, especially because such doctors are closer to the strictly biomedical clinical practice than to the expanded and person-centered care, defended by the specialty.[8]

Although the general profile of family and community doctors indicates that the category is mostly composed of women aged 39 years who live in large urban centers,[9] little or nothing is known about the sociodemographic profile of family and community doctors who work in supplementary health in Brazil. Taking this into consideration, in the present study we aimed to analyze the sociodemographic profile of family and community doctors who work in the supplementary health network in Brazil.

METHODS

This is a quantitative study with the application of a self-administered electronic questionnaire. The questionnaire was prepared with objective questions divided into four blocks:

1. sociodemographic data;
2. information on undergraduate education;
3. family and community doctors;
4. work experience.

For this article, the answers obtained in block 1 of the questionnaire were used.

As this is a poorly studied and unquantified population, the sample was obtained through the snowball technique, which consists of a non-probabilistic technique that uses the reference networks of a seed, defined as the starting point, which makes the first recommendations. This type of sampling can be used for groups that, like the one in the present study, are difficult to reach and that do not have estimates as to their actual universe.[10]

One of the researchers in this study, who is a family and community doctor who worked, at the time of the research, in the supplementary network at a clinic in Natal (state of Rio Grande do Norte), acted as a snowball seed, recommending the family and community doctors who worked in the supplementary network. The recommendations of the seed were invited to participate in the research and, after completing the questionnaire, they made new recommendations, which may or may not be from their own work environment. Recommendations previously made were discarded, as well as those who did not respond to the invitation or those who did not accept to participate in the research.

Other exclusion criteria were: not having title of specialist in FCM or not working, at the time of the research, in an insurance company, health insurance plan, or private clinic that is part of the supplementary health network.

Data collection was terminated when recommendations were exhausted, as no new responses to the questionnaire were obtained. Thus, the entire network established by the researcher used as a seed and his recommendations were explored.

The questionnaire was applied between July 2022 and June 2023, obtaining a total of 162 responses, of which seven were excluded according to the aforementioned criteria. A total of 155 responses remained, with data on age, state of residence, marital status, per capita income, skin color/race, sex/gender and sexual orientation, and whether they have children. The data were tabulated in an Excel spreadsheet and analyzed with the aid of the statistical software IBM Statistical Package for the Social Sciences version 22.0, from a descriptive perspective of the relationships between the surveyed variables. The relationships between the variables of the sociodemographic profile were analyzed using χ^2 independence tests (or Fisher's exact test) for cross tables, adopting $p<0.05$ as significant.

It is worth mentioning that this study was linked to the Master's Program in Public Health of Universidade Federal da Paraíba, was submitted to the Research Ethics Committee of the Center for Medical Sciences of the same educational institution and approved, under the Certificate of Presentation for Ethical Consideration No. 42482721.7.0000.8069, complying with the guidelines on research involving human beings established by Resolution No. 466, of 2012, of the National Health Council.

RESULTS AND DISCUSSION

Among the 155 respondents, 65 (41.93%) were from states in the Southeast region, while 31 (20%) were from the South, 30 (19.35%) from the Midwest, 28 (18.1%) from the Northeast, and one (0.65%) from the North. The states of São Paulo, Goiás, and Paraná had the most participants, the first accounting for 60 (38.7%) responses. The only representative of the North region was from the state of Pará. The South was the only region that had participants from all its states. In the Midwest, we could not encompass family and community doctors in Mato Grosso do Sul, while in the Southeast, Espírito Santo had no participants in the research. In the Northeast, we obtained no answers from the states of Alagoas, Ceará, Maranhão, Piauí, and Sergipe. In Chart 1 we show in detail the number of responses obtained from each federation unit, and the percentages of the sample selected by region only serve as an approximation, in view of the non-probabilistic sample planning used in the research.

Chart 1. Description of the selected sample of family and community doctors according to their region of origin.

Region	**North**			**Northeast**			**Midwest**			**Southeast**			**South**	
Federation Unit	Pará	Bahia	Paraíba	Pernambuco	Rio Grande do Norte	Federal District	Goiás	Mato Grosso	Minas Gerais	Rio de Janeiro	São Paulo	Paraná	Rio Grande do Sul	Santa Catarina
Quantity	1	8	3	3	14	7	15	8	11	3	60	15	12	4
Total	1			28			30			74			31	

In the medical guide found on the institutional website of the National Confederation of Medical Cooperatives (*Confederação Nacional das Cooperativas Médicas* – Unimed, a Brazilian medical work cooperative and health insurance operator), there is a survey of family and community doctors who work in its network.[11] In this survey, the region with the highest number of family and community doctors is the South, followed by the Southeast and the Midwest, supporting the hypothesis of a greater insertion of the FCM in the supplementary network of the South and Southeast regions of the country. Similar to our research, some states do not have any family and community doctors registered on the website, most of them from the North region; however, it is worth mentioning that these data refer to professionals who work at Unimed, which is not even the largest supplementary health institution in the country.

