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FAMILY HEALTH STRATEGIES: ABOUT MANAGEMENT, WORK PROCESS AND HEALTH CARE

ESTRATÉGIAS DE SAÚDE DA FAMÍLIA: SOBRE GESTÃO, PROCESSO DE TRABALHO E ASSISTÊNCIA À SAÚDE

ESTRATEGIAS DE SALUD DE LA FAMILIA: ACERCA DE LA GESTIÓN, EL PROCESO DE TRABAJO Y EL CUIDADO DE LA SALUD

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ABSTRACT

Objective: investigating the process of labor and management of Family Health Strategies and the satisfaction of users in relation to the services provided. **Method:** a field study that included 743 subjects (users, health professionals and managers) from 12 municipalities of Rio Grande do Sul, using questionnaires and interviews to collect data analyzed with SPSS 20.0 software and the Content Analysis Technique. The research project was approved by the Research Ethics Committee, Protocol nº 23771/09. **Results:** users evaluate positively the assistance, prioritize medical consultation and curative actions; health professionals highlight the interdisciplinarity of actions; nurses as managers of activities, difficulties on promotion and prevention and communication at work; managers cite financial difficulties and organization of actions from the existing demands. **Conclusion:** there is the need for expansion of actions of prevention and promotion, consolidating the proposal of the family health model in the study area. **Descriptors:** Family Health; Community Participation; Health Management; Health Care.

RESUMO

Objetivo: investigar o processo de trabalho e de gestão de Estratégias de Saúde da Família e a satisfação de usuários frente aos serviços prestados. **Método:** estudo de campo que compreendeu 743 sujeitos (usuários, profissionais da saúde e gestores) de 12 municípios do Rio Grande do Sul, utilizando questionário e entrevista para coleta de dados analisados com o software SPSS 20.0 e pela Técnica de Análise de Conteúdo. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, protocolo nº 23771/09. **Resultados:** usuários avaliam positivamente a assistência, priorizam consulta médica e ações curativas; profissionais da saúde destacam a interdisciplinaridade das ações; enfermeiros como gerentes das atividades, dificuldades nas ações de promoção e prevenção e na comunicação no trabalho; gestores citam dificuldades financeiras e organização das ações a partir das demandas existentes. **Conclusão:** há necessidade de ampliação das ações de prevenção e promoção, consolidando a proposta do modelo de saúde da família na região estudada. **Descritores:** saúde da família; participação comunitária; gestão em saúde; assistência à saúde.

RESUMEN

Objetivo: investigar el proceso de trabajo y la gestión de las Estrategias de Salud de la Familia y la satisfacción de los usuarios a través de los servicios prestados. **Método:** un estudio de campo que incluyó a 743 sujetos (usuarios, los profesionales sanitarios y los gestores) de 12 municipios de Rio Grande do Sul, con el uso de cuestionarios y entrevistas para recopilar datos analizados con el programa SPSS 20.0 y la Técnica de Análisis de Contenido. El proyecto de investigación fue aprobado por el Comité de Ética de Investigación, Protocolo nº 23771/09. **Resultados:** los usuarios evalúan positivamente la asistencia, priorizan consulta médica y acciones curativas; profesionales de la salud destacan la naturaleza interdisciplinaria de las acciones; enfermeras como gestoras de actividades, dificultades en la promoción y la prevención y la comunicación en el trabajo; administradores citan las dificultades financieras y la organización de acciones de las demandas existentes. **Conclusión:** es necesaria la expansión de la prevención y la promoción, consolidación de la propuesta del modelo de salud familiar en el área de estudio. **Descriptor:** Salud de la Familia; Participación de la Comunidad; Gestión de la Salud; Cuidado de la Salud.

