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MANAGEMENT IN PRIMARY HEALTH CARE: DISCOURSES ABOUT THE SEARCH FOR RESPIRATORY SYMPTOMATICS OF TUBERCULOSIS[1]

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ABSTRACT: The study aimed to analyze the discourse of Primary Health Care managers about the search for respiratory symptomatics as an epidemiological surveillance action of tuberculosis. A qualitative study was undertaken, guided by the theoretical and analytical framework of French Discourse Analysis. Data were produced in May 2012 through semi-structured interviews with 14 subjects. Two discursive blocks were produced: marks of power in the execution of the search for respiratory symptomatics; resistance strategies in the search for respiratory symptomatics. Discursive positions were grounded in the traditional management model, making it difficult to incorporate the search for respiratory symptomatics as a participatory action that integrates health staff, managers and the community. Insufficient human resources, workload and rigor in achieving goals favor postures of immobility among the professionals. It is concluded that the managerial work outlined in the health surveillance model encourages the mobilization of practices that contribute to qualify the search for respiratory symptomatics in Primary Health Care.

DESCRIPTORS: Tuberculosis. Power. Health service administration. Qualitative research.

GERÊNCIA NA ATENÇÃO PRIMÁRIA À SAÚDE: DISCURSIVIDADES SOBRE A BUSCA DE SINTOMÁTICOS RESPIRATÓRIOS DA TUBERCULOSE

RESUMO: Objetivou-se analisar discursos de gerentes da Atenção Primária à Saúde sobre a busca de sintomáticos respiratórios como ação de vigilância epidemiológica da tuberculose. Estudo qualitativo, norteado pelo referencial teórico-analítico da Análise de Discurso de matriz francesa. Os dados foram produzidos em maio de 2012, por meio de entrevistas semidirigidas com 14 sujeitos. Produziram-se dois blocos discursivos: vestígios de poder na efetivação da busca de sintomáticos respiratórios; estratégias de resistência na busca de sintomáticos respiratórios. Posições discursivas pautadas no modelo de gestão tradicional, dificultam a incorporação da busca de sintomáticos respiratórios como ação participativa que integre equipe de saúde, gestores e comunidade. Insuficiência de recursos humanos, sobrecarga de trabalho e rigorosidade no alcance de metas favorecem posturas de imobilismo dos profissionais. Conclui-se que o trabalho gerencial pautado no modelo de vigilância em saúde estimule práticas de mobilização que contribuam na qualificação da busca de sintomáticos respiratórios na Atenção Primária à Saúde.

DESCRITORES: Tuberculose. Poder. Administração de serviços de saúde. Pesquisa qualitativa.

GESTIÓN EN LA ATENCIÓN PRIMARIA EN LA SALUD: DISCURSIVIDADES SOBRE LA BÚSQUEDA DE SINTOMÁTICOS RESPIRATORIOS DE LA TUBERCULOSIS

RESUMEN: El estudio objetivó analizar los discursos de gerentes de Atención Primaria de Salud en la búsqueda de sintomáticos respiratorios como acción epidemiológica de vigilancia de la tuberculosis. Estudio cualitativo, basado en el marco teórico y analítico del Análisis del Discurso de matriz francesa. Los datos fueron producidos en Mayo de 2012 por medio de entrevista semiestructurada con 14 sujetos. Se produjeron dos bloques de discurso: los rastros de poder en la ejecución; estrategias de resistencia en la búsqueda de síntomas respiratorios. Posiciones discursivas basadas en el modelo de gestión tradicional hacen que sea difícil de incorporar la búsqueda de sintomáticos respiratorios como la acción participativa que integre el personal de salud, los administradores y la comunidad. Recursos humanos insuficientes, carga de trabajo y el rigor en el logro de metas proporcionan posturas inmovilidad de los profesionales. Se considera que el trabajo gerencial basado en el modelo de vigilancia de la salud podría fomentar la movilización de prácticas que contribuyan a calificar la búsqueda de sintomáticos respiratorios en la Atención Primaria de Salud.

DESCRIPTORES: Tuberculosis. Poder. Administración de los servicios de salud. Investigación cualitativa.

