Revista de Enfermagem UFPE On Line
ISSN: 1981-8963

J Nurs UFPE on line.
2022;16:e253285
DOI: 10.5205/1981-8963.2022.253285
https://periodicos.ufpe.br/revistas/revistaenfermagem

QUALITY OF WORK LIFE OF PRIMARY CARE PROFESSIONALS
QUALIDADE DE VIDA NO TRABALHO DE PROFISSIONAIS DA ATENÇÃO BÁSICA
CALIDAD DE VIDA EN EL TRABAJO DE LOS PROFESIONALES DE ATENCIÓN PRIMARIA

Aline Maria dos Santos Maganhoto[1], *Thays Peres Brandão* [2], *Ailton de Souza Aragão* [3]

ABSTRACT

Objective*:** to understand the elements that make up the Quality of Work Life (QWL) from the perspective of Family Health Strategy professionals in a municipality in Triângulo Mineiro, Brazil. ***Method*:** a quantitative/qualitative research was conducted with professionals from a Family Health Unit. Data was obtained through the Total Quality of Work Life (TQWL-42) questionnaire and qualitative interview, submitted to descriptive analysis using the instrument's software and thematic content analysis. ***Results: concerning the descriptive data, there was a predominance of females 89.3%, 50% were married, and the average length of service was 44.4 months. The Environmental/Organizational sphere of the Quality of Work Life achieved the best score, totaling 45.4 points, and the Self-Assessment sphere had the lowest score, with 13.8 points. Concerning the qualitative data, the perspectives that most impacted the Quality of Work Life were infrastructure and salary deficits. ***Conclusion:*** The analysis of the QWL of Family Health Strategy professionals showed that the workers evaluated the Quality of Work Life through the TQWL-42 questionnaire as unsatisfactory, with a tendency to be neutral, but, from a qualitative perspective, they classified it as good with points to be improved.

***Descriptors*:** Quality of Life; Occupational Health; Nursing; Family Health Strategy.

RESUMO

Objetivo*:** compreender os elementos que compõem a Qualidade de Vida no Trabalho (QVT) na perspectiva dos profissionais da Estratégia Saúde da Família, em município do Triângulo Mineiro, Brasil. ***Método*:** pesquisa quantitativa/qualitativa, realizada com profissionais de uma Unidade Básica de Saúde da Família. Dados obtidos por meio do questionário *Total Quality of Work Life*-42 (TQWL-42) e entrevista qualitativa, submetidos à análise descritiva, por meio do software do instrumento e da análise temática de conteúdo. ***Resultados*:** nos dados descritivos, obteve-se predominância do sexo feminino 89,3%, 50% eram casados/as e a média do tempo de atuação foi 44,4 meses. A Qualidade de Vida no Trabalho apresentou a esfera Ambiental/Organizacional com a melhor pontuação, totalizando 45,4 pontos e a esfera Autoavaliação da QVT a menor pontuação, sendo 13,8 pontos. Nos dados qualitativos, as perspectivas que mais impactam a Qualidade de Vida no Trabalho destes profissionais foram os déficits de infraestrutura e salarial. ***Conclusão: a análise da QVT da equipe de Estratégia

Saúde da Família demonstrou que os profissionais avaliaram a Qualidade de Vida no Trabalho, por meio do questionário TQWL-42, como insatisfatória, com tendência para neutro, mas, perspectivamente, classificaram-na como boa, porém com pontos a serem melhorados.
Descriptores: Qualidade de Vida; Saúde do Trabalhador; Enfermagem; Estratégia Saúde da Família.

RESUMEN

Objetivo: comprender los elementos que componen la Calidad de Vida en el Trabajo (CVT) en la perspectiva de profesionales de la Estrategia de Salud de la Familia en un municipio del Triângulo Mineiro, Brasil. ***Método:*** se realizó una investigación cuantitativa/cualitativa con profesionales de una Unidad de Salud de la Familia. Los datos fueron obtenidos a través del *Total Quality of Work Life*-42 (TQWL-42) y entrevista cualitativa, sometidos a análisis descriptivo utilizando el software del instrumento y análisis de contenido temático. ***Resultados:*** hubo predominio del sexo femenino 89,3%, 50% estaban casados y la antigüedad laboral promedio fue de 44,4 meses. La esfera Ambiental/Organizacional de la Calidad de Vida en el Trabajo alcanzó la mejor puntuación, totalizando 45,4 puntos, y la esfera de Autoevaluación obtuvo la menor puntuación, con 13,8 puntos. En cuanto a los datos cualitativos, las perspectivas que más impactaron en la Calidad de Vida en el Trabajo fueron infraestructura y déficit salarial. ***Conclusión:*** El análisis de la CVT mostró que los trabajadores evaluaron la Calidad de Vida Laboral a través del cuestionario TQWL-42 como insatisfactoria, con tendencia a ser neutra, pero, desde la perspectiva cualitativa, la clasificaron como buena con puntos a mejorar.
Descriptores: Calidad de Vida; Salud Laboral; Enfermería; Estrategia Salud de la Familia.