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INTRODUCTION

The Family Health Strategy (FHS) sets up as a model of care focused on prevention, promotion and rehabilitation of individuals, often the first contact of the user with the health system, which implies a vision expanded in ways of seeing and doing health. The FHS is the bet for the reorganization of health practices that caters to family, developing actions that include epidemiological, social, economic, and cultural of the health-disease, aimed at replacing the traditional model of technicalities and curative care. This health policy aims to redefine roles and responsibilities of each level of government, assigning a central role to the municipalities where the community appears as the reason for the FHS and should be identified as subjects able to assess and intervene by modifying the system and strengthening the make the democratic health.¹

New FHSs are deployed and others are retrofitted to different realities. Therein lays the relevance of specific studies, like this, on family health aspects in certain local and regional contexts and which may provide experience to other realities. Thus, the investigations carried out by the Group of Studies and Research in Health (GEPS) at the University of Santa Cruz do Sul (UNISC)/RS have contributed to the analysis of reality FHSs located in the central region of Rio Grande do Sul state (area spanning the 13th Regional Health District), considering the peculiarities and particularities of these health realities.

As regards the dynamics of FHSs services, the research group believes in his studies, significant changes and implications of the organization of society on the impacts on subjectivity and ways of living and working people in the materiality of health professions and even the definition of the existence of some of them. In addition, other effects and health work transformations standing at the frontier of global production processes, such as the restructuring process are relevant, new forms of work organization, with enormous changes in the deregulation of labor, employment and working conditions. Among these modifications, can be detached, the logic of health professionals working process and management of health facilities, factors that stimulated the development of the present study, involving different actors in this scenario, as users, health professionals and managers of FHS. Despite the existence of studies on perceptions and experiences of

these actors in these health services, it is not usual evaluation/analysis from subjective criteria, based on empirical studies that seek to re-signify experiences and values and at the same time, expand the "meaning" of results beyond measurable performance goals.²

A key distinguishing feature and the study area was the FHSs of reality constituted municipalities, mostly by extensive rural areas, reflecting an overview focused on assistance to a population with characteristics not only urban.³The intention was to translate this reality in their characteristics and specificities, with social, economic, political and cultural factors that may be crucial for the organization of health work, such as geographical isolation, limited access to health services, individuality values and community liaison, lack of consistency the legal protection and limited economic opportunities that encourage, for example, the problem of family violence.^{4,5}

It is understood that such studies contribute to lifting regional data of health work and their interpretations, addressing the best allocation of human, physical and financial resources in order to improve the quality of care provided to the population served by the Unified Health System (SUS), by the Family Health Strategy.

OBJECTIVE

- Investigating the work process and FHSs units for management and satisfaction of users across the services provided by them.

METHOD

This is a field of study conducted with users, health professionals and FHSs managers of 12 municipalities located in the central region of the state of Rio Grande do Sul, which constitute the area covered by the 13th Regional Health District. The municipalities have studied around 200 thousand inhabitants⁷ and have 23 FHS units, with 140 micro areas, covering a total of 22,220 families. These municipalities were part of the research entitled "Health: A Look into the Strategy in the municipalities of the 13th Health Regional Coordination/RS"; developed by GEPS UNISC, which gave rise to this article. The municipalities of the study are made up of descendants of German and Azorean people, dedicated, in rural areas, the creation of pigs, poultry or dairy cattle, facing growing corn, tobacco, eucalyptus or fruit, or even directed to the association of diverse cultures. In urban areas, we highlight the trade and many

industries, which give the region a significant economic development.

Data collection consisted of two stages, the first being, with users and with the following health professionals and managers. To address the intentional sampling study presents five families of each micro-area, randomly chosen in the family records of FHS units. In visiting family, held in Community Health Agent company, was part of the study, the subject present in the residence, over 18 years, to accept voluntarily participate by signing the Informed Consent and Informed, totaling 669 members users study. In addition to the users, the study participants eleven healthcare managers (a coordinator of the FHS and ten Municipal Health Secretaries) and 61 health professionals with university education (24 nurses, 22 doctors and 17 dentists) belonging to these units, which is, in the last two segments of subjects, the universe of this population, with the exception of the participation of a health manager who was on vacation during data collection in the city. The study involved 743 individuals.

