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The nurse's work in primary health care

O trabalho do enfermeiro na atenção primária à saúde

Trabajo del enfermero en la atención primaria de salud

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Abstract

Objective: To describe the organization of the work of the Nurse in primary health care in the Brazilian regions. **Methods:** Cross-sectional study of secondary data from the external evaluation of the National Program for Improving Access and Quality of Primary Care (PMAQ), which included 17482 ESF, and other primary care models, adherent to the program, in 3,972 participating municipalities, covering all Brazilian states. **Results:** Highlights a differentiated position of the professional Nurse in the primary health care staff, pointing to the expansion of the limits of professional performance, adding administrative activities to the practices of direct assistance to the user. **Conclusions:** The insertion of Nurses in primary healthcare staff has brought new models in the care production with a new standard for the production of care, which alters not only the mode of organization of the production process, in conformity with the interests of capital, but reverses the core of the care's technology.

Keywords: Primary Health Care; Family Health; Health Evaluation; Nursing.

Resumo

Objetivo: Descrever a organização do trabalho do enfermeiro na atenção primária à saúde nas regiões brasileiras. **Métodos:** Estudo transversal de dados secundários oriundos da avaliação externa do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ) que englobou 17482 ESF e outros modelos de atenção básica, aderidos ao programa, em 3.972 municípios participantes, abrangendo todos os estados da Federação. **Resultados:** Destacam uma posição diferenciada do profissional enfermeiro na equipe da Atenção Primária à Saúde, apontando para a ampliação dos limites de atuação profissional, agregando as atividades administrativas às práticas da assistência direta ao usuário. **Conclusões:** A inserção do enfermeiro em equipes da atenção primária à saúde tem suscitado novas modelagens na produção do cuidado com um novo padrão de produção de cuidados, que alteram não apenas o modo de organização do processo produtivo, conforme os interesses do capital, mas inverte o núcleo tecnológico do cuidado.

Palavras-chave: Atenção Primária à Saúde; Saúde da Família; Avaliação em Saúde; Enfermagem.

Resumen

Objetivo: Describir la organización del trabajo de enfermería en la atención primaria de salud en las regiones brasileñas. **Métodos:** Estudio transversal con datos secundarios obtenidos de la evaluación externa del Programa Nacional para el Mejoramiento del Acceso y Calidad de la Atención Primaria (PMAQ) que incluía 17482 ESF y otros modelos de atención primaria, se adhirió al programa en 3972 municipios participantes, cubriendo todos los estados brasileños. **Resultados:** Destaca una posición diferenciada de la enfermera profesional en el equipo de atención primaria de salud, que apunta a ampliar los límites de desempeño profesional, agregando actividades administrativas a las prácticas de asistencia directa al usuario. **Conclusiones:** La inserción de las enfermeras en los equipos de atención primaria de salud ha provocado nuevos modelos de atención en la producción con una nueva atención estándar de producción, que alteran no sólo la forma de organización del proceso productivo, ya que los intereses del capital, pero los reveses la tecnología de la base de la atención.

Palabras clave: Atención primaria de salud; Salud de la Familia; Evaluación de la Salud; Enfermería.

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INTRODUCTION

One of the main challenges faced by the Unified Health System (SUS) in the present days is to ensure the quality of their management and care that are provided to the communities, once it must englobe the principles of integrality, universality, equity and social participation[1].

The Ministry of Health has prioritized the implementation of public management based on the monitoring of actions and assessment of the processes, structures and results. Much effort has been employed to establish initiatives that ensure the quality of the health services offered to the Brazilian society, encouraging then the amplification of qualified access in the various existing contexts in the country[2]. Among these initiatives, there is the National Program for Improving Access and Quality of Primary Care (PMAQ) which aims to ensure that the Primary Health Care (PHC) be set as the preferred gateway to the health system. This program understands that the organization of the PHC has the potential to resolve most of the problems and health needs of the population through the promotion, protection and the rehabilitation. Its goal is to develop a complete care that has an impact on the health status and autonomy of people, on the determinants and on the health conditions of communities[2].

