



PROFILE OF THE FAMILY HEALTH STRATEGY PROFESSIONALS IN NATAL-RN
PERFIL DOS PROFISSIONAIS DA ESTRATÉGIA SAÚDE DA FAMÍLIA NA CAPITAL POTIGUAR
PERFIL DE LOS PROFESIONALES DE LA ESTRATEGIA SALUD DE LA FAMILIA EN LA CAPITAL POTIGUAR

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ABSTRACT

Objective: to evaluate the profile of the Family Health Strategy (FHS) professionals in Natal (RN). **Methods:** descriptive study, of quantitative nature, which had a probability sample of 475 professionals who answered a structured questionnaire. The research project was approved by the Research Ethics Committee, Protocol No. 0298, on 09/07/2008. **Results:** although professionals with 44.4 ± 8.33 years old have been acting for 16.69 ± 8.00 years in the public network, they have short stay in the current workplace (7.38 ± 2.83 years), which evidences high turnover; 14.9% ($f = 71$) have parallel work, despite the exclusive dedication work type; and have a demand of attendances (3108.31 families/staff) exceeding what is recommended. **Conclusion:** despite following an ideal model, the FHS has barriers in the profile of its professionals, which hinders the operation of the service. **Descriptors:** Public Health; Program Evaluation; Family Health Strategy; Professional Profile.

RESUMO

Objetivo: avaliar o perfil dos profissionais da Estratégia Saúde da Família (ESF) em Natal (RN). **Método:** estudo descritivo e exploratório, de cunho quantitativo, o qual contou com uma amostra probabilística de 475 profissionais que responderam um questionário estruturado. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, protocolo n° 0298, em 09/07/2008. **Resultados:** os profissionais com $44,4 \pm 8,33$ anos, apesar de atuarem há $16,69 \pm 8,00$ anos na rede pública, possuem curta permanência na locação atual ($7,38 \pm 2,83$ anos), evidenciando alta rotatividade; 14,9% ($f=71$) possuem trabalhos paralelos, apesar do regime de dedicação exclusiva; e uma demanda de atendimento (3.108,31 famílias/equipe) superior às diretrizes. **Conclusão:** apesar de seguir um modelo ideal, a ESF possui entraves no seu perfil de seus profissionais, que dificultam a operacionalização dos seus serviços. **Descritores:** Saúde Pública; Avaliação de Programas; Estratégia Saúde da Família; Perfil Profissional.

RESUMEN

Objetivo: evaluar el perfil de los profesionales de la Estrategia Salud de la Familia (ESF) en Natal (RN). **Método:** estudio descriptivo y exploratorio, de cuño cuantitativo, el cual contó con una muestra probabilística de 475 profesionales que respondieron un cuestionario estructurado. El proyecto de investigación fue aprobado por el Comité de Ética en Investigación, protocolo n° 0298, en 09/07/2008. **Resultados:** los profesionales con $44,4 \pm 8,33$ años, a pesar de actuar hace $16,69 \pm 8,00$ años en la red pública, poseen corta permanencia en la locación actual ($7,38 \pm 2,83$ años), mostrando alta rotatividad; 14,9% ($f=71$) poseen trabajos paralelos, a pesar del regimen de dedicación exclusiva; y una demanda de atención (3.108,31 familias/equipo) superior a las directrices. **Conclusión:** a pesar de seguir un modelo ideal, la ESF posee trabas en el perfil de sus profesionales, que dificultan la operación de sus servicios. **Descriptores:** Salud Pública; Evaluación de Programas; Estrategia Salud de la Familia; Perfil Profesional.

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INTRODUCTION

The selection of professionals with appropriate profile for working in the Family Health is one of the determining factors for its proper functioning, enabling its success or failure. It is necessary, therefore, that researchers in the fields of social and labor psychology, health and administrators are more interested in this type of study, since, despite its relevance, evaluative studies on the profile of professionals working in the FHS are still scarce.

