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Management in the Family Health Strategy: workloads and structured institutional violence

Gestão na Estratégia Saúde da Família: cargas de trabalho e violência institucional estruturada

Gestión en la Estrategia de Salud de la Familia: cargas de trabajo y violencia institucional estructurada

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ABSTRACT

Objectives: to understand the relationship between workloads and institutional violence in Family Health Strategy managers' practice. **Methods:** qualitative research using theoretical triangulation and data from semi-structured interviews. Participants were 35 managers of Basic Health Units in the five Regions of Brazil, who worked in the Family Health Strategy. We used thematic analysis and ATLAS.ti for data analysis. **Results:** workloads were analyzed, showing relationships with institutional violence. Thematic categories emerged: "related to the management work itself"; "related to other instances of health system management"; "related to users and community". There was an interrelationship between increased managers' workloads and institutional violence. **Final Considerations:** the Family Health Strategy is relevant for universal access to health and requires favorable institutional conditions for its effectiveness. Adverse scenarios lead to increased workloads, approaching institutional violence. **Descriptors:** Primary Health Care; Workload; Workplace Violence; Health Manager; Family Health Strategy.

RESUMO

Objetivos: compreender a relação entre cargas de trabalho e violência institucional na prática dos gestores da Estratégia Saúde da Família. **Métodos:** pesquisa qualitativa com triangulação teórica, por meio de entrevistas semiestruturadas. Participaram 35 gestores de Unidades Básicas de Saúde das cinco regiões do Brasil que atuavam na Estratégia Saúde da Família. Na análise dos dados, utilizaram-se análise temática e o *software* ATLAS.ti. **Resultados:** as cargas de trabalho foram analisadas, evidenciando relações com a violência institucional. Surgiram categorias temáticas: "relacionadas com o próprio trabalho de gestão"; "relacionadas com outras instâncias de gestão do sistema de saúde"; "relacionadas aos usuários e população adstrita". Verificou-se inter-relação entre aumento das cargas de trabalho dos gestores e violência institucional. **Considerações Finais:** a Estratégia Saúde da Família é relevante para o acesso universal à saúde e requer condições institucionais favoráveis para sua efetividade. Cenários adversos geram aumento de cargas de trabalho, aproximando-se da violência institucional.
Descritores: Atenção Primária à Saúde; Carga de Trabalho; Violência no Trabalho; Gestor de Saúde; Estratégia Saúde da Família.

RESUMEN

Objetivos: comprender la relación entre cargas de trabajo y violencia institucional en la práctica de gestores de la Estrategia Salud de la Familia. **Métodos:** investigación cualitativa con triangulación teórica, a través de entrevistas semiestructuradas. Participaron 35 gestores de Unidades Básicas de Salud de las cinco regiones de Brasil que actúan en la Estrategia de Salud de la Familia. Para el análisis de datos se utilizó el software de análisis temático y ATLAS.ti. **Resultados:** se analizaron las cargas de trabajo, evidenciando relaciones con la violencia institucional. Emergieron categorías temáticas: "relacionadas con el propio trabajo de gestión"; "relacionado con otras instancias de gestión del sistema de salud"; "relacionadas con los usuarios y la población inscrita". Hubo una interrelación entre el aumento de la carga de trabajo de los gerentes y la violencia institucional. **Consideraciones Finales:** la Estrategia de Salud de la Familia es relevante para el acceso universal a la salud y requiere condiciones institucionales favorables para su efectividad. Los escenarios adversos generan mayores cargas de trabajo, acercándose a la violencia institucional.
Descriptores: Atención Primaria de Salud; Carga de Trabajo; Violencia Laboral; Gestor de Salud; Estrategia de Salud Familiar.

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INTRODUCTION

The Family Health Strategy (FHS) is a public policy that came to reorganize and qualify Primary Health Care (PHC) in Brazil aiming at reorienting the work process, strengthening the principles and guidelines of the Unified Health System (SUS - *Sistema* Único *de Saúde*). It aims to increase the problem-effectiveness and impact on the health situation individually and collectively, but also to improve the cost-effectiveness ratio. Since its implementation, FHS has been expanding health services and actions, having as characteristic the territorialization and multidisciplinary care provision.