Thus, this level of care should be operationalized through the exercise of democratic and participatory care and through management practices in the form of teamwork aimed at populations of defined territories. This should be guided by the principles and guidelines of SUS, from which specific functions and features take place[1]. The PHC must also operate complex and varied care technologies to assist in the managements of demands and health needs of higher frequency and relevance in their territory, observing risk criteria, vulnerability and resilience and the ethical imperative that recommends that all demands, need for health or suffering must be accepted[1].

In this context, the organization of the work process in PHC is critical for the team to move forward in ensuring both the universality of the access as for the integrality of the care and the improvement of the well-being and the work itself[2]. Thus, the PHC requires professionals with wide knowledge that in addition to technical expertise, may develop the dimensions of the policies and management for the health service, assuming then the role of self-managers.

The work in the health field as the incorporation of knowledge and practices that emerge from the space of micro-policies has the potential to reveal how the production of care is governed through the flow of responsibilities, production and reappropriation of needs, wishes, demands, solutions and boundaries that surround the everyday life of health services[3]. Thus, considering the relevance of the appropriation of knowledge about the health work process in PHC highlights the importance of assessing the work of professionals that add knowledge about the process and what the possible implications in the construction of care lines that make the work in the health field would be.

The data produced through the PMAQ, in the context of PHC in the country, represent the analyzer axis with emphasis on the activities performed by nurses in the service scenario, recognizing the relevance of international scientific literature on the APS and its plurality as a form of organization of the health system with peculiarities of specific programs and services in Brazil[4].

Thus, this study aims to describe the organization of the nursing work in the APS in Brazilian regions.

METHODS

It is a cross-sectional descriptive study based on secondary data from the external evaluation of PMAQ which comprised 17.482 Family Health Strategy (ESF) and other primary care models, adhered to the program, in 3.972 participating cities, covering all states of the Federation.

The PMAQ was established by Decree Nº 1,654 GM/MS, of July 19, 2011, and targets the extension of qualified supply of health services within the SUS. It focuses on the assessment as a permanent strategy for the central decision-making and as an action to improve the quality of health actions in the SUS. It is organized into four stages: adhesion and contracting, development, external evaluation and recontracting[2].

The stage of external evaluation of the PMAQ was conducted by educational and/or research institutions contracted by the Ministry of Health for the development of instruments for data collection and field work, by applying different evaluation processes.

Data collection took place from June to September 2012, in the units that have joined the Assessment Program and that established the contracting. Each city could include all or only part of their teams, respecting the limit of adhesion equivalent to 50% of their Teams for Family Health. The field team for data collection consisted of a supervisor and three to four interviewers from various professions who participated in the application of assessment modules composed of multiple questions.

The data presented in this article are from the Module II of PMAQ, which includes interviews with key informants, i.e., those professionals appointed by the staff to answer questions about the structure and organization of the work process. Therefore, the nurses were chosen mainly as key informants to respond the questionary which englobed issues related to their work and to the team at the APS. The data related to team work were excluded after the selection of specific data that include the objective of this study.

The information obtained from the survey instrument has originated a database that has been stored in Microsoft Excel

2010 *software* and that served as the basis for this study. Data were transferred to the SPSS 20.0 for the carry out of descriptive analysis through absolute and relative frequency and then presented in table format.

Frequency data were organized in four tables.

1. Table 1 shows the affirmative answers to three variables: if the respondent was a nurse; if the coordinator was a nurse; and their period as member of the team, if the respondent was a nurse. The total percentage of each variable make a total of 100%. There are only the answer 'yes' to the first two variables.
2. Table 2 shows the variables on further training: If they have additional training; if they a specialization course 1; specialization 2; Master's Degree 1; and Master's Degree 2. Each displayed result corresponds only to the answer "yes" to each variable and each percentage is the percentage of answers 'yes' in relation to the total of respondents. We could add up the percentages.
3. Table 3 shows the results of only one variable: the types of employment bonds according to the Federal Unit (FU).
4. Table 4 shows the affirmative answers to five variables related to the activities performed by nurses in the sample of respondents nurses: reception; selecting users on the agenda; shared agendas; puerperium consultation; and home care. The total percentage of each variable is equal to 100%. Here we presented, for all variables, only the answer 'yes'.

