

THE ENTIRE FAMILY HEALTH: LIMITS AND POSSIBILITIES IN VIEW OF THE TEAM¹

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ABSTRACT

The article comes up a qualitative study that sought to identify the limits and possibilities for achieving completeness in family care in a Family Health Team from the perspective of health professionals in a city in Rio Grande do Sul collection data was performed by means of semi-structured interview aimed at professionals working in the Family Health Strategy, using thematic content analysis. Results showed that according to health professionals, the difficulties for completeness refer to lack of staff time to plan activities, deficiency in service structure and limitations of professionals to perform procedures and intervention techniques-healing. Consider the experiences gained during the training and professional career as an opportunity to achieve a comprehensive care. It was evident concern with the organization of practices in their more technical aspects, which overlaps the reflections and discussions about the completeness of families. This study highlights the complexity present in the health field for the consolidation of a comprehensive care, and this is strongly influenced both by professionals as the organizational dimension and political services.

Keywords: Integral Assistance to Health. Services of Health. Family Health. Primary Health Care.

INTRODUCTION

Health in Brazil has undergone major changes in the eighties and nineties, with the creation of the Unified Health System (SUS). Although the current health system, supported by the Federal Constitution of 1988 and regulated by Law 8080/90, faces a constant ideological and political struggle in an attempt to reverse the model of care focused on curing diseases, directing you to a holistic and of the human being.

In this perspective, the entire health care becomes critical as practical guiding health actions.⁽¹⁾ As a fundamental principle of the NHS, completeness is the right that people have to be met on the set of their needs, and on duty the state must provide health services organized

to meet these needs holistically.⁽²⁾ As a polysemic term, refers to "a set of values that is worth fighting because they relate to an ideal of a fairer and more supportive".^(1:41) The completeness has worked as a picture-goal, one way of indicating (albeit synthetically) desirable characteristics of the health system and the practices that are performed on it.⁽³⁾

Thus, it is expected that the completeness is not taken just as a concept, but as a regulative ideal, which is almost impossible to be fully established, but it should look closer.^(3,4) It is known that practices and health services, in accordance with what is established in the legislation governing the system should be arranged in the logic of the action integral. In this context, the Health Strategy (FHS) emerges as a new dynamic in the health services, establishing a relationship of bond and co-

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responsibility with the community in pursuit of providing comprehensive care to individuals and families through change the object of attention.

The increasing emphasis on family has resulted in a change in the way it is perceived in the context of health.⁽⁵⁾ In the ESF, this core is understood as a unit of care, considering the functioning and family experiences as factors that influence health and illness of its members. To understand the health of the family becomes necessary to understand its complexity and multidimensionality and multidiversity.⁽⁶⁾

In this sense, the family began to establish itself as a basic form of care and, therefore, the object of assistance. Thus, under the ESF is possible to promote comprehensive care directly to the family, with the purpose to identify their health problems and establish actions that seek to meet their needs, according to the socio-cultural context in which it is inserted.

However, there are many obstacles that hinder the realization of the full care, since it is a fight that cannot be won alone, but requires the mobilization of all professionals, managers and users.⁽⁴⁾ The position of the professionals is fundamental to the effectiveness of completeness, however, health workers, given their training and practice predominantly focused on traditional biomedical model, still seem to view the individual ill, isolated, fragmented, with no insertion in a sociocultural context and family, which creates a gap completeness in health care.

Thus, when considering the full care builds throughout the praxis of professionals and health services, it is important to understand how health practices are set by health and how it can facilitate or hinder the achievement of completeness.⁽¹⁾ From the understanding of the limits and possibilities of care professionals' view on the family health team, you can understand how practices are closer or more distant completeness, allowing to expand the reflections and discussions about the completeness and its implementation the ESF.

Based on these considerations, the question is: what are the limits and possibilities perceived by health professionals to enable the full scope of the ESF? This article aims to identify the difficulties and facilities to enable the entire

family in the care of a team of ESF from the perspective of health professionals.

METHODOLOGY

This is a qualitative descriptive exploratory research developed in a team of Family Health Strategy in a small city of Rio Grande do Sul. This city has sixteen health units, eight units of ESF.

For the selection of research subjects, adopted the following criteria: be acting in the FHS team for a period exceeding one year, excluding the study professionals who were removed due to leave or vacation. Thus, for the explanation of the study to the subjects of research, we chose to attend the meeting of unit staff in order to present the research objectives. We conducted the first contact with professionals, and after confirmation of their participation in research, the interview was scheduled, according to the availability of the subject and the researcher.

