

Organization of health services in the family health strategy: perspectives of basic unit managers

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ABSTRACT. To analyze the organization of services offered in the Family Health Strategy, from the perspective of Basic Units managers. Analytical, qualitative study, carried out through a focus group, with the participation of 25 managers of Basic Family Health Units in a pole city in the West of Santa Catarina. For systematization and data analysis, the Discourse of the Collective Subject was used, based on the theory of social representations, which resulted in three Central Ideas. Three Central Ideas emerged: 'The influence of Structural Factors for the Development of Services in the Family Health Strategy', 'Care and management organization of work in the Family Health Strategy' and 'Access and user's satisfaction from the perspective of Basic Health Units managers'. Some challenges were evidenced in management practices, such as inadequate infrastructure, professional turnover and conduct based on the medical-hegemonic model. The difficulty in offering comprehensive, individualized, and longitudinal care was emphasized, which directly influences user's satisfaction. The health care model and the articulation of the network determine the forms of care and management organization of services, which impact on guaranteeing access and resolution in the care provided to users.

Keywords: Family health strategy; quality of health services; unified health system.

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Introduction

Primary Health Care (PHC) practices in Brazil are structured by the Family Health Strategy (FHS), recognized as one of the most successful experiences in the world (Geremia, 2020). This study understands the concept of PHC based on the offer and organization of actions and services from the perspective of access to comprehensive health care, guided by the social determination of the health/disease process, consistent with the expanded concept of health exposed in the Magna Carta of 1988 (Fausto et al., 2018).

According to Starfield (2002), PHC is characterized by four main attributes: attention to first contact; longitudinality; comprehensiveness and coordination of care; and derived attributes, which qualify the actions of these services. PHC services in Brazil are organized in a decentralized manner, with autonomy of the municipalities for the coordination and execution of services, which are materialized in the physical space of the Basic Health Unit (BHU), in which multidisciplinary teams work with a community and family focus, mostly Family Health Teams (FHT), (Brazil, 2017).

The contributions of PHC in the population's health conditions are evidenced through results related to equity and rationality in the use of resources, expansion of access to health with action from social conditioning and determinants of the health and disease process (Starfield, 2002; Pan American Health Organization [PAHO], 2007). Studies show that this health care model led to a reduction in hospitalizations for PHC-sensitive conditions and infant mortality, emphasizing the inversely proportional relationship of these data with the increase in the number of FHT (Macinko, Guanais & Souza, 2006; Rasella, Aquino & Barreto, 2010; Dourado et al., 2011; Cecilio & Reis, 2018).

Despite these advances, PHC faces old and new challenges, such as: inadequate structure of health services; low articulation of PHC with other services in the care network; insufficient hiring and retention of qualified professionals to work in PHC, decrease in vaccination coverage, increase in the search for secondary

care services for causes that could be resolved in PHC, difficulties of the team in managing chronic diseases and coping with communicable diseases (Arrelias et al., 2017; Cecilio & Reis, 2018; Fausto et al., 2018).

In addition to these obstacles, it is worth noting that PHC professionals and services have resisted the SUS's devaluation, accelerated by fiscal austerity measures and the continuous unfunding of health policies, implemented by EC 95/2016, as well as by the changes in the allocation of public resources with the current financing model and peripheral treatment of PHC in the health services, increasingly assuming an individualizing approach to the care and financing model (Celuppi, Geremia, Ferreira, Pereira & Souza, 2019; Geremia, 2020; Morosini, Fonseca & Baptista, 2020).

That said, in order to offer comprehensive health services that meet the attributes of PHC, it is necessary to increase the demand for management and support for multiprofessional teams, considering the growing complexity of care involved in comprehensive health care. Then comes a valuable actor, the BHU manager. This function comprises attributions of planning, coordination, direction and control of the actions carried out by the teams, associated with technical, administrative and psychosocial knowledge and skills.

The health manager is the protagonist in the process of managing local obstacles and operationalizing health policies, thus exploring the potential of services and being responsible for evaluating and encouraging actions offered so that these are consistent with the principles and guidelines established by the SUS (Nunes et al., 2018). Faced with these concerns, the question arose: How is the organization of the services offered in the FHS, from the perspective of BHU managers?