INTRODUCTION

The ongoing effort to implement the principles and guidelines of the Unified Health System (SUS), in combination with the expansion of the Health Care Networks (HCN), focused on the decentralization of the actions and services to the cities, have transformed the Brazilian health scenario since the 1990's.[1-2]

In that context, the managers of the Primary Health Care (PHC) units perform functions related to the management of clinical-care actions, to the knowledge and administrative skills and to the mediation of interdisciplinary work, with a view to solving the individual and collective health needs.[3-4] Thus, management turned into an essential activity to qualify PHC, which is considered the preferential entry door to the public health system, contributing to the decentralization process of health actions to the local management.[5]

The governance of the SUS is complex, especially in relation to other social systems, due to the fact that the managers are permanently confronted with a decision process that produces a balance among the management objectives, such as equity, efficacy, efficiency, quality and user satisfaction.[6]

Therefore, the management competences need to be developed to the maximum, in the form of knowledge, skills and attitudes that permit multiprofessional action in the prevention of diseases, in the promotion and recovery of health and in the rehabilitation of people.[7] The construction of these competences also implies the articulation between personal and relational attitudes, which will jointly contribute to transform the reality in health.[8]

This article examines the discourse of PHC unit managers on the active search for respiratory symptomatics (SRS), which represents an important health surveillance action, with a view to the short-term location of people with persistent cough who are considered suspects of pulmonary tuberculosis (TB).[9] The planning, development and assessment of this health action demand management articulations established in the web of the effects of meaning of the power and resistance. These social practices are exercised at different levels and at distinct points of a social network.[10]

The question that guided this study was: how does the discursive position of manager affect the search for respiratory symptomatics in primary health care?. Thus, the goal is to analyze the discourse of managers working in primary health care units on search for respiratory symptomatics as an epidemiological surveillance action of tuberculosis.

METHOD

This qualitative study rests on the theoretical-analytic framework of French Discourse Analysis (DA) according to Michel Pêcheux. This interpretive discipline is constituted as an intermediary theory in the relation among Linguistics, considering the non-transparency of language; Marxism, as the legacy of historical materialism; and Psychoanalysis, in the relation between ideology and the unconscious.[11-12]

The study participants were 14 managers working in the 25 health services that belong to the PHC of a medium-sized city in the interior of the State of São Paulo. Six of these subjects worked at Primary Health Care Units (PHCU), seven at Primary Family Health Care Units (PFHCU) and one at the Teaching Health Center (THC). As a criterion for inclusion in the sample, managers were considered who had occupied the function for at least one year. As an exclusion criterion, being on leave of absence from work was adopted.

To produce the data, the semistructured interview technique was applied during 15 days in May 2012. The questions that guided the interview were

focused on the following aspects: political articulation in municipal management, PHC organization for the development of epidemiological surveillance of TB and operation of SRS at the local level. The reports were recorded, transcribed and treated using resources in the software Atlas.ti®, version 6.0 (codes, families, memos, reports).

The language material was analyzed in accordance with the procedures of discourse analysis, which are: passage from linguistic surface to discourse, passage from discursive object to discursive formation and passage from discursive process to ideological formation.[11]

Concerning the ethical commitment for scientific research involving human beings, it is highlighted that this study received approval from the Research Ethics Committee of the *Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo*, under number 078/2012. All participants previously signed the Free and Informed Consent Form. The participants' testimonies were coded by means of letters, according to the subjects' social function (m – manager) and Arabic numerals, in the order in which the interviews were held (from 1 till 14).

RESULTS AND DISCUSSION

The study subjects are female, between 27 and 52 years of age, with a mean age of 37.8 years. What the professional background is concerned, it was identified that 12 subjects held an undergraduate degree in Nursing, one in Nursing and Midwifery and one in Medicine. Concerning the activities performed at the health services, 13 subjects reported working in management and clinical care in Nursing at the same time, while one worked exclusively as a manager. The length of experience in management and at the same health service ranged between one and four years, with a mean experience of 2.7 years.

All subjects reported having taken at least one complementary training course during their professional trajectory, but only six indicated specific courses in health management. In this respect, many health professionals knowingly become unit managers without specific training for this function,[1] which compromises the development and improvement of their competences.

This information is relevant to understand the production conditions in the strict sense (immediate context) and in the broad sense (historical-social and ideological context)[11] the discourse analyzed was contextualized in. In accordance with the proposed objective and the methodological procedures of DA, two discursive blocks were produced: Marks of power in putting in practice the search for respiratory symptomatics and Resistance strategies in the search for respiratory symptomatics.