Thus, the study population was composed of a skeleton crew represented by a nurse, a doctor, and two nurses and technicians dentist, totaling five professionals. Stresses that the FHS of the municipality were in a transition period, since new Community Health Agents (ACS) were included in the team in 2010, so we chose not to include them in one study as they were in the process of adaptation and training to perform the activities of its function.

The technique of data collection chosen for this work was the semi-structured interview, since it allows obtaining the information necessary to accomplish the objectives. The interview was conducted from October 2010, on the premises of the health unit, using a set script containing questions related to health care offered in the unit, difficulties and facilities for the practice of completeness, as well as the understanding of the professionals on the comprehensive care. For greater reliability, the interviews were recorded and transcribed.

To conduct the study, the project was submitted to the Ethics Committee in Research of the Regional Integrated University of High Uruguay and Missions (URI) and approved under number 004/2010. In addition, we requested permission to conduct institutional

research of the Municipal Health municipality, according to the regulations, and the head of the health facility.

Participants who agreed to participate received the consent being signed prior to the start of the interview. Were taken into account all ethical research involving humans, governed by Resolution No. 196/96, the National Health Council To guarantee anonymity, the subjects were identified by the letter "P" followed by Arabic numerals in ascending order (P1, P2, P3, P4, P5). With respect to data collection, it was concluded from the moment it reached saturation data, ie when there was a sufficient number to allow recurrence of certain information, without neglecting content considered significant.⁽⁷⁾

A thematic content analysis of the data was based on three phases: pre-analysis, material exploration and processing of results and their interpretation.⁽⁷⁾ The pre-analysis aimed to operationalize and systematize the initial ideas occurring transcripts of taped interviews, and reading the content of these have emerged some possible associations with the goal of research, getting an overview of the data.

The second phase was organized by the exploration of material and treatment results by defining significant stretches, sorted by clipping, enumeration and aggregation, in order to reach the core of understanding the text. Finally, the third phase was the interpretation by categorizing the data by grouping the elements, ideas, or expressions, thus from the speech three categories emerged: Meanings of completeness, limits and possibilities for comprehensive care and health care the ESF.

RESULTS AND DISCUSSION

The comprehensive care family health is a concept that has several meanings, and the organization of health services as one of the meanings of comprehensiveness emerges as the key issue to be addressed for change of health services, in order to put it operating in a user-centered and their needs.⁽¹⁾

In this study, the subjects showed in some of his speeches perceived difficulties and facilities within the ESF to achieve comprehensiveness in care families. Professionals identified the lack of

staff time to plan activities as a complicating aspect of comprehensive care:

To take good care must sit down to plan [...] (P1)

It's hard [...] in the post, there are many activities to be developed in daily life, you cannot plan the actions (P2)

We even had the idea of doing lectures on oral health in school, but still cannot sit for organizing this, it is enough demand. (P3)

[...] We try to see the whole of the patient, but sometimes it is much running here in the post. (P5)

The subjects of the study revealed unable to participate in the planning of health service in which they operate. Present as a difficulty factor, excess activity in the service, which causes lack of time to articulate the various work and plan the actions to be undertaken under health. What happens often is that professionals hold themselves to fulfill bureaucratic tasks, finding no time to think of activities that will conduct the service, as shown in the professional speaking P4 "is so much paper, so much paper, to fill and organize, that when we see the day has passed [...] there's no time for the patient and to do other things."

From this, one can say that this situation makes the team acting on isolated cases, according to the demand of the population, because there is little time to plan and implement collective actions aimed at prevention and the promotion of community health.

The development of a work piecemeal, in which each professional conducts its activities in a disjointed manner, independent of the actions of others, can significantly contribute to practices that do not meet the health needs of the population, moving away from comprehensive care.⁽⁸⁾

Allied to this, one of the study participants to report about the care that develops in unity characterizes the lack of structure in the service as a factor that gives the impossibility of completeness, as the following expression:

The unit has no ACD {referring to the dental assistant} as stated in the manual, so that complicates the care [...] cannot serve as I wanted because it is difficult without the aid of ACD (P3)

Due to this situation, we can say that from the point of view of the worker P3, lack of human resources contributes to the decline in the quality of services provided. And, if the entirety of the work processes in NHS depends in part on issues such affinity with the work, depends on the conditions of employment to which the employee is subjected. One reason for this is the lack of assistance from the Ministry of Health to states and municipalities to ensure comprehensiveness, coordination and integration and to overcome the dichotomies of health action.

