Esc Anna Nery 2021;25(1):e20200093

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Family health team work management

Gestão do trabalho de equipes da saúde da família

Gestión del trabajo en equipo de salud familiar

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RESUMO:

Objetivos: Descrever o perfil, formação complementar, aspectos sobre educação permanente, vínculo e plano de carreira de profissionais de equipes da Saúde da Família. **Método:** Pesquisa descritiva de abordagem quantitativa. Participaram 78 membros de equipes multiprofissionais. Os dados foram coletados em 2016, por meio de um instrumento para caracterizar o profissional e as dimensões de tempo de atuação e qualificação dos profissionais das equipes, formas de contratação e modalidades de vínculos profissionais, plano de carreira e remuneração variável e educação permanente. As análises foram geradas no *software* IBM SPSS versão 21. **Resultados:** A distribuição de médicos e enfermeiros é homogênea, percebe-se uma redução de agentes comunitários de saúde. Foram mais frequentes as características: vínculo trabalhista regulado pela Consolidação das Leis Trabalhistas, baixa formação complementar para a atenção primária à saúde, até um ano de trabalho na equipe, com baixa formação complementar para área e iniciativas de ações de educação pela gestão. **Conclusões e implicações para a prática:** Existem fragilidades que podem interferir na organização do processo de trabalho influenciada pelos eixos da formação e formas de contratação.

Palavras-chave: Recursos Humanos; Gestão em saúde; Atenção Primária à Saúde; Saúde da Família; Enfermagem.

RESUMEN

Objetivos: Describir el perfil, la capacitación complementaria, los aspectos sobre la educación permanente, el vínculo y el plan de carrera de los profesionales de los equipos de salud familiar. **Método:** Investigación descriptiva con enfoque cuantitativo. Participaron 78 miembros de equipos multidisciplinarios. Los datos se recopilaron en 2016, utilizando un instrumento para caracterizar al profesional y las dimensiones de tiempo de actuación y calificación de los profesionales del equipo, formas de contratación y modalidades de vinculo profesional, plan de carrera y remuneración variable y la educación permanente. Los análisis se generaron en el software IBM SPSS versión 21. **Resultados:** La distribución de médicos y enfermeras es homogénea, se observa una reducción en los agentes comunitarios de salud. Las características más frecuentes fueron: vinculo de trabajo través de la Consolidación de las Leyes del Trabajo, baja capacitación complementaria para la atención primaria en salud, hasta un año de trabajo en el equipo, con baja capacitación complementaria para el área e iniciativas de acciones educativas por parte de la gerencia. **Conclusiones e implicaciones para la práctica:** Existen debilidades que pueden interferir en la organización del proceso de trabajo influenciado por los ejes de la capacitación y las formas de contratación.

Palabras clave: Recursos Humanos; Gestión en Salud; Atención Primaria de Salud; Salud de la Familia; Enfermería.

ABSTRACT

Objectives: To describe the profile, complementary training, aspects about permanent education, bond and career plan of professionals from Family Health teams. **Method:** Descriptive research with a quantitative approach. Seventy-eight members of multi-professional teams participated. Data were collected in 2016, using a tool to characterize the professional and the dimensions of time of work and qualification of the team's professionals, ways of hiring and modalities of professional bonds, career plan and variable remuneration and permanent education. The analyzes were generated by using IBM SPSS software version 21. **Results:** The distribution of physicians and nurses is homogeneous, one notices a reduction of community health agents. The most frequent characteristics were: legal and formal employment relationship, low complementary training for primary health care, up to one year of work in the team, with low complementary training for the area and initiatives of educational actions by management. **Conclusions and implications for practice:** There are weaknesses that can interfere in the organization of the work process influenced by the training axes and forms of hiring.

Keywords: Workforce; Health Management; Primary Health Care; Family Health; Nursing.

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Submitted on 03/27/2020.
Accepted on 06/29/2020.

DOI:https://doi.org/10.1590/2177-9465-EAN-2020-0093

INTRODUCTION

In Brazil, the advance of Primary Health Care (PHC) is the result of intense arrangements in the state apparatus and strong international influence on investments. In 2006, the Ministry of Health (MS) published the first National Basic Care Policy (NBCP), with the Family Health Strategy (FHS) as the preferred model for reorganizing PHC in the Single Health System (SHS).[1]

FHS comprises the organization of processes and democratic management through communication-negotiation with the protagonism of health professionals. Thus, for the organization of health work in PHC there is an articulation between physical and technological resources and human capital.[2] With regard to the organization of personnel, since the institutionalization of the FHS, the guideline provided for the formation of multi-professional teams with responsibility in territorial scope.