FHS/PHC is a way of caring for and organizing health services, guided by principles and guidelines for free universal health care along the SUS lines. However, this model is expressed in an institutional political scenario tensioned by neoliberal policies where capitalist accumulation is hegemonically based as a guiding principle of sociability, strongly affecting public services, as is the case of health.

This context, including administrative fads prior to the FHS implementation, such as the administrative reform proposed by Bresser Pereira (Brazilian economist and social scientist) in 2002, greatly affects public services with a neoliberal ideology and a productivist focus, creating a fertile scenario for institutional violence. These changes modify work pace, the nature and division of tasks, socio-professional relationships, working conditions and requirements in terms of expected work results, in addition to prescribed procedures. All these aspects increase the requirements on workers when carrying out work activities[1]. These strategies, when applied without taking into account the characteristics of health services and the public service, can cause suffering at work characterized as structured institutional violence. These fads affect both users and workers of health services, constituting fertile ground for the naturalization of institutional violence. This, in turn, has the potential to cause physical and psychological harm to workers, mainly because part of representatives of institutions should promote care and respect of human rights[2].

The extensive restructuring in the health sector towards privatization and rationalization of services has influenced working conditions and employment, bringing layoffs, salary cuts, salary freezes, less comfortable shifts, heavier workloads and casual work as a consequence. This set of factors can generate a climate of violence driven by uncertainties and vulnerabilities[3].

The World Health Organization (WHO) considers violence to be "any incident in which a person is abused, threatened or assaulted in circumstances relating to their work"[3]. For the International Labour Organization (ILO)[4], work-related violence is any incident action or behavior of a person against another that leads to aggression, offense, injury or humiliation in their work or as a consequence of labor.

Violence is a social and health issue, characterized by the presence of economic and infrastructure problems that the various health services suffer, and also by sociocultural aspects related to violent practices of an institutional nature, not constituting a punctual or personal issue. In fact, what characterizes institutional violence is the frequency and high distribution of episodes of violence that are expressed as neglect of care, all forms of social discrimination, physical and sexual violence influencing the work result[5].

All these issues may be related to the form of management adopted in the institutions, with the possibility of being potentiated by ineffective management, considering problems in the adopted models and all the complexity of the management process in complex institutions and hierarchical structures such as in PHC. Moreover, institutional violence happens in a naturalized way in the health work process and is more evident when it relates to increased workloads.

Workloads are elements of work that interact with each other and with workers' body, triggering changes in biopsychic processes that manifest themselves in potential or apparent physical and psychological wear and tear[6], which can be enhanced in environments permeated by violence, lack of support and protection to workers.

Studies on violence in health work usually use the perspective of violence inflicted on users of services by professionals/workers or users on workers/professionals[7-9]. However, this study seeks to address the perspective of structured institutional violence on Basic Health Unit (BHU) managers that work in the FHS care model.

Structured institutional violence is that exercised in service-providing institutions, both in the health area and in other areas such as education or justice. It is presented in the form of action or omission, lack of access or even poor quality of services. It is also characterized through established rules, bureaucratic and political relations that reproduce social structures and power asymmetry in unequal relations. This structural violence is hidden in educational and economic policies, disseminating its effects on entire populations and/or groups, whether by the denial of social achievements or other forms of violence[10-11].

Institutionalized violence encompasses aspects related to work violence, such as the deterioration of working conditions and the new productivity paradigms, which increase the exposure of workers to the risk of accidents and illness, and aspects of work-related violence, which involve relationships in the exercise of the activity (bosses, peers, users)[12].

The urgent need to improve the effectiveness of management in public health services is recognized, aiming at protecting and improving users' and workers' quality of life. The WHO has shown concern about providing safe working conditions and valuing health workers, designating 2021 as the "International Year of Health and Care Workers", especially in recognition of their actions during the COVID-19 pandemic[13].

In this perspective, the theme of institutional violence is aligned with the Sustainable Development Goals (SDGs), notably goal eight, which aims to "promote inclusive and sustainable economic growth, full and productive employment and decent work for all", and goal 16, that seeks "effective, accountable and inclusive institutions"[14-15]. To promote safe and violence-free work environments, collective efforts are needed as foreseen in the SDGs, culminating in greater resolution of health services and quality of care offered to populations.