It should be noted that understanding the managerial organization and the work dynamics of the FHS is essential to assess the quality of services and to disseminate good practices adopted by BHU managers. Furthermore, understanding the vision of these actors and the uniqueness of their competences is still an undervalued topic in scientific productions (Henrique, Artmann & Lima, 2019), which justifies the relevance of this study, which aimed to analyze the organization of care offered in the ESF from the perspective of BHU managers.

Method

This study has a qualitative approach, in which interpretation and data analysis are based on the theory of social representations. This one starts from the knowledge and practical experiences of individuals and groups, developing in the relationships and in the set of ideas between subjects or through group interactions (Moscovici, 2002) and seeks to understand the facts from the social reality. From this, the research had the participation of 25 BHU managers from a pole municipality in the western region of Santa Catarina, Brazil, which contains 26 BHU's and 53 FHS's.

Participants were chosen out of convenience, based on the following inclusion criteria: acting as BHU manager and performing the function for at least six months. As exclusion criteria were defined: professionals who were in any condition of absence from work, such as vacations, medical certificate or who did not show up on the day scheduled for data collection.

With the support of the Municipal Health Department, the BHU managers were contacted, previously invited via telephone or WhatsApp to participate in the study, and informed about the data collection procedures. For data collection, the focus group strategy was used, aiming to collect information on a given topic through interactive discussion between participants and the researcher, who meet in a single place, providing mutual learning and exchange of experiences (Kinalski et al., 2017).

The focus group took place in the auditorium of the Municipal Health Department, before the monthly meeting with BHU managers and municipal administration. Thus, if someone did not accept to participate in the research, they could only arrive for the meeting, safeguarding the right not to participate in the study. Only one manager did not attend. In order to avoid embarrassment on the part of the participants, only BHU managers and three researchers remained in the auditorium, one of them a doctor, who was the facilitator, and two undergraduate students, all with experience in focus group research.

Initially, the Free and Informed Consent Term (FICT) was read and after the professionals signed the agreement, the focus group was started. At this point, the motivation of the study was presented, due to the need to identify limits and the possibility of qualifying access to PHC services in the municipality, a demand debated in the Municipal Health Council. Afterwards, each FHS manager was asked, when starting his speech in the group, to introduce himself with his "fictitious" name, which was described on his badge that was randomly given by the research team. To ensure anonymity of identity in the dissemination of results,

participants were coded with the names of “cities” at the time of the focus group (Rio de Janeiro, São Paulo, Florianópolis, among others).

The focus group was held in a single meeting, in October 2019, with the support of a semi-structured script, containing triggering questions, organized into two major axes: 1) Quality in the health care organization; and 2) Quality in the health management organization. The questions were read one by one by the facilitator during the meeting, which lasted 90 minutes, reaching data saturation.

As it was a group of 25 people, considered large for a focus group, the strategy of repeating some questions was used. Thus, some questions were carried out in a different way, with the same approach, providing opportunities for speech and mitigating possible damages. The interviews were audio-recorded and transcribed by the research team. Field notes were also made at the time of data collection, which facilitated the process of identifying the speeches in the transcript.

Data were manually analyzed using the Collective Subject Discourse (CSD) method, derived from the theory of social representations, which consists of a qualitative tool that seeks to faithfully express the thinking of a population on a given topic. Initially, a thorough analysis of the interviews was carried out, identifying and underlining Key Expressions (KE) in the text. These KE were excerpts from the interviews that revealed the essence of the content addressed. After signaling the KE, the set of similar expressions was united, creating the Central Ideas (CI), which succinctly describe the meaning of a composite of speeches. Subsequently, the CIs were grouped and the CSD were constructed on the subject in question (Ferreira et al., 2018; Lefèvre & Lefèvre, 2003). From the interviewees’ speeches, three categories of analysis emerged, with the speeches coded in CSD 1, CSD 2 and so on.

This research work was approved by the Ethics Committee in Research with Human Beings of a public university in Santa Catarina, through opinion No. 2,492,799, CAAE 80747517.8.0000.5564, on February 9, 2018.