Once notices that in the published reviews of the NBCP, there were significant changes in the form of organization.[3] The review of the NBCP, published in 2017, when the reform of the State was being discussed, presented health management with new possibilities of professional bonds and, in particular, the forms of hiring personnel, which triggered a proliferation of transitional employment bonds in PHC.[4] However, even with the changes in the initial proposal, the NBCP is still the main guideline in the SUS for organizing the population's access to PHC and health services.[5]

It should be noted that the changes that have occurred in the Brazilian PHC policy have signaled challenges for the conduct of health care.[3] In this context, in recent years, work at the FHS has been weakened in practice by individual actions of professionals, in addition to the professional contempt and wage earning,[6] a situation that was being verified before the changes in the 2017 NBCP and that, since its publication, reinforces the fragmentation by specialized work in the opposite direction of multi-professional teamwork.

Thus, it has been noted in the legal-administrative structure of the SHS, including the PHC, the accelerated hiring of professionals with different salaries to perform similar work, establishing a multiplicity of salaries, bonds and forms of hiring.[7]

For the PHC the concessions in the form of bonds and the normalization of labor relations have repercussions on the fragility of labor rights with implications that directly reflect the proposal of the attention model. In this sense, the possibility of studying, based on data from the National Program for Improving Access and Quality of Primary Care (PMAQ-AB), allows us to observe the situation of work and health workers in PHC.[8]

It is considered important for workforce planning the perception of the worker under his or her work, which is essential to ensure the conduct of the health system,[9] as it is co-participating in actions and decisions and can favor specific strategies for local health management.

In this way, recognizing the processes of labor management dynamics that go through education to the SUS worker proposes to health management to expand strategies that can be transformative of health practices.

The relevance of PHC in the area of health system care and management added to the importance of team management to enable work in the FHS and the possibility of contributing to the construction of knowledge to support the development of strategies to qualify PHC work and favor management in decision-making in order to generate benefits, justified this study. The objective of this investigation was to describe the profile, complementary training, aspects on permanent education, bond and career plan of professionals from Family Health teams.

METHOD

This is a descriptive study of a quantitative approach, carried out in a municipality in the middle north of Mato Grosso.

In that municipality there was a progressive investment in the coverage of PHC by joining the Mais Médicos Program (PMM), which propelled the quantitative increase of professionals and resulted in increased access. Data from the Ministry of Health's Secretariat of Primary Care show that, in 2013, the municipality had 47.61% coverage of PHC and that, after joining the PMM, it increased coverage to 71.9% in 2014, 82.2% in 2015 and 98.3% in 2016, making this year the apex of PHC services for the local reality, in just three years.

This study integrates a set of researches developed in the quadrennium 2015-2018, with teaching-service integration and in partnership established with the municipal health management through the Health Organizations Quality Office (EsQualOS/UNEMAT). As part of the research protocol, it was agreed to scientific dissemination after the delivery of final reports to management.

To participate in the study, for convenience, ten registered family health units were invited to receive the evaluation of the 3rd cycle of PMAQ-AB. This selection of convenience is justified because they are registered for evaluation of the 3rd cycle of the PMAQ and have a complete multi-professional team during the period of data collection of the research. As for the team members, all were invited and accepted to participate in the study.

Seventy-eight professionals, members of the multi-professional team (nurse, physician, nursing technicians, receptionist, community health agents (CHA), dental surgeon and oral hygiene technician) participated in the study. The data were collected in the second half of 2016 on a face-to-face visit by the researchers responsible for each health unit, after scheduling by phone, according to the best day and time for the team to participate. The collection was guided through a structured tool of sociodemographic profile and one available in the guide of PMAQ[10] Module II - Interview with a Professional of the Primary Health Care Team and Verification of Documents in the Primary Health Care Unit. In this study, the following topics were used: time of action, complementary training and qualification of family health team professionals, hiring forms and modalities of professional bonds, career plan and variable remuneration, and permanent education, which are systematized in Chart 1.

After data collection, there was double typing in an electronic spreadsheet, in which the analyses were generated through IBM

SPSS® *software* version 21 and presented in tables with their absolute values and percentages. For analysis and discussion purposes, the results were presented in blocks, according to the dimensions selected in Chart 1.

All research ethics aspects were respected, in accordance with Resolution 466/12, with the appreciation and approval of the Committee on Ethics in Research with Human Beings (CEP) under CAEE number: 51340215.0.00005166.

Chart 1. Variables according to dimensions of work management analysis in Basic Care.