In order to contribute to the emerging debate about work-related violence and institutions committed to the protection of health workers, this study seeks to addressing the relationship between workloads and institutional violence in FHS managers' practice.

OBJECTIVES

To understand the relationship between workloads and institutional violence in FHS managers' practice.

METHODS

Ethical aspects

The investigation followed all the ethical precepts set out in Resolution 466/2012 of the Brazilian National Health Council, including presentation of the study for prior authorization and signing of the Informed Consent Form by participants. The project was approved by the Research Ethics Committee. As a way to maintain anonymity, participants were identified by codes.

Study design and theoretical framework

This is qualitative research, triangulating the theory of workloads and precepts of work-related violence expressed in WHO formulations, following the COnsolidated criteria for REporting Qualitative research (COREQ) guidelines.

Setting and participants

The study setting, intentionally chosen, sought to include: states in the five regions of Brazil; Basic/Local Health Units (BHU) that exclusively offered care in the FHS model for more than a year; BHU considered of good quality, according to indications of leaderships of municipality/region and/or according to data from the second cycle of the Brazilian National Program for Improving Access and Quality of Primary Care (PMAQ-AB - *Programa de Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica*, 2012). We included five BHU from Amazonas (North region), five from Rio Grande do Norte (Northeast region), five from Distrito Federal (Midwest region), eight from Santa Catarina (South region) and 10 from Rio de Janeiro (Southeast region), totaling 33.

To define the managers participating in the study, we included those who had at least six months of experience in the position of BHU manager, and at least one manager per BHU, totaling 35 participants. Professionals removed from work were excluded for reasons of any nature. All the invited managers agreed to participate in the study.

Participants were categorized with: abbreviation of participants' occupational (M=Manager; A=Administrator; N=Nurse; P=Pharmacist; CHW=Community Health Worker; N=Nutritionist; D= Dentist; P=Psychologist; Soc=Sociologist; NT=Nursing Technician); acronym of participating region (N=North; NE=Northeast; MW=Midwest; S=South; SE=Southeast); subsequent order number of the interviews, as in the examples: NMSE1 (Nurse Manager Southeast 1); AMN2 (Administrator Manager North 2).

Data collection and organization

This study integrates macro research on the subject with the participation of researchers from 08 universities in the five regions of Brazil, from July 2014 to February 2019. Initially, data were collected in the South, Southeast and Midwest regions, and in the period from 2018 to 2019, data from the North and Northeast regions were added. The long period of data collection was necessary with a view to including the five regions of Brazil.

Data were collected in person by a team of previously trained researchers, using interviews. The interviews were guided by a semi-structured and standardized script by the researchers, submitted to pre-test. After adjustments, the final script consisted of three parts, the first identifying the manager (sex, age, profession, education, time of experience as a manager, as a manager in FHS, type of contract and working hours); the second, BHU identification data (total of Family Health teams (FHt), team members, teams' working hours, total and characteristics of the population assisted, information on team meetings and frequency, presence and team members of the Family Health Support Center (NASF - *Núcleo de Apoio à Saúde da Família*), service flowchart, scope and extension of the territory); and the last part, addressing workloads (information about the position, qualifications for management, elements that hinder and facilitate the work process, autonomy in management, management support, use of health indicators, use of planning, articulation with the NASF, relationships with other management instances, relationships with FHS, relationships with users, working instruments, FHS proposal, and the interface of all these aspects in workloads). Also, in this third part of the interview, managers were able to list the three main elements/factors present in their work process that generate an increase in their workloads.

The interviews were recorded, carried out in the workplace, by prior appointment, and the interviews lasted about one hour.

Data analysis

The interviews were transcribed and went through thematic analysis[16], with the help of ATLAS.ti version 9. The analysis took place in order to identify quotation from the interviews that describe the actions/activities performed by managers in their daily work and the elements/aspects that generate increased workloads. Codes were assigned to these significant quotations, which were later organized into thematic groups according to the study's theoretical frameworks[3-4,6]. The findings allowed the development of three thematic categories showing interfaces of institutional violence with increased workloads. Workloads "related to the management work itself", "related to other instances of health system management" and "related to users and community".

