Original Article

The micropolitics of the work of health professionals in health centers: regarding the health needs of families

MICROPOLÍTICA DO TRABALHO DOS PROFISSIONAIS DE SAÚDE NA UBS: VISÃO SOBRE NECESSIDADES DE SAÚDE DAS FAMÍLIAS

MICROPOLÍTICA DEL TRABAJO DE PROFESIONALES DE SALUD EN LA UBS: VISIÓN SOBRE NECESIDADES DE SALUD DE LAS FAMILIAS

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ABSTRACT

The objective of this study was to understand the strengths and limitations of the process of nursing work at a health center in terms of recognizing the health needs of the population. The methodological framework used was social research in the qualitative perspective, with discourse analysis based on hermeneutics-dialectics and founded on the Theory of Praxis Interpretation of Community Health Nursing. The data were collected by means of semi-structured interviews, and the working processes of the teams were examined according to the Analyzing Flowchart of the Model of a Health Care Service. In conclusion, there are limitations in the daily working process of the nursing team regarding the recognition of the health needs of the population. Coping with these needs consisted of the identification of complications, relegating the social determinants of the poor life conditions associated with the health-disease process to a secondary concern.

DESCRIPTORS

Health services needs and demand
Family health
Community health nursing
Public health nursing

RESUMO

Este estudo teve como objetivo compreender as potencialidades e limitações do processo de trabalho da enfermagem de uma Unidade Básica de Saúde para o reconhecimento das necessidades de saúde da população. A vertente metodológica utilizada foi a pesquisa social, na perspectiva qualitativa, tendo como base de análise dos discursos a hermêutica-dialética, e como alicerce a Teoria da Interpretação Práxica da Enfermagem em Saúde Coletiva. Os dados foram coletados por meio da entrevista semiestruturada e os processos de trabalho das equipes foram analisados através do Fluxograma Analisador do Modelo de Atenção de um Serviço de Saúde. Concluiu-se que há limitações no cotidiano do processo de trabalho da equipe de enfermagem à medida em que o reconhecimento e enfrentamento das necessidades de saúde perpassavam pela identificação de agravos instalados, deixando em segundo plano os determinantes sociais das más condições de vida associadas ao processo saúde-doença.

DESCRITORES

Necessidades e demandas de serviços de saúde
Saúde da família
Enfermagem em saúde comunitária
Enfermagem em saúde pública

RESUMEN

Estudio que objetivó comprender las potencialidades y limitaciones del proceso de trabajo de una Unidad Básica de Salud, para reconocer las necesidades de salud de la población. La vertiente metodológica utilizada fue la investigación social en perspectiva cualitativa, teniendo como base de análisis de los discursos la hermenéutica-dialéctica, y como fundamento, la Teoría de la Interpretación Práxica de Enfermería en Salud Colectiva. Datos recolectados mediante entrevista semiestructurada, los procesos de trabajo de los equipos fueron analizados por Flujograma Analizador del Modelo de Atención de un Servicio de Salud. Se concluye en que existen limitaciones en el cotidiano del proceso de trabajo del equipo de enfermería, en la medida en que el reconocimiento y enfrentamiento de las necesidades de salud apenas pasaban por la identificación de padecimientos instalados, dejando en segundo plano los determinantes sociales de las malas condiciones de vida asociadas al proceso salud-enfermedad.

DESCRIPTORES

Necesidades y demandas de servicios de salud
Salud de la familia
Enfermería en salud comunitaria
Enfermería en salud pública

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INTRODUCTION

Twenty years ago, the Single Health System (SHS) was founded with the objective of ending unequal access to health care in the country, entering the Constitution of the Federative Republic of Brazil, on October 5, 1988, as the result of an intense social mobilization. Given the importance of health as the right of every citizen and the duty of the State, principles were created in order to make it a reality, namely: Universality, which is the guarantee of health care to all citizens by the system; [1]; Integrality, which is an articulated and continuous set of individual and/or collective services and actions in all care levels; and Equality, understood as the supply of appropriate health actions to meet the needs of every individual, who is considered an indivisible being within society. Moreover, there are the guidelines that rule the SHS organization, namely: Regionalization and Hierarchy, Resolvability, Decentralization and Participation of the Citizens, which reorganize care, allowing for the implementation of doctrinal principles, allowing greater autonomy in the health centers and greater knowledge of the health needs of the population[1].