Legitimized in the 1988 Constitution,¹ the Unified Health System (SUS) is referred as the "set of all actions and health services provided by federal, state and local agencies and public institutions, directly and indirectly administrated, and of the foundations maintained by the Government".² It can also include private institutions, that should participate complementing inadequate or non-existent health services.³ Because of the amplitude of the SUS, its actions and health services work in an integrated manner, in a regionalized and hierarchical network, in a single system organized by doctrinal principles (universality, comprehensiveness and equity) and organizational guidelines (decentralization, hierarchy/regionalization and popular participation).^{2; 4-5}

Within this system, the Family Health Strategy (FHS) is seen as the main door for primary care, acting through a minimum multidisciplinary team consisting of a doctor, a nurse, a nursing assistant (NA), dentist, dental assistant (DA) and from four to six community health workers (CHW's), who act in a workweek of 40 hours, focusing on promotion, prevention and recovery of health.⁶⁻⁷ In its theoretical guidelines, health management is distributed in the municipalities according to territorial division of health districts (HD). In this case, the city of Natal has five health districts: HD South, HD West, HD East, HD North I and HD North II, which should have a defined territory, responsible for the registration and monitoring of the population covered by each area: from 600 to 1,000 families, and must not exceed the maximum of 4,500 people; the recommended average is 3,000 inhabitants.^{1;7-8}

It is a model that is, if not perfect, ideal, inspired by the examples of assistance to families existing in Cuba, Canada, Sweden, England, but in practice it has been the subject of criticism by its users, media and academic community, for its reality in the practice of health care in Brazil is very

adverse to the theoretical idealized model of universal, comprehensive, hierarchical and equal access.³

In this scenario, the evaluation of social programs and government strategies emerges as a key tool to assist, through feedback, the decisions of managers with respect to implementation, process and results achieved by its services.⁹⁻¹⁰ Thus, it contributes to the pursuit of improved services, helps to raise awareness in the population as citizens in demanding effective results of public services, mitigating the Brazilian belief that public services are poor and therefore are of low quality.¹¹⁻² It is observed, however, that most of these studies still focuses primarily on the complaint of users, not devoting enough attention to the assessment of the profile of SUS professionals and managers.¹²⁻³

Given the above, the present study rescued the importance of knowing the professionals who work in public services through a multidisciplinary perspective of doctors, psychologists and administrators, uniting knowledge about the functioning of the FHS and its guidelines, analysis of behavior and work in public health and health professionals screening and management.

This article aims to evaluate the profile of professionals who work in teams of the Family Health Strategy (FHS) in Natal, Rio Grande do Norte/RN, in order to carry out a survey to characterize these professionals, analyzing whether this is one of the barriers to the operation of services. Therefore, authors sought:

- To identify a biodemographic profile of FHS professionals (gender, marital status, whether they have children belonging) of professionals working in the Family Health Strategy;
- To set an experience profile in the professional Unified Health System (checking the time of work in the profession, time of work in public health and time of bond to the current FHS where they are currently working) in order to verify its turnover;
- To characterize the bond and labor demand of the FHS professionals (employment relationship, working hours, number of daily attendances; existence of other parallel work).

METHOD

This is a descriptive study of quantitative nature, that had a probabilistic sample consisting of professionals from the FHS minimum multidisciplinary teams (doctor, dentists, nurses, nursing assistants, dental

assistants - DA's and community health workers - CHW's) of Natal, selected through the randomizer software from the listing of professionals provided by the Municipal Health.

It is estimated that there are 1,187 active professionals in Natal, distributed in 116 teams, 37 in FHS's of the five health districts. For a population of this size, with a confidence level of 95% and a sampling error of 5%, it was necessary a minimum sample of 291 participants.¹⁴ In respecting the diversity of the city and the heterogeneity of the number of professionals, the sample was distributed by professional category and health district. After the distribution, authors strained to maintain a minimum number of 30 subjects by professional category, which is the minimum amount per quota recommended for statistical comparisons. Thus, the sample distribution increased to 475 professionals, divided into 25 units.

It is still highlighted that participants were excluded in this probability sampling due to three reasons: 1) refusal to participate in the research; 2) professional did not work anymore at FHS or the data from the Municipal Health was out of date; 3) absence of the professional (vacation or leave). Thus, regarding the excluded CHW's, they were replaced by the professional featured above them in the list of names of all the city professionals or, in second option, by the name below them. As for other categories of workers who have only one professional in the team, when the selected professional was unavailable, there was a new draw.