Data collection took place between the years 2010 and 2012. It was made with the users in their homes, using a form with 17 closed questions with great options, good, fair, poor, poor, do not use it, not opined, about the satisfaction of the physical facilities, services, actions provided by the FHS and care of health professionals. With managers and health professionals, the data was collected through previously scheduled interview, recorded audio and transcribed after, and held on the premises of the Municipal Health and FHSs, respectively. The interview form of health professionals watched 13 open questions and focused on the relationship with the community, working staff and management and aspects of the work process. The managers' interview form consisted of 11 open questions covering aspects of organizational and financial planning of FHSs. It should be noted that climate change, with several periods of heavy rain interfered significantly in the collection of research data step, especially with users, as there was to the distance to the localized residences, mostly distant, in rural areas with difficult access. Several times, the collections were delayed and canceled due to weather these disorders.

The analysis of quantitative data of users was conducted through numerical and absolute laminates supported by the software Statistical Package for Social Sciences (SPSS) for Windows, version 20.0. Qualitative data from interviews with health professionals and

managers were analyzed based on the content analysis technique, producing up themes. Thus, from the guidelines laid down for the study, the categories of analysis and data analysis were built and complemented from the contact with empirical reality.⁶

The research had the project approved by the Research Ethics Committee of UNISC under the Protocol 23771/09.

RESULTS AND DISCUSSION

Among the 669 members of the study, prevailing females (79,7%) and mothers (65,3%), mean age 47, elementary school (78,4%) and occupation in agriculture (37,5%). The fact that the interviews were conducted in the homes of users and during the day contributed to the predominance of women as research subjects.

Among the 63 health professionals, nurses (38,1%) predominated, followed by doctors (34,9%) and dentists (27%), female (63.5%), mean age of 33 years old and acting the FHS 1 to 5 years (39,7%).

The 11 participants managers, mostly, were male (54,5%), mean age 41, graduated (54,5%), nurses or civil service as a profession (27,3%) and acting in public management between 1 and 5 years (91%).

◆ Users: satisfaction of questions about the service

Regarding the evaluation of services, 82% of users are satisfied with the services provided, and that 61,8% of users reported using permanently the services of FHSs. The reasons for seeking treatment were found to be a priority in consultations with various health professionals; in disease situations; by proximity of service and availability of drugs. Even with the significant part looks of respondents focused on pathology for search assistance in the FHS, there is a perceived need for monitoring of chronic diseases, which leads to the pursuit of health facility for care, monitoring and prevention complications⁷. This aspect was also observed in the present study that showed that users use the service for reasons related to health care and other professionals.

On services provided by the Family Health Strategies users rated positively (excellent and good) the following items they asked: community health agent of care (93,9%); nursing care (89,4%); Vaccination service (83,7%); physical facilities of the unit (82,7%); drive location (88,2%); home care team (86,3%); medical care (76,8%); drug distribution (65,2%); dental care (48,1%) and the distribution of tokens (43,8%). The use of services was better evaluated by the users of

that organizational strategies and services flows as access and welcoming, which agrees with findings of other studies.^{8,9}

The confidence of users, in relation to the health team actions and the care of their family, was high, since 79,1% responded affirmatively when asked. This finding is in line with other findings, 10 since the accountability of the professional to the user health status is constituted in one of the essential elements of an effective host, awakening the user a feeling of confidence in the professional providing such assistance.

The majority - 74,4% - of the subjects exposed in solving their health problems, however, 61,7% needed health care in another location/service. It turned out that one of the factors that lead users to seek other care facilities was the lack of medical professionals. Therefore, in view of this, we question the solving of the shares in FHS units and the effectiveness of the referral and counter reference advocated in health regionalization policy. An important aspect verified was that geographic distance was not mentioned by users as a problem for the search for health services, since it is a predominantly rural region, with extensive and remote areas. A major problem faced by small municipalities is the lack of human resources for health.¹¹ It is difficult to find doctors residing in these locations, most of which comes from larger cities in the region, adding to that the low-paid professional, which does not stimulate new hires. This situation causes a feeling of lack of protection to the user, depending on shifts in search of other services.