The health needs are captured (or not) by the health professionals and this capture of needs is associated with their view of the world, built throughout their existence, which allows them to elaborate their way of intervening in reality. Perspectives regarding the disease process may be founded in two frameworks: Public Health and Community Health.

It is necessary to consider the way in which health needs are presented and guide work, since different forms of organizations of life result in different needs, different ways of meeting those needs and, consequently, different delivery methods of the work processes.

The first one, public health, is subordinate to a positivist comprehension, in which society is conceived as a totality of subsystems that search for balance and stability, and the health conception follows the same logic of an organism working in balance, free of disease. Public health is based on the hegemonic chain of multicausality, which determines that the cause of disease is the sum of factors leading to body imbalance and, consequently, to the disease. However, this explanation conflicts with certain factors in providing a rationale to explain the disease process occurring in different social classes[2-3].

On the other hand, community health is based on the dialectical and historical materialism, theory that *recognizes the political role of man as a social agent of transformation of reality, rather than a mere receiver of social influences*, and aims at the interpretation and transformation of reality[3]. This theory supports and interprets the Theory of Social Determination of the Health-Disease Process, which considers both the biological and the social dimensions of health, particularly the latter determinant in this process, contrary to the multicausal theory. Life in society is marked by the way in which each individual is integrated into the production mode, which determines their way of living and relating to the world, and corresponds to different standards of fatigue and strengthening.

Work is understood as the intervention of the human being over nature, ruled by a social need that drives the subject into action and presenting intentionality; in other words, a work project is in mind at the beginning of the process[4].

> The labour process, in its simple and abstract elements, is a purposeful activity aimed at the production of use-values. It is an appropriation of what exists in nature for the requirements of man. It is the universal condition for the metabolic interaction between man and nature, the everlasting nature-imposed condition of human existence, and is therefore independent of every form of that existence, or rather it is common to all forms of society in which human beings live[5].

In analyzing the work process, a study[6] raises the discussion of the micropolitics of work, in which it highlights the importance of the *live work* in action and the *dead work*, consisting of the products or means – tools or raw materials − already produced by human work. In the area of health, the consumption of health actions by the service user happens at the exact moment that the action is produced. This meeting is an intercessory space of relations, in which both the worker and the user and/or population have needs.

Another study[7] reflects on the importance of integrality and equality in the organization of professional practices and uses health needs as the center of interventions in these practices, mainly the potential for improvement in listening when assisting people who are seeking health care. The author highlights the challenge in conceptualizing health needs, associated with the appropriation and implementation by workers in their routine, as something that allows mediation between the complexity of the concept and its comprehension by the workers, aimed at more humanized and qualified care.

The same author[7] considers that when people seek health care, they carry along a *little basket of needs* that must be heard and translated by the team, since it may relate to the search for a solution to adverse life conditions which the person has faced or is currently facing.

It is necessary to consider the way in which health needs are presented and guide work, since different forms of organizations of life result in different needs, different ways of meeting those needs and, consequently, different delivery methods of the work processes[8]. Therefore, it is necessary to consider two different plans: the plan concerning the creation and social satisfaction of human needs and the plan concerning the relationship between the work of health and the system of needs.

In a doctoral thesis, an author[9] studied the health needs of people living in the area surrounding a health center, using as reference the way they are incorporated in the development of the work performed by the health professionals of the health center.

This author studied the health needs recognized as being the objects of the health actions at a health center, and came to the following conclusion: there is a need for the presence of the State, which is responsible for the guarantee of services that promote social well-being and whose absence represents the lack of guarantee of access to universal care; there is a need for social reproduction, related to the state's responsibility for the several services needed to maintain social reproduction, in which the health-disease process is understood as being a discrepancy between the potentials for strengthening and fatigue within the profile of social reproduction; and there is a need for political participation, related to the participation of the population in response to the needs resulting from the absence of the State, as well as its political organization in the exercise of the defense of rights.

Based on these considerations, the objective of this study was to understand the work process of professionals at a health center in acknowledging the population's health needs.

METHOD

The methodological framework used in this study was social research in the qualitative perspective, with data analysis based on hermeneutics-dialectics, with the understanding that it is necessary to consider the historical process of dynamism, temporariness and social transformation in order to comprehend the change in the work process of health services. Therefore, there is agreement with another study [10] that *there is no point of view out of history, nothing is eternal, fixed and absolute; thus, there are neither ideas, not institutions or static categories*.