DIMENSIONS OF ANALYSIS	VARIABLES
Work time, profile and training of the PHC team´s professionals	Profession of the interviewee Are you the team coordinator? How long do you work on this AB team? Do you have or are you in further training? Which of these training processes do you have?
Permanent Education	Are there continuing education actions in the municipality that involve Basic Care professionals? Do these permanent education actions contemplate the demands and needs of the team? In which of these actions has the team participated or participated in the last year?
Ways of hiring and modality of professional bonds	What is your contracting agent? What is your type of bond?
Career plan and variable remuneration	Do you have a career plan? Do you have time progression in the plan? Do you have a career plan based on performance evaluation or development (merit)? Gratuities for training/title? Do you have incentive, reward, financial reward for performance?

Source: Adapted from the document - Health Closer to You: Access and Quality National Program for Improving Primary Care Access and Quality (PMAQ) Summary document for external evaluation, published by the Ministry of Health[10]

Table 1. Distribution of PHC team members, according to professional profile, categories of participation and type of complementary training, from a municipality in the middle-North Mato Grosso region, 2016

	N	%
Profession		
Physician	10	12.82
Nurse	10	12.82
Dental- surgeon	07	8.97
Nursing Technician	10	12.82
Oral Hygiene Technician	07	8.97
Receptionist	10	12.82
Health Community Agent	24	30.78
Team Coordination		
Nurse	10	100
***Work time of professionals in the team**		
1 year	52	66,66
2 years	07	12.82
3 years or more	19	20.76
***Complementary training**		
Higher- level professionals who have or are in complementary training	15	55.55
***Type of Complementary training**		
Specialization in Family and Community Medicine /Family Health	04	26.66
Other specializations	09	73.34

Source: Extracted from the research database. * Adapted from document: Health Closer to You: Access and Quality National Program for Improving Primary Care Access and Quality (PMAQ) Summary document for external evaluation[10]

RESULTS

The results are presented in four tables: Table 1 shows the stratified quantitative profile by profession, team coordination, time members worked on the health team, complementary training, and type of training; Table 2 presents the results referring to Permanent Education (PE); Table 3 refers to the forms of hiring and modality of employment of professionals; and Table 4 presents the overview of career plans in the municipalities.

One notices that the coordination of the units is done by nurses more frequently, that the teams have little time in the area of coverage and that the complementary training in the area of PHC is low. Although there were moments of training actions, participants pointed out that the topics addressed did not

Table 2. Distribution of responses of PHC team members regarding Permanent Education (PE) in a municipality in the middle -North Mato Grosso region

	N	%
Existence of permanent education actions	63	80.76
Actions that comprise the needs of training	42	66.66
Type of permanent education actions in the last year*		
Telehealth	26	19,40
Telediagnosis	8	5,97
Teleconsulting	12	8,95
EAD/UNASUS	23	17.16
In person courses	63	47.01
Tutorial /mentoring	2	1.49

Source: Extracted from the research database. * Adapted from document: Health Closer to You: Access and Quality National Program for Improving Primary Care Access and Quality (PMAQ) Summary document for external evaluation[10]; ** In the variable, multiple answers are allowed

Table 3. Distribution of PHC team members according to the type of bond of a municipality in the middle-North Mato Grosso region, 2016

	N	%
***Workers who report that they have as a contracting agent**		
Direct administration	78	100
Outsourcing	-	-
***Type of bond**		
Statutory public servants	4	5.12
CLT contract	3	3.84
Temporary contract by the public administration governed by special legislation (federal, state, municipal)	71	91.04

Source: Extracted from the research database. * Adapted from document: Health Closer to You: Access and Quality National Program for Improving Primary Care Access and Quality (PMAQ) Summary document for external evaluation[10]

Table 4. Distribution of the overview of the career plans of the PHC team members of a municipality in the middle-North region of Mato Grosso, 2016

	N	%
*Professionals have a career plan	4	5.12
*Professionals have incentive, gratuity, financial award for performance	-	-
*Professionals have in their career plan seniority progression	4	5.12
*Progression by performance evaluation or development	-	-
*Progression by degree and professional training	-	-

Source: Extracted from the research database. * Adapted from document: Health Closer to You: Access and Quality National Program for Improving Primary Care Access and Quality (PMAQ) Summary document for external evaluation[10]

comprise the needs of the work. It can be observed no aspects related to the career plan, considering incentives, gratification, financial award for performance evaluation and/or progression by degree and professional training.

DISCUSSION

A total of 68 health professionals and 10 receptionists participated in the interviews. Of these, 12.8% were nurses, 12.8% physicians, 8.9% dental-surgeons, 12.8% nursing technicians, 8.9% oral hygiene technicians, 30.7% ACS and 12.8% receptionists.