[1]Federal University of Uberlândia/UFU. Uberlândia (MG), Brazil. ORCID: [1] 0000-0002-9920-1317
[2]Federal University of Uberlândia/UFU. Uberlândia (MG), Brazil. ORCID: [2] 0000-0003-4365-1228
[3]Graduate Program in Environmental and Occupational Health, Institute of Geography, Federal University of Uberlândia/UFU. Uberlândia (MG), Brazil. Federal University of Triângulo Mineiro/UFTM. Department of Community Health. Uberaba (MG), Brazil. ORCID: [3] 0000-0002-0793-2594

*Article extracted from the master's thesis entitled **A QUALIDADE DE VIDA (DO) NO TRABALHO DA EQUIPE DE PROFISSIONAIS DA ATENÇÃO PRIMÁRIA EM SAÚDE**, Federal University of Uberlândia/UFU, 2021.

How to cite this article
MAGANHOTO, Aline MS; BRANDÃO, Thays P.; ARAGÃO, Ailton S. Quality of work life of primary care professionals. J Nurs UFPE on line. 2022;16:e253285 DOI: https://doi.org/10.5205/1981-8963.2022.253285

INTRODUCTION

In recent years, there has been a significant increase in research on the impact of work on workers' quality of life due to the number of sick professionals.1 Therefore, the relationship between the attention given by policymakers and the effects that psychosocial risk factors and stress generate at work is considered relevant.[1,2]

The scope of workers' safety and health has been extended beyond the traditional one, centered on the diagnostic model of biomedical therapy. Thus, the work of professionals in occupational safety, behavioral medicine, occupational health psychology, and social well-being are currently added, recognizing the need for people to have a healthy and economically productive life.[2] In this context, reflections on Quality of Life (QoL) arise that allow understanding of the relationship between humans and well-being constructs and the factors that support this interaction.1 Quality of Life consists of the extent to which basic human needs are fulfilled concerning personal or group perceptions of subjective comfort, well-being, and completeness.[3]

From the 1970s onwards, the understanding of QoL concerning workers' health came to be considered one of the ultimate goals of medicine and health services, and since then, there has been an exponential increase in research on the quality of work life (QWL).[2,3]

Thus, QWL aims to provide greater humanization of work, with an increase in the well-being of professionals, not dependent on the concept of job satisfaction.[4] It is important to highlight that this condition intervenes in the health-disease process of professionals in the work environment and personal life, hence the need to reflect on QWL.[5]

When considering that the QWL is built on the dynamics of work relationships, the National Health Plan highlights the need to know the territory in which Primary Health Care professionals work, as it makes it possible to achieve the objectives of this policy and allows for the development of basic territorial actions, in places where productive activities and situations of risk are identified.[6] Health professionals are included in this context.

Health care professionals working in the Family Health Strategy (FHS), even providing a service of low technological density, are affected by complex relationships, given the great demand for connections with patients, families, and social environments in which they are inserted.[7]

Given Brazil's current political and economic situation, few experiences and instruments guide and train FHS professionals to provide high-quality health care and resolution, consequently affecting the QWL of primary health care professionals.[7]

In Brazil, the FHS is composed of a multidisciplinary team with different specialties, supporting public health actions and the construction of humanized and holistic health care practices, which are crucial for the consolidation of the Unified Health System.[8]

The FHS is the preferred gateway to the SUS, characterized by the low technological density demanded in health care. While on the one hand, there is a great resolution of health complaints, on the other hand, there is a significant increase in the demand for care, as well as a scarcity of material and human resources, affecting the system's resolution and causing an overload of the professional team, negatively affecting the QWL in these health care units.[9]

Due to the importance of these professionals and the satisfactory performance of their functions for the success of health policies focused on PHC, mainly on disease prevention and health promotion, this study is justified by the relevance of deepening the knowledge about the QWL of these workers, subsidizing strategic actions to improve their health. In this sense, the following research question was elaborated: What is the characteristics of the QWL of professionals working in the FHS?

To answer the question above, we defined the objective of this study - to understand the elements that make up the QWL from the perspective of Family Health Strategy professionals in a municipality in Triângulo Mineiro, Brazil. The relevance of studying the QWL of FHS professionals lies in the combination of methods adopted, as the data obtained with the Total Quality of Work Life (TQWL-42) were problematized in the light of the professionals' statements, offering an analysis of the complexity of QWL in Primary Care.

METHOD

This article is part of a master's thesis developed in the Graduate Program in Environmental and Occupational Health of the Federal University of Uberlândia. This is a quantitative/qualitative and descriptive study aiming at the construction of an interpretation of the reality of PHC workers through a bibliographic stage - carried out to help the researchers get more familiar with the problem - and a field-based stage - allowing direct data collection with study participants.[10]

The research was carried out at a Family Health Unit (FHU) in Uberlândia, Triângulo Mineiro, Minas Gerais, Brazil. Uberlândia was chosen because it has an estimated population of 700,000 inhabitants and a low FHS coverage, estimated at 32.8% in 2018.[11] The Family Health Unit selected for the study was recommended by the Municipal Health Department, as it is part of the municipality's PHC and has two FHS teams and professionals from different areas.

The study included health care workers belonging to the professional categories of the FHU, who consented to participate, aged 18 or older, and those carrying out work activities during the data collection period. Professionals who were not interested in participating and those who were absent from work activities for personal reasons were excluded due to the impossibility of contact.

The population consisted of 34 professionals from the participating FHU. The population sample was calculated using the Minitab® software, using a confidence level of 80% and a margin of error of 5%,[12] totaling 28 participants. Next, participants were invited to participate in the qualitative stage, but only 13 subjects met the inclusion criteria.