This study is founded on the Theory of Praxis Interpretation of Community Health Nursing – TPICHN[11], which constitutes a theoretical-methodological milestone regarding the question of nursing intervention in the health-disease process of the community:

> In its methodological framework, it is the dynamic systematization of capturing and interpreting a phenomenon articulated to the processes of social production and reproduction regarding the health and disease status of a certain community, in the mark of its conjuncture and structure, within a historically determined social context; of intervening in this reality and, in this intervention, continually re-interpreting the reality in order to interject instruments of intervention again[11] .

TPICHN presents a systematizing proposal with five stages, namely: a) capture of the objective reality; b) interpretation of the objective reality; c) construction of the intervention project within the objective reality; d) intervention in the objective reality; and e) reinterpretation of the objective reality.

From this point of view, it was considered important to highlight the different segments of the phenomenon, which are the singular, particular and structural dimensions, in order to comprehend the dialectical interrelations between the parts and the whole. Therefore, the structural dimension is constituted by the macro politics of health, considering the health policies developed in the municipality of São Paulo; the particular dimension is associated with the organization of the health services; and the singular dimension refers to the routine of the work process of health professionals at the health center. However, they do not exist independently- there is permeability within these dimensions. The present study focused on the singular dimension of the phenomenon and encompassed two of the five stages proposed by the TPICHN, which are the capture and interpretation of the objective reality.

The secondary source consisted of statistical data from the region, while the primary data was obtained from the discourses of the health professionals who were part of the family health teams at the Jardim Maracá health center, totaling 24 interviewees. The identification of the subjects was designed to maintain their anonymity. Hence, the subjects' names were coded by the letter P and followed by a numerical digit, for instance, P1 (Professional 1), P2 (Professional 2) and so forth. The teams were identified as T1, T2, T3 and T4.

Regarding the research technique, data collection was performed through semi-structure interview, in which the study subjects had the opportunity to reflect about the reality they experience in the care of the population, allowing the authors to capture the points of view and thoughts/feelings of the interviewees. The interviews were recorded, transcribed and their content was used for analysis.

Ethical principles were respected as the project was approved by the Committee of Ethics in Research of the Nursing School of the University of São Paulo, under process no. 783/2008/CEP-EEUSP, complying with the requirements of resolution no. 196/96 of the National Health Council. Interviewees received a *Free and Clarified Consent Form*, which explained the research and requested both the provision of necessary information and their authorization to participate in the study.

The analysis of the data collected in the interviews was based on the tool named *Analyzing Flowchart of the Model of a Health Care Service*[6]. The flowchart is an analyzing tool of the healthcare working process, which questions the *what, why and how* of the working process and, at the same time, reveals the way institutional subjects organize their routine. It is used in different fields of knowledge to visualize the organization of work processes, linked to a chain of production.

This tool may reveal *cracks* and *flaws* that the institutional agents cause or encounter within the routine, which allows interested parties to question the functional meanings of the service, the different modalities of games of interests and the alternative ways to operate more effectively and efficiently.

Therefore, this study aimed at reflecting on the processes used by the teams of the Family Health Program (FHP) of a health center, specifically within the nursing team, with the purpose of verifying the way nurses acknowledge and cope with the health needs of the population, as well as analyzing the difficulties encountered in acknowledging and coping with these needs, in order to contribute to the comprehension of the technological universe of the live work in action.

Initially, the authors performed an analysis of the *input of the development of the productive chain* and, later, the analysis of the *products resulting from the care stemming from the identified needs*, which are presented as follows [12].

RESULTS

Work process of the professionals of the Family Health Strategy (FHS)

The flowcharts evidence the following types of input to the care flow of the health center: home visits, presented in 13 flowcharts; appointments, presented in 3 flowcharts; and users already monitored by the team and/or others seeking out the health center to meet a demand, presented in 4 flowcharts. Similar to the different types of input, there were different products resulting from the care provided to meet identified needs, which are directly related to the operation methods of the teams and the professionals. In order to identify these data, the professionals were asked to answer the question: *After the identification of the needs, what was done?* The answers are transcribed below:

> (...) seeing the needs of this population, besides this man's needs,, a special group was created for them, a group for people with hypertension and diabetes, in order to connect with a greater quantity of the people who cannot see the doctor on a weekly basis because the schedule is too busy (...) (P2, T3).

> (...) work with these people so that they will come in to be tested, because only after the tests is it possible to detect the disease and to start treating it (P2, T4).

> Besides providing the device, (...) we provide her with a medication at home, (...) so that she receives her medications (P2, T1).