Results and discussion

The 25 BHU managers in the studied municipality, two men and 23 women, had an average age of 35 years. The average time of experience in management was six years. It is noteworthy that all the managers interviewed were nurses, which reveals the role of this professional in the FHS, both in care and management. In this sense, it is imperative to train an efficient and creative nursing professional, with the ability to overcome the challenges in the management of services within the FHS, also offering care based on the SUS principles (Santos, Silva & Santos, 2021).

Based on the data analysis, three CIs emerged, namely: 1) The influence of structural factors for the development of services in the Family Health Strategy; 2) Care and management organization of work in the Family Health Strategy; 3) Access and user’s satisfaction from the point of view of managers of Basic Health Units; which will be presented and discussed below.

IC 1 – The influence of structural factors for the development of services in the Family Health Strategy

The testimonies below reveal that the physical space of the health units presents inadequacies, hindering the development of quality care.

CSD 1: Today I’m having difficulty with service at the unit because I don’t have space, my demand four years ago was 2,100 users and now I have 3,500. I have nowhere else to expand, the structure will limit users’ access. The planning is outdated, without rooms and without adequate structure to offer care.

CSD 2: In my unit there is no accessibility for people with special needs. There is no ramp to get to the meeting rooms, only a ladder, so accessibility is lacking. We have always had users with physical disabilities, we also don’t have Braille for the visually impaired person. We have this difficulty of access for people with disabilities.

CSD 3: The unit where I work is in a rented building, it was completely adapted. So when you call the user, he is usually not in your field of vision, and very often you have to call him multiple times. There is no access conditions in that unit to organize a service. This is a matter of inadequate structure, which management should think about and provide better working conditions.

Within the FHS, even with major improvements over the years, structural problems persist in different Brazilian realities (Bousquat et al., 2017; Facchini, Tomasi & Dilélio, 2018; Fausto et al., 2018; Neves et al., 2018), also evidenced in the present study. The physical structure is one of the main components for the

analysis of the quality of the FHS. When the structure is adequate, the development of care processes and their results are more effective, which highlights the structure as a determining variable for the performance of PHC services (Bousquat et al., 2017; Neves et al., 2018). According to Donabedian (1980), the structure of a health service concerns relatively stable conditions, fundamentally evaluating the characteristics of the care resources. Among them are instruments, material and human resources, physical context and facilities, financial resources, organization of care and adequacy to current regulations.

The National Primary Care Policy (PNAB) assigns the duty of government to ensure a structure that meets the sociodemographic parameters of the enrolled population (Brazil, 2017). When the units have structural inadequacies to meet the demands of the territory or lack of accessibility, they generate circumstances that restrict the population's access to the gateway to the health system and, consequently, accentuate social inequities. It is noteworthy that physical access is a condition capable of facilitating or obstructing the use of the health service, directly interfering with the relationship between demand and entry into the service (Poças, Freitas & Duarte, 2017).

In this sense, the structural flaws and consequent barriers in accessing the service can make users more susceptible to diseases or even delay the treatment of situations already diagnosed, such as people with uncontrolled hypertension and diabetes²¹. In addition, it is worth remembering the issue of accessibility for people with special needs, as highlighted by CSD 2. Several studies identify this limitation, demonstrating difficulty or impossibility of providing care to this population group (Martins et al., 2016; Paula, Silva, Tassinari & Padoin, 2016; Moreira, Lima, Vieira & Costa, 2017; Poças et al., 2017).

It is worth mentioning another factor regarding the structural conditions refers to the maintenance of equipment that already exists at the BHU.

CSD 4: When I make a technical call to the maintenance team, in addition to taking a long time to respond, when they arrive, the necessary parts are missing. The team leaves and you are left with the problem waiting two to three months. There's little quality and unwillingness, as if we're asking for a favor, it feels like it's not their job.

CSD 5: Maintenance is essential, we need to insist on the preventive maintenance agenda in meetings of the Health Department. Without improvements, we work with scrapped things, there is no preventive maintenance.