Data were collected through two instruments, including the TQWL-42. This instrument was created and validated in Brazil, and it has been chosen because it treats QWL globally - without prioritizing a specific aspect - following the molds of the WHOQOL instruments - whose psychometric properties are globally accepted.[13]

The instrument has 47 questions, five for the characterization of the interviewees, with data on age, sex, marital status, education, and length of service. The second part consists of 42 questions, subdivided into five spheres, each formed by four aspects with two questions each, totaling 40 questions, plus two questions that address the QWL self-assessment from the respondents' point of view.[13]

The second instrument was an essay interview created from the scenarios and situations adopted by the TQWL-42 and tested by the researchers. It contained the following questions: 1. Do you wake up, get up and develop your work activities in a good mood? 2. What negative feelings do you have the most in your life? How often do you notice them? 3. Are you satisfied with your work conditions? (regarding the number of people who work with you, work overload, interpersonal relationships and teamwork, relationship with the manager, physical conditions for work, and remuneration), and 4. On a scale of bad to good/excellent, how do you rate your QWL? Why do you classify it like that?

The main researcher, who was unknown to the participants, collected data in two stages before the commencement of the study. The first stage was conducted in person at the participating health unit and took place in March 2020 through the application of the TQWL-42 questionnaire, registered on paper and converted into a digital file. The second stage, due to the pandemic, took place online. The contacts of the participating professionals were obtained through the application of the TQWL-42 and confirmed or updated through the WhatsApp®

instant messaging platform. Later, in May 2021, the qualitative interview was sent to the participants who consented to answer it, through the same platform, with an option for audio or written comments. One hundred percent of the participants opted for written answers that, later, were transcribed in full using Microsoft Excel® and organized according to the questions of interest.

The QWL classification was made using a scale[14] whose average scores for the aspects and spheres are converted, in Microsoft Excel®, into a scale from zero to 100, using the following formula: [COMPUTE X1_100=(X1-4)*(100/16)]: in which X means the value of the answer referring to the question on a given aspect. In this scale, the central point is given by the value of 50, characterized as an intermediate QWL. Values below and above this central point, between 25 and 75, are characterized as dissatisfaction and satisfaction, respectively. Values not included in the 25-75 range show respective trends towards total dissatisfaction and satisfaction. Following this reasoning, the possible QWL classifications are shown in Figure 1.

Figure 1. Scale of satisfaction with the quality of work life.

RANGES[14]	**RESULTS**[14]	**TENDENCIES**[14]
0 to 6.25	Highly unsatisfactory	Highly unsatisfactory[14]
6.26 to 18.75		Neutral
18.76 to 25		Unsatisfactory
25.01 to 31.25	Unsatisfactory	Highly unsatisfactory
31.26 to 43.75		Neutral
43.76 to 50		Neutral/satisfactory
50.01 to 56.25	Satisfactory	Neutral/unsatisfactory
56.26 to 68.75		Neutral
68.76 to 75		Highly satisfactory
75.01 to 81.25	Highly satisfactory	Satisfactory
81.26 to 93.75		Neutral
93.76 to 100		Highly satisfactory

Source: Ponta Grossa, PR, Brazil, 2009.

The calculations of the QWL questionnaire allowed the assessment of scores, and the descriptive analysis was performed by tabulating each participant's score using the software provided by the instrument's creators.[13] The Microsoft Office Excel® tool, created in SPSS® language by the author of the instrument, was used, leading to the creation of TQWL-42 based on the five steps provided in the syntax provided by the WHOQOL group: (I) checking whether the 42 items were filled in with responses between 1 and 5, (II) converting the inverted questions (RECODE A11 A41 B11 C21 D31 D41 E31 (1=5) (2=4) (3=3) (4=2) (5=1), (III) calculating the scores of the spheres and aspects, (IV) transforming the scores to a scale from zero to 100, and (V) excluding respondents whose number of unanswered items exceeds 20% of the total.

These steps have specific formulas in the program, and, as the answers are released, data are generated according to aspects and spheres.[13]

Qualitative data were submitted to thematic content analysis, maintained reflexivity, and followed the pre-analysis stages, including the floating reading of the narratives. In the material exploration stage, significant expressions or words were found, coded, and treated, leading to the results, interpreted using the framework proposed by Minayo.[15]

In order to expand the information, the data from the TQWL-42 questionnaire was triangulated with the answers to the interviews, which made it possible to explore and understand the components and perspectives that influence the QWL of PHC professionals.

The study comprised the regulatory guidelines and norms for research involving human beings, framed in Resolutions 466/2012[16] and 510/2016[17] of the Brazilian National Health Council, under opinion No. 3,769,535. In addition, participants were anonymized, preceded by the term worker, according to sexual orientation, followed by an Arabic number, assigned in the TQWL-42 questionnaire and maintained during the interviews.

RESULTS

All 28 study participants who agreed to answer the questionnaire did so completely, without loss.

Regarding the descriptive data, there was a predominance of females: 25 women (89.3%) and 14 (56%) were married. Regarding the length of service, the average was 44.4 (±45.8) months. Concerning education, 22 (78.6%) completed graduate studies, and 15 (53.6%) participants completed high school. Tables 1 and 2 show the profile of the study participants.

Table 1. Descriptive data of the study. Uberlândia, MG, Brazil, 2021.