> (...) we have to care, to watch her medications, to pay attention to the expiry date, because she has taken expired medication, and the treatment is our concern (P4, T3).

> (...) The family doctor referred him to a neurologist and thought the medication he was taking was not enough, so he was sent to a specialist in order to see whether the specialist could start any new medications, and that was done (P6, T2).

Based on these and other answers, it is possible to infer the following possibilities regardingdirection of the work processes: a) meeting the demand for care through group work (i.e. hypertension/diabetes groups); b) diagnosis and treatment of disease; c) follow-up through home visits (orientations, sample collection); d) follow-up through medical or nursing appointments; e) referral to secondary care, according to need; f) referral to other professionals at the health center; g) provision of materials for patients in home care; and h) registration in programs (home medications, ambulance program, distribution of strategic materials).

Work process of the nursing team of the Family Health Strategy

In the analysis of the nursing team, the singular dimension (work process routine) was in agreement with the teams' view of the health-disease process. The flowcharts evidenced a practiced focus on the individual and on the individuals' condition. Therefore, the work process offers care that is congruent with a biological focus, one that is health-centered, individual and curative, taking into consideration and alternating between hypertension, tuberculosis, and pregnant women with Rh-negative blood or a history of pre-eclampsia.

Although the focus is still on the disease, the flowcharts showed that the view of the professionals takes into account the determinants of the disease process. Some examples of the speeches complete the analysis and help us understand this process:

> I have an old case of a patient who was undergoing hemodialysis there in Itaquera (...) we were trying to transfer her (...) to stop this hemodialysis in Itaquera and to get her transferred here. Since the person responsible for her, her husband, said he was very interested, possibly due to financial questions (...). Her husband could not afford to take her to Itaquera, to perform hemodialysis, and when he could, he spent too much on travel (P2, T1).

> One day a young woman came to take a urine test to see whether she was pregnant, and we verified that she was; you could tell by her clothes that she did live under the best conditions (...) she had gone through pre-eclampsia in both her pregnancies, and she cried desperately because her husband used to hit her and he did not want the baby at all (P6, T3).

DISCUSSION

It is possible to perceive that there was a prevalence in the use of technologies guided by biomedical knowledge,

which prioritizes the biological signs and symptoms of the subjects, to the detriment of the creation of a bond and the intercessory processes of interpersonal relationships. A study[6] brought forth this discussion regarding hard, soft-hard and soft technologies, which correspond, respectively, to materials and equipment, technical knowledge, and intercessory processes of relationships. These concepts contribute to the understanding that there is a prevalence of the use of equipment (materials, rules and organizational structure) and technical knowledge, corresponding to hard and soft-hard technologies.

There are two centers of thought that guide the identification of health needs by the FHS professionals, which are the *health needs related to present health conditions* and the *health needs related to poor living conditions*[12]. The first category indicates that the daily practices of the professionals are impregnated with the concept of health in an idealist view of the world, based on the idea that the disease results from the unbalance of subsystems and is linked to a pathologic order. The second category, however, indicates the comprehension of health needs beyond the biomedical perspective, which considers the different factors (ability/access to work, access to clean water, housing conditions) affecting the users and families in the productive process of capitalist societies as determinants in the process of becoming ill.

By exploring the speeches and flowcharts, it was observed that the products resulting from the work routine at the health center reveal health practices that consider the disease process as the main axis, in congruence with the hegemonic model of health care based on the medical, individual and curative model[13]. Hence, the manifestations of points of regularities or irregularities of man's corporality, historically determined by the form of social insertion of the individuals into society, are considered to be external to the subjects, who are seen as ahistorical beings.

Considering that the TPICHN conforms to the historical and dialectical view of the world, the understanding of the health-disease process takes place through social determination. Therefore, health and disease are not seen as static points, but as a constant process in flux, determined by the way human beings are integrated into a certain society, based on work, to produce their existence[14].

Based on these considerations, it was inferred that, as the identification of the health needs related to poor living conditions allows a broader reflection of the health-disease process, the prevalent use of hard and soft-hard technologies may be considered a limitation in the work process of the teams, since it is the result of a biological view of the health needs, related to diseases already present.

There was an expression of soft technology in the form of home visits, creating a bond which was fundamental for the continuation of the work process, even in the background. Authors[13] state that home visits allow them to operationalize the conception of social determination of the health-disease process, comprehending the relationships between the individuals that constitute a family and the way these relationships contribute to the existence of protective or vulnerability processes in health and disease. These authors provide a foundation to identify a potential that may be explored in these teams: home visits associated with soft technology.

