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ORIGINAL ARTICLE

PRODUCTION OF CARE FOR RESOLUBILITY OF THE FAMILY HEALTH STRATEGY: KNOWLEDGE AND DILEMMAS

PRODUÇÃO DO CUIDADO PARA RESOLUBILIDADE DA ESTRATÉGIA DE SAÚDE DA FAMÍLIA: SABERES E DILEMAS

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ABSTRACT

Objective: to analyze the Production of Care for Resolubility of the Family Health Strategy (ESF). ***Method***: this is a qualitative, critical analytical study that used the semi-structured interview and the systematic observation in family health units as data production techniques. The technique for data analysis was Content Analysis in the Thematic modality. ***Results***: among the knowledge, Production of Care aims to assess the needs of individuals; Resolubility, solve the health problems of patients; and Interdisciplinarity is identified with the Family Health Support Unit. ***Conclusion***: there is a shortage of inputs and health workers, limited quotas of procedures and specialties among the dilemmas of daily life. ***Descriptors***: Care Production; Family Health Strategy; Solvability.

RESUMO

***Objetivo*:** analisar a Produção do Cuidado para resolubilidade da Estratégia de Saúde da Família (ESF). ***Método*:** estudo qualitativo, crítico-analítico, que utilizou como técnicas de produção de dados a entrevista semiestruturada e a observação sistemática em unidades de saúde da família. A técnica para análise dos dados foi a Análise de Conteúdo na modalidade Temática. ***Resultados*:** dentre os saberes, a Produção do Cuidado visa avaliar as necessidades dos indivíduos; Resolubilidade, resolver os problemas de saúde dos usuários; e Interdisciplinaridade, identifica-se com o Núcleo de Apoio à Saúde da Família. ***Conclusão*:** dentre os dilemas do cotidiano, estão falta de insumos e de trabalhadores de saúde, cotas limitadas de procedimentos e especialidades. ***Descritores*:** Produção do Cuidado; Estratégia de Saúde da Família; Resolubilidade.

RESUMEN

***Objetivo*:** analizar la Producción del Cuidado para resolubilidad de la Estrategia de Salud de la Familia (ESF). ***Método*:** estudio vualitativo, crítico analítico, que utilizó como técnicas de producción de datos la entrevista semi-estructurada y la observación sistemática en unidades de salud de la familia. La técnica para análisis de los datos fue el Análisis de Contenido en la modalidad Temática. ***Resultados*:** dentro de los saberes, Producción del Cuidado visa evaluar las necesidades de los individuos; Resolubilidad, resolver los problemas de salud de los usuarios; e Interdisciplinaridad se identifica con el Núcleo de Apoyo a la Salud de la Familia. ***Conclusión*:** dentro de los dilemas del cotidiano, están la falta de insumos y de trabajadores de salud, cuotas limitadas de procedimientos y especialidades. ***Descriptores*:** Producción del Cuidado; Estrategia de Salud de la Familia; Resolubilidad.

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INTRODUCTION

The Federal Constitution by Law 8080/90 consolidated the creation of the Unified Health System (SUS), a conquest of the Brazilian population by ensuring health as a right of all and a duty of the State, starting with the VIII National Health Conference in 1986, with a focus on people through actions to promote, protect and recover health, in an integrated articulation of care actions and preventive activities.[1]

This achievement has historically been shaped in the last decades, particularly in the 1980s, with the Sanitary Reform movement, focusing its struggles on the creation of a healthcare model based on health surveillance, in the face of criticism of the hegemonic biological model as an alternative prevention of diseases and health promotion guided by determinants of the health-disease process.[2] Thus, the challenge was centered in dismembering the practice procedure-centered in search of the production of health care in an integral, responsible and resolutive way.