Marks of power in putting in practice the search for respiratory symptomatics

DA proposes the dislocation from the notion of single meaning to the polysemic concept. Thus, the subjects produce and are affected by multiple meanings although, according to the concept of forgetting 2, they can attempt to unmistakably correspond words with things.[11] This event becomes possible as DA considers that the notion of subject is split, offset by the unconscious, heterogeneous. Therefore, it does not consider the individual, but the subject of the discourse that carries marks of the social, the ideological, the historical, in other words, the form-subject.[13-14]

The taking of the word becomes well known when inscribed in a certain discursive formation (DF), which corresponds to the (not empirical, but discursive) place where the meanings are constituted. In this DF, there is the search for regularity, which exists in the dispersion of the discursive elements, so that the subjects are questioned as talking subjects when they affiliate with the DFs.[13]

What the management is concerned, this can be perceived as conditioning and conditioned to the *modus operandi* of the health services' production, being a producer and at the same time product of a certain context. Thus, the management actions become susceptible to the different social actors' influences (federal, state and municipal managers, health team and health service users) interested in the different health policies.[4]

The following excerpts present mutually incoherent discourse, considering that the effects of senses in the mobilization of the health team differ from the health education approach, restricted to the transmission of information, which seems to lie at the base of the managers' work.

We do orientation with the agents [Community Health Agents (CHA)]*! We called on the agents to participate, we transmit the information for them to take part in the visits, when they identify* [the respiratory symptomatics], *forward to the unit* [...] (m4).

[Nursing] *technicians are mobilized for that* [SRS] *and the agents identify them at home too. They campaign, deliver pamphlets, we visit the waiting room, in the hypertension and diabetics group, give advice on the symptoms* [...] (m5).

I gave the pamphlets [information on TB] *and I explain: you visited, perceived that the user is coughing a lot, he already offers, he takes the containers. Each agent already took the container, to offer it to the patient* [...] (m6).

From the perspective of DA, the position-subject is a relation of identification between the enouncing subject and the subject of the knowledge (form-subject). Thus, when different individuals relate with the subject of the knowledge in the same DF, will turn into ideological subjects, which can occupy the same or different positions.[14] Alternation is observed in the position-subject the managers assume, which happens based on the attempt to take power. This, in turn, does not act solely in a certain place; on the opposite, it is reflect in a network, mainly because, from this perspective, the individuals can both undergo and exercise its action.[10]

When determining that the CHA or nursing technician should practice SRS for TB surveillance, the manager takes on a position of governance, of control. On the other hand, the signifiers "mobilized" and "participate" are related to a discourse of empowerment and autonomy, of the professionals involved in the action as well as the users the intervention will target. In this context, the contradiction and movement of the power is observed in relation to the position-subject of the manager.

It should be highlighted that the health surveillance actions are increasingly signified as care produced in the collective dimension, beyond the attitudes of supervision and control. Then, and based on the current concept of health surveillance,[15] the signifiers "mobilization" and "participation" represent fundamental processes for the practice of a surveillance model from the perspective of health promotion.

In the immediate context of the symbolic production of discourse, social changes are promoted, operated at the level of the power relations.[16] Thus, the affiliation of meanings with others permits the constitution of historical-semantic networks of signification, which produce the repetition of the discourse, as well as its (re)formulation.[13]

The memory also stands out in this conjuncture. It should be clarified that, in discursive terms, the memory cannot be understood like in the individual psychological concept, but in the senses of convergence between the mythical, social and historical memory. Thus, what is said is linked to a meaning that rests on the historicity of the discourse, that is, on the interdiscourse.[12] This, in turn, produces statements that affect how the subject signifies a certain situation, based on which the discursive knowledge permits each taking of the word.[11]

As the signifiers change meaning depending on the positions of who employs them, this movement becomes possible through the ideological functioning, characterized as a mechanism that presents an established, crystallized statement to the subject, as if the meaning that appears were evident, natural, obvious.[13] And it is based on this context that the change of position with a view to the taking of the power observed in the managers is legitimized.

As to taking the position of holders of power, studies[17-18] reveal that the administrative actions, as well as the decision making, is directly related to the figure of the manager, in which the normative and bureaucratic management style predominates,[17] whose main objective is to conquer and maintain spaces of power.[18] This phenomenon, however, tends to turn into situations of management isolation, hampering the construction of spaces of interaction with the other members of the health team, as it does not favor moments of collective production and knowledge and experience exchange.[17]

Although the subjects of this study are ruled by disciplining DFs, based on the compliance with standards and rules, a reaction to this type of discourse is observed, mobilized based on the daily work practices, especially regarding the operation of the SRS. Marks of this change can be perceived in the difficulty to achieve the target set by the Ministry of Health, based on the Pact for Life, which establishes the investigation of 1% of the population concerning the possibility of respiratory symptomatics within the territories.[19] Against this proposal, the city where this research was undertaken reached only 23.7%[20] of the total agreed upon, strengthening the sense of the action against the target imposed.