Considering that there is no national database on family and community doctors who work in the supplementary network, it can be understood that, with the sample numbers of the present study, we achieved good national representation, comprising 15 of the 27 federation units.

Conversely, the average age of the research participants was 35.7 years (26–69 years), maintaining the value when analyzing the sexes separately (men=35.3 and women=35.8). The state with the highest average age was Paraíba (46.3 years), whereas the lowest average was found in Minas Gerais (30 years). These data corroborate the 2023 Medical Demographics,[12] which points to a process of rejuvenation of the Brazilian medical professional, estimating that more than 85% of doctors will be between 22 and 45 years old in 2035. In this article, 146 (94.14%) of the participants were already in the age group of 22 to 45 years, demonstrating the representativeness of our sample.

When analyzing the physicians who compose the FHS of the metropolitan region of Recife (state of Pernambuco), Guarda et al.[13] found that most professionals were in the age group above 40 years, while Nogueira et al.[14] found an age pattern below 30 years among physicians working in the FHS of Ponta Grossa (state of Paraná). It is noteworthy that, in these studies, often, doctors working in the FHS are not specialists in FCM, as in the case of Ponta Grossa, where only 1.6% of professionals were specialists.

The 2023 Medical Demographics[12] points to FCM as the second specialty with the youngest average age in Brazil (41.5 years). Rodrigues et al.[15] argue that this may be related to the greater supply of vacancies in medical residency, especially after 2013, with the creation of the Mais Médicos Program.[16] In addition, in the 2018 Medical Demographics,[17] single individuals and those with no children predominated in this specialty, which is consistent with the low average age.

Furthermore, in the aforementioned Unimed Medical Guide,[11] it was observed that many professionals have another specialty, which may point to the choice of FCM as the first specialization or kickoff of the career, as the FCM specialist earns a 10% bonus in residency tests for other specialties. This characteristic reinforces the low average age found among these professionals.

Regarding race/skin color, two participants (1.3%) preferred not to answer the question. Of the 153 respondents, 106 (69.29%) self-declared to be white, while 40 (26.1%) self-declared to be Black, being 37 (24.18%) brown and three (1.96%) Black; and seven (4.57%) self-declared to be Asian.

These data reflect the whiteness that permeates both undergraduate education and residency programs and the job market of the medical profession. The Medical Demographics points that the percentage of self-reported Black and brown medical students accounted for 28.2%,[12] a datum similar to that found in the present study. Although this number does not indicate a significant growth of self-declared non-white students in medical courses when compared to previous years, an exponential growth is noticeable, especially after 2012, the year of approval of Law No. 12.711, which instituted the mandatory system of ethnic-racial quotas on admission to universities and which has been recently reformulated.[18]

Souza et al.[19] also pointed, as in the present study, to the low inclusion of the Black population in the medical category even after the institution of ethnic-racial quotas. The authors state that this may occur due to the short period of the institution of the quotas, considering that the people benefiting from this public policy are still completing their medical undergraduate course and residency, or due to the lack of public policies that, in addition to access, guarantee the permanence of these students in the university. For now, the white race/skin color predominates in the profession, which is also evidenced by the 2019 Medical Demographics.[20] In this study, 67.1% of medical graduates were white, while 3.4% self-declared to be Black and 3%, brown.

Regarding sexual orientation, 127 (81.94%) of the participants self-declared to be heterosexual; 18 (11.61%), homosexual; nine (5.8%), bisexual/pansexual; and one, (0.65%) asexual. It should be noted that neither the current Medical Demographics nor articles whose authors analyze the profile of family and community doctors address information on the sexual orientation of Brazilian doctors. Nevertheless, such an approach is of paramount importance, as medicine is an institution that promotes norms and behaviors that most often choose to exclude diversities such as lesbian, gay, *travesti* and transgender, queer, intersex, asexual, pansexual, non-binary populations and individuals of other gender expressions (LGBTQIAPN+).[21] Thus, an environment marked by heteronormativity prevails, in which the formal curriculum and the relations of the everyday spheres of training and work tend to propose non-hegemonic sexualities as a deviation from the norms, which heteronormativity itself helped to create.[21] Shedding light on sexual orientation allows studies such as this to highlight the lack of representation of this population in the medical environment.