The study was approved by the Research Ethics Committee of the National School of Public Health in the opinion 32012 on 06/06/12.

RESULTS

Table 1 shows the absolute (N) and relative (%) frequencies, by UF to the variables related to the respondents. In the collection process, the external assessment of the PMAQ, it was found that most professionals indicated by the teams to report on the working process organization were nurses. Note that the lowest percentage of respondents nurses was in the Federal District (82%) and the highest was in Pará (99%). Among these nurses, most of them were the team coordinator, with a percentage ranging from 81% (Paraíba) to 97% (Roraima).

Table 2 shows the further training of the respondent nurses. The results presented are for courses that have been completed or that are in progress.

High percentages are noted for further training, ranging from 71% to 97% in Acre and in Espírito Santo. The results of completed specialization course or course in Family Health showed significant percentages ranging from 26% in Alagoas to 76% in the Maranhão and Roraima. For specialization in Public Health or Collective Health, the percentages are lower, ranging from 10% in Roraima up to 48% in Alagoas.

In Table 3 are found the main types of employment relationships of the respondent nurse, an important aspect to be considered, since it can hamper the professional bond with the service and with the population served, which is an inseparable feature of the work.

Regarding these variables, the results are different depending on the FU, but in most of them, the relationship bond as public servant is prevalent. The exceptions are the states of Amazonas, Amapá, Bahia, Maranhão and Roraima, where temporary contracts prevail and in Rio de Janeiro, where the main link is the contract by the Consolidation of Labor Laws (CLT).

In Table 4, we sought to examine whether, in the units where nurses were the respondents, the following functions were being carried out by them: participation in the reception, booking users appointments in their agenda, participating in the shared agenda and home caring.

The results presented here show that the nurses' work is multidimensional, linking care and management practices, and point to the low percentage of participation in relation to the scheduling of users activity.

DISCUSSION

The results highlight, to the universe of this study, a different position of the nurse professional in the PHC team. It points to the expansion of the limits of their professional performance to adding administrative activities to the practices of direct assistance to the user, which confirms previous studies that point to the intensification and expansion of the nurse's activities in the ESF, both in the area of care and health education as the management of health services[5].

The PMAQ data show that, in the PHC, the graduate professionals delegated to the nursing professional the role of cognitive authority in passing information about the work processes organization. Often, besides coordinating the nurse work and supervising the work of community health workers, many maintenance activities and control of services are under the management of this professional, being the unit in general, under the responsibility of nurses.

In the context of this research, among the various activities performed by nurses in everyday practice, it stood out the administrative and bureaucratic activities. In this sense, Waldow[6] states that nurses in Brazil have been gradually moving away from activities strictly related to caring and have been focusing their work process in administrative activities, with emphasis on the organization of business services, planning and control of team work. The great number of activities at the PHC and on the networking with multidisciplinary teams, interdisciplinary approach,