As instrument to collect the data for this research we used a profile characterization questionnaire containing three focus issues: 1) biodemografic characterization of professionals; 2) description of experience in the SUS; and 3) characterization of the bond and labor demand of the FHS professionals.

Considering the ethical aspects related to research involving human subjects, initially the study was approved by the City Health Department and the Research Ethics Committee of the HUOL-RN under the protocol number 0298, on 09/07/2008. After the drawn of the sample, the visits to the Family Health Units were made, where participants were informed of the study objectives and procedures, being asked also that they sign an Informed Consent Form. And the instrument

was applied individually, guaranteeing anonymity of their collaboration and confidentiality of their answers.

The analysis of measured data was performed in two processes: 1) descriptive statistics (frequency, percentage, mean, standard deviation) were used in the managers' characterization data to provide biodemographic information, description of their educational, technical and professional profile; and 2) Shapiro-Wilk and Kruskal-Wallis were used, respectively, to test the normality of the data and to make comparisons of results by professional categories (doctor x nurse x nursing assistant ...).

RESULTS

Results will be presented in the order of goals. Initially, the description of biodemographic profile of professionals will be performed using the variables gender, age, marital status, having (or not) children, education (secondary, technical or higher education). Then the experience of professionals in the public health will be presented: time of work in the profession, time of work in the public health, time of work in the Family Health Unit (FHU) they are currently working. Finally, the characterization of the bond and professional labor demand will be held: weekly working hours, existence of parallel jobs (whether they have another job), employment relationship (civil servant or service contract), salary, number of daily attendances and number of households/users under the responsibility of each Family Health Team (FHT).

◆ **Biodemographic Profile of FHS Professionals**

By analyzing only the valid responses (without missings) with the Shapiro-Wilk and Kruskal-Wallis tests, it was found that most professionals are women (87.4%), married (64.3%) and have children (80.5%) (see Table 1). Their mean age is 44.4 ± 8.33 years old, with non-normal data (0.99; $p = 0.00$), which are different between the different professional categories (150.63, $p < 0.05$). Thus, it was found that doctors are the category with the highest standard deviation in age (45.13 ± 10.58), ranging from 27 to 62 years old, and the CHW's are those with the lowest mean age (39.89 ± 3.7), as seen in Table 2.

Table 1. Characterization of professionals working in the Family Health Teams by gender, marital status and presence of children (N= 475).

Variables	Levels	F	Percentage (%)
Gender	Female	410	87.4
	Male	59	12.6
	TOTAL	469	100
Marital status	Single	113	23.8
	Married	295	62.1
	Separated	51	10.7
	TOTAL	459	100
Having children	Yes	376	80.5
	No	91	19.5
	TOTAL	467	100

Table 2. Characterization of professionals working in the Family Health Teams by age (N= 475).

Variable	Mean and SD	Median	Mode	Minimum/Maximum
Doctor	45.13 ± 10.58	45.50	50.00	27/62
Nurse	47.24 ± 3.27	47.00	47.00	40/57
Nursing Assistant	50.60 ± 7.16	50.50	57.00	32/64
Dentist	48.83 ± 7.39	48.40	44.41	30/66
Dental Assistant (DA)	48.81 ± 6.08	49.00	49.00	31/63
CHW	39.89 ± 7.03	39.00	39.00	28/61

◆ Experience profile of Professionals in the Unified Health System

As for the experience in the position, the mean time in the profession is 16.91 ± 8.29 years, which is similar to the time working in public health (16.69 ± 8.00). It is also noteworthy that the mean time of work in the current FHS is 7.38 ± 2.83 years. There is highlight for CHW's, who stood out to be those with shorter time of work in the profession (16.91 ± 8.29) among the professional categories, with normal data approved by the Shapiro-Wilk test (0.96; p = 0.00) and a statistically significant difference presented

by Kruskal-Wallis test (311.82, p <0.05), and the shortest time in public health (10.57 ± 3.59), with normal data (0.96; p = 0.00) and significant difference (311.05; p <0.05). In relation to the time of work in FHU's, CHW's (8.05 ± 2.73) and nurses (7.96 ± 2.98) were the categories with longer length of stay, and dentists (5.76 ± 2.16) and the DA's (5.66 ± 2.04) stood out for the shorter length of stay, with normal data (0.94; p = 0.00), and statistically significant differences observed by Kruskal Wallis test (53.80; p <0.05) (see Table 3).