RESULTS

Of the 35 participants, there was a predominance of females (74.3%), aged between 20 and 40 years (54.3%), nursing profession (71.4%). Regarding education, university education predominated (90.7%) followed by 5.6% with high school and 2.8% with technical education. Regarding the type of contract, most were public/statutory (57.1%), the others had a temporary or Consolidation of Labor Laws (CLL) contract (42.3%). The weekly working hours at BHU was 40 hours for all participants.

The elements present in the work process of BHU managers who work with the FHS/PHC care model, and which generate an increase in workloads, are shown in Figure 1, according to the magnitude verified in the coding process, signaling the belonging of the codes to the thematic categories described in Figure 2.

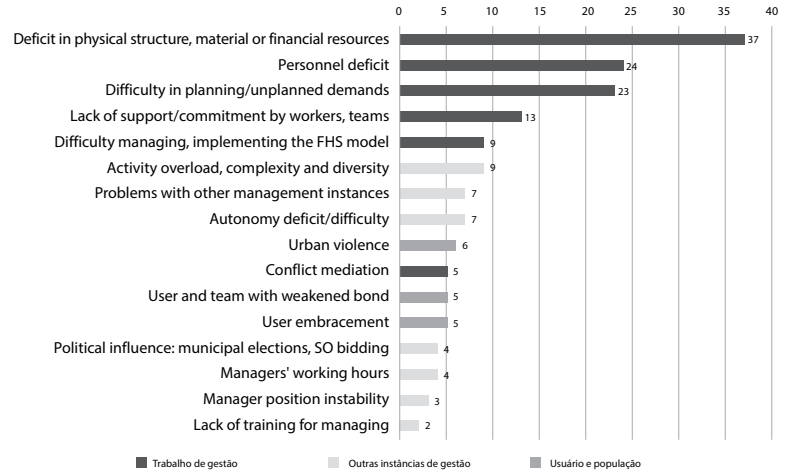
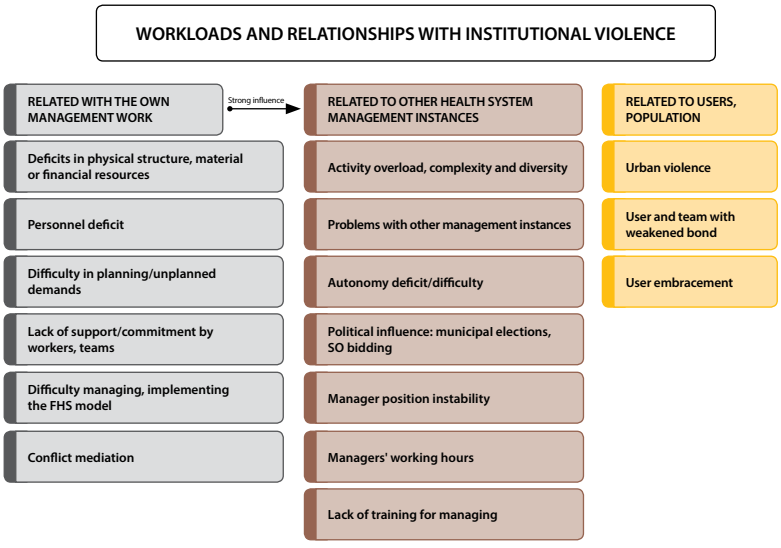


Figure 1 - Elements that generate an increase in Family Health Strategy managers' workloads in Brazil, according to the magnitude of coding and the belonging to thematic categories, Florianópolis, Santa Catarina, Brazil, 2014-2019



SO - Social Organization; FHS - Family Health Strategy.

Figure 2 - Workloads of Family Health Strategy managers and interfaces with institutional violence according to thematic category, Florianópolis, Santa Catarina, Brazil, 2024-2019

The findings were organized into three thematic categories and are presented in Figure 2, according to the specificity of managers' work, the relationships with other SUS management instances and the relationship with users/population/community (understood as individuals and collectives of the territory attached to care units that work with the FHS/PHC care model).

There was a strong relationship between workloads and health system institutional characteristics. The persistence of these factors in managers' practice, most of which go beyond the scope of governance of this group of workers, is close to what is defined in the literature as institutional violence.