In line with these findings, studies[21-22] in different regions of the country have also observed the non-compliance with the target to investigate respiratory symptomatics. They also appointed that the lack of minimal health teams to work in PHC,[21] as well as the incipient valuation of the health professionals directly involved in the SRS for TB, including the CHA, are some of the factors that make the practice of this health surveillance action unfeasible.[22]

As managers, it is observed that the interviewed subjects are exposed to an environment of enforcement and charge, with a view to the compliance with the productivity established for the health unit under their management, as observed in the following fragments:

they [coordination of the TB control program (TCP)] *really demand this aspect of the silent unit that*

is not reporting anything, that is not searching, that is not doing any test. They really require that! Their part, they do that correctly. They demand! (m3).

we have a systematic worksheet we have to complete… when he comes, when he does the test, when this, when that. So, we only do it in the morning and send everything, and they supervise and charge: look, you didn't complete that, you didn't do this, you didn't do that! (m11).

there was a time we [health team] *were playing, I said: 'look, in a couple of days we're going to do a sputum smear to ourselves, everyone in here has to reach the targets'* (m14).

In addition, many organizational and structural elements can represent obstacles to the management work, including the insufficient number of human resources and the inappropriate health service structure are characterized as the main barriers in the study subjects' "discourse", as observed in the fragments:

it was more difficult because the number of staff remained the same to do an additional job, right?! [...] (m6).

there's an employee missing from reception, because there have to be at least three. I've got two [employees], *so there's one missing! In the regulation really, which is the sector that regulates the tests, there should be two and I've got one. So, everyone is overloaded!* [...] (m9).

this [health unit] *was crowded yesterday, the day before yesterday!* [...] (m10).

negative point is the problem of the unit itself, of the structure? Because, like, there are few employees and we can't work like that, right, very regular because of the [insufficient] *number* [of staff] (m13).

The long list of PHC actions and services, the different health care models, the implementation of the Family Health Strategy (FHS), the decentralization of health actions, in addition to the scarce structural and human resources, are characterized as some of the aspects that suggest the discontinuity in management work.[18,23]

Nevertheless, the rapid and continuing changes in the public health context have demanded, more than ever, management postures in accordance with the adaptation and solution of the problems in the contemporary society. Therefore, competency-based management is needed, built on pro-activeness and individual responsibility, on practical intelligence of the situations, based on the knowledge gained and transformed,[24] with a view to the strengthening of the political and social role of PHS, among others, as the preferred door for the access of respiratory symptomatics of TB to the public health system.

Resistance strategies in the search for respiratory symptomatics

The continuing requirements concerning the SRS posed to the manager and charged by him/her offer the space needed for the resistance phenomenon. As power is a phenomenon that takes place in the practice of human social life, based on this context, resistance becomes a possible counterpart. It should be clarified that resistance cannot be understood as an inversion of power, as there is a relation of coexistence between both.[25] Therefore, work environments in which rules and standards are imposed as unchangeable conditions can favor resistance, whether through the breaking of rules or the possibility of inventing other modes of dealing with the rules, of transforming them.[26]

As the DF is the place where the meanings are constituted, the subject is revealed based on the identification process with the DFs. Nevertheless, when affiliated with a certain DF, the subject necessarily erases/denies that many others and, thus, the identification process is characterized as moving, unfinished and uninterrupted. When affirming [...] *we only execute the work and send everything, and they supervise and charge* [...] (m11), the interviewed manager takes on the position of a worker, whose actions are hardly affected and transformed by critical thinking and participatory processes.

Particularly in the context of TB surveillance, this position assumed in the discourse implies a commitment of the ability to develop innovative management work. In the functioning context of the language, the managers' discourse can experience polysemy, that is, the dislocation and rupture of processes of signification.[11] In the language material analyzed, mechanisms of resistance were observed against the ongoing incorporation of the SRS into the health services, as illustrated in the fragments:

we [health team] *have not only tuberculosis!* [...] (m1).

I think it's a problem [referring to TB] *that is treatable, which you can control…eh…I can't see anything, frightening!* [...] (m7).

In this discourse, it is observed that TB does not belong to the group of the most relevant health concerns in the territory under the responsibility of the health units of managers m1 and m7. This process reflects processes of signification on the disease and the inclusion of TB surveillance in PHC.