Table 3. Characterization of professionals working in the Family Health Teams by time of work in the profession, in public health and FHU (N=475)

Professional Category	Time of profession	Mean and SD	
		Time in public health	Time in FHU
Doctor	18.40 ± 10.30	16.73 ± 9.99	6.60 ± 3.58
Nurse	22.35 ± 3.56	21.15 ± 4.09	7.96 ± 2.98
Nursing Assistant	24.49 ± 5.69	23.27 ± 5.82	7.08 ± 2.64
Dentist	27.38 ± 6.08	23.75 ± 5.61	5.76 ± 2.16
Dental Assistant	19.11 ± 5.67	25.68 ± 5.01	5.66 ± 2.04
CHW	16.91 ± 8.29	10.69 ± 8.00	8.05 ± 2.73

◆ Characterization of Bond and Labor Demand of FHS Professionals

With regard to professional relationship, it was found that most (96.2%) said having weekly workload of 40 hours as provided by the Ministry of Health (MOH). Only 0.4% (f = 02) said working 20 hours and 0.4% (f = 02) reported working 8 hours. It is highlighted that 2.9% (f = 14) did not answer this question. However, these responses have questionable validity, probably due to social desirability to say what is prescribed as their

obligation by Ministry of Health. This fact was noted by the difficulty in finding some professionals in the FHU's, where it is known that they do not work every day. Through the data, it was also observed that 88.4% (f = 420) of the professionals are civil servants and 4% (f = 19) are contracted servers, and 7.6% (f = 36) did not answer, with no significant difference in responses between the categories [x2 (N = 439; 2) 5.68; p> 0.05], see Table 4.

Table 4. Characterization of professionals working in the Family Health Teams by working hours and type of employment (N= 475)

Variables		Doctor	Nurse	Nursing Assistant	Dentist	DA	CHW
Workload	40 hours	29	41	87	39	36	225
	20 hours	0	0	0	0	0	2
	8 hours	1	0	0	0	1	0
Employment relationship	Civil	28	41	79	36	37	199
	servant						
	Service contract	1	0	3	3	0	12

As for the demand of attendances, it was observed that professionals claim that on average each Family Health Team is responsible for 3,108.31 ($\pm$ 2,239.36)families, which is equivalent to 11,044.32 people ($\pm$ 5,314.78).

Regarding the number of attendances per day, it was found that the mean of attendances among professionals is 56.05 ($\pm$ 103.98), with normal data approved by the Shapiro-Wilk test (0.55; p = 0.00) and with a statistically significant difference presented by Kruskal-Wallis test (72.51; p <0.05). It is highlighted that CHW's are those who claim attend more people per day (M = 75.68 $\pm$ 135.28). And the dentists (13.73 $\pm$ 6.54) and DA's (11.72 $\pm$ 6.08) have the smallest means of attendances.

Data also show that 14.9% (f = 71) of professionals have other work, whereas 82.7% (f = 393) said they did not have another job, and 2.3% (f = 11) did not answer. It was observed a significant difference between the professional categories, [χ^2 (N = 464; 1) 89.67; p <0.05], in which doctors are the professionals who most have claimed to have parallel work (f = 21; 70%).

With regard to the monthly remuneration of professionals, the mean salary is R\$ 1,857.48 $\pm$ 1,568.94, with statistically significant difference between the professionals with high education (R\$ 4,215.57 $\pm$ 1,686.28), technical education (R\$ 1,616 18 $\pm$ 379.16) and secondary education (R\$ 966.46 $\pm$ 266.60), with normal data (0.70; p = 0.00), and statistically significant difference (193.99, p <0.05). These values range from 500.00 to 10,000.00 reais, in which doctors have higher monthly income and CHW's have lowest income.

DISCUSSION

The primary purpose of the Unified Health System is to enable universal access of health in Brazil, with quality services provided by qualified professionals.⁷ The qualification of health workers who are involved in management processes and of professionals who work in the Family Health Units probably

is a factor that interferes in efficiency, efficacy and effectiveness of the Unified Health System. Based on this assumption, this study aimed to evaluate the profile of professionals working in the Family Health Strategy in Natal-RN, for a system model focused on such audacious principles, of universality, equity, comprehensiveness, such as the Unified Health System⁷, requires training and change in its professionals' profile.