When we choose the production of care for resolubility of the Family Health Strategy (ESF) as the object of study, we feel the need to delimit such an understanding, hence we assume the conception of Care Production as the way to make health from relational technologies or light technologies and live labor in the face of a revolutionary process that expands the way of producing health in the subjectivities that are formed in the world of work and care.[3] Light technologies are conceived as the technologies of relations or of bond production relations, autonomization, acceptance, and management, in a living work as an expression, giving meaning to work in action, at the exact moment of its productive activity.[4]

Therefore, we have the clarity that one of the greatest challenges of the Care Production for construction of the expanded SUS is in the process of negotiation in each public space, in which there is a meeting between the three actors (patients, workers, and managers) and based on the centrality of the patient.[5] It is also important that workers and managers present significant political, theoretical and technical knowledge of Care Production so they can understand the diversity and manage their spaces with wisdom and flexibility, prioritizing the demands according to reality.

This study has as social relevance the opportunity to bring knowledge about the Family Health Strategy in Care Production through the resolubility of health problems and social demands. Such knowledge will be able to subsidize managers, health workers of the family health team, and patients with responsibility for management actions in the Care Production in accordance with identified health needs.

The objective of this study was to analyze the Care Production for Resolubility of the Family Health Strategy.

METHOD

This is a qualitative study on the critical analytical side, which was the most appropriate modality for this study in the relations established among the participants of the research since the health issue relates a complex interaction between physical, psychological, social and environmental determinants of the human condition.

The fields of study were the Family Health Units (USF) in the municipality of Feira de Santana - BA, with inclusion criteria for USF with complete teams, that is, a minimum team with a doctor, a nurse, two nursing technicians, one dental surgeon and four community health agents; USF with its own headquarters and at least one year of operation; and USF who participated in the National Program for Improving Access and Quality of Primary Care (PMAQ-AB).

After authorization from the Ethics and Research Committee (CEP)/UEFS to start the research, we selected the family health units (USF), totaling five units, three of them based in the urban area and two in the rural area.

We used semi-structured interview and systematic observation as the techniques of data collection. The participants of this study are divided into two groups:

Group I: Health Workers of the Family Health Strategy (physician, nurse, nursing technician, dental surgeon, oral health assistant, community health agent). Group II: patients of the health services of the Family Health Strategy.

Among the inclusion criteria for delimitation of the participants we highlight: a) workers with at least one (6) months of experience in the health unit of the family studied; b) patients enrolled in USF and over 18 years old, who attended the unit surveyed at least twice in the last semester.

Therefore, from a certain number of participants, speeches reached exhaustion by their repetitiveness in this study. Thus, 17 participants were delimited, being Group I, nine health workers respectively identified in the text with numbers 1, 2, 10, 11, 12, 13, 14, 15 and 16 and of group II, eight patients represented by numbers 3, 4, 5, 6, 7, 8, 9 and

17 considering the increasing order of each interview, moment of each study participant. The study participants are represented as follows: respondent 1, we mean R 1 and so on.

The method was the Analysis of Thematic Content, to seek the deepening of the data collected from the interviews and observations. Because this is a study involving human beings, this research is based on Resolution 466/12 of the National Health Council[6]. In this way, we respect ethical and moral principles with the participants of the research, although we understand that all research with human beings besides benefits also presents risks. This production includes part of the results of the master's thesis with approval protocol of the Ethics and Research Committee (CEP) CAAE 31669414.9.0000.0053, opinion embodied in 733.003 and date of the report June 16, 2014.

RESULTS AND DISCUSSION

The Care Production has the challenge of giving resolubility to the needs of patients regarding their demands of health care, to develop their actions. The production of care refers to the daily life, to the place where events, manifestations, details, and situations occur, relative to the dimension of the minutiae part of everyday life and qualify as determinants of sociality, which in our understanding will depend on the Work Process of health workers and managers.[7]

For health workers, demonstrated in the R2 speech, Care Production aims to assess the needs of individuals to give their resolubility, that is, a goal to achieve a goal.

> *Care Production is to evaluate the patient according to their needs, trying to solve according to the possibilities, if we cannot solve the problem, right? [...] (R2, Group I).*

The concepts of health workers for Care Production focus on assessing the needs of patients to work from the perspective of providing health care. However, we think that the biggest problem lies in the form or manner in which this evaluation is being performed. The quality of consistently evaluating the health problems of a community, both individual and collective, associated with the meticulousness, sensitivity, and breadth of the evaluator´s gaze in search of this resolubility.

