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MANAGEMENT IN HEALTH: THE WORKERS LOOK OF A RURAL FAMILY HEALTH[1]

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ABSTRACT
The management of health work in the Family Health Strategy (FHS) democratic and participatory consists of one of the great challenges of this level of health care. In this sense, we developed this qualitative study aimed to analyze the professional conceptions of the Family Health Strategy (FHS) on management of health work. Semi-structured interviews were conducted with 10 professionals from a rural family health unit of a medium-sized city in the interior of São Paulo. Data were analyzed using thematic-categorical content analysis. Obtained three categories of analysis: Organization of health work for the achievement of goals; The management marked by rationality and focused on the nurse; Facilities and difficulties that permeate the construction of collective spaces in the FHS. It is considered that there is a need to pay attention on how the management work has taken place in the FHS, with the need for the wareness of the individuals by pacts and team decisions, ensuring the speaking and listening all. Moreover, it is important that there is a process evaluation of the implemented actions and pacts made by health professionals.

Keywords: Health management. Health service administration. Primary health care. Primary care nursing..

INTRODUCTION

The classical theory of scientific management (Taylorism and Fordism) guide the working methods in logic of rationality, seeking uniformity in the implementation of tasks for all workers. In them, impersonal relations prevail at work and keeps the rigidity in this Division, fragmenting it and separating the design of its execution. To achieve such claims, the selection and training of workers, in order to impose a proper way standardized work, in addition to managing the job quite strict[1].

This management model centered on tiering, raises stock of domination an individual about the actions of others and all culminates in reducing domination of the autonomy and freedom of the people. This fact is the Foundation of Managerial Hegemonic Rationality[1.2].

It's clear the influence of this model of work organization of capitalist society about the health work, including in the way it has been managed. As a result, the deletion of spontaneity and initiative, where a subjectivity production geared just for adaptation to worker process[2].

When it comes to management in the context of health, referring to the work done locally, IE, inside a health unit. Furthermore, it is noticeable that the management model of labor established, in a health establishment, has close relationship with the production model of care which is aligned to the project local management[3].

There are indications that the Organization of the Brazilian public health system, designed in a hierarchical manner, through health care at levels of primary, secondary and tertiary, denotes the influence of administrative and scientific theories. However, a possibility of overcoming this hierarchical design consists in the rearrangement of these levels through the structuring of Health Care Networks (RAS), whose connection is triggered in the production of meetings between users and workers for the co-production of health care[4].

[1]Article originated from the master's thesis entitled "work in health management: the conceptions of professionals and users of the family health strategy", presented at Programa de Pós-Graduação em Clinical Management of University of San Carlos in the year 2013.

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In RAS, the primary health care (PHC) must exercise the role of care capacity. It consists of a level of attention that is configured as the gateway of all the problems and needs of the users of the health system, as well as coordinating or integrating the attention provided at some other level[5].

In Brazil, the family health Strategy (FHS) was designed in order to meet the requirements set out by the APS, being declared as a way to modify the health care model, and meet, so conclusive, most health needs of the population of a territory attached, from prevention, promotion, treatment and recovery[6].

A tecnoassistencial design that supports the construction of networks of care, acceptance and production meetings, with trigger power links and appreciation of people's lives, must seek a reputable management model for excellence of actions that still uphold the classical or scientific, administrative and which refer to the centralization of managerial actions only to an individual on the team.

It is understandable that decentralization as a process based on sharing ideas, strategies, problems, solutions and managerial functions that extend beyond health professionals, managers and users of the health service, taking into account the principles of co-management in health. Consists of democratic and participatory strategy where, everyone involved in the process of work, make up a collective responsible for decision making[1.6].

Although this country has continental extension and family health teams in rural areas, is tiny scientific production that addresses the reality of health care in those territories. Thus, this research was elaborated, taking into account that, in General, when compared to urban groups, rural groups are less numerous, characterized by smaller cultural, social and economic diversity. It is assumed that the existing relationship between professionals and users from a rural health service can provide a higher possibility of existing connections between them, bonds, favoring a joint organization of the work in health (relevant Department to establish co-management1 in health).