Data found in this study show that in the biodemographic profile the mean age of these workers is 44.4 $\pm$ 8.33 years old, in which CHW's are younger (39.89 $\pm$ 7.03), perhaps due to that fact that they are mostly people from the community who are still studying, as shown in the literature;³ and doctors are professionals who have the highest standard deviation, which can infer the confirmation of literature that this category is predominantly made up of newly trained doctors, who are in the FHS before entering the residency, and professionals in end to career, who seek FHS to complement retirement.^{3;15} These factors are alarming because the conception of job opportunity in FHW as a mere temporary position in the beginning or end of their careers contributes to the increase in turnover of professionals, which is the first obstacle that undermines the whole structure of the strategy.

The experience profile in SUS supports this concern. It was found that professionals have 16.91 $\pm$ 8.29 years of work in the profession and 16.69 $\pm$ 8.00 years in the public health, so it can be inferred that most professionals have just completed their studies and graduated and have immediately started working in the public system. It can be noticed, however, that the time of work in the current location is much more recent, only 7.38 $\pm$ 2.83 years. This evidences a high turnover of professionals working in the Family Health Strategy, which is the greatest difficulty for the accomplishment of its principles, because, as shown in the literature, this is the starting point for a vicious cycle of errors: this situation of professionals with little time of work and high turnover prevents the training

of these professionals for acting in Family Health, also damaging the creation of bond between the team and the community, consequently impairing the vision of comprehensiveness of the user as individual and humanization of care.

With regard to the characterization of the employment relationship, it was observed that 96.2% of respondents said working 40 weekly hours, which means 8 hours daily, Monday to Friday, morning and afternoon. These data are questionable, and a probable social desirability in claiming to do what is recommended, is attributed to them,⁷⁻⁸ since many of these professionals were not present throughout much of the week; authors even had difficulty in finding them in units for the interviews. This reality is not exclusive to Natal, as shown in the literature.³

It is also seen that, despite being another variable subject to social desirability, at least 14.9% (f = 71) of professionals openly declared to have another job, and doctors stood out among professionals with parallel work, which is another factor that makes the workload questionable. After all, it is not very feasible to have other activities while working in the Family Health Units from 8 a.m. to 17 p.m., with lunch break. It is also noteworthy that even if the performance of both were feasible, it is not accepted by law, that requires exclusive dedication.⁸

As for the labor demand of the FHS professionals, it was observed that each Family Health Team is responsible for 3,108.31 ($\pm$ 2,239.36) families, which is equivalent to 11,044.32 people ($\pm$ 5,314.78). This numbers are excessively beyond the prescribed by law: from 600 to 1,000 families, and it should not exceed the maximum of 4,500 people.⁶⁻⁸ This is the challenge found in SUS services in general,^{3;5;-12-4} because the high demand makes it impossible to provide quality care, forcing practitioners to perform a high number of daily attendance (56.05 $\pm$ 103.98), probably faster and little humanized.

CONCLUSION

The Unified Health System is a system inspired by international models, which follows ideal principles and the Family Health Strategy is the main gateway to primary care, changing the health care model from the dressing to health promotion and disease prevention. This, however, was implemented from hunger map elaborated by the Applied Economic Research Institute (IPEA), giving access to health care to those who once had no access to any type of service, generating contentment with poor quality services,

dictated by the saying "it is better than nothing".

Over the years, however, a new approach from tax payers who pay public services has been growing in society. Rights holders expect quality services, which must be constantly evaluated in the search for verification of effective results of government programs and actions. The Family Health Strategy in Natal follows this ideal model, but like in the rest of the country, it has barriers that separate its theoretical guidelines from its practical reality. The system needs urgent changes that start from the remuneration of professionals, with carrier plans and valuation of these workers, so that the FHS is no longer a "temporary plan" of rotating professionals, who cannot even be trained due to short time of work. This will also avoid the absence of these professional in the units, who pretend to meet the workload, and managers pretend not to notice their absence, by accepting that they need to have parallel activities to supplement low wages. Furthermore, if the workload was indeed required, there would be no available professionals, which actually already occurs in the outdated staff of the public health network of Natal.

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