The *first thematic category* concerns factors that generate increased workloads related to what typifies management work, which in this study were the most significant. In general terms, BHU managers' work involves: managing the environment/setting in which health care work is carried out; managing the collective of workers (health professionals and other workers who work in the care unit); and managing the care model itself, involving health care quality and planning management (from its elaboration, production and assessment of results). BHU managers recognize the importance of these activities, but given the difficulties of implementing them or carrying them out as prescribed, they experience an increase in workloads.

In this category are the most significant workloads: deficits and difficulties in working conditions and environment; problems in various aspects of collective work management (people management); problems related to planning management, with a strong emphasis on interference caused by unplanned demands; and multiple difficulties to implement an innovative, complex care model that demands the participation of those who carry out care work, in addition to involving relationships with users, the population and other social institutions. Quotations from managers' reports stand out below:

> *A higher speed internet, a room for regulation, a pharmacy in this unit, a regulation that works* [an effective system for dealing with patient needs], *as decreasing the number of people who need to have surgery would reduce my workload.* (SocMNE2)

> *Lack of support from the municipality to the health units. Lack of human resources, lack of support in terms of materials and maintenance* [...]. *High demand and low resolution.* (NMS3)

> [Numeric deficit] *of teams, but we don't have the physical structure to support.* (NMS7)

> *What increases workloads the most is demand that comes from outside.* [...] *from the health department, which has a demand that is not planned. You plan something and, all of a sudden, there is a demand from them that falls into and you have to deal with it, but you have a deadline and this increases our workload too much.* (NMMW3)

> *You get frustrated for never being able to fulfill a plan, I always make a metaphor "even to cross a street, we plan, we see that the light is open, sometimes you go a little slower to give yourself time to you don't have to stop, you look at the cars, right? You do all the planning to cross that street. When the light turns off, you planned and it's time to cross, then a car comes and runs over you", then you go by like, "oh, if I take the risk of being run over, maybe it's better not to plan, I'll go across, get run over, run over". You get tired of being run over all the time.* (NMSE4)

> *I see a beautiful model; the difficulty is because we are still not able to work as we should. I don't see the strategy really working as a gateway, like the pillar, so this is a bit tricky.* (NMN3)

The *second thematic category* deals with the relationship with other instances of health system management. We grouped aspects that are beyond the governance of BHU managers. It is noteworthy that the totality of what appears in the first thematic category has

a strong relationship with other management instances. In some cases, governance is almost nil, as in the provision of instruments and the workforce necessary for the FHS/PHC implementation.

The following quotations illustrate the findings of the second thematic category:

> *I can't carry out my duties* [...] *I feel frustrated because I really wanted to play the role of supervisor and I can't. The demands for other things from other sectors are very large and it turns out that those on the front line have to solve* [...] *I think it overwhelms in an emotional sense. We get tired, it's a tiring business.* (NMMW4)

> *Secretary sometimes doesn't give us resources to work, and I miss that support.* (NMMW2)

> *We are in two moments that increase the load, which is the pre-election moment and the pre-bidding moment of Social Organization* [SO]*, this causes a greater uproar within the units, both of the professionals have a fear of "the OS will change, I will be fired, I will have no job".* (NMSE1)

> *A training for the position, I think it is lacking to have subsidies of work methodology. I entered a position that you learn by doing, without any contribution.* (NMSE1)

> *We work 40 hours a week, but you actually work a lot more. Sometimes you are there at the unit, you go to a meeting and then you extend that time, it's not like "I come in at 8 a.m. and leave at 5 p.m. sharp".* (PMSE2)

In the *third thematic category*, which concerns the increase in workloads related to users and community, urban violence and problems in relationships with users stand out. In situations where there is user embracement, teams and managers are faced with complex and difficult-to-solve problems, generating increased workloads.