Thus, the quality of this evaluation is compromised given the difficulties faced by the health workers in the service, where they are configured to break with the roots of production of procedures and deal with the technical and social division of the work in the team, seeking a more democratic, participatory and respectful of differences job, establishing bonds and accountability, which has often remained hidden behind technical or technical work.[8]

Resolubility in health services means a response to health demands according to individual and collective needs, either at the "gateway" or at other levels of care of the system to ensure access to care with the host, bond, and accountability, aiming at an Integral Care Production.[9] In this sense, we understand that to answer the health needs of the patients in the USF requires a Care Production based entirely on the purpose of solving the problem presented, in all its dimensions.

Other speeches of health workers translate resolubility as problem-solving, in convergence with patients´ speeches.

> *Well, let everything is solved in the unit right now, which we need the unit to serve us right [...] (R4, Group II).*
>
> *For me, it is to solve all the health problems of my family (R5, Group II).*

From this understanding about resolubility, we see the creation of an expectation regarding the resolution of all health problems or needs in the health care network. To that end, the Care Production in the USF should be responsible for the resolubility of the community's health demands through its representation as the entrance door of SUS, considered to be 'preferential' in most situations, a possibility to solve health problems of Basic CAre.

We present some difficulties mentioned by the ESF patients to solve their health problems, such as appointments, medications, vacancies for exams, among others.

> *Not all of them, not all of them can solve it [...]because sometimes they also lack the materials, for example, they are not having it here, the 'television' [online marking system] is not even working there to make the calls [...] (R17, Group II).*

During our observation, we witnessed, in those moments, that when they went to the unit's pharmacy in search of the medication prescribed by the unit's own doctor, some patients did not have the solubility of the problem presented-access to medication, either because it was missing or by the network does not offer the type of medicine, or also the lack of materials to perform home dressing, besides to broken equipment such as gurneys and chairs.

We also saw that in one of the USFs, at that moment, , due to technical problems, the digital system hindered to operate the electronic equipment, which limited the scheduling of guides and consultations in the unit, and consequently delayed medical and

nursing care, that health workers did not have access to the electronic medical record.

A paradox, since we understand that the worker, on the one hand, should be concerned with developing activities of integral action, to give solace to the demands of the community or needs of the repressed demand, but the units do not have the necessary resources to do so.[10]

However, faced with this situation, we noticed that, even though ESF health workers try to solve the problem of the patient, they often find such limitations/difficulties in the USF that prevent them from acting to give solace to the demands.

However, we believe that when such workers do it, it may be due to the need for a humanized health practice, or even the family health team does not lose its credibility in the community due to commitment and bonding.

Specifically, we observe that lack of inputs, in general, can affect the Production of Care, which leads to the weakening of interpersonal relationships health worker-patients (light technologies) imbricated in the service. There are other limits in the system that interfere in the resolubility of the Care Production in the ESF, such as the insufficient number of workers, which interfered in the service, also causing a work overload.

The patient´s speech reinforces this situation by contextualizing the resolubility with limited effectiveness due to the lack of health workers in the service which leads to the disarticulation of the same with the central regulation and marking of exams.

> *[...] but if you go and there is not a doctor, or do not have a nurse that can indicate to you, and pass you an exam or the exam goes to the Secretary, stay there all the time then come back again, and you cannot even take it and cannot solve anything (R3, Group II).*

This was a situation experienced by us, as we had the opportunity to observe the patients at the reception of the unit in search of information about the procedures guides or specialties delivered more than two months ago (SIC) for scheduling in the Appointment Center, but they are still had not been delivered to patients.

We note that the absence of some health workers in the USF studied perhaps due to noncompliance with schedules, or due to non-hiring, which limits the access of patients to the units in search of the resolubility of their health problems. Also, we have seen that there are also problems related to the organization in the network, due to the significant loss of guides of specialties and procedures sent to the Regulation Center for scheduling.