Table 1. Absolute frequency and percentage of respondent nurses PMAQ Module 2

UF	Respondent Nurse		Nurse coordinator		Period as part of the team (Nurse)					
					< 1 year		1 to 4 years		5 years +	
	N	%	N	%	N	%	N	%	N	%
AC	31	97%	27	87%	9	29%	16	52%	6	19%
AL	320	94%	273	85%	69	22%	133	42%	118	37%
AM	159	92%	152	96%	66	42%	70	44%	23	14%
AP	44	88%	38	86%	23	52%	11	25%	10	23%
BA	1433	93%	1341	94%	475	33%	759	53%	199	14%
EC	870	96%	783	90%	228	26%	389	45%	251	29%
DF	23	82%	20	87%	8	36%	9	41%	5	23%
ES	281	88%	264	94%	79	28%	140	50%	62	22%
GO	629	93%	594	94%	206	33%	302	48%	115	18%
MA	106	95%	101	95%	42	40%	37	35%	27	25%
MG	2739	94%	2623	96%	730	27%	1387	51%	619	23%
MS	172	93%	158	92%	47	27%	81	47%	44	26%
MT	213	97%	202	95%	83	39%	86	41%	42	20%
PA	348	99%	332	95%	143	41%	142	41%	61	18%
PB	571	91%	465	81%	129	23%	265	46%	177	31%
PE	934	93%	844	90%	208	22%	512	55%	213	23%
PI	340	92%	311	91%	45	13%	161	48%	128	38%
PR	905	91%	850	94%	255	28%	375	42%	272	30%
RJ	888	85%	820	92%	269	30%	467	53%	152	17%
RN	387	94%	343	89%	98	25%	194	50%	95	25%
RO	90	93%	87	97%	16	18%	54	61%	19	21%
RR	33	97%	27	82%	12	36%	10	30%	11	33%
LOL	734	90%	655	89%	170	23%	351	48%	210	29%
SC	1041	94%	976	94%	328	32%	511	49%	200	19%
SE	209	85%	153	73%	48	23%	90	43%	71	34%
SP	2100	92%	1962	93%	560	27%	1123	54%	412	20%
TO	276	90%	246	89%	95	35%	114	41%	66	24%

and inter-sectorial articulation, can apparently distance nurses from direct assistance and contact with the users.

Management is not only the organization of the labor process, but what goes on among all the parts that constitute it. It is the knowledge production place in which to plan, administer, manage, decide, execute and evaluate can not be separated[7].

In the context of integral care, it is stated that the management activity is part of the care practices, i.e., caring and managing are not mutually exclusive activities, but complementary and can be carried out through direct actions of the health care professional towards the user and through the delegation and/or coordination with other health team members[3].

According to Matumoto et al.[8], the work of nurses in PHC is guided along two lines: production of care and management of the therapeutic process; and management of health activities and the nursing staff. The authors state that developing managerial actions is an activity that predominates in the work of nurses in Basic Health Units. They also recognize the conflicts and tensions that constitute the daily work in relation to the disputes for space and knowledge with other professionals, and the technical e prerogative limitations determined by the rules and protocols on their professional exercise and the organization of the work process of PHC teams.

Table 2. Absolute frequency and percentage of additional training of the respondent nurse

UF	Further Training		Specialization Course 1		Specialization Course 2		Master's Degree 1		Master's Degree 2	
	N	%	N	%	N	%	N	%	N	%
AC	22	71%	9	41%	8	36%	0	0%	0	0%
AL	278	87%	71	26%	133	48%	1	0%	1	0%
AM	129	81%	43	33%	43	33%	1	1%	2	2%
AP	29	66%	15	52%	7	24%	0	0%	0	0%
BA	1175	82%	393	33%	442	38%	10	1%	17	1%
EC	768	88%	438	57%	168	22%	11	1%	8	1%
DF	20	87%	12	60%	9	45%	2	10%	1	5%
ES	272	97%	124	46%	99	36%	0	0%	7	3%
GO	469	75%	209	45%	149	32%	6	1%	9	2%
MA	93	88%	71	76%	22	24%	1	1%	0	0%
MG	2218	81%	1492	67%	531	24%	26	1%	21	1%
MS	158	92%	92	58%	43	27%	1	1%	0	0%
MT	164	77%	60	37%	58	35%	3	2%	0	0%
PA	240	69%	71	30%	49	20%	0	0%	2	1%
PB	512	90%	296	58%	194	38%	5	1%	12	2%
PE	849	91%	398	47%	332	39%	5	1%	13	2%
PI	297	87%	172	58%	125	42%	2	1%	0	0%
PR	766	85%	332	43%	223	29%	3	0%	12	2%
RJ	716	81%	387	54%	113	16%	6	1%	19	3%
RN	329	85%	109	33%	81	25%	9	3%	4	1%
RO	81	90%	41	51%	22	27%	2	2%	0	0%
RR	29	88%	22	76% 2	3	10%	1	3%	1	3%
LOL	618	84%	368	60%	199	32%	8	1%	9	1%
SC	858	82%	505	59%	204	24%	11	1%	8	1%
SE	178	85%	63	35%	58	33%	0	0%	1	1%
SP	1814	86%	1131	62%	464	26%	17	1%	23	1%
TO	203	74%	67	33%	66	33%	3	1%	4	2%