> *Violence rate increasing in this region.* (NMSE5)

> *When there is no established bond between users and their reference professional, this influences to increase* [workloads] *because you have to mediate this relationship. When the team manages to reach the point of bonding with that population,* [...] *you see a very different relationship, which is really a user embracement, which is longitudinal.* (NMSE1)

> *Loads increase, because when users come here to complain, they don't arrive well. They arrive screaming, wanting to kill one. So, who are they going to kill? Who do they see up front? I! "Hi, how are you?", "All right, nothing", "Oh my God". So, this increases our overload a lot, why? Because it reduces my planning time,* [...] *time to respond to all the planning that we have already developed* [...]. *And this causes me stress, because I'm going to stop* [...] *to solve some demand, you know? And I'll be known as "the manager who didn't meet the demand". This is all overload.* (NMSE5)

DISCUSSION

The research results show a significant relationship between the increase in workloads of BHU managers who work with the FHS/PHC care model and the institutional macro-political scope. FHS is an innovative care model in relation to the biomedicine classic[17-18] and can be understood as a non-material technological innovation in health, of the incremental type. This model proposes a new form of work organization, an expanded work object, broadening the expectation and product vision of health work[18].

It is a complex model that demands conditions for its implementation. However, what is prescribed by the instituted policy, with persistent and frequent demand for results, in conditions that make it difficult or impossible to implement, is close to what is defined as institutional violence[5]. Studies on the importance of an institutional scenario have grown and multilateral agencies such as the UN and WHO recognize the importance of efficient, sustainable institutions that promote safe environments for users and workers[14-15]. This guideline is important for achieving universal access and assumes relevance for health work, which is highly dependent on the workforce[13,19-20].

According to the analysis of the research results, it is observed that loads present in the work of managers have an interface with institutional violence and are related to the management work itself, with other instances of SUS management and with the people who live in each community.

The lack of decent working conditions, without access to technologies that would facilitate and qualify work, such as access to the internet, regulatory center for access to other health services, lack of human resources, lack of materials and supplies characterize an environment in which there is institutional violence structured like that exercised in/by health institutions in the form of action or omission, lack of access or even poor quality of services. It is evident the violence and inflexibility of established rules and bureaucratic and political relations that reproduce social structures and power asymmetry in this unequal relationship, where managers' level of responsibility is not equivalent to their decision-making power, an aspect also identified by other studies[21-22].

Organizational configuration is as important as the physical environment[3]. From this perspective, the limited physical area[22] of most units may be a factor that makes a specific room impossible for managers work. The lack of privacy makes it difficult to approach in conditions that require greater privacy, a fact recognized in another study[23].

It was observed that there is a strong relationship of inadequate personnel sizing with the increase in workloads and institutional violence. The importance of an adequate sizing for universal access and coverage in health was confirmed, considering that human resources in health are the central pillars for the work process organization. It is worth noting that there are many studies on staff sizing for the hospital area[24-25], but few are specific to PHC, especially FHS[26-27].

In some discussions is mentioned that there was progress in the constitution of PHC teams due to improvement in the institutionality of human resources in the sector and by the definition of policies and long-term plans, but "the role of human resources for health as agents of social change is still undervalued and there is a perception that human resources constitute an ever-increasing cost as opposed to an investment to improve health and development"[28]. Inequities remain in health professionals' availability, arrangement and quality of health, both between countries and between levels of care and the public and private sectors, with high rates of migration and mobility, precarious working conditions,

low productivity and quality of performance. Even when human resources are available, where human resources exist, they do not always have the appropriate profile and skills to improve the population's health[28], aspects also identified in our study.

Development of human resources in health is one of the essential public health functions (EPHF-6) and requires policies, regulations and interventions related to training, employment, working conditions and distribution of human resources. These are actions of responsibility of health authorities; however, actions with other sectors other than health are required[29]. From this perspective, they require long-term strategic planning, and this rarely happens in relation to health policies in Brazil. Changes in infra-constitutional legislation often occur, greatly weakening the SUS, given the successive changes that occur in the National Primary Care Policy (PNAB), which have affected the FHS structure.

Moreover, research on violence in PHC shows that the health team workforce profile has significantly influenced the occurrence of violence in these scenarios, and organization aspects influence notification and conduct in coping with violence[30-32]. Conflict mediation, which is intrinsically linked to intrafamily relationships and the fragility of the user embracement between users and FHS teams, it is a form of veiled institutional violence, normalized in the daily routine of health care. The absence of flows to deal with cases of aggression between people denotes the institution's indifference to victims, who face mostly alone the situation of violence[31] and has interfaces in the feeling of recognition at work[33].