CSD 6: We are going to home visits without a sphygmomanometer, the device has already been requested a dozen times. I only have one sphygmomanometer in the entire unit, if I take it out of the vitals room, all users who pass through there will not have their blood pressure measured. Material resources are needed to provide adequate care. The equipment is also structural, we don't have a computer, we don't have a television, we don't have enough tables.

The PNAB mentions that, in addition to infrastructure, it is necessary to offer adequate working conditions for professionals (Brazil, 2017). The lack of periodic maintenance and of adequate material resources and supplies damages the service, interfering with the work of professionals, the safety of users, the resoluteness of care, in addition to leading to higher expenses due to possible loss of equipment.

Institutional support from municipal management is an important strategy to overcome the difficulties identified in the study. In this way, it is believed to be relevant for the institution to provide spaces and flows to encourage co-management and participatory work between professionals and managers, with a view to improving management processes in the SUS.

It is noteworthy that important investments were made in the BHU infrastructure in recent years with the Requalification Program for Basic Health Units, implemented by the Health Ministry in 2011, aiming to financially invest in the maintenance, renovation, expansion and construction of new units (Brazil, 2020). However, the reality of the BHU analyzed in this study still raises concerns about structural problems.

When analyzing PHC advances and problems in Brazil, Bousquat et al. (2019) showed synergistic relationships between the structure of services, the work of health professionals and the final quality of the FHS. Structural improvements are essential for the qualification and expansion of the resolution of PHC actions, since these inadequacies directly affect the clinical and managerial conduct exercised by health professionals and the care offered to the population.

IC 2 – Care and management organization of work in the Family Health Strategy

One of the great challenges for personnel management in PHC is the turnover of health professionals, characterized by the constant flow of workers in and out of services, which negatively influences the bond, co-responsibility and, in general, the organization of work (Barbosa, Damasceno, Silveira, Costa & Leita, 2019).

CSD 7: The highest professional turnover is seen in the medical area, so there is no bond between professionals and users. It is difficult to follow what is valued by the FHS, knowledge of the territory, care from pregnancy, birth, to the elderly.

The deficit of health professionals in PHC, especially medical professionals, is an obstacle throughout the national territory. There is a poor geographical distribution of these professionals, with a greater concentration in capitals and coastal areas, and a shortage in small municipalities, economically less developed regions or with fewer professional opportunities (Bousquat et al., 2019).

The turnover can culminate in the low number of qualified professionals, difficulty in creating bonds and teamwork, to clutter organizational flows and contribute to the loss of user's confidence (Barbosa et al., 2019). Instability in human resources organization in PHC generated by professional turnover weakens the work dynamics of the teams. In these scenarios, BHU managers assume the role of encouraging interpersonal relationships, seeking to reinforce trust and cooperation between teams, in order to reduce the impacts generated by this situation (Lopes, Henriques, Soares, Celestino & Leal, 2020).

The CSD shows the influence of medical turnover on the care bond between professionals, teams and their relationships with users. The bond is a powerful facilitator of therapeutic relationships, considered essential for comprehensive care according to the FHS, which favors the user's search for the health service and makes him recognize the BHU as a usual source of care (Santos, Mishima & Merhy, 2018). The approximation with the context of the territory and the development of the bond with the community work as factors to stimulate the doctor's permanence in the PHC, even in vulnerable regions (Cortez, Guerra, Silveira & Noro, 2019). It is believed that with the promotion of specific public policies and stimulation of regional development, such as the 'More Doctors Program', which has been gradually replaced by the 'Doctors for Brazil Program', launched in 2019, this scenario of professional/medical turnover and the deficit in family health training can be permanently modified (Santos, Romano & Engstrom, 2018; Bousquat et al., 2019).

CSD 13 highlights that the lack of bond compromises the therapeutic relationship between professional and users.

CSD 13: I also witness users' dissatisfaction with medical conduct on a daily basis, for not having the bond, for the indifferent attitude of the doctor, for not giving guidance, in short, as the popular saying goes, 'short and sweet' at the end of the consultation.