All nursing professionals assume the coordination of PHC teams, which generates duplicity of activities, management and assistance. In Latin America, discussions are emerging to advance the standardization of nursing practice, proposing advanced practices and minimum training,[11] with a view to characterizing a possible increase in the scope of practice of nurses, which may contribute to improving access and coverage in health.[12]

In relation to the time of performance of these members, it can be observed that 66.6% of the interviewees reported having less than one year of performance in the team and 12.8%, up to two years.

Contracts made in this context do not ensure fixation. In Brazil, studies on human resources in the PHC show high turnover,[5] little incentive for salary and professional progression in line with low working conditions and involvement of professionals in the transformation of the care model, justified by incipient training,[13,14] which compromises the effectiveness of the care model designed for PHC,[15] in addition to harming the quality of care and user satisfaction.[16]

The CHAs, which represent a workforce essential to the FHS, have undergone a major change in the composition of the health team, according to the NBCP of 2017.[17] Furthermore, the qualification of this professional to assume the duties of guidance and monitoring of multiple health conditions is questioned.[18] It is noted that various forms of brief and intermittent qualification have been opportune to the CCA and, although it has been configured as an alternative to the demand for services, it represented, at a certain point, a space for advancement that has not been confirmed.[19]

Another aspect to be considered in this municipality concerns the progressive investment of PHC coverage, which characterized the expansion of access from 2014, after emergency provision of physicians by PMM, which required the local management to organize services and quantitative increase and fixation of physicians and, consequently, of other professionals to the primary level. However, there was a decrease in coverage in subsequent years: 2017 was 85.4%, 83.9% in 2018, and by November 2019, coverage was 80.2% in 22 Family Health units.[20]

Regarding complementary training, 55% of the higher-level professionals declared to have concluded or to be attending some postgraduate course, only 10% of the physicians and 30% of the nurses declared to have concluded specializations in the area of PHC.

It is worth mentioning that 90% of the physicians declared having concluded residency in a Medical or Surgical Clinic and none of the interviewees mentioned any residencies in Family Health or Family and Community Medicine and Public Health/Collective Health residencies.

For the qualification of the work process in health, valuation and satisfaction of the worker, the Ministry of Health has encouraged the management to implement activities of Permanent Education in Health (PEH). Thus, the PEH can be understood as a powerful labor management device and is anchored in the National Policy on Continuing Health Education (PNPS).[21]

Among those interviewed, 80.7% said they participated in training activities offered by the municipal government, but the largest number of professionals indicated that the topics addressed did not include training needs. In this regard, it is necessary to review how the demands that professionals have made at the operational level have been distributed, or how the analysis of referrals to teleconsulting is carried out. Among those who claimed to have participated in the permanent education actions, the most frequent modalities were the face-to-face courses, which reinforces the need to expand the use of the telehealth education platform in these services.

From the perspective of a municipality in the interior of the state of Mato Grosso, with a network that has a computerized structure in the services with access to the Internet, the incentive in the use of telehealth can make possible, in the scope of the management, directing to the permanent education plan and, from the perspective of the professionals, the capacity to institutionalize, in the service, teaching strategies, which can be shared in the team.

In this sense, to overcome territorial extension and inequities in the distribution of services, telehealth enables the use of technological resources for interaction between health professionals and the network of services, and can promote, in addition to improving teamwork, access to diagnostic and therapeutic support resources, expanding the coordination of PHC care.[22]

Professionals have recognized that the use of Tele-education services has been attributed to their application in care support.[23] The contribution of Telehealth, as a support device for health teams, enhances the expansion of access and quality of care.[24,25]

In this sense, the provision of continuing education for teams can contribute to the strengthening and expansion of access to PHC through the qualification for professionals.

As for hiring, the highest percentage is for direct temporary contracts with the public administration, which suggests greater fragility of work bonds. This may represent limits to the construction of the work process in health facilities, as a model of family health, which presupposes the establishment of bonds.

In municipalities with a larger population in the PHC, outsourcing, flexibilization of work relations and hiring by CLT are more present.[26] However, processes of flexibilization significantly change the context of work in the health field.[27]

Specifically, for the CHA, there is an intensification of administrative activities to the detriment of the time for home visits added to a work proposal for the collection of information

and the filling of information systems, resulting in a tension in unequal employment relationships and precarious working conditions with underpaid.[28]

Given the limits imposed by economic policy, it is important to remember that there are mechanisms for hiring personnel through Non-Governmental Organizations (NGOs) and Civil Society Organizations of Public Interest (Oscip), whose expenditures are accounted for as "third-party services" and not as "personnel expenses,[29] devices used to circumvent the Fiscal Responsibility Law. This shows the need for a mechanism to create possibilities to increase spending, without being confronted with the law of fiscal responsibility and respecting contracting.