Specialization and Master's Degree 1: Family Health. Specialization and Master's Degree 2: Public Health or Collective Health.

Thus, management is part of care and should be developed in a responsible and committed manner with the health needs in order to carry out the care practices, which have the collective and the family as the focus of attention.

Moreover, in a broader perspective on family care, according to Oliveira and Marcon[5] the working process should be structured based on the actions and relationships of professionals with families, once establishing and maintaining relationships with family interfere in the quality of the care provided. In what concerns the necessary expertise, these authors emphasize the importance of technical-scientific knowledge (know-how) and especially the ability to relate (know-be) with the families and with team members, showing commitment, involvement and ethical postures, which are aspects more easily achieved when one is affected, supportive and involved in what they do.

Regarding the period of work as part of the team, it was observed that about 50% of nurses work in the team from one to four years. A separate analysis of the states in Brazil shows that the percentage of nurses working in the same team for less than a year ranges from 13% in Piauí to 52% in Amapá. Although, in most states, the nurses are part of the team for over a year, it is noteworthy that the turnover of these professionals affects their bonding with the community and the quality of the care. In addition, constant changes of workers on the team carry workload

Table 3. Absolute frequency and percentage of the main types of employment bonds of respondent nurses

UF	Statutory public servant		Commissioned position		Temporary contract		Public employee CLT		CLT contract	
	N	%	N	%	N	%	N	%	N	%
AC	13	42%	0	0%	5	16%	3	10%	9	29%
AL	201	63%	3	1%	45	14%	28	9%	40	13%
AM	30	19%	6	4%	119	75%	0	0%	1	1%
AP	10	23%	0	0%	27	61%	0	0%	2	5%
BA	389	27%	34	2%	747	52%	53	4%	130	9%
EC	413	47%	46	5%	293	34%	21	2%	34	4%
DF	23	100%	0	0%	0	0%	0	0%	0	0%
ES	136	48%	9	3%	59	21%	10	4%	63	22%
GO	317	50%	15	2%	251	40%	8	1%	32	5%
MA	19	18%	9	8%	63	59%	11	10%	3	3%
MG	1034	38%	59	2%	1292	47%	77	3%	237	9%
MS	124	72%	5	3%	29	17%	4	2%	8	5%
MT	129	61%	18	8%	37	17%	0	0%	24	11%
PA	106	30%	2	1%	193	55%	3	1%	40	11%
PB	369	65%	7	1%	159	28%	6	1%	22	4%
PE	303	32%	28	3%	461	49%	4	0%	128	14%
PI	226	66%	3	1%	59	17%	31	9%	9	3%
PR	508	56%	21	2%	49	5%	227	25%	84	9%
RJ	104	12%	63	7%	219	25%	26	3%	419	47%
RN	110	28%	25	6%	224	58%	6	2%	20	5%
RO	81	90%	3	3%	3	3%	1	1%	2	2%
RR	1	3%	2	6%	28	85%	0	0%	1	3%
LOL	466	63%	10	1%	58	8%	62	8%	118	16%
SC	610	59%	40	4%	115	11%	194	19%	77	7%
SE	128	61%	4	2%	42	20%	32	15%	3	1%
SP	472	22%	30	1%	33	2%	340	16%	1209	58%
TO	174	63%	9	3%	76	28%	0	0%	13	5%

for those who remain and require the training of new workers, increasing costs and the weakening of the work processes[9].