The proposed changes to the new model of care require an adequate physical infrastructure and human to ensure efficiency in service delivery and thus reaffirm the commitment of the NHS to the community. Being the health unit for the reference user's first contact with the health system, it is necessary to have physical, human and structural compatible with this proposal and the actions of health professionals in relation to this commitment.^(9:268)

At the mention of the way in which exercise care unit, the study participants refer to care for the feelings and emotions expressed by the user and family hamper the application of technical knowledge and limit the performance of some procedures, which in view of surveyed, undertakes the care, distancing the assistance of a full care.

Assistance, family anxiety that often hinders the exercise of a particular procedure, you cannot see the whole (P1)

When I go to the service, what more difficult to meet people is when they are anxious to consultation [...] you cannot serve well. (P2)

Is bad!! I find it difficult to care for, in cases of pain or infection, the child does not cooperate and does not allow the intervention, there will soon doing to meet soon, so she would not cry (P3)

It can be seen in the speeches, the devaluation of the family as a contributor of care once the professional referring to the anxiety of the family as a threshold found in the search for comprehensive care, we can infer that he considers relevant family participation in the care process. Therefore, studies point to the family as important for the promotion of care to their families, constituting a health system with

values, beliefs, knowledge and practices that guide the actions of health.^(10, 11)

Thus, it is interesting that health professionals begin to value in their practices, the need to understand the family and the way she interacts with a view to building a full care. The health worker, particularly nurses, key player in the professional system of care, must seek an effective interaction to give support and assistance to families in various care situations.⁽¹¹⁾

Realize the vision that permeates biomedical care actions in the FHS family, since it is not clear in the speeches of appreciation or educational practices aimed at promoting the health of the population. When the health worker if the difficulties refers to comprehensive care as a simple inability to perform a procedure, it is possible to say that the perspective of this work, comprehensive care is related to the completion of a particular procedure.

Still, in the speeches analyzed, as well as factors that have formed as a limiter for comprehensive family care were some aspects discussed as facilitators of professional practice from the perspective of comprehensive care. The performance of the team Minimum FHS was referred to as a process that favors the promotion of comprehensive care. The multiprofessional teamwork is considered by respondents, an important tool and strategy for the reorganization of the work process within the ESF in the direction of wholeness, as shown below:

One thing that is easy to put the patients is referred to medical appointments, nursing consultation, dental appointments, procedures, and other services [...]. (P1)

Scheduling is more for me, but I see that the staff is always running up ahead, the technical [...] every child passes once the doctor or nurse that provides easy care. (P3)

[...] In the PSF has several professional enough hand labor. (P4)

[...] The good thing here is that no one goes without care, someone always answers. (P5)

In view of professionals, comprehensive care expands as it sets up a process of directing users to the team members. The lines depict a logical service-centered individual care, incorporating

the biomedical model as a tool for care and health care. In contrast, it is known that a comprehensive care requires a process of communication in which all professionals acting in community, to ensure interdisciplinarity.⁽¹²⁾

In contrast, it is noteworthy that when asked what the professionals needed to provide comprehensive care, respondents said the doctor, the nurse, the nursing staff and the dentist. Only one of the subjects highlighted the presence of ACS in this process, as observed in the fragment of speech P2 "[...] we were a good time agentless {ACS} which made things more complicated, without a connection to the community now with the entry of new, hopefully everything is back to normal."

From this, we observe that the view of most professional advocates who oppose regulating guidelines FHS, since you cannot think of completeness without considering the workforce of the ACS. However, the discourse of P2 shows that the ACS has an important role in the care of families enrolled in the catchment area of the units, not only for facilitating the population's access to health services and actions, but mostly for being the link between health teams and community.⁽¹³⁾ Thus, the ACS brings benefits to the community in that it interweaves the diverse knowledge of each professional involved, contributing to a vision of the human being in a multidisciplinary way.