Variables	No	%
Sex		
Male	3	10.7
Female	25	89.3
Profession		
Community health agent	10	35.7
Social worker	1	3.6
Administrative assistant	3	10.7
Pharmacy assistant	1	3.6
General services assistant	1	3.6
Dentist	2	7.1

Variables	No	%
Nurse	2	7.1
Pharmacist	1	3.6
Physiotherapist	1	3.6
Doctor	2	7.1
Psychologist	1	3.6
Oral health technician	1	3.6
Nursing technician	2	7.1
Age group (years)		
≤ 30	11	39.3
31 - 40	8	28.6
41 - 50	6	21.4
≥ 51	3	10.7
Marital status		
Single	12	42.9
Married	14	50.0
Widower	1	3.6
Divorced	1	3.6
Education		
Incomplete elementary education	0	0.0
Complete elementary education	0	0.0
Incomplete high school	0	0.0
Complete high school	15	53.6
Incomplete higher education	3	10.7
Complete higher education	4	14.3
Incomplete graduate education	0	0.0
Complete graduate education	22	78.6

Table 2. Average of the variables Age and Length of Service. Uberlândia, MG, Brazil, 2021.

Variables	Average	Standard deviation	Minimum	Maximum
Age	36.1	11.1	21	63
Length of service (in months)	44.4	45.8	01	180

Figure 2 presents the spheres, aspects, and scores of the questionnaires answered by the research participants.

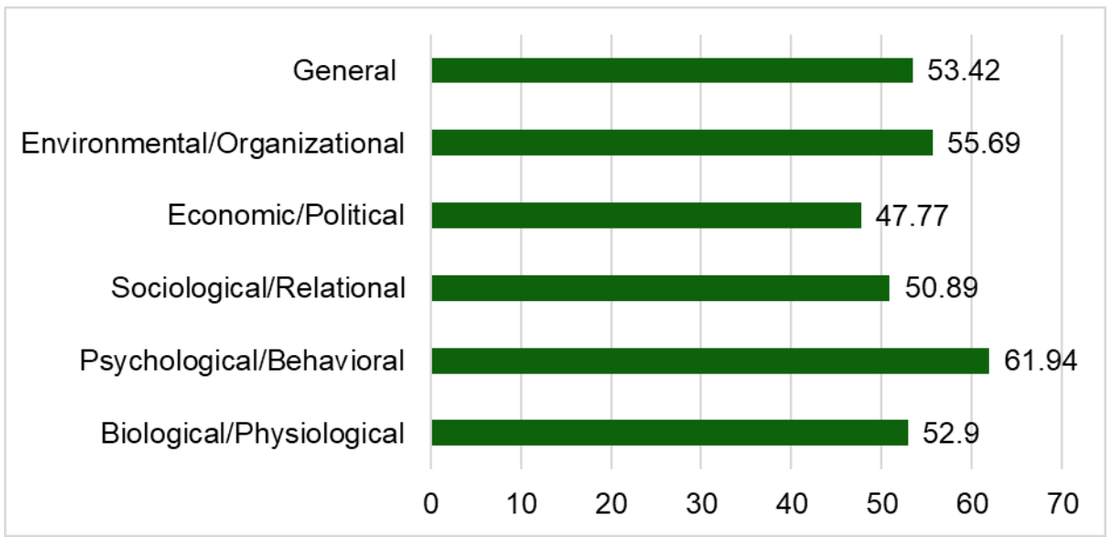
Figure 2. Spheres, aspects, meaning, and TQWL-42 scores obtained from PHC professionals. Uberlândia, MG, Brazil, 2021.

Spheres	Aspects	Meanings[18]	Scores
A. Biological / Physiological	A 1. Physical and mental disposition	Time to rest between a journey	24.5

Spheres	Aspects	Meanings[18]	Scores
	A2. Work ability	The ability to carry out what is proposed	14.5
	A3. Health and social care services	Absence of health services and assistance	41.0
	A4. Rest time	Lack of time between one journey and another to rest or sleep	30.1
B. Psychological/behavioral	B1. Self-esteem	Work-related self-satisfaction	18.2
	B2. Task significance	Understanding the value and importance of work	17.0
	B3. Feedback	Understanding how correctly the tasks are performed or not and feedback received from higher hierarchical levels	21.5
	B4. Personal and professional development	Opportunity for development and recognition in the workplace	35.7
C. Sociological / Relational	C1. Freedom expression.	Freedom to express ideas and opinions without confrontations	42.9
	C2. Interpersonal relationships	Occurrence of disagreements in the work environment	18.0
	C3. Autonomy	Science of being able to make some decisions without the need for prior consultation with superiors	34.9
	C4. Leisure time	The practice of leisure activities	38.3
D. Economic/Political	D1. Financial resources	Availability of financial resources	39.4
	D2. Extra benefits	Lack of extra incentives	44.3
	D3. Working hours	Feeling of exhaustion	29.8
	D4. Job security	Fear of layoffs, unit changes, and job instability	14.3
E. Environmental/Organizational	E1. Work conditions	Good working conditions	23.7
	E2. Development opportunities	Insufficient perspective on personal and professional growth	45.4
	E3. Variety	Routine in the execution of tasks	21.8
	E4. Task identity	Opportunity to complete tasks fully	15.0
F. Self-assessment of quality of work life	F1. Self-assessment of quality of work life		13.8

From the calculations of the QWL questionnaire shown in Figure 2, in the B Psychological/Behavioral sphere, It can be observed that the scores from B1 to B3 tended to be "highly unsatisfactory", except for B4, whose score was "unsatisfactory". In the E-E2 Environmental/Organizational sphere, the aspect "development opportunities" presented a relatively high score, totaling 45.4 points, and the sphere F-F1, Self-Assessment of QWL, had the lowest score, corresponding to 13.8 spots. The spheres evaluated by the workers, related to their meanings, obtained a predominantly "unsatisfactory" score, with a tendency for "neutral" and "neutral/satisfactory".