The nursing team evidenced a consonant view with the theory of multicausality, which considers the possibility of division of the man into individual parts to be treated. The theory of multicausality

> relates the cause of the disease to causal factors of health and illness, whose control favors the non propagation of the disease. These factors act as a sum of the causes, without attributing weight to each one of them and, thus, society and social organization also constitute causal factors, as well as the biological constitution of man. The abnormal behavior of one of these sets of factors may cause an imbalance within the system and, consequently, the emergence of disease[3].

It was observed that the intervention of the nursing team affects the profiles of vulnerability of the social groups (tuberculosis, high-risk pregnancy, hypertension, diabetes), mediated by means/instruments such as nursing appointments, group meetings and knowledge regarding epidemiological surveillance. It is possible to state that the results of the present study agree with those of other studies [15-16], which indicate a prevalence of curative activities centered on the disease process, where intervention by the nursing work process includes traditional instruments of public health.

Regarding the profiles of vulnerability, a study [17] defends the idea that *the measure of any of these profiles [of vulnerability] alone cannot express the hierarchized network that explains the health-disease process*. The authors add that social classes or groups are different, involved in work and life in unequal ways and, similarly, they become ill and die in different ways. However, they raise the question that there are few indicators to assess the potentials of strengthening that contribute to determine more accurately the reality of life and health.

It is necessary to highlight that the profiles of morbidity and mortality are important to describe the results of the health-disease process, but cannot be separated from the idea that they result from the vulnerability or the strengthening that stem from work and the way of living.

Therefore, understanding the organization of the population in *blocks*, which are constantly intermingled, helps in understanding the profiles of strengthening or vulnerability of the population. These *blocks* are individual, family and structural plans[17]. The individual plan is associated with the singular dimension of the individuals' lives; the family plan involves the particular dimension of the lives

of the families and their integration into a social class; and the structural plan is related to the structure of the society. In a dialectical relationship, all of these plans are dynamic and coexist independently as centers or *blocks*, denying and proving themselves at the same time.

In this context,

> the health-disease process is manifested through different phenomena (...) and may be expressed in individual or on a singular level; as part of the social group whose element of association is work, which is part of the social structure[3].

CONCLUSION

Although the Analyzing Flowchart has contributed to the comprehension of how social agents organize their work routine, this study shows the difficulty of the professionals in verbalizing the presence of *cracks* involving the micropolitics of their work.

Nevertheless, the analysis of the work process of the teams demonstrated that there was acknowledgement of the health needs of the population, considering disease as the main axis, and the products resulting from the micropolitics of the work of the health center professionals are marked by the use of technologies guided by biomedical knowledge.

The present study showed that, in the routine of the work process, the nursing team follows the functionalist view of the health-disease process of the teams, offering care characterized by biological needs, health-centered, individual and curative, consonant to the theory of multicausality, which attributes similar weights to the causes of disease. Regarding the interventions targeting the profiles of vulnerability of the assisted population, it was verified that they must be reviewed, as they encourage punctual activities regarding the health-disease process of individuals, families and society as a whole, detrimental to actions of prevention and health promotion in the community.

To some extent, there was an expression of the understanding of the health needs beyond the biomedical perspective, which was understood as a potential of the nursing team. Although the focus is still on the disease, there was an understanding of health needs resulting from poor living conditions, which are determinants in the disease process.

In face of a work project limited to the treatment of illness, it is understood that the shape of the work process is limited to the set of signs and symptoms evidenced by the individuals. This is a characteristic of the technical health care model marked by individualist and curative care, which encourages the users to search for a health service in order to reestablish their health, creating a cycle of supply and demand for this type of care. Therefore, these practices do not offer ideal conditions in which to identify and/or capture any other health need.

Understanding the health-disease process in its social dimension, relating the way in which society is organized to prevent the emergence of risks or potentials that determine the processes of illness and dying, leads to the triumph of the functionalist paradigm with a broader view of the work of healthcare as a social practice, part of society and having a macrostructural articulation with the political processes that influence the public social and health policies.

It is fundamentally important for professionals to visualize themselves as the main agents within the work process, considering that the territory is heterogeneous and the life possibilities of the individuals are also heterogeneous, allowing different forms of social reproduction. Hence, it is necessary to perform a critical and conscious social practice examination of the historicity of the procedural reality and the health-disease process of the society, whose result derives from social contradictions and is in constant transformation.

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