Assuming that planning in family health requires a collective, with complementarity and interaction of all the professionals involved, when fragmentation occurs in planning, undermines the work process and reflected in a lower coverage of the needs of individuals. For of comprehensive health must work as a team, regardless of the area, in order to foster dialogue between health professionals, as well as the collective definition of user assistance as the central focus of health.⁽¹⁴⁾

Allied to teamwork, when asked about the factors noted in the service that favors the construction of a comprehensive care, are investigated in view of the commitment of the professional service and the pursuit of addressing the needs of the user as tools that contribute to the consolidation of comprehensive care.

Possibilities within the team are committed to try and do the best solve the problem of the person. (P1)

In the health service network {} is so professional when he straightens want [...] we seek at least always try to find a solution to that problem [...]. (P2)

Bah! I think it has to be integral to solve what the person has, in my case, heal the pain she feels, this will cause her welfare. (P3)

I think it's full, because here the whole patient is referred to the nurse or medical professional for proper treatment so you can meet everyone. (P4)

[...] The different here in the post is that we try not to let anyone leave without being attended at least some scheduling we do. (P5)

In these fragments, shows up a clinic focused on prescriptive act and production procedures. The speeches is remarkable the traditional model of health care that has the disease its object the user intervention, which may make insufficient assistance for the care demands brought by the subjects.

The resolution of user needs is understood by professionals as an attitude that only promotes the solution of immediate problems, ie, for the care you need to be resolute, "minimum" meet the problem presented by the user. Although this is a common form of activity and communication of the professionals in this ESF, it is believed that only conducts and technical information are not sufficient to promote a care within the perspectives of the ideal of completeness.

The resoluteness which refers comprehensiveness is one that is linked to instrumental resource and expertise of the professionals, but welcomes to the action, the link established with the user, the meaning given in the professional / user, which suggests subject of the meeting with the sense of influencing the health field.⁽¹⁵⁾ Thus, the resolution of the perceived needs of users in the speeches of professionals to refer only to conduct biomedical research.

Complementing the aspects described above, professionals point out the qualifications and professional experience as important factors to comprehensive care:

To care full, not many difficulties have security procedures because I worked in a hospital and it helps! (P1)

Technically yes, I am prepared to look after. (P2)

As I had never worked in post before, when I got here, I had to seek more information, to make a post Specialization {} because here we see all, different from practice, that more or less we know the cases that have that appear here requires knowledge and technical skill. (P3)

Care?! See the whole patient requires knowledge [...] I'm ready, I worked in the pediatric unit and have done course for ambulance transport, high risk and pre-hospital care. (P4)

My experience in the hospital helps me a lot I think; I can understand what the patient means, complaints. (P5)

It is evident that professionals value the experiences gained during the training and professional trajectory, whereas these factors allow them to perform their duties with the highest quality and safety, providing opportunities for completeness. It is observed in these reports valuing technical skills and knowledge focused on clinical, because for these professionals, completeness can be achieved when developing a technically safe and effective practice.

Albeit excluding and focused on the disease, the doctor-centered model demonstrates credibility from the perspective of staff. According to the participants, the technical support, practical skill and experience hospital presents sufficient for meeting the demands of health problems for which they are affected families belonging to FHS.

Such understanding goes against the desired comprehensive care in health services, since this involves an environment with many ingredients that go beyond the rational dimension and welfare practices to achieve relational and subjective able to meet the health needs of families.⁽¹¹⁾

Note also that concern about the family is not expressed in the speeches of the subjects, even when inserted into a strategy that seeks to reorient the new model of health care focused on family care. The classic model flexnerian, technician, biologist, facing the hospital practice and doctor-centered is a type of behavior that predominates in the discourse of

health workers, which does not address the health needs of the population.

It is clear, therefore, be relevant to an educational process for all FHT members, incorporated into the daily work that can guide the development initiatives of professionals and transformation strategies of health practices.⁽¹⁶⁾

Thus, it is believed that continuing health education will enable FHS workers a professional qualification that seeks not to restrict the user to only look at the aspect of the pathophysiology of disease. It is necessary to see the user as a singular subject, inserted in a family context, with experiences and stories that should be considered during the process of care. For this, the processes of training, qualification and continuing education and interdisciplinary work, must be constant and really connected with the needs of the NHS and completeness of its proposal to become effective.

FINAL CONSIDERATIONS

The adoption of new paradigms in the field of public health, in the context of the practices in the FHS, faces distinct challenges, since there are several factors that limit and enable a professional practice guided by the regulative ideal of integral health. The results that emerged from the testimony of professional signal the complexity present in the health field for the consolidation of a comprehensive care, and this is strongly influenced both by professionals as the organizational dimension and political services.