The patients reinforce the difficulties in the ESF regarding this disorganization of the health system or network, about the scheduling of prescription, represented in the R7 speech.

> *[...] as I already told you, the center that we cannot get the service by sending the prescription there, and when I say sometimes, I do not know if it's the fault of the station, or if it's the central regulation, they prescription us back these guides, for example, I have a prescription there with more than six months, which never came [...] (R7, Group II)*

We noticed that some patients arriving at the unit reception, requesting information, about their prescriptions delivered to the unit for scheduling at the central station, the response at the reception was always the same as “the prescription had not returned with their scheduling.” We have identified requests for consultations and exams with more than 30 days without any response. When patients questioned the destination of the prescriptions, they were informed that they were in the Appointment Center, with no details of the progress of the schedule or if the prescription was actually there or lost in the scheduling flow, for example, when the prescriptions are diverted to other USFs.

We agree that the obstacles related to the organization of the scheduling flow of quota prescriptions further extend the repressed demand, since the loss of vacancies by diversion from the scheduled guide to the wrong location or by the disinformation of the family health team, or of the reception professionals, not because of them, but because of the disarticulation of the network itself or the flow of appointment.

The long waits for care, information or consultation portray the situation, which the patients subordinate, while a repressed demand, to receive attention, a reality that reduces the credibility of the health team, limiting the Continuity of Care Production, and medium and high complexity services.[11]

In fact, quotas and scheduling vacancies do not correspond to patients´ needs, generating a repressed demand. Schedules were done in a single day, with a notice attached to the unit with posters and information from Community Health Agents. Many patients sought reception outside of the scheduling day in an attempt to be able to schedule it, but without success.

Despite the deficit in quotas for scheduling procedures and specialties, the population still believes in the model that strengthens

the health medicalization, with a focus on outpatient specialized care. In this sense, patients suffer more and more from believing in the need for those services and not having access to services and/or health practices due to lack of space, or being able to schedule without needing it, or what usually happens when the patients need the scheduling. However, it is difficult to find the service that attends to the health problem at that moment, again weakening the resolubility in the ESF.

Thus, the Basic Care becomes exclusive and without guarantee of service to the patients of the repressed demand, who are forced to arrive earlier, forming large queues at dawn, in an attempt to schedule the attendance of the desired service.[10]

Consequently, the quantitative quotas for procedures and specialties of the health services may generate conflicts in the USF for health workers, as well as for the patients, explained in the following statements.

> *[...] not at the moment, what we see is punctual, now is how I told you sometimes the only conflict is that there the demand of the scheduling of the prescriptions only, which I think the worst is that there, right, the greatest conflict is this (R2, Group I).*
>
> *[...] but through people who come often wants to be attended, or for example is a quota they want the person to mark the exam without marking without having in the quota, then the conflict is there through there (R17, Group II).*

We understand that the problems of scheduling and the lack of vacancies/quotas for prescriptions of procedures/specialties and the conflicts that occur in the ESF become vulnerable and fragile. This situation may contribute to the restructuring of the strategy, limiting the resolubility due to the conflicts experienced in daily life, which should further aggravate the fact that the population overestimates the medicalization in health by seeking, more and more, specialized care, not always necessary.

From this view, an imaginary was formed in the health services between workers and patients, making an illusory association between quality in the assistance and inputs exams, medicines and specialized consultations. On the one hand, the managers of the Unified Health System (SUS) coexist with a great pressure of demand for these assistance resources, which cannot be answered, often generating long waiting times for some procedures.[12]

In Brazil, prompt care actions are still a reality in Basic Health Care, that based on complaint-behavior and not on the integral care of the individual, much less on actions in defense of life.[13] Thus, it is necessary to rethink the practice of health considering the possibility of aggregating alternatives that value promotion and prevention as one of the priorities of the Care Production in the ESF with the development of the practice of a Permanent Education in Health (EPS), which could consequently lead to intrinsic autonomy of the team to give resolubility to health problems.