The respondent nurses presented percentages below 10% of master's degrees, completed or underway in Family Health and Collective or Public Health. Although emphasizing the need to improve the service provided to the population by health professionals, based on the qualifications, training and improvement of their performance, the Pan American Health Organization (PAHO) alerts about university curricula that address the professional training guided by a curative paradigm, hospital-centered and fragmented in knowledge and in the approach to health, as they value the specialties without the global comprehension of the human being and the process of becoming ill. Thus, the quality of professionalization can strengthen a performance based on the concept of care model or the organization of the service or deformed work practice, where it is observed devaluation or even inexistence of proposed public health actions within the community[10].

It should also be emphasized the importance of continuing education, which should start from the introductory training in the team, by all teaching models and media available, as well as according to the realities of each context, assuming that this process should be privileged from the concrete reality of health practices, through active methodologies considering its determinants and limitations, in order to seek interaction with the work demands[10].

Table 4. Absolute and percentage frequency by Federation Unit of the main activities carried out by nurses in the sample of respondent nurses

UF	Reception		Booking users on the agenda		Shared agenda		Puerperal consultation		Home care	
	N	%	N	%	N	%	N	%	N	%
AC	13	42%	0	0%	21	68%	31	100%	28	90%
AL	250	78%	1	0%	250	78%	318	99%	319	100%
AM	77	48%	0	0%	88	55%	155	97%	150	94%
AP	26	59%	0	0%	36	82%	44	100%	44	100%
BA	1068	75%	4	0%	944	66%	1417	99%	1421	99%
EC	639	73%	2	0%	767	88%	858	99%	862	99%
DF	19	83%	1	4%	23	100%	22	96%	22	96%
ES	212	75%	0	0%	253	90%	251	89%	280	100%
GO	391	62%	10	2%	382	61%	581	92%	620	99%
MA	79	75%	0	0%	94	89%	106	100%	105	99%
MG	2409	88%	30	1%	2130	78%	2310	84%	2707	99%
MS	132	77%	1	1%	132	77%	152	88%	171	99%
MT	108	51%	1	0%	167	78%	197	92%	203	95%
PA	230	66%	2	1%	263	76%	339	97%	335	96%
PB	315	55%	1	0%	397	70%	565	99%	565	99%
PE	534	57%	3	0%	782	84%	930	100%	928	99%
PI	144	42%	0	0%	299	88%	327	96%	330	97%
PR	670	74%	1	0%	604	67%	704	78%	894	99%
RJ	804	91%	9	1%	659	74%	815	92%	878	99%
RN	247	64%	0	0%	309	80%	381	98%	379	98%
RO	30	33%	1	1%	74	82%	85	94%	86	96%
RR	7	21%	0	0%	25	76%	32	97%	32	97%
LOL	595	81%	1	0%	499	68%	528	72%	724	99%
SC	857	82%	0	0%	841	81%	821	79%	1037	100%
SE	120	57%	0	0%	155	74%	209	100%	209	100%
SP	1974	94%	1	0%	1630	78%	1829	87%	2084	99%
TO	148	54%	0	0%	248	90%	269	97%	274	99%

At the PHC, the nurse has progressively been taking over administrative activities such as the maintenance of services and health programs, identified as bureaucratic activities. Jonas et al.[11], in a study about nurses' managerial function in the ESF, point out that the nursing management function has been reduced to a bureaucratic organization of activities of services, which can overload the professional. Such aspect bring the professionals to a point of tension in which they must carry out bureaucratic administrative work for managing people and supplies instead of works related to the care aspect. The authors report that with the bureaucratization, the nurse's work becomes mechanized. They warn for the risk of injuries to the users, since management is an intermediary that allows the assistance while the represents the final activity. Thus, it becomes clear the need for a management process shared with all that the nurses' role is not imprisoned by activities which, in essence, do not include their intervention object.