Graph 1 presents the scores of each sphere and the general result according to the TQWL-42 syntax.



Graph 1. Scoring of the spheres and general results, elaborated by the syntax of TQWL-42[13], with the survey data. Uberlândia, MG, Brazil, 2021.

After applying the data collection instruments, interviews were carried out with 13 participants. Table 2 shows the participants' responses.

Table 2. Transcription of the narratives of the interviewees. Uberlândia, MG, Brazil, 2021

Participant	Question 1	Question 2	Question 3	Question 4
1	Sometimes	Sometimes, indifference.	Satisfied	Good. However, many things can be improved.
2	Yes	No negative feelings.	I am satisfied	Great. I like what I do, and I don't feel overwhelmed.
3	Yes	Fear / when I am at work (Covid-19 contamination).	Satisfied	Excellent (due to positive results).
4	Yes	Discouragement. Weekly.	Yes	Good. There is a good relationship between management and staff.
5	Usually yes	Dissatisfaction. Several times a week.	No	Good, but there are points to be improved.
6	No	Feeling of not being good enough. All the time.	No	Good. It has positive advantages such as being close to home and schedules. On the other hand, some people and situations bother me, but not to the point of destabilizing me.
7	Yes	Willingness to disappear. Once during the month.	Yes	Good, because I like my job.
8	Yes	I have no negative feelings.	No	We should have more professionals.
9	Yes	Sometimes something doesn't work out, but not always.	Yes, but not with some co-workers.	Good.
10	I don't always wake up in a good mood for work due to the physical and mental state that this	I try to work with my negative feelings every day. I notice that it is very frequent, practically every day.	The structural part of the unit doesn't help much. There are 12 of us in a place that would fit, at most,	Good, but there is still a lot to improve on the space.

Participant	Question 1	Question 2	Question 3	Question 4
	pandemic is causing, but I commit to my service and try to do my best.		6. I try to work well with my colleagues, respect each other's space, and relate well to the coordination. The salary is not good, but it is what we have.	
11	Yes	Sometimes a little sad.	I am satisfied with the working conditions, the number of people who work with me is satisfactory, the team relationship is good, the management helps us a lot. Working conditions and pay are satisfactory.	Good. The public we assist is humble and devoid of information, which causes a bit of stress. However, this is normal within the health care area.
12	Not always. Depends if I was on call the night before. It depends on the clinical conditions' support, material, and possible resolution. Some circumstances are quite frustrating.	On a professional level? I often get stuck in protocols. I feel powerless.	Yes, but this answer is not linear.	Good. There are ups and downs, but they can be overcome.
13	Yes	Lack of motivation at times. Sometimes.	Yes, I am satisfied.	Good. I have a good relationship with the team. I work close to home and enjoy my work.

When analyzing the contents of the participants' speeches, through the answers to the questions, concerning Question 1, which was about waking up in a good mood (a) for work activities, the majority (67%) said "yes". The data demonstrate a positive level of satisfaction among health professionals at the participating unit concerning work activities. Thus, the data found in the TQWL-42 questionnaire, which showed a satisfactory score of 52.90 in the Biological and Physiological spheres, are corroborated.

In Question 2, referring to negative feelings in life and how often they were perceived, it was found that the majority, 77.0%, reported feelings such as "indifference", "fear", "sadness", and "wanting to disappear", and one participant added the Covid-19 pandemic. As for the frequency, these feelings are manifested daily. These emotions negatively impact QWL and are in line with the Self-esteem aspect, with a score of 17.0, classified as unsatisfactory - especially in the Job Security item, whose score was 14.3.

As for Question 3, about satisfaction with work conditions, most participants expressed satisfaction (69.0%) against 31% who answered "no". Among those who answered, "no", they stated that "the structure of the unit is not satisfactory, the salary is low, and they have difficulties in relationships with co-workers" (Worker 10). The expression of the worker is consistent with that obtained in the TQWL-42: a score of 47.77, considered "unsatisfactory" in the political-economic sphere.

On the other hand, among the positive responses, it was reported that "the number of employees in the unit is satisfactory, the team relationship is good, and there is support from the manager [...]" (Worker 11). There was evidence of consistency with the score of the Organizational Environmental sphere - a score of 55.69, considered "satisfactory".

In question 4, which dealt with the classification of QWL into "poor", "good," and "excellent", 69.2% answered that the QWL was "good" added to the fact that they work "close to home" and have "flexible hours" and "enjoy working". Fifteen and three-tenths percent rated the QWL as "excellent" and 8% as "poor". This aspect contrasts with the TQWL-42, whose QWL self-assessment score was 13.8, therefore, "highly unsatisfactory". Consistent with the quantitative data, Worker 6 argued that the incomplete team at the health unit affects the QWL. Moreover, he added that [...] on the other hand, some people and situations between users and professionals bother, but not to the point of destabilizing me" (Worker 6). Worker 13 indicated positive QWL elements: "I have a good relationship with the team, I work close to home, and I really like my job ".