Different from the previous statements, the R13 (health worker) has the following understanding regarding the autonomy of the family health team for the resolubility of health problems:

> *Not autonomy, because there is a hierarchy, so we, unfortunately, do not, if there is a hierarchy we have to take the problem, that is, to the health department, to solve the patient's problems (R13, group I).*

Even with some fragility, this speech leaves implicit for a 'partial' autonomy of the health team in the solvency of the patients´ health problems. 'Partial autonomy' depends on the Department of Health (Management) to provide solidity to Care Production and continuity to the process. Therefore, we question that the political autonomy of the ESF teams falls short of the desired since there is still the overvaluation of technicality and the distance from the reflection on thinking and doing in health.

The fact that the patient also does not have the autonomy to solve the problems in the network, directing them to other instances, medical reports are necessary for this, which, in fact, leads us to question how health workers believe they have the knowledge in the Care Production, with only its autonomy and decision-making power as to the path to be taken to resolve the health demands of patients.

On the other hand, patients have an 'autonomy' of a decision about which treatment option is best, or what they want to be guided by their personal choices and influence of sociocultural aspects, as a possibility to increase the social perception of utility and the value of the medical services organizations. Also, we believe that it is important to also value the patient as a protagonist of knowledge, and his autonomy as a resolubility power for his health problems, which would certainly bring changes and another look at interdisciplinarity and multidisciplinarity in health.

Interdisciplinarity as support for resolubility is implicitly put in the speech of health workers, like R2, when they affirm that there is interdisciplinarity in the activities

developed at the USF, with the Family Health Support Center (NASF), among others. In the meantime, we questioned: is there, concretely, an interaction between the diversity of the knowledge and practices of the subjects, that is, the exchange in the production of knowledge or only the joint action of several professional categories?

> *We work together with other professionals, the NASF, which is the core family health support with a psychologist, physiotherapist, social worker, physical educator, has the CRAS [...] students, also the FTC [[...]] contact the school, health program at school, then several things, SESI, when there is a health fair, we get in touch with other sectors, firemen, etc. (R2, Group I).*

We had the opportunity to observe the presence of NASF professionals in the ESF by organizing embroidery groups/workshops, but we did not see an interaction work, the partnership of the family health team in the construction of the activity, with the exchange of knowledge and practices from the needs of the ESF patients. At that moment, there was no involvement of the multiple knowledge, from the specialties to the Care Production in the ESF, that is, interdisciplinarity.

Interdisciplinarity is characterized by the intensity of exchanges between specialists and the level of real integration of subjects within the same research project[15]. Regardless of the theme, the discussions are currently aimed at questioning what can characterize, in fact, and in law the Collective Health as a multidisciplinary field in terms of discourses (disciplinary knowledge) and practices (forms of intervention). Thus, this multidisciplinarity should not be limited to offering multiple activities, but rather to provide the exchange of knowledge and practices in response to multiple and interdisciplinary needs.[16]

Thus, we understand that multidisciplinarity is also an instrument of support for the health worker by establishing a differentiated relationship with the patients, and this aspect is welcoming, with aspects related to the bond, commitment, responsibility for health and autonomy, to the importance of this relationship.[17] For this reason, we understand that light technologies should generate satisfaction during the Care Production in search of resolubility. Thus, it is clear that care based on patient listening and respectful, welcoming, resolute and competent professional performance should provide the patient-health service link, since this link should improve the Care Production in the ESF, allowing workers know their patients and the priorities of each one, facilitating their access to health practices and services.

The advances of the ESF referred by explicit health workers in the R15 speech are related to the bonding of the family health team with the community.

> *[...] in fact, a breakthrough that I have had is by self-worth, links with patients, links with the team, programs that we can put forward and have results, [...] (R15, Group I).*

However, patients R3 and R5 differently think of health workers about the link between them and health workers in the ESF. For the patients, there is no such link, due to the high turnover of health workers in the family health units or even the lack of interpersonal relationship between them. In fact, we have seen that some ESF health workers had recently been relocated or replaced by other workers, for no apparent reason or justification. Also, at that time, many patients expressed the desire to mobilize for the claim of a certain worker for the link already created.