Considering that a process in construction, and after more than twenty years of the implementation of the ESF, wonders: how ESF rural workers conceive managerial practices in your daily work?

It is considered that direct the focus to the reality experienced daily by the actors involved and understand the tricks and tactics adopted by them, to give the daily working process progress, can generate reflections relevant to everyday management of ESF services. Therefore, the objective, here, analyzing the conceptions of the ESF professionals about managing the rural health work.

METHODOLOGY

It is descriptive, analytical and qualitative approach, developed into a medium-sized municipality in the State of São Paulo, which has Regional Health 5 covering 17 teams of ESF[2], Er (UPA), central medical specialties (Ceme), hospital units, Psychosocial Attention Center (Caps), among other services.

The city has a form of management organization within the family health Units (FHU) so as not to presuppose the existence of a single official and/or specific to your development. The reference to the USF management are (a) doctor, nurse and dentist every USF team. These should manage the service and promote the participation of all those involved in decision making and in the organization of work, counting, even with other local workers and users (mainly through the Councils Local Managers-LGC).

We decided, therefore, to perform this study with a USF rural professionals in which one of the authors inserted, while resident program of Multidisciplinary Residency in family health and Community, for the development of their professional master's dissertation.

Health workers were invited to participate in the research during a team meeting, during which the proposal and research objectives were clarified and agreed upon. From then on, decided a joint date and for which interviews were conducted individually.

Consented to participate in this 10 health workers research team, being they: 1 doctor, 1 nurse, 1 dentist, 1 Dental Office Assistant, nursing assistant 1 and 5 community health Agents (ACS).

Exclusion criteria of the subjects of the research were: meet on vacation and/or health/maternity license, at the time of data collection, and be acting in that USF less than 6 months. Sought to associate the time of operation and the possibility of acquiring location information that could reflect the reality experienced in the everyday life of this service.

Semi-structured interviews were carried out in August 2012 with the following main issues: "tell me what you mean by work management in health", "tell me who develops activities work in health management at USF where you act" and "tell me what the facilities and/or difficulty exercising health co-management at USF."

The collected data were analyzed by means of thematic analysis-protection that consists of the following steps: 1) reading of floating exhaustive reading texts to be analyzed; 2) definition of provisional hypotheses about the contents read; 3) determination of record that can be words, phrases, or paragraphs; 4) definition of the themes that are composed by agglomeration of record which have similar meanings; 5) analysis of the themes and 6) analysis of categorical text that consists of size the themes, theoretical or empirical criteria[7].

The interviews were audio recorded only after the consent of the interviewee and signing the informed consent (TFCC) in accordance with resolution 466/2012. The interviews were transcribed verbatim and analyzed later.

In order to preserve the identity of the subject, the interviewees were identified with the letter P followed by the sequential number of the interviews.

The project was approved by the Research Ethics Committee of the Universidade Federal de São Carlos (UFSCar), with the certificate of introduction to Ethics Assessment (CAAE) 01223012.0.0000.5504 number.

RESULTS AND DISCUSSION

The team interviewed was composed mostly by women and only one male person. It is noteworthy that 50% of respondents had higher level education degree, although some still find themselves acting professionals who require only high school for its implementation.

Were composed themes from the agglomeration of the registry and these themes, in turn, were analyzed and scaled into three categories: 1) Organization of work in achieving health goals, 2) marked by rationality and management with a focus on nurse and 3) facilities and difficulties that permeate the construction of collective spaces in the ESF.

Organization of work in achieving health goals

This category corresponds to reports submitted by the subject that reflect elements about the conception of the organization of work in health. Some professionals have identified as a strategy to plan and organize actions in order to establish goals and deadlines in order to develop a good health care. This notion can be perceived by means of some reports:

> I understand the Organization of work in health as a logical [...] with goals, with deadlines and with ... How do I say ... with same guidelines(P03)?

> We have to have a ... have to have a plan [...] For us to be able to work and develop a good community health care (P05).

> The Organization of work in health facilitates much more people then this ... is. it gets to where we really want to, okay?(P06).