DISCUSSION

In this research, there was a predominance of females and married professionals with an average work time of three years.

A descriptive cross-sectional study carried out with 120 professionals from primary health care units in the eastern district of Foz do Iguaçu, in Paraná, Brazil, showed similar results to those of this study - most participants were aged ≤ 45 years (53.3%), and were female (82.5%).[9]

Paradoxically, the proportion of male and female professionals in the health area has changed over the years, showing a trend toward increasing male workers in the various professional categories in the health area.[19] Concerning the predominance of married professionals, the findings corroborate research in which a higher frequency of individuals living with a partner was observed.[5-9,20]

The data of this study shows that the average length of service of the professionals of the units surveyed was 3.7 years. Campos and colleagues[21] observed a higher frequency of individuals who had worked between zero and one year. Another study[22] found that most professionals worked for between three and 10 years. With these data, it is evident that the time of work in PHC is very variable.

The analysis of the Spheres in a consolidated way, as shown in Graph 1, shows that the Psychological/Behavioral sphere obtained the highest score, with 61.94 points, while the Economic/Political sphere reached the lowest score, totaling 47.77 points. Another study conducted with health workers[23] found a high score in the Psychological/Behavioral sphere (77.37) versus a low score in the Environmental/Organizational sphere (63.05 points). Another study with nurses from the public health network[24] found a significant number of highly satisfied workers concerning the task significance aspect of the QWL, with an average score of 83.49. However, aspects such as health and social care services, development opportunities, working conditions, extra benefits, working hours, personal and professional development, and rest time were rated unsatisfactory.

Similar to our findings, participants from another study[9] demonstrated that the QWL of PHC workers is directly linked to satisfaction with the ways of working, the quantity and quality of material resources, people and structure, the organization of the work process, the ways of caring, the results obtained, and the feeling of being recognized.

The QWL is influenced by the number of professionals working at the FHU. According to Ordinance No. 2436, of September 21, 20178, which regulates the National Primary Care Policy, the FHS must be composed of a nurse, nursing assistants or technicians, a physician, community health agents, a dental surgeon, oral health technicians, and oral health assistants. The present research covered the professional categories indicated by the Ordinance. However, the teams were incomplete, as some participants mentioned the need to work a complete them. Therefore, the work overload influenced the participants' QWL.[7,9]

The National Primary Care Policy[8] presents the attributions of each PHC worker according to the aforementioned legal provisions that regulate the exercise of each of the professions, and, regardless of the position or function developed, it is emphasized that health professionals, especially in the FHS, should understand that collaborative practice facilitates teamwork and, therefore, contributes to improving the coexistence of professionals, as well as the health care provided.[7]

The actions developed by Primary Health Care professionals have peculiarities. For example, they require few technological resources, allied to the low demand for secondary or tertiary health care among the targeted public.[25] In this way, they dedicate themselves to creating bonds with the communities, obtained through closer coexistence with the community and in constant and welcoming dialogue. Strategies are often crossed by poor resolution due to the scarcity of human resources, materials, and low incentives from public management, which are likely to affect the QWL.

The data from the qualitative responses showed a positive level of professional satisfaction. This circumstance can provide the development of quality tasks. Moreover, this is necessary to meet the health demands of users so that it does not negatively affect the QWL of PHC workers.[5-20]

Regarding the feelings expressed in question 2, these can be aggravated due to the work management in PHC. A study[26] carried out with 50 PHC nurses in Paraíba, Brazil, showed that the organization of work with management strategies focused on productive production and anchored in pressure and excessive work rhythms cause general discomfort at work, which impacts QWL.

In a contradictory way, in theory, the National Humanization Policy (NHP), published in 2013,[27] presents the organization and implementation of healthy and welcoming workspaces as one of the guidelines, which is relevant for a good work process, with consequent development and promotion of QWL. However, it presents many impasses in practice.[28]

In order to corroborate the items that affect the QWL of PHC professionals, a literature search,[29] carried out in the time frame from 1988 to 2016, collected several factors that can change the QWL and found that salary is a factor that greatly affects the QWL.

The data from question 3 align with a study[9] that indicates that the socio-professional relationships in the FHS teams are predominantly positive. Providing health professionals with good working conditions and an adequate workload is essential for the best performance of their activities, as it allows experience and knowledge to be effectively applied for the benefit of patients, families, and co-workers.[25] However, this data contrasts with the Economic/Political sphere, in which the absence of extra benefits (44.3) and lack of job security (14.3) generated workers' dissatisfaction, influenced, for example, by neoliberal resource contention policies.[5,9,20,21]

Based on the data obtained in this study, a positive level of satisfaction was observed among health professionals at the participating unit, which is similar to the results found in other surveys carried out in Brazil and abroad.[9-25-30]

The TQWL-42 data, linked to the narratives, allowed us to grasp the spheres that impact the QWL of PHC professionals and point out their perspectives, showing that QWL was classified as good, but items such as infrastructure and remuneration were negatively evaluated.

CONCLUSION

The analysis of the QWL of FHS workers in Brazil through the TQWL-42 questionnaire revealed an oscillation between the assessed spheres. It was found that the QWL is sensitive to the dynamics of social determinants, observable in political, social, economic, legal, and cultural history. These variations influence how workers self-assess their QWL - the sphere that presented the worst assessment (13.8).