One of the aspects mentioned in relation to FHS was the difficulty in implementing this care model, both due to unmet demands, demographic and epidemiological changes in territories, and the social and economic inequalities that are intrinsically linked to access to the health system due to the presence of violence in the territory linked to organized crime. Allied to these aspects is a strong tendency towards the Flexnerian model, to the detriment of the focus on health surveillance in the assigned territory. This fact may be related to undergraduate curricula in the health area, still very focused on the biomedical model, even so long after the implementation of this[34-35] policy.

The relationships of FHS unit managers with municipal management were cited as an aspect that can increase workloads, and these managers feel, many times, violated in their doing. In the reports, fragile intersectoral processes can be identified in the areas of governance, both in training for human resources in health, professionalization, regulation of professional practice and, mainly, in working conditions, which affects the way violence is institutionalized.

Another interesting finding was the quotation of the period for municipal elections and bidding processes for hiring SO to manage PHC. In relation to the municipal election, the issue raised was the fragility of employment relationships, since many are not public employees with stability and protection against discretionary dismissal, and this causes insecurity in workers, which can become a mass of maneuver in electoral periods. It is also highlighted the lack of career plans that define the functions, characteristics, remuneration, workload and career, considering that many are administered by SO.

The SO, according to legislation, are private institutions with a non-profit purpose, with the obligation to invest their financial surpluses in the development of their own activities[36]. However, it is not the reality that is presented in PHC management in Brazil.

By analyzing the ten largest SO in the country, scholars[37] proved that SO are present in several cities and geographical regions, and question their philanthropic purpose, since they can direct funds received for the payment of institution directors.

All this policy of outsourcing the management of public agencies comes in the logic of state reduction, showing to be negative for essential services[36,38]. The construction of effective, responsible and inclusive institutions has been recognized as an important requirement for sustainable economic growth, as recommended in the SDGs, especially in goals eight and 16[14].

Although the aspects related to the development of FHS managers' work depend on the support provided by other management instances, it is also in this space that greater autonomy for decision-making occur. However, given the research data, it is perceived that the lack of autonomy and planning are present, causing stress, frustration, anguish and anxiety, especially due to the lack of control of the labor process and lack of support from the team. Centralization of decisions, vertical management and deficits on the organizational flows are highlights presented as difficulties at work[3,21]. It is observed that occurs "delegation of responsibility to managers without the equivalent delegation of decision-making power, transferring responsibilities for the implementation of centralized decisions, but without the prerogative of being able to modify them according to local need"[21].

FHS professionals are also faced with territorial violence, marked by drug trafficking and armed conflict, generating constant stress due to the risk of death and interference in the work process organization, data that corroborate with other studies[10,31-33,39].

In relation to user embracement, problems arising from their weakening with users were found, especially due to incidence of conflicts and the need to manage them. The effective user embracement also generated an increase in FHS managers' workloads, as this policy proposes that family-centered care be given, from their social context and physical environment, consequently leading health professionals to a more intimate contact with the living conditions of these subjects. Considering the restrictions presented in work organization, lack of infrastructure, personnel deficit and unmet demands, there is a difficulty of managers and other health professionals to assist users respecting PHC attributes with regard to first contact care, longitudinality, comprehensiveness and coordination of care between care levels in a synchronized way. This impossibility of meeting the PHC attributes is yet another demonstration of the institutional violence structured in the context of SUS.

Study limitations

The results concern the work of managers who work in good quality scenarios, chosen intentionally, suggesting that the magnitude of the problem is even greater.

Contributions to nursing and health

The findings indicate that new studies on institutional violence in FHS can contribute to addressing the problem and to

reorient health policies and practices, especially in the sense of improving the quality of services, meeting users', team workers' and local managers' needs.

FINAL CONSIDERATIONS

There is a significant relationship between increased workloads of BHU managers who work with the FHS/PHC care model and the political-institutional scenario in which this work takes place.

FHS materializes the precepts of PHC, being a non-material technological innovation with relevant potential for achieving universal access to health. It is a new complex care model that requires institutional conditions for its effectiveness, which has been hampered by: persistent deficits in physical structure, material, financial and workforce resources; by the excess of demands and climate of insecurity; by the fragmentation in health service supply; for problems in labor relations; the lack of training/training for management; and by the environment of instability in institutional relations and with the community. This daily reality, sometimes normalized and/or veiled, generates an increase in local managers' workloads and approaches institutional violence.

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