> We plan on actions and then executes, you know? As all planning [...] it is very important to direct (P02).

It is considered that the Organization of work in health implies the need of spaces intended for the planning and evaluation of the actions, set out together. One of the difficulties for the team to build this process occurs when the care is focused, in the form of assistance to spontaneous demand. In addition, it is important that actions be programmed also from epidemiological data, considering that demand, for example, in tune with the social, cultural and economic realities[8], as well as with the needs of users who live in the territory attached to USF, in this particular case, consists of a rural reality.

One of the difficulties of workers of the ESF, however, consists of the rural access to households that, in most cases, are far away

from each other, requiring inventive strategies for locomotion, besides favorable climatic conditions[9]. This fact certainly influences negatively the workers approach the reality of users, making the joint organization of the health worker, in rural areas.

However, by understanding the work in health as a process, in the case of something that occurs at the contact between professional and health service user and vice versa, and these do not consist of predetermined machines and, yet, considering the work as something that depends on the users and the needs that arise from the experiences in everyday life should establish the organization of work in health in the process, that is, as something dynamic and in constant construction.

This is a collective that tension given produce acts caregivers, taking advantage of interpersonal relationships, going to meet the combination of strategies that emphasize the collective construction and horizontality, where everyone involved and are partners, i.e. plans who performs[10].

No, in the reports presented by the professionals, the presence of an evaluation process of actions performed either on time or procedure. The use of autoavaliativos tools may be able to qualify the processes in the APS because they trigger the Act by targeting action reflective of the teams[11]. Therefore, you have to discuss about what seems obvious to the eye and this process can occur from reflections between the actors involved in the planning and implementation of actions.

A few lines refer to the need for clear guidelines and they can direct the actions at work, going to meet the understanding, in fact, the reason that the planning of these actions is carried out, because it is assumed that it is from the clarity of a care project will organize a strategic planning, aiming to achieve a final product.

By rationality and management with a focus on nurse

In this category, it is possible to evidence the design professionals about managing job in health that, in addition to the issues related to the Organization itself, contains considerations regarding the arrangement of workers of this team and how does the Division of power between them.

The reports demonstrate the existence of a reproduction of the managerial rationality, heavily centralized in the hegemonic male nurse:

> [...] identify someone who performs this function of managing the nurse (P09).

> [...] I identify who stands out in this part... Management nurse, of course (P04).

> [...] someone who has more prominence on the part of management? UM ... the nurse... (P08).

With respect to the management of work in ESF, describes that the centrality of the managerial actions for nurse is justified, usually by the approach that has themed management during the training process. This is less evident among doctors and dentists. Remember that the modern nursing (nineteenth century) arose precisely from the need to organize the military hospitals for the care of soldiers involved in the war. Therefore, it appears already exercising the management to take over the Organization of the care environment[12].

The nurse has built a historical process in the performance of functions related to coordination and the management of teams, occupyingthis role in health services, throughout the ages.

In historical context, the formation of the nurse came the development of management practices of the health work, assuming some features as: discipline, centrality in control, monitoring of actions, among others, and which refer to the managerial hegemonic model. Whereas the organization of work in health requires a process of collective construction and that meets the demands of the population, comprehensively, there is need for critical eye to the process of training and qualification of a trader[13.14].

The formation of nurses can be a power for the development of health management, when aligned to the assumptions of production collective, democratic, that enhances the participation of everyone, as well as the development of a culture of evaluation in the planning and execution of the practices carried out.

The co-management itself does not presuppose the centralization of management

actions on a specific professional[1, 2, 6], and therefore the nurse uses this competence and other inherent in his professional practice to approach, direct and articulate to other team members and the general public in contributing to its implementation.

A work in the rural area of municipality in the State of Minas Gerais points the need to embrace, including with regard to management actions, popular participation in order to democratize health management, according to the needs felt, experienced and reported by the local population[15].

Facilities and difficulties that permeate the construction of collective spaces in ESF

In this category are reported difficulties and facilities for the construction of collective spaces, from the questions about the development of co-management in health. Considering initially, brought by the subject, they all pertain to issues related to the Union by members that make up the group, bringing the call that teamwork is essential to the exercise of co-management in health:

> Well, I think the facility is that everybody talks to everybody(P06).