Although the overall result (53.42) indicates a "satisfactory" assessment of the QWL, this score indicates a "tendency to neutral/unsatisfactory". In other words, the containment of resources in the SUS, for example, through the Constitutional Amendment 95, has a practical implication on the salaries and infrastructure of the Units - they prevent, on the one hand, workers from feeling assured to plan trajectories in PHC consistently. On the other hand, they interrupt the performance, maintenance, and consistency of health care and health promotion ties with communities.

By unifying research strategies, the study contributes in a purposeful way to the advancement of PHC studies in Brazil, given its relevance as a gateway to the Unified Health System, aiming at the effectiveness of the right to universal healthcare, as well as for the understanding that QWL is sensitive to social determinants.

CONTRIBUTIONS

AMS Maganhoto and TP Brandão: adjustments to instruments, data collection, treatment, and text writing. AS Aragão: study design, writing, and review of analyzes and text.

CONFLICT OF INTERESTS

Nothing to declare.

ACKNOWLEDGEMENTS

We thank the workers of the Family Health Strategy of the surveyed municipalities in Minas Gerais.

REFERENCES

1. Freitas HN de, Silva SM de C. Qualidade de vida no trabalho: estudo de caso sobre o processo de adoecimento que acomete os bancários. R. Eletr. Ci. Soc. apl. [Internet]. 2020 [cited 2021 Feb 14];8(2):19–57. Available from: https://revista.fisul.edu.br/index.php/revista/article/view/102

2. Nordenmark M, Hagqvist E, Vinberg S. Sickness presenteeism among the self-employed and employed in northwestern europe: the importance of time demands. Saf Health Work [Internet]. 2019 Jun [cited 2022 Feb 14];10(2):224–8. DOI: https://doi.org/10.1016/j.shaw.2019.01.003

3. Camargo SF, Almino RHSC, Diógenes MP, Oliveira Neto JP de, Silva IDS da, Medeiros LC de, et al. Qualidade de vida no trabalho em diferentes áreas de atuação profissional em um hospital. Ciênc. Saúde Colet. [Internet]. 2021 Apr 19 [cited 2022 Feb 15];26:1467–76. DOI: https://doi.org/10.1590/1413-81232021264.02122019

4. Freitas EA de, Freitas EA de, Santos M de F dos, Félis KC, Filho IM de M, Ramos LSA. Assistência de enfermagem visando a qualidade de vida dos pacientes renais crônicos na hemodiálise. Rev Inic Cient Ext. [Internet]. 2018 Jun 26 [cited 2021 Feb 14];1(2):114–21. Available from: https://revistasfacesa.senaaires.com.br/index.php/iniciacao-cientifica/article/view/59

5. Tambasco L de P, Silva HS da, Pinheiro KMK, Gutierrez BAO. A satisfação no trabalho da equipe multiprofissional que atua na Atenção Primária à Saúde. Saúde debate [Internet]. 2017 [cited 2022 Feb 14];41:140–51. DOI: https://doi.org/10.1590/0103-11042017s212

6. Brasil. Plano Nacional de Saúde 2020-2023 [Internet]. Brasília: Ministério da Saúde 2020 [cited 2021 Jan 12]. p. 159. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/plano_nacional_saude_2020_2023.pdf

7. Teixeira ÁAL, Silva HA da, Nascimento MSC, Ribeiro KG, Pereira LKL, Coutinho CF, et al. Qualidade de vida profissional de trabalhadores de saúde que atuam na atenção primária à saúde. Brazilian Journal of Health Review. 2021 [cited 2022 Feb 14];4(4):14606–20. DOI: https://doi.org/10.34119/bjhrv4n4-020

8. Brasil. Portaria nº 2.436 de 21 de setembro de 2017. [Internet]. 2017. [cited 2022 Feb 14]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html

9. Lima GKM de, Gomes LMX, Barbosa TL de A. Qualidade de Vida no Trabalho e nível de estresse dos profissionais da atenção primária. Saúde debate [Internet]. 2020 Nov 16 [cited 2022 Feb 15];44:774–89. DOI: https://doi.org/10.1590/0103-1104202012614

10. Creswell JW, Creswell JD. Projeto de pesquisa: métodos qualitativo, quantitativo e misto. 5th ed. Porto Alegre: Penso; 2021. 264 p.

11. Brasil. e-Gestor Atenção básica [Internet]. Brasília: Ministério da Saúde, 2019 [cited 2022 Feb 14]. Available from: https://egestorab.saude.gov.br/paginas/acessoPublico/relatorios/relHistoricoPagamentoEsf.xhtml

12. Souza ER. Manual de uso da estatística em pesquisas na FEAMIG: planejamento amostral, estatística descritiva e inferências [Internet]. Belo Horizonte: FEAMIG; 2020 [cited 2021 Jan 12]. 105 p. Available from: https://www.feamig.br/wp-content/uploads/2020/12/Manual-Eustquio-Site-PPDC-03-12-20revProfWilson-Gabriela-Ma%CC%81rcia-2.pdf

13. Pedroso B, Pilatti LA, Gutierrez GL, Picinin CT. Construção e validação do TQWL-42: um instrumento de avaliação da qualidade de vida no trabalho. Rev. salud pública. [Internet]. 2015 Jul 16 [cited 2022 Feb 15];16(6):885–96. DOI: https://doi.org/10.15446/rsap.v16n6.30224