Set in a pediatric hospital, Laignier and Lima[12] found that the nurse's departure from the direct care is related to the emptying of the contents of activities historically exercised by these professionals, who have increasingly directed their activities to related procedures: hospital organization, visiting patients, supervision of the care exercised by other members

of the nursing staff and other bureaucratic activities. Besides that, with the emergence of other professions such as physiotherapy and speech therapy, the departure is reinforced by the disputes concerning practices and knowledge towards some care practices that historically are associated with the nursing work.

Therefore, handling the routine services in their various dimensions of organization and the chance to speak by the APS staff, as noted in our results can be interpreted through different views. Among them are: the lack of availability of other professionals to detain on all the team work processes; the perspective of the professionals of only being responsible for the portion of work related the corporation to which they are linked; the greatest dedication and concern for the progress of workflows; the abandonment of direct care in hospitals may be being transferred to the medium level nursing professional and, in the case of primary care, for community health workers; and the search, through a more managerial profile and less caregiver for more recognition and professional status on the team and the company, pointing to a reconfiguration of practices or even to a new productive restructuring, as enunciated by Franco[3].

The results presented show the changes in the institutionalization process of the nursing professional, which traditionally was a care practice but now presents new challenges led by their integration in primary care teams, whose work includes administrative practices that are linked to traditional management processes. These changes point to a diversification of possibilities in the labor market, of the capital requirements and the need to define policies related to health work in primary care and training of qualified professionals to work in public health.

Regarding the employment relationships, these results are consistent with the study by Girardi et al.[9] on working bonds in the ESF between 2000 and 2010, which points to a trend of work implementation. However, the occurrence of temporary contracts by 70% of the cities studied by the authors shows that the precariousness of the bonds still constitutes an important problem to be faced.

To Cotta et al.[10] there is a serious crisis in the health professionals working situation who work in the SUS and, among the main aggravating factors in Brazil is the proliferation of informal employment contracts and non-payment, by many employers, of the social security contributions that is their responsibility to finally deprive rights of workers guaranteed to them by law, such as vacation, guarantee fund for length of service (FGTS), licenses, thirteenth salary and retirement. The authors claim that these professionals remain at the mercy of partisan political instability and differences between governments that succeed each other in power, fact that is very present in the reality of Brazilian municipalities.

FINAL CONSIDERATIONS

Although the goal of PMAQ study alone was not the work of nurses, the data obtained in fieldwork with a view to assessment of basic care and diagnosis of infrastructure through the census in PHC units in Brazil indicate the form how nurses were present in almost all services in the Brazilian states as key informants.

Data collection does not allow us a more qualified analysis of this finding, but tells us what may be an ongoing reconfiguration in the ways that this professional has been reorganizing their work processes, moving away from the traditional model that has supported the training and the historicity of the profession.

The inclusion in the PHC team has raised new care production modeling, since, at this level of attention, the techno-assistance model in dispute also requires the handling of soft technologies, listed both in relationships and in the bond, the qualified hearing and reception of patients.

These technological configurations are related to the processes of productive restructuring, i.e., They reveal that may be ongoing changes that have been introduced in production systems, impacting the work processes, generating changes in the way of developing products and effectively modifying forms to care the people. At the same time, it was realized also the production of a certain technological transition, brought by a new standard of care production, which alters not only the mode of organization of the production processes, according to the capital interests, but the technology core of the care, inverting it, in regards to soft technologies. These situations have been generating mixed feelings, which both can lead to tensions, disputes and revealing choices of different intentions, and to the feeling of recognition and appreciation, as it seems to have been outlined in this study, from the many job production particularities in primary health care.

The analysis of the work in the health field at the PHC points to a necessary search for overcoming the fragmentation of the work processes, the relationships among the different professionals and the understanding of health as the mere absence of disease (biomedical health culture) as well as for the expansion and strengthening of the concept of health as a social, economic, cultural production and of quality of life.

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