Regarding gender identity, 102 (65.80%) study participants are cisgender women and 53 (34.2%), cisgender men. There were no transgender participants in our research. This finding is similar to that of Rodrigues et al.,[9] in which 58.1% of the family and community doctors who participated in their study were women. According to the 2023 Medical Demographics,[12] among doctors, 48.6% are women; however, for 2024, there was a projection for women to be the majority (50.2%) in medicine. This growth may continue in the coming years, as the majority (61.1%) of newcomers to medical schools in 2019 were women.[12]

The feminization of medicine has been a national and global trend. It is capable of reflecting not only the conquest of feminist movements,[22] but also the promotion of means that guarantee equal access to a professional career, through the confrontation, in recent decades, of barriers that had been imposed by society,[7] such as the belief that women's most important mission lies in their home, between the care of their partner and children and other domestic activities, putting their success outside this environment in the background.

We also sought to analyze the per capita family income of the participants using the same criteria of the Brazilian Institute of Geography and Statistics for determining social classes in Brazil, based on the number of minimum wages. Class A has an income above 20 minimum wages; class B has a defined income between 10 and 20 minimum wages; class C, between five and 10; and class D, below five minimum wages. Of the participants, six (3.87%) preferred not to answer this question. Of the 149 who answered it, 75 (50.33%) had an income between 10 and 20 minimum wages (class B); 43 (28.87%), above 20 minimum wages (class A); 29 (19.46%), between five and 10 minimum wages (class C); and only two (1.34%) had a per capita family income below five minimum wages, classified as class D.

In Chart 2 we show income levels according to gender identity. The χ^2 test showed p=0.233, indicating no significant relationship between income and gender identity. However, we observed that 36.2% of men earn more than 20 minimum wages, while only 24.5% of women reach this level of income. It is noteworthy that the six people who omitted their income were cisgender women.

Chart 2. Cross tabulation between gender and income.

		Gender identity		Total
		Cisgender man	Cisgender woman	
Value of per capita family income (in minimum wages)	1–5	0	3	3
	5–10	12	19	31
	10–20	25	52	77
	Over 20	21	24	45
Total		58	98	156

Furthermore, in Chart 2 we notice that there are no cisgender male participants with an income below five minimum wages. In contrast, over 20% of cisgender women have an income of less than 10 minimum wages, whereas the percentage of cisgender women with an income greater than 20 minimum wages is 13% lower than the proportion of men in the same category.

Although feminization in Brazilian medicine has been discussed in the last decade, several authors[7,22,23] have already reported that this process is not being accompanied by equal pay, or even by the achievement of women in leadership positions in medicine, which would explain the lower salaries.

Despite the wage difference between cisgender men and women, more than half of the participants in the research are classified as class A. The 2023 Medical Demographics[12] demonstrated, according to the Federal Revenue Service, that the average monthly income of Brazilian doctors is BRL 30.1 thousand, that is, above 20 minimum wages, which also places them in class A. Both scenarios reinforce the medical class in the elite of society.

When analyzing the presence of children, only 52 (33.55%) of the 155 participants had one or more children under the age of 18. The median was 0 (0–4; interquartile range – IQR=1), with 103 (66.45%) individuals having no children under 18 years of age; 26 (16.77%), two children; 18 (11.61%), one child; seven (4.52%), three children; and one (0.65%), four children under 18 years. These findings are similar to those of Miranzi et al.,[24] who found that most FHS doctors in the regional council of Uberaba (state of Minas Gerais) had up to two children. In addition, in this study we showed that the highest average number of children was concentrated in family and community doctors who were over 40 years old (1.33 children per participant), followed by those who were 30 to 39 years old (0.43 children), and then by those who were 29 years old or younger (0.2 children).

Most physicians who are fathers aged between 30 and 40 years (52.6%), while most physicians who are mothers aged between 40 and 50 years (51.4%). This reflects the greater freedom that men have to start a family and maintain their professional activities and, therefore, they do it earlier, while women still bear most of the responsibility for the home and the family[25] — thus, they may end up choosing to be mothers at a more advanced stage of their lives, for fear that this will hinder their professional career.

When correlating having children with the gender of family and community doctors, we observed, through Fisher's exact test, that there is no significant relationship (p=0.908) between gender identity and having children, in such a way that 33% of the men and 34% of the women in the sample have children. Nevertheless, it is noteworthy that the trend pointed out by the study is that doctors do not have children (66.6%, 108).

As previously discussed, we noticed that female doctors have a lower income than male doctors, but we investigated another important factor about such wage inequality. According to Chart 3, income above 20 minimum wages is concentrated among cisgender men who do not have children. Despite being the majority in our study, among professionals who do not have children, women were not the majority among participants with an income above 20 minimum wages. This reinforces the hypothesis that women who participated in our study continue to earn less than men regardless of whether they have children or not.

Chart 3. Cross tabulation between income and gender according to having children.