14. Timossi L da S, Pedroso B, Pilatti LA, Francisco AC de. Walton's model adaptation for quality of work life evaluation. Editora da Universidade estadual de Maringá [Internet]. 2009 [cited 2022 Feb 15];20(3):395–405. DOI: https://doi.org/10.4025/reveducfis.v20i3.5780

15. Minayo MC de S. O desafio do conhecimento: pesquisa qualitativa em saúde. 14th ed. São Paulo: Hucitec; 2014. 416 p.

16. Brasil. Resolução 466 de 12 de dezembro de 2012. [Internet]. Brasília: Ministério da Saúde; 2012 [cited 2021 Nov 15]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html

17. Brasil. Resolução 510 de 07 de abril de 2016. [Internet]. Brasília: Ministério da Saúde; 2016 [cited 2021 Nov 15]. Available from: http://conselho.saude.gov.br/resolucoes/2016/Reso510.pdf

18. Gerheim MS, Hildenbrand LMA. Possíveis e impedimentos ao trabalho do professor educadorpedagogo no setor privado de ensino. Com a Palavra o Professor. 2020;5(11):117–31.

19. Ferreira GP, Almeida MC de. Experiências e percepções relacionadas ao gênero nas práticas profissionais de homens terapeutas ocupacionais. Cad. Bras. Ter. Ocup. [Internet]. 2022 Feb 11 [cited 2022 Feb 15];30(e2984). DOI: https://doi.org/10.1590/2526-8910.ctoao22622984

20. Lourenção LG. Qualidade de vida, engagement, ansiedade e depressão entre gestores de Unidades da Atenção Primária à Saúde. Rev. port. enferm. saúde mental. [Internet]. 2018 Dec [cited 2022 Feb 15];(20):58–64. DOI: https://doi.org/10.19131/rpesm.0227

21. Campos FF, Reis MLC, Pires Júnior DR, Rocha R de O, Aguiar GAB, Anjos LS, et al. A satisfação dos profissionais das estratégias de saúde da família em relação às condições de trabalho. Revista Intelectus [Internet]. 2020 [cited 2021 May 10];57(1):20–40. Available from: http://www.revistaintellectus.com.br/artigos/63.747.pdf

22. Suyama EHT, Lourenção LG, Cordioli DFC, Cordioli Junior JR, Miyazaki MCOS. Estresse ocupacional e sintomas osteomusculares em Agentes Comunitários de Saúde. Cad Bras Ter Ocup [Internet]. 2022 Jan 7 [cited 2022 Feb 15];30. DOI: https://doi.org/10.1590/2526-8910.ctoao22692992

23. Barbosa ML, Menezes TN de, Santos SR dos, Olinda RA, Costa GMC. Qualidade de vida no trabalho dos profissionais de saúde no sistema prisional. Ciênc. Saúde Colet. [Internet]. 2018 [cited 2022 Feb 15];23(4):1293–302. DOI: https://doi.org/10.1590/1413-81232018234.09292016

24. Ribeiro E dos S, Silva EKV da, Jatobá L de A, Andrade WN, Miranda LN. Qualidade de vida no trabalho de enfermeiros de instituições hospitalares da rede pública. Enfermería Global [Internet]. 2021 [cited 2021 Jun 12];63(488):475–88. DOI: https://doi.org/10.6018/eglobal.456911

25. Brandão TP, Aragão A de S, Querino RA, Maganhoto AM dos S. A qualidade de vida (do) no trabalho da equipe de profissionais da atenção primária em saúde no triângulo mineiro. Revista Recien. 2021;11(36):43–53. DOI: https://doi.org/10.24276/rrecien2021.11.36.43-53

26. Oliveira MM de, Pedraza DF. Contexto de trabalho e satisfação profissional de enfermeiros que atuam na Estratégia Saúde da Família. Saúde debate [Internet]. 2019 [cited 2022 Feb 15];43(122):765–79. DOI: https://doi.org/10.1590/0103-1104201912209

27. Ministério da Saúde B. Política Nacional de Humanização [Internet]. Brasília: Ministério da Saúde; 2013 [cited 2021 Feb 19]. 16 p. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_humanizacao_pnh_folheto.pdf

28. Lima A de S, Farah BF, Bustamante-Teixeira MT. Análise da prevalência da síndrome de Bunout em profissionais da Atenção Primária em Saúde. Trab. Educ. Saúde (Online). 2018 [cited 2022 Feb 15];16(1):283–304. DOI: https://doi.org/10.1590/1981-7746-sol00099

29. Soares LMB, Borges A dos S, Santos DO dos. Qualidade de vida no trabalho (QVT) nos profissionais de enfermagem. Orientac soc. [Internet]. 2020 Dec 17 [cited 2021 Feb 15];20(2):e026–e026. Available from: https://revistas.unlp.edu.ar/OrientacionYSociedad/article/view/10889

30. Dixit J, Goel S, Sharma V. A comparative study on the level of satisfaction among regular and contractual health-care workers in a Northern city of India. J Family Med Prim Care [Internet]. 2017 [cited 2022 Feb 15];6(2):416–23. DOI: https://doi.org/10.4103/jfmpc.jfmpc_278_16

Correspondência

Thays Peres Brandão
E-mail: thaystpb24@gmail.com

Submissão: 16/02/2022
Aceito: 07/09/2022
Publicado: 11/01/2022

Section Editor:Thaís Araújo da Silva

Scientific Editor: Tatiane Gomes Guedes

Manager Editor Maria Wanderleya de Lavor Coriolano Marinus