From the perspective of health professionals working in family health, the difficulties to achieve completeness refer to lack of staff time to plan activities, as well as the limitations refer professionals to perform procedures and interventions-healing techniques. Still, the lack of adequate infrastructure demands required in service is identified as a factor that hinders the approach of completeness in health practices.

As potential possibilities for the comprehensive care approach, respondents consider the experiences gained during the training and professional career as factors that allow the worker to perform their duties with greater quality and safety.

Starting with the discourse of research subjects, highlights the idea that for them the concern with the organization of practices in their more technical aspects overlaps the reflections and discussions about their role in promoting the health of families. However, it is important that a comprehensive care depends on both the professional and the other actors involved in the system, acting as the perspective of integral means to break not only with a traditional model of training, but also involves the reorganization of services and critical analysis work processes.

By knowing the limits and possibilities of completeness, from the vision of health workers, it is possible to deepen discussions on

completeness in order to mobilize the potential of collective organization for change and strengthening of health practices within the care families.

It is noted that the process of continuing education of staff is indispensable, in order to promote reflexive actions on the different levels of health care for families, identifying its different dimensions in search of a comprehensive care. Interestingly, managers and health workers understand that completeness can be articulated in the actions and services of preventive and curative health, individual and collective, and at all levels of system complexity.

INTEGRALIDADE NA SAÚDE DA FAMÍLIA: LIMITES E POSSIBILIDADES NA PERSPECTIVA DA EQUIPE

RESUMO

O artigo trata-se de uma pesquisa qualitativa que buscou identificar limites e possibilidades para viabilizar a integralidade no cuidado à família em uma equipe de Saúde da Família a partir da perspectiva dos profissionais da saúde, em um município do Rio Grande do Sul. A coleta de dados foi realizada por meio de entrevista semi-estruturada direcionada aos profissionais que atuam na Estratégia de Saúde da Família, utilizando a análise de conteúdo temática. Os resultados mostraram que de acordo com os profissionais de saúde, as dificuldades para integralidade se referem à falta de tempo da equipe para planejar as atividades, deficiência na estrutura do serviço e limitações dos profissionais ao realizar procedimentos e intervenção técnicas-curativas. Consideram a experiências obtidas durante a formação e a trajetória profissional como uma possibilidade para alcançar um cuidado integral. Evidenciou-se a preocupação com a organização das práticas em seus aspectos mais técnicos, o que se sobrepõe a reflexões e discussões sobre a integralidade das famílias. Evidencia-se a complexidade presente no campo da saúde para consolidação de um cuidado integral, sendo que esse é fortemente influenciado tanto pelos profissionais, como pela dimensão organizacional e política dos serviços.

Palavras-chave: Assistência Integral à Saúde. Serviços de Saúde. Saúde da Família. Atenção Primária à Saúde.

INTEGRALIDAD DE LA SALUD DE LA FAMILIA: LÍMITES Y POSIBILIDADES EN VISTA DEL EQUIPO

RESUMEN

El artículo es un estudio cualitativo que buscó identificar los límites y las posibilidades de lograr la integridad en la atención de la familia en un equipo de salud de la familia desde la perspectiva de los profesionales de la salud en la ciudad de Río Grande do Sul colección los datos se realizó mediante entrevista semi-estructurada dirigida a los profesionales que trabajan en la Estrategia Salud de la Familia, mediante análisis de contenido temático. Los resultados mostraron que, de acuerdo a los profesionales de la salud, las dificultades para la totalidad se refieren a la falta de tiempo del personal para las actividades del plan, la deficiencia en la estructura de servicio y limitaciones de los profesionales para llevar a cabo los procedimientos y técnicas de intervención de curación. Tenga en cuenta las experiencias adquiridas durante la formación y la carrera profesional como una oportunidad para lograr una atención integral. Era evidente preocupación con la organización de las prácticas en sus aspectos más técnicos, que se superpone a las reflexiones y discusiones acerca de la integridad de las familias. Este estudio pone de relieve la complejidad presente en el campo de la salud para la consolidación de una atención integral, y esto está muy influenciado tanto por los profesionales como la dimensión organizativa y servicios políticos.

Palabras clave: Asistencia Integral a la Salud. Los Servicios de Salud. Salud de la Familia. Atención Primaria a la Salud.

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