Has children				Gender		Total
				Cisgender man	Cisgender woman	
No	Income (in minimum wages)	1–5	fi	0	2	2
			%	0	100	100
		5–10	fi	6	9	15
			%	40	60	100
		10–20	fi	17	38	55
			%	30.9	69.1	100
		Over 20	fi	16	15	31
			%	51.6	48.4	100
	Total		fi	39	64	103
			%	37.9	62.1	100
Yes	Income	1–5	fi	0	1	1
			%	0	100	100
		5–10	fi	6	10	16
			%	37.5	62.5	100
		10–20	fi	8	14	22
			%	36.4	63.6	100
		Over 20	fi	5	9	14
			%	35.7	64.3	100
	Total		fi	19	34	53
			%	35.8	64.2	100
Total	Income	1–5	fi	0	3	3
			%	0	100	100
		5–10	fi	12	19	31
			%	38.7	61.3	100
		10–20	fi	25	52	77
			%	32.5	67.5	100
		Over 20	fi	21	24	45
			%	46.7	53.3	100
	Total		fi	58	98	156
			%	37.2	62.8	100

fi: absolute frequency.

This indicates that gender wage inequality is not exclusively about the double maternal journey, but rather about patriarchy, rooted in the profession mostly built by men. Despite the feminization of medicine, this patriarchy reinforces men in high command positions of hierarchy and management, which is where the highest salaries are concentrated, considering that the cultural stereotype of manager belongs to men, while women are seen as less capable leaders.[26]

This absence of women in leadership positions in health had already been evidenced by Waskiewicz et al.[27] in hospitals in the Southern region of Brazil, in addition to Portes and Dallegave,[26] who discuss the role of gender and race equity committees as ineffective in terms of access to decision-making positions.

In Chart 4 we observe that the relationship between having children and income level was deemed significant according to the Fisher's exact test (p=0.039) at the significance level α=0.05, indicating that 70.5% of family and community doctors who have a higher income level do not have children.

Chart 4. Cross tabulation between the variables income and having children.

			Has children		Total
			No	Yes	
Income (in minimum wages)	Up to 10	Counting	17	17	34
		% in income	50	50	100
	Above 10	Counting	86	36	122
		% in income	70.5	29.5	100
Total		Counting	103	53	156
		% in income	66	34	100

A limiting factor of this article is that we could not identify whether the cause of this decrease in income among doctors with children is because they earn lower wages or if the per capita family income decreases due to the greater number of dependents in the household. Therefore, we emphasize the need for future studies that can better analyze this issue.

We noticed the prevalence of the Brazilian medical standard in these professionals, whose predominant profile is cisgender, heterosexual, white, adult women belonging to class A. Some of these characteristics end up being more evident, such as the prevalence of heterosexuals and white individuals, which may be related to the private sector, which often further reinforces the elitism of the category.

As stated by Oliveira et al.,[8] the accentuation of such characteristics can be explained as an attempt to undo the shock caused by the contact with difficult life stories that often belong to a reality outside the context of doctors with the described profile. This would happen, according to the authors, due to the difference between the profile of users of health insurance plans, who are mostly white women of classes C and D, while most users of primary health care are Black women of classes C, D, and E.

CONCLUSION

Despite the difficulties of comparison with other studies in the literature, due to the scarcity of scientific articles whose authors address the sociodemographic profile of family and community doctors and, more specifically, who work in the supplementary network, this article fulfilled the objective proposed herein. We covered important topics, such as the delimitation of the profile of family and community doctors who work in supplementary health (cisgender, heterosexual, white, adult women with children and belonging to social class A).

Two other limiting factors of the study were the lack of participants from some Brazilian states and the lack of representativeness of the North region of Brazil. We could not ascertain whether this lack of representation consists of a distance between professionals in this region, causing them not to be recommended in the adopted methodology, or if this indicates that the phenomenon of FCM in the supplementary network has not yet effectively reached the health insurance plans and companies of the North region. Further studies in these regions are necessary for a better understanding.

The analysis of the relationships between the variables of the sociodemographic profile was not able to predict the statistical relevance of the relationship between the surveyed variables, with the exception of level of income according to having children, which showed a significant relationship.

Due to the similarity of the sociodemographic profile of these professionals with other Brazilian doctors, we could not highlight strong evidence that family and community doctors with a certain profile are more likely to work in the supplementary network. The investigation of the responses collected with the fields of training and professional performance, also included in the applied questionnaire, can establish stronger correlations in this sense and will be published subsequently.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

JGXQ: Investigation, Methodology, Project administration, Writing – original draft. MACS: Investigation, Methodology, Writing – original draft. ILO: Formal analysis, Writing – review & editing. JCLL: Data curation, Methodology, Supervision, Writing – review & editing. JS: Formal analysis, Project administration, Supervision, Visualization, Writing – review & editing.

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