In view of the importance of bonding in the perception of BHU managers, it is necessary to invest in light care technologies in the user's care, adopting behaviors of open communication, reception, humanization and empathy, which tends to improve interpersonal relationships and patient adherence to BHU and in improving health treatment and self-care (Zoboli, Santos & Schweitzer, 2016; Santos et al., 2018). It is possible to recognize the attributes of PHC as determinants of quality and of good management and work organization practices for the realization of humanized and resolute care, associated with the creation of a longitudinal link between users and the PHC health team (Santos et al., 2018).

In addition, the FHS proposes to change the hegemonic model of care with a focus on disease, mostly biological, for the reorganization of work that prioritizes linkage to preventive logic, with an approach focused on the unique needs of users (Brito, Mendes & Neto, 2018). However, the results found still reveal the presence of a practice focused on the disease, valuing the 'user who really needs attention', referring to an acute clinical condition, as mentioned in CSD 8.

CSD 8: The patient who really needs attention, knowing he is sick, needing a more urgent exam and referral with priority, we can solve it.

The fact is that PHC still lacks greater clinical resolution for recurring complaints that can be resolved there, seeking comprehensive care. The development of integrality in the FHS involves the ability to act for the prevention of diseases, so the workforce must be guided by this principle (Costa, Ferraz, Trindade & Soratto, 2020). By focusing on curative measures, PHC distances itself from its principles and from the consolidation of a continuous source of care that understands the multicausality of the health-disease process. To this end, we seek to overcome the model that restricts health care to actions aimed at curing and controlling symptoms, generating the fragmentation of care (Santos et al., 2018).

The care organization aimed at treating the sick user, focused on curing the disease, is different from the organization based on the health needs identified from the knowledge of the territory and its vulnerabilities. Spontaneous demands can indicate important health needs of the population; however, this should not be a

structuring axis of the organization of the FHS, but rather the analysis of the epidemiological profile of the community, enabling the planning of more effective actions for health promotion, prevention and recovery (Esmeraldo, Oliveira, Filho & Queiroz, 2017).

IC 3 – Users’ access and satisfaction from the perspective of managers of Basic Health Units

From the perspective of BHU managers, users’ satisfaction is related to meeting their needs and expectations regarding health care. This fact is linked to the resolution of services.

CSD 10: This issue of user’s satisfaction or dissatisfaction is pending, because it depends on what they need and the service is not always able to offer everything, especially in our territory of social vulnerability. There are those who leave satisfied with their service and with the guidelines, but the user who seeks something else that goes beyond what is offered, will leave dissatisfied.

A study carried out on users’ satisfaction at BHU shows that satisfaction is a multifactorial phenomenon. In the users’ perception, satisfaction goes beyond the use of high technologies and professional technical quality, as it is associated with the availability of attention by professionals and active listening. These are strategies that strengthen the bond and should be expanded to the entire team, as it is crucial for the quality of the health process (Arruda & Bosi, 2017).

Rodrigues et al. (2018) reveal that users with the highest level of satisfaction are those with greater socioeconomic vulnerability and low level of education; the authors emphasize that satisfaction is directly related to the quality of care, work process, easy access, interaction and guidance of the team with the user, in addition to knowledge about the responsibility of this health care point in the service network.

CSD 10 emphasizes the difficulty that health services have in offering comprehensive and resolute care that meets the demands of users. In this sense, the articulation between different professionals helps in the construction of an intersectoral communication channel, identifying and understanding the different contexts in which individuals are inserted (Reuter, Santos & Ramos, 2018). Multiprofessional networking contributes to the achievement of some principles that guide the work in PHC, such as the longitudinality and comprehensiveness of care, which are determining factors for the resolution and quality of PHC services.

Another aspect mentioned by the BHU managers were the “hyper-user users”, who constantly seek the service in search of care. In this scenario, managers need to be attentive to the work of the teams and the needs of users, rescuing and stimulating care management, bonding and qualification of care, based mainly on welcoming and active listening.

CSD 11: To those who have a different complaint every day, these are the ones who do the ombudsman the most, they are the ‘hyper-users’ who are always dissatisfied with the SUS. I observe that the user who really needs it will be served.