Regarding the decision making of FHSs related assistance to community enrolled, 88.5% of them, said they did not participate. In this regard, the concept expanded health care aims to user participation in educational groups for learning about the care of your health, contributing to the interaction of the health-disease process and, consequently, in the transformation of individuals committed to their health and community to its surroundings.¹² Low participation of users in the event of decision making FHSs points to the lack of interest and motivation of the population, giving the impression, in the view of managers and health professionals, users are seen as disinterested within the blame for being oblivious to the social control processes, requiring therefore be mobilized and educated, or as tax services that, in some way, hinder team work.¹³

◆ Health professionals: about the work process

When analyzing the work process, professionals highlighted as a factor that contributes to the progress of the activities, good relationship with the community and work team:

Is the best possible, both on the part of the staff of the community, it is very quiet. (p1)

The good relationship between community and work team shows up as a result of effective link in the professional performance requires greater understanding of the social context and health of each individual/family. The family health teams establish a stronger bond with users compared to traditional health centers.¹⁴

The activities and work action teams are organized from four factors: previous schedule of activities, establishing schedules of tasks per shift, on demand in the service to users and internal activities always decided in multidisciplinary team meetings, coordinated by professional nurse:

In the afternoon we work in communities [...] (p2); we have free morning and afternoon are the demand schedules. (p3)

It appears that the organization of work is focused on the establishment of the daily routine in team activities in attending the user and the internal activities of teamwork, pointing to the importance of reflecting teams on their work processes, reviewing the division of labor, for the development of a more integrated work. In this understanding, teamwork is a system strategy to deal with the intense process of specialization in health care, aiming interdisciplinarity. For it is a practice that aims to rebuild, working with other professionals in an interdisciplinary way, speak about the work process of professionals in the FHS can be a difficult task considering the professional diversity, location and the very understanding of the subject. In this context, the work process can be characterized by identifying different configurations and multiple relationships and crossings, limiting the possibility to present it in a homogeneous way.

The work process can be characterized by identifying different configurations and is defined as the activity focused on the production of use values in order to satisfy human needs, regardless of social forms they take and the social relations of production. Its meaning is essentially qualitative and refers to the usefulness of the result of the work. Already the organization of work covers the content and composition of tasks, which, in turn, implies the division of tasks in the production process of work and forms of relationships built among workers.¹⁵

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Family health strategies: about management...

In the historical process of the FHS units, as also observed in the present study, the management of meetings and also the service has just focused on the professional nurse, and there is, however, a formalized process for choosing this to the position. The manager must along with his team and users, organize work so as to meet the common needs. This enables better democratization and not the construction based only on the organizational culture of a single individual, such as the nurse. The participation of several professionals fosters the promotion of co-management in health services advocated by FHSs, establishing collective management.¹⁶

For the proper development of work activities, cited as favorable aspects responsiveness of the community, capable staff for assistance, work team integration and support of management:

I think the community is already adapted, knows the team work. (p4)

Support I think is the training of the team, the team is well structured to meet, and the interrelation is very good, (p5)

He (Manager) shows open and receptive, assisting in the development of the work. (p6)

The strengthening of ties between professionals and users expressed satisfaction managers at work, enabling educational actions based on community needs.¹⁷ From this perspective, the team work distance vision focused on the disease, allowing reciprocal ways of workers relate to each other and with others, allowing greater user participation in decisions involving your life and the health-disease process, making them subjects of their life process and exercise their autonomy.¹⁸

And unfavorable aspects of the work process, the professionals mentioned the little acceptance and not understanding of the service users on the team's actions and purposes of the service in the health promotion approach and work overload, with few professionals. Thus, health education actions in the community are not carried out by the teams very often, due to the culture of the users on the predominance of curative actions to the detriment of health promotion and disease prevention, and also the resistance of the population to educational activities:

A negative point is the culture of the people, because unfortunately we would like to work more with prevention of the disease. (p7)

The culture of smoking is somewhat difficult to you take the idea of people that smoking

is harmful; this region has very striking that. (p8)

Look sometimes overload of the own team, you have to take a vacation, go to meetings out of the city, events, and there's a cover to other, it carries enough. (p9)

Users often are unaware of the proposal from the FHS, seeking the service, only to remedy their care needs. In this view, actions of professionals remain focused on the demand of the population, which continues with the same habits and living conditions that contribute to the illness.¹⁹ While we should not reduce the primary provision of medical consultations; this attention cannot abdicate the clinical care provided by doctors, but they have to integrate it to the responsibilities of Public Health. The difficulty of FHSs move in this perspective can be a result of under construction strategy.¹⁴ limitations on working conditions, both material and structural compromise the quality of care of professionals working in the FHS.¹⁷

The organizational efficiency of work processes in the investigated FHSs also proved to be hampered by the high turnover of professionals. This reflects the loss of strategic considered professional, since the community already knows with which work and, with respect to dynamic political, social and cultural, potentiate the process of education in health recommended by the FHS model.²⁰

Despite these hindering aspects, the quality of services has been defined by health professionals as very positive and satisfaction with the work is translated by the recognition of the population against the work, the good relationship with the community and because they enjoy the activity engaged:

It's a satisfaction work on this unit, I'm pretty happy, I'm proud of what I do here, like the community, I like working here, because everyone is recognized. (p10)

In addition to the aspects highlighted, professionals' satisfaction can be guided also by the fact that they work in a health policy with ideals of social justice and equality that socially values the work.²¹

♦ Health managers: in relation to the organization and planning of actions

In the view of managers, shares of FHSs are organized through the annual strategic planning, where they are suitable as the reality of each FHS and developed with the participation of health workers. It was mentioned by them to community participation in the preparation of this planning. Situational strategic planning

enables the reality of view on which you want to intervene, enabling the participation of all actors that permeate this reality, highlighting the vision and their perception.

The analysis/monitoring of the relationship between production and expenditure in the budget is done through the production of the record in the computerized system - System of Primary Care Information (SIAB) - with supplementary funds by the municipality. Among the difficulties in management, pointed out that the funding from the federal government has not given full coverage to the costs of the strategies, requiring financial compensation from municipalities. The precariousness of the financial resources of the investigated municipalities was cited as one of the main factors that hinder the implementation of the FHS. Most states do not offer any kind of incentive for the implementation and/or operation of the FHS; however, the state government incentives are essential to enhance the resources in the field of primary care, contributing to the quality of services.²²

This is why the SIAB was quoted by the managers of the municipalities investigated as an important tool for ensuring the planning of actions, despite being a regionalized, vertical and centralized system, getting the local and regional levels as mere on-lending data. Lose, then, the municipal authorities and local teams, then, being the SIAB one regionalized information system, which enables, through its indicators, micro-location problems, a fact invaluable for planning and decision-taking at the local/regional.²³

Regarding the forms of communication and dissemination strategies and actions and information between teams of the units and the community, the speeches of the managers agreed with professionals, putting that communication is mainly through the CHA:

By their own Community Health Agents, who bring to the team meetings the complaints of the population. (g1)

This facilitated communication process occurs at CHA fact know the community and its needs. Points to the quality of this communication to occur, often hierarchically, guided by the health system itself and established both by the technical team and by the community.²⁴ For the implementation of mechanisms of coordination and interaction between workers, managers and SUS users, the municipal health manager is configured, in this scenario, as the main actor to expand and strengthen the channels of communication, because through this gives a greater social control in the SUS.¹⁶

Regarding the systematic assessment tools of user satisfaction on the services provided by FHSs, they commented their absence, however, mentioned the Ombudsman industry in the City Health Department as a service to users express their criticisms and suggestions. The community, in the view of managers, through their representatives, has room to suggest and comment on the decision making on actions to be taken by the strategies; however, is still little participation.