No aspects related to the career plan were identified, considering incentives, gratification, financial award for performance evaluation and/or progression by degree and professional training. However, it is worth mentioning that four statutory employees fit into the criteria of career progression by length of service. By career plan only, four members of staff, because they were statutory, fit into the progression by seniority.

The worker class struggle has led to the recognition of constitutionally guaranteed rights, the career plan being a powerful management tool, especially when aggregated with other subsidies, such as gratification, performance evaluation and progression by qualification,[7] but there are limitations on implementation in the health sector.

It can be affirmed that the incorporation of the Job, Career and Salary Plans (PCCS) in the municipalities is still fragile. State interference in the construction of a career plan for the FHS is recognized, in addition to the non-existence of PCCS or incipiency in its institution, especially in smaller municipalities.[30] However, the PCCS is an instrument that mobilizes and enhances the motivation of workers, contributes to the valorization, establishment and perspective of career in service.[31]

The already recognized limits of difficulties in attracting and retaining professionals and the lack of consolidation of the career plan, positions and salaries as a strategic instrument for labor management[29] have been worked on by the Secretariat of Labor Management and Health Education (SGTES) through technical cooperation projects with municipalities and states to leverage initiatives to strengthen the Program for the Depreciation of Labor in the SUS (DeprecarizaSUS), however, there is still a lack of demonstrations of monitoring and evaluation capacity, and recognized HR managers are unaware of the DeprecarizaSUS.[32]

However, these issues are like important challenges for the management and workforce in PHC of SHS, capable of considerably impacting the organization of the care model, the work process, and the effectiveness of health care practices.

It is considered that the consolidation of PHC in recent years is one of the most relevant movements in the advancement of universality in SUS, with FHS being the axis that has anchored this process. Although the studied municipality may have achieved the expansion of PHC through federal and municipal investments after the PMM, the hiring fragilities and fiscal adjustments in the reduction of social protection expenditures, given the national scenario, opened gaps for the flexibility of the dedication of multi-professional team members, reduction of workload and decrease of the presence of CHA in the team.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

In this study, the professionals had little activity time in the unit, low education in the area and weak work bonds, which has repercussions on the PHC workforce in this municipality. There are impacts on the management and organization of care, although the coverage has expanded.

The nurse is an articulator of the PHC and of the double occupation of team coordination and assistance, but he needs to be attentive to the accumulation of functions exercised by these professionals and to the multiple tasks they perform.

The formation for PHC is still incipient, which configures fragilities for the effectiveness of attention and commitment to change the culture of the population itself. Qualification is emerging, in this case, to promote spaces for improvement in the work process. Thus, the use of permanent education actions by the management may help to change this profile.

The precarious nature of the work relationship is highlighted, which can lead to rotation and discontinuity of actions in teams. In this case, it is necessary to resume the dialogue towards the organization of the work process and strategies that help to give continuity to the care in the face of these exposed situations

In the management of health work, the valorization of health workers and their work, through the PCCS, is one of the strategies that can fix and engage effectiveness in the performance of health work, but there is a growing advance of neoliberal initiatives, which have reverberated into more effective possibilities of investment in human capital.

As a contribution, the study shows the nuances of the reality of local management to articulate human resources policy in the implementation of PHC. It reinforces strategic axes in health management, such as lifelong education, telehealth, and the challenges of internalizing services in the face of institutional political aspects that may or may not favor the establishment of professionals.

The limitations of this study are related to the understanding of the local scenario and, although these limitations print the reality exposed to think about guidelines for dealing with these human resources, they corroborate the findings that are gaining concretion in several regions of the country, whose scenarios are peculiar like this, and can help the state and the Ministry of Health (MS) through the Secretariat of Labor Management and Health Education (SGTES) to adopt strategies growth qualification strategies

In this sense, it is recommended that new studies be conducted in other scenarios to learn about and explore the use of the data captured by the PMAQ -AB evaluations.

AUTHOR'S CONTRIBUTION

Study design. Acquisition, data analysis and interpretation of results. Literature review. Writing and critical review of the manuscript. Approval of the final version of the article. Responsibility for all aspects of the content and integrity of the published article. Josué Souza Gleriano

Data analysis and interpretation of results. Literature review. Writing and critical review of the manuscript. Approval of the final version of the article. Responsibility for all aspects of the content and integrity of the published article. Gisele Caroline Riche Fabro

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