Analyzing CSD 11, it is recognized that BHU managers do not feel comfortable/prepared for the management of patients who are ‘hyper-users’ of the service. This fact becomes evident when justifying that this user’s profile is the most complaining in relation to the team’s work. To build relationships to address this issue, BHU managers should encourage comprehensive care measures for users, aiming to understand the specificity and uniqueness of each case (Cruz, Almeida, Figueredo & Santos, 2017; Fernandes, Souza & Rodrigues, 2019; Souza, Santos & Romao, 2020).

In this context, it is conceived that the ‘hyper-user’ seeks the BHU to be heard, as it is a welcoming space, in which individuals can express their feelings and anxieties beyond their family life (Santos et al., 2018). It is believed that to minimize the cases of hyper-users in health services, it is essential to change the behavior and posture of professionals while caring for these individuals, developing a unique care practice, recognizing the family structure and its social context, in addition to improving other skills such as active listening, therapeutic communication and self-care promotion (Sousa, Esperidião & Medina, 2017).

Thus, BHU managers need to articulate health service networks, multidisciplinary relationships, and integration between teams, which work together with the ESF team, according to Oliveira et al. (2017) and Fernandes et al. (2019) seeking to resolve the constant demands expressed by these users of the health system.

Previously, it was discussed how the permanence of the disease-centered model is a practice that influences the work of FHS professionals; in addition, such a model has such complex roots that it is also capable of influencing the user’s satisfaction. A survey (Esmeraldo et al., 2017) presented two models of care - the biomedical model, centered on the disease, and the FHS, focused on prevention and health promotion.

The results emphasized that users seek care only in situations of illness, seeking short-term curative results, which attests that curative care is still rooted in the culture of the population. Thus, it is necessary to advance in the re-signification of some concepts and restructuring of professional practices, aiming to bring the care provided in PHC services closer to the preventive model and the social determination of the disease.

CSD 12: The patient already knows what he wants when he seeks the unit. He is not satisfied simply with the results of the exam and guidance on lifestyle changes, physical exercise and dietary reeducation, because he did not leave the unit with a prescription for medication, a request for an exam or referral to a specialist.

CSD 12 reveals that user's satisfaction is related to the medicalization and hyper-specialization of health practices, because, in this scenario, users seek the unit with their pre-established intentions and leave the service satisfied when their intentions are achieved. In this way, emerges the challenge of overcoming the curativistic model and of making professionals and health services responsible for the deconstruction of this paradigm and the empowerment of users.

Final considerations

The organization of services in the FHS encompasses challenges in managerial practices such as structural fragility, instability in technical support, periodic maintenance of equipment and unavailability of basic materials necessary for health care. Added to this is the high turnover of health professionals, especially physicians, in addition to the predominance of the hegemonic/curative model. These factors, from the perspective of UBS managers, directly influence the user's satisfaction with the health service, which is subjective and singular, and interfere with the ability of the service and the network to offer comprehensive, individualized and longitudinal care.

It is worth remembering that the FHS is understood as the most important point of the network in promoting the quality of health care, presenting excellent coverage in the studied municipality, which takes care of people, indicating regulation of specialized consultations, exams and other procedures. However, the results showed that the clinical actions the FHS is responsible for are sometimes not attended to with greater resoluteness, as the teams have difficulties in attending users with common complaints and hyper-users, who demand excess drug prescriptions. In this way, dissatisfaction with the services provided can be generated. Such dissatisfaction may also be related to the fragile connections of users with the FHS, especially because they do not understand its proposal without giving up clinical resolution.

These managers' perceptions make it possible to induce, formulate and operationalize policies and strategies that help decision-making in the qualification of the organization of services in the FHS. Thus, from the perspective and intention of BHU managers, the health care model and network articulation determine the forms of care and management organization of services, and these impact on guaranteeing access with quality, resolution and safety in the care provided to users.

The limitations of this study were the difficulties faced by BHU managers in understanding their effective attributions regarding the organization of services and the management of FHS teams, as well as the low production of research and dissemination of knowledge about management practices in PHC. As contributions of this research, we mention the opportunity to identify and analyze the perception of BHU managers about the organization of services offered in the FHS, with a view to instigating reflections in search of qualifying this sector and bringing scientific evidence of organizational practices in the FHS, highlighting the importance of nurses as the main professional in the management of services within the PHC.

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