However, we understand that this rotation of workers may be linked to fragile employment links, inadequate working conditions, and issues of structure and scarcity of equipment for performance, low remuneration and even cases of reported moral harassment.

These issues constitute a problem of the organization of health services management within SUS that needs to be addressed in the face of the challenges, from the precarious forms of selection and hiring of workers such as low wages, which can interfere with satisfaction or demotivation of the teams; the distributive inequity of the work force, and the poor performance of the worker.[18]

Nevertheless, even in inadequate work conditions and incomplete work hours, the permanence of medical professionals in the USF surveyed allowed the presentation in the speeches of some patients a tone of medicalization of health, that is, the valorization of the medical professional's performance by the prescriptions and compliance with biological and biomedical norms and behaviors.

The medicalization of health or social has a connection with broad sociocultural, political and scientific transformations related to the incorporation of standards of conduct of biomedical origin. As we can see, it is associated with the legitimized, officialized and professionalized forms of care and treatment in modernity, led by biomedicine.[19] The more one values medical behaviors, the

more one needs them, the more labor shortages and, consequently, we will have more turnover and a shortage of health workers.

The speech of R4 reinforces how difficult the short stay and performance of the medical professional in the ESF.

> *[...] that the doctor comes once a week, for example, you have to call on Monday so the doctor attends you on Friday, and to schedule, on Friday so the doctor attends you the on Monday, that's difficult is that [...] (R4, Group II).*

We witnessed that four of the five USFs surveyed did not comply with the 40 hours required of their employment contract, a contractual reality in the municipality studied. We also emphasize that in two of them doctors attended only twice a week; the other physicians, although they worked during the week, had a reduced daily workload, leaving the unit shortly after the end of the appointments, previously scheduled and some emergencies.

A reality that shows the valorization of the medical workforce, its shortage in the labor market in Primary Care and health practices focused on medicalization, contributing to the patients to seek the medicalization because they believe to be the only way to solve their problem. However, we understand that integrality begins with the organization of work processes in Primary Care, where care must be multi-professional, not only medical, operating with guidelines such as reception and linkage to patients and accountability of the team for their care.[12]

In this way, proximity and capacity for the reception, attachment, accountability, and resolubility are essential for the implementation of Primary Care as the initial contact and entry point for patients of the public health network.

Also, for health workers, as in R12, solvency is conceived while also making the patients and the multidisciplinary team responsible for the health problems of the population assigned to the USF area.

> *[...] the question of accountability, as I have already said, also in the members of the multidisciplinary team, as well as to make the patient himself, as a constructor himself, responsible for his own health [...] (R12, Group I).*

The accountability or co-responsibility for health problems, both by the patients and by the NASF multidisciplinary team, referred by health workers, portrays the importance of the involvement of these actors in Care Production, in search of their autonomy for resolubility of health problems, not only limiting this process to the family health team.

The sharing of responsibilities and the delineation of the path to be covered in health care networks, for solving demands, should be part of the cycle with interdisciplinarity and above all, the beliefs and social issues that should permeate the basis of care, with a view to community satisfaction.

CONCLUSION

The Care Production in the USF in their daily practices, faced with the experiences and dilemmas of health workers in the public health network, there are still many challenges to be overcome in order to reach the resolubility of health problems.

The Production of Health Care in Primary Care needs to take priority in the conduction of the resolubility in the health needs of the ESF patients. Among the dilemmas of daily life, we highlight the relational bond weakened by the workers' turnover, as well as the relative autonomy of the team, and the passivity of the patients; the lack of materials, drugs, health workers, and schedules for exam scheduling; and the disorganization of the scheduling system of the prescriptions, generating conflicts in the ESF.

We cannot fail to highlight as an advance the relevance of the efforts, often given by workers and patients, in alternative ways with attempts to achieve the dreamed resolution of health problems; and the multi-disciplinarity in NASF activities and other institutions as support for resolubility. Such efforts are important for the work process of the Multidisciplinary Care Production and responsible for health actions, based on a teamwork for the effectiveness of the resolubility of the health needs of the patients of the Family Health Strategy.

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