This though is associated with the social construction, in the form of collective memory, that TB is under control. Nevertheless, epidemiological data

revealed that, in 2013, Brazil diagnosed 71,123 new cases, corresponding to an incidence coefficient of 35.4/100,000 inhabitants.[19] Although TB is a severe public health problem, it is quite frequently neglected on the public policy agendas, under the illusion that it is a disease of the past and is already solved.[27]

It is a mistake to think of TB as an emerging disease, in view of its constant representation in terms of incidence, nor re-emerging, as there has never been a significant period of decline in the disease. Therefore, its occurrence is ongoing and with high rates,[28] demanding continuing articulations and actions among all social actors involved (managers, health professionals and community).

Thus, it is observed that the managers reproduce the discourse of putting TB to the background as a way of resisting the power established by the targets set in PHC, legitimizing their immobile posture towards the problem. This movement becomes possible as, amidst this game between what has been and has to be said, the subjects and meanings move, attribute and gain meaning.[11]

In the discursive perspective, the silencing is understood based on two fundamental concepts: constitutive silence, in which one word necessarily erases another, and local silence, which can be prohibited/censured by saying.[29] Marks of silencing were observed, reverberated based on the subjects' position of prohibition and censorship. Thus, the managers silence their statements and also erase/deny their oppressor, in the figure of the TCP coordination, with a view to signifying their resistance, as observed in the following fragments:

Ah, can I talk? [on the coordination of the TCP] (m2).

Can I tell you in all sincerity? [...] (m8).

Censorship, as a phenomenon of oppression, will try to stifle the discourse to suffocate the meanings that are current. In the managers' discourse, however, attempts to resist the power were observed, using the same mechanism that tries to oppress it, the silencing. This process becomes possible as, in the attempt to censure what is said, the silence of oppression is directly affected by the rhetoric of the oppressed, which reverberates as a new attempt to resist. Thus, based on the concept of DF, the silence incessantly works on its limits to play with the contradiction of meanings of the subject's identification.[29]

Thus, it is understood that the effects of meaning of resistance, echoed in the managers' discourse, have exerted influence by producing stagnation in the operation of the SRS for TB in the city where this research was undertaken. In this sense, a study[30] developed with nurses revealed that these professionals, in view of the authoritarian impositions of the superiors, as well as the patients under their care, rested on the immobility and conformism as a way to represent their reduced exercise of power and the insufficient resistance towards the ethical problems faced in daily hospital work.

It should also be highlighted that there is an important relation between the hiring modalities of the health professionals, especially in the FHS, and the silencing of the discourse. In a study[31] undertaken in the state of Minas Gerais, it was revealed that few professionals had been hired through a public exam, with the predominance of the outdated incorporation of patronism, clientelism, through political indication. These contexts favor environments in which hiring and dismissal are facilitated, resulting in the absence of stability, dissatisfaction of the professionals, staff turnover and, consequently, discontinuity of care and of the bond with the users/population.[32]

If, on the one hand, exercising the management of health units is complex, on the other hand, it is fundamental for the construction of a high-quality public health system. Therefore, for the sake of effective change in the power relations among the different actors in PHC, the managers need to develop skills to question their reality and job practices, thus understanding the thin lines the power weaves in their daily work, especially concerning health surveillance actions for TB control.

FINAL CONSIDERATIONS

Like other studies, in this study, aspects were also observed that promoted management based on the traditional model, in which the decisions are exclusively anchored in the manager's figure. Consequently, the interviewees produced meanings of control and stress related to the compliance with targets, which favor immobility and conformism towards the problem of operating the SRS for TB surveillance. Thus, the managers need to consider the incorporation of the different social actors involved in health surveillance (municipal coordination, health team and community), with a view to establishing partnerships in the planning and execution of actions in line with the needs and particularities of each territory.

In addition, testimonies were observed on environments of work overload, resulting, among oth-

ers, from the lack of minimal teams for the execution of the SRS. In addition, frailties in the organization of PHC, represented by the imposition of targets that ignore the local-regional particularities, were appointed as factors that hinder the satisfactory operation of the SRS from the viewpoint of a health surveillance action.

The management should be competency-based, with a view to considering environments of articulation and negotiation with higher levels (municipal management and TCP coordination), with a view to the identification of the problems and, mainly, the indication of solutions that surpass the barrier of conformism, in the framework of the surveillance model in PHC.

The results observed in this study should provide the opportunity for further research on the management of the SRS for TB, in order to build a set of knowledge that can support improvements in the public health context, especially concerning TB control actions in PHC.

Limitations are admitted in this study, as the interpretive gestures of the other health professionals are not considered, who constitute a work team with the manager. In addition, the subjective context the theoretical-analytic reference framework adopted rests on, as well as the intrinsic incompleteness of discourse, could mobilize other interpretive gestures, which could consequently reverberate other effects of meaning based on the problems presented in this study.

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