> Oh... I don't know... I think so: the team is well together ... have this facility to talk to each other, you know? All get along here (P10).

It is observed that there is good communication between the members that make up this group. However, this communication can be more permeated by the need to maintain good relations between them than setting up an organizational arrangement for joint implementation of actions.

Teamwork, as facilitator, consists in carrying out tasks that are performed by the given number of professionals, conscious and coordinated way, in order to set these tasks to which happen in direction and purpose only, and not disjointed actions of quantities juxtaposing way alienated[16].

In this way, some authors[17], discussing the health of the family in Portugal, claim that workers ' autonomy in forming their own teams was seen as something that provided to professional satisfaction and personal motivation to work. The authors relate to appreciation of the professional opinion of the possibility of the development of teamwork.

A prerogative relevant to strengthening health co-management consists in the fact that the project you want to build is clear to all. It is believed that the interactive processes that occur in the health team make up a network of conversations, where workers undertake inter-subjectively, through language, working together, with the purpose of achieving a singular goal[18]. This fact leads to assume that is healthy, teamwork, the confrontation of existing conflicts, especially to be able to plot a common strategy.

The difficulty presented by the group for the development of co-management in health walks towards the lack of commitment of professionals for the execution of tasks listed together, which is a key point that can be evidenced through some reports:

> Look, the difficulties that I notice is the commitment [...] a commitment on the part of all in the execution of the tasks (P01).

> [...] when the staff assumes certain function, they do not always undertake to implement it (P07).

The commitment in the planning and execution of tasks, especially when drawn together, is something desirable and permeates the National Policy of Humanization establishing strategies able to generate care extended to subjects and communities through the Therapeutic Project, for example[6].

In addition to the lack of commitment, there's also the difficulty of getting all the subjects involved in the work process to participate in the exposition of his ideas and insights:

> Difficulty are the professionals who are no longer so participatory (P02).

> We face a great difficulty with the King's interest ... is ... the other professionals involved, right? It's so hard! (P03).

The principles of co-management include the participation of all those involved in the work process, without centralization of functions on a specific individual, but with the construction of actions agreed between the people involved in this process which must corresponsabilizar by decision making [1, 2.6].

There is, however, that the effective participation of all members involved in the

organization of work in health is also identified as a difficulty. It is assumed that the participation is not a content capable of being transmitted, nor in a skill that is acquired through training, but in behavior that can be built through critical reflection and maturation by the subject himself. In addition, the establishment of standards and/or strict guidelines is not able to generate a work of collective way[19].

Provide that the subject involved participate actively in discussions involving the management of work in health is something that requires at least an understanding of the purpose of the work process for them. In General, the very technical and social division of labour keeps the workers of the seizure of the purpose of the work that, in the case of health, could be the production and care of life[13].

To guarantee moments of reflection on professional practice, or on the fact that individuals set up as members of a group, as the team meetings, may constitute actionable strategies to feed some ownership of the subject in relation to the understanding of grouping and its role in the same[20].

These spaces provide the clarification of expectations, frustration and dissatisfaction that surrounds the world of work in health and help to minimize the suffering of State workers who deal daily with complex scenarios of population health. Is in dispute, different desires and expectations for work, and the great challenge which is to constitute the group around a common project that produces more job satisfaction and better quality of life and health for the population.

FINAL CONSIDERATIONS

You have to pay attention to the way you work in health management has been designed by the ESF professionals and practices arising from this conception. The problematization of the centralization of functions on some (some) member (s) of the Group and the work, in an attempt to get everyone to participate in all stages of the work management, are some indications that direct to a possibility of managing based on co-management.

The existence of a moment for the planning and targeting of actions such as the team meetings, is strategic. However, these moments should be appropriate with commitment. The organization and in all the activities to be listed and discussed can be a starting point for this process to occur with dynamism. In addition, the speech and listening spaces must be guaranteed.