Search about the satisfaction and evaluation of users is a fundamental task for management, since his understanding may indicate strategic and operational decisions that may influence the level of quality of services provided. The development of a system of evaluation by users of satisfaction can be an important tool for the development of health management strategies at the municipal level, adding to the efforts already made in the standardization of tools, supported by many developed quality programs and widely disseminated in the country.²⁵

The culture centered care in the medical professional figure was also identified as a problem for to implement the recommended care model by the FHS. Before the curative model reported by managers of these municipalities, it is emphasized that this still configured as the prevailing work organization model in which, are relegated the leves.²⁶ Technologies While the perception of a new care model is not assumed by teams FHS, the practice focused on physician consultation and management of the disease will not be transformed. We need to have the team members assimilating the strategy as an innovative practice and restructure maker of health actions, with rescue of a broader view of the health-disease process and the relations between members of the healthcare team. In turn, the rapid expansion of health strategy units of the family in Brazil in the last 10 years reaffirmed the importance in the new model as reorganizing practice of primary health care. Since then, it has become necessary to discuss issues related to qualification and resolution of health teams. Mainly because most professionals that integrate the family health teams still form within a curative logic, assistance focused on disease and not in promoting health.²⁷

Also the high turnovers of health professionals in the FHS, as well as the lack of human resources and political party interference have been identified as unfavorable aspects. In a survey conducted in São Paulo there was the dissatisfaction of

users on the physician's work, because the high turnover (37,4% at 1 year) of these professionals affect the bond and the lack of continuity in health care.²⁸ the main causes of turnover are presented casualization of the labor contract, the fragmentation of training, the authoritarian management style, lack of ties to the community and poor working conditions. With regard to partisan political issues identified by managers, they can cause reductions in enthusiasm, discontent, dissatisfaction, and frustrate expectations and is one more reason for the turnover of professionals working in public health services.²⁰

Managers mentioned the lack of user queues in demand for care services, as previous schedules of activities are performed. Under this approach, the lack of queues and the implementation of the practice of host were listed as facilitating factors for the development of health actions in FHSs, reorganizing the daily work process. The host as operational directive of health work is still an ongoing process in health facilities studied the family, in general, varying in design, attachment level and daily reorganization strategies.²

As for the training of professionals, managers mentioned isolated and specific actions, not featuring a health training policy in the municipality. Recognize flaws in this process and the need to review the operation of it. When they occur, the trainings are held by municipal professionals and geared mainly to the CHAs. It was noticed that the municipalities do not develop this policy, requiring the training proposals be contextualized in the reality of work in health and the subject of a worker to valuation policy.

CONCLUSION

These research findings unveil coexist in the FHSs of the cities studied, elements that are distinct to make health models: the traditional - focused on health care - and the model of health promotion recommended by the strategies, the first hegemonic, and the second, an attempt to consolidate the assumptions of the Unified Health System (SUS). Unveiled to the incipient promotion and health prevention, communication between management and workers and aspects related to non-Community user participation. It was noticed that these are still unaware of their co-responsibility for health and the actual proposals of the model. The managers were emphatic about the financial aspects as

obstacles for improving the quality of care and services FHSs.

For health professionals, the data show the need to improve the care and the organization of activities in order to ensure the quality of the actions and collective participation in building services. Suggestions are made as necessary; expand the forms of attention to health through prevention and promotion actions. These developments should contribute to the consolidation and strengthening of the proposals of the FHSs, the studied region and contribute to the resolution of their actions.

It was noticed that many of the situations identified in the study are not distinct from other health care facilities located in non-rural areas, demonstrating that the geographical and economic characteristics of the study area do not seem to influence the aspects investigated. Therefore, to present the results to the members and departments, the study helped foster reflection and dialogue on the subject with the municipalities studied and also by the 13th Regional Coordination of Health, which is collaborating for taking effective action in primary health care in the region.

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