Still, it is necessary that there should be monitoring and evaluation procedure of settlements and activities listed by the members that make up the team and which should be developed by those responsible for each task. A way that is linked to the systematization of care plans and that can assist in this process is the adoption of case discussions, according to Therapeutic Natural designs.

There was no, from the reports, the difference between a rural and an urban USF, in the sense of the assumption in this production, since raised in no time was mentioned the participation of users in the process of co-production of management of health work, going to meet the already carried out and existing productions on this theme at USF.

It is hoped that this study will contribute to the production of knowledge about work in health management for portraying how that has been designed and developed by professionals of a rural ESF, serving as support for these constructs of interventional strategies for the development and improvement of management, based on the principles of health co-management. However, he has the edge to be a case study in a USF rural, but provides clues to how management has been designed for those professionals and shows that does not differentiate substantially the design of USF.

Thus, it becomes essential to deepening the theme in an attempt to understand beyond the conceptions of professionals and users about the management job. Indicates if other studies that address the institutional dimensions of the work process in health, in an attempt to obtain indicative that contribute further to the work management in rural as urban both ESF.

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GERENCIAMENTO EM SAÚDE: O OLHAR DE TRABALHADORES DA SAÚDE DA FAMÍLIA RURAL

RESUMO

O gerenciamento do trabalho em saúde na Estratégia Saúde da Família democrático e participativo consiste em um dos grandes desafios desse nível de atenção à saúde. Nesse sentido, desenvolveu-se este estudo qualitativo com o objetivo de analisar as concepções de profissionais da Estratégia Saúde da Famíliasobre gerenciamento do trabalho em saúde. Foram realizadas entrevistas semiestruturadas com 10 profissionais de uma Unidade de Saúde da Família rural em cidade de médio porte do interior de São Paulo. Os dados foram analisados por meio da análise de conteúdo temático-categorial. Obtiveram-se três categorias de análise: Organização do trabalho em saúde para o alcance de metas; O gerenciamento marcado pela racionalidade e com foco no enfermeiro; Facilidades e dificuldades que permeiam a construção de espaços coletivos na Estratégia Saúde da Família. Considera-se que existe a necessidade de se atentar para o gerenciamento do trabalho na Estratégia Saúde da Família, com a necessidade de que os sujeitos se corresponsabilizem pelas pactuações e decisões tomadas em equipe, garantindo a fala e a escuta de todos. Além disso, é relevante que haja avaliação processual das ações implementadas e dos pactos realizados pelos profissionais de saúde.

Palavras-chave: Gestão em saúde. Administração de serviços de saúde. Atenção primária à saúde. Enfermagem de atenção primária.

GESTIÓN EN SALUD: LA ÓPTICA DE TRABAJADORES DE LA SALUD DE LA FAMILIA RURAL

RESUMEN

La gestión del trabajo en salud en la Estrategia Salud de la Familia (ESF) democrática y participativa consiste en uno de los grandes retos de este nivel de atención a la salud. En este sentido, hemos desarrollado este estudio cualitativo con el objetivo de analizar las concepciones de profesionales de la ESF sobre la gestión del trabajo en salud. Fueron realizadas entrevistas semiestructuradas con 10 profesionales de una Unidad de Salud de la Familia rural de una ciudad de tamaño mediano en el interior de São Paulo-Brasil. Los datos fueron analizados mediante el análisis de contenido categorial temático. Se obtuvieron tres categorías de análisis: La organización del trabajo en salud para el logro de los objetivos; La gestión marcada por la racionalidad y con enfoque en el enfermero; Facilidades y dificultades que permean la construcción de espacios colectivos en la ESF. Se considera que existe una necesidad de atención en cómo se ha llevado a cabo el trabajo de gestiónenla ESF, con la necesidad de que los sujetos se corresponsabilicen por los pactos y las decisiones del equipo, asegurando el habla y la escucha de todos. Además, es importante que exista un proceso de evaluación de las acciones realizadas y los pactos realizados por profesionales de salud.

Palabras clave: Gestión en salud. Administración de los servicios de salud. Atención primaria a la salud. Enfermería de atención primaria.

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