Characterization of Family Health Teams and their work process

CARACTERIZAÇÃO DAS EQUIPES DA SAÚDE DA FAMÍLIA E DE SEU PROCESSO DE TRABALHO

CARACTERIZACIÓN DE LOS EQUIPOS DE SALUD DE LA FAMILIA Y SU PROCESO DE TRABAJO

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ABSTRACT

This study aims to learn the characteristics of Family Health Strategy (FHS) teams from a Regional Health Coordination of RS, identifying its difficulties in the work process. It is a qualitative exploratory-descriptive study, with a questionnaire application. Results revealed a group of young females with recent professional education. Regarding the work process, some difficulties observed were: the hiring model, the lack of infrastructure of the health units, the difficulty to work in teams, the lack of specialization of the employees, the non-comprehension of the population about the FHS proposal and even the reporting of the lack of difficulties. Some of the results corroborate the data reported by the literature, but the last two items were poorly explored in other studies, constituting relevant aspects to be considered in the work process and in the implementation of the FHS.

KEY WORDS

Family Health Program.
Patient care team.
Working conditions.
Primary Health Care.

RESUMO

Este estudo tem por objetivo conhecer as características das equipes da Estratégia de Saúde da Família (ESF) de uma Coordenadoria Regional de Saúde do RS, identificando suas dificuldades no processo de trabalho. Trata-se de uma pesquisa qualitativa do tipo exploratório-descritiva, com aplicação de questionário. Os resultados revelaram uma faixa etária jovem, feminina e com formação profissional recente. Quanto ao processo de trabalho, foram observadas algumas dificuldades, dentre elas: a forma de contratação, a falta de infra-estrutura das unidades de saúde, a dificuldade de trabalhar em equipe, a falta de especialização dos trabalhadores, a não compreensão da população sobre a proposta da ESF e até mesmo o relato da ausência de dificuldades. Alguns dos resultados corroboram dados relatados pela literatura, no entanto os dois últimos ítens foram pouco explorados em outros estudos, constituindo aspectos relevantes a serem considerados no processo de trabalho e na implementação da ESF.

DESCRITORES

Programa Saúde da Família.
Equipe de assistência ao paciente.
Condições de trabalho.
Atenção Primária à Saúde.

RESUMEN

Este estudio tuvo como objetivo conocer las características de los equipos de la Estrategia de Salud de la Familia (ESF) de una Coordinadora Regional de Salud del RS, identificando las dificultades en el proceso de trabajo. Se trata de una investigación cualitativa del tipo exploratorio-descriptiva, con aplicación de cuestionario. Los resultados revelan una faja etaria joven, femenina y con graduación profesional reciente. Respecto del proceso de trabajo, se observó la presencia de algunas dificultades, entre ellas: el modo de contratación, la falta de infraestructura de las unidades de salud, la dificultad para trabajar en equipo, la falta de especialización de los trabajadores, la incomprensión de la población sobre la propuesta de la ESF y hasta incluso el relato de ausencia de dificultades. Algunos de los resultados corroboran datos reseñados en la literatura, mientras que los últimos dos han sido poco explorados por otros estudios, constituyendo aspectos relevantes a ser considerados en el proceso de trabajo e implementación de la ESF.

DESCRIPTORES

Programa de Salud Familiar.
Grupo de atención al paciente.
Condiciones de trabajo.
Atención Primaria de Salud.

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INTRODUCTION

The United Nations (UN) designated 1994 as the International Year of the Family, thus, the Ministry of Health in Brazil created the Family Health Strategy (FHS), trying to follow the guidelines foreseen in the Brazilian Unified Health System (SUS), especially, having the family as the structural axis of the determinant and conditioning factors of the health-disease continuum of the population, the recipient of care[1].

The FHS aims to reorient the Brazilian care model and the reorientation project is a driving force in the SUS. Besides a new structure, it is a reform in the forms of work and in the relationships between professionals and users. The FHS proposes to work with an enrolled clientele, focused on the family, establishing bonds through a multi-professional team. These professionals should plan their actions based on the realities of the lives of the families who receive care. Thus, the action of the team requires the implementation of new theoretical references and the (re)organization of the work process[2].

The basic or nuclear team recommended by the FHS consists of a generalist physician, one nurse, two nursing auxiliaries and five to six community health agents and, depending on the city, it also has the support of professionals from the oral health, mental and rehabilitation teams[2].

...the FHS incorporates and reaffirms the basic principles of the SUS [...] and is established on three major pillars: the family, the territory and the responsibility, in addition to the support of team work.

In this way, the FHS incorporates and reaffirms the basic principles of the SUS – universal access, decentralization, integrality and community participation – and is established on three major pillars: the family, the territory and the responsibility, in addition to the support of team work. The present study considers workers and managers as members of the health team. The theoretical framework used was that of the health work process.

In the new care model, the work process should have specific characteristics. Professionals should have particular qualities and profiles, once the emphasis of care is not on the technical procedures, but on the interrelation among the team/community/family and on team/team interrelations[3].

The interest in developing this study emerged from the report of the difficulties experienced by one Regional Health Coordination office (RHC) in the interior of the state of Rio Grande do Sul (RS) of working with the health teams. Among these difficulties there are: physician-centered care; difficulties in working with the enrolled population; greater focus on healing than on preventing; difficulty in planning, assessing and on teamwork, among others.

OBJECTIVE

This study sought to know the characteristics of the family health teams and to identify the difficulties faced in their work process.

METHOD

Type of Study

This is field study is exploratory, descriptive and qualitative.

Characterization of the study's participants

The study's participants were 126 workers from the FHS teams and municipal managers from a Regional Health Coordination office in the interior of the state of RS, consisting of 26 cities and 39 family health teams.

The inclusion criteria were: being professionals acting in cities which were part of the RHC linked to the FHS who agreed voluntarily to participate in the research by signing a free and informed consent form and filling out the data collection instrument.

Ethical aspects

The present research followed the ethical guidelines established in Resolution 196/96 from the Brazilian National Health Council, thus respecting the regulating standards of research with human beings. Data were collected after approval of the Research Ethics Committee of the Federal University of Santa Maria (UFSM), report n. 23081.016231/2007-62.

Data collection methods

A semi-structured questionnaire with both open and closed questions was used for data collection. The instrument consisted of two sections: the first regarded participant's personal data, aiming to outline the profile of the workers and managers of the FHS. The second section consisted only of open questions related to aspects of the work process. Data collection was carried out in July and August 2007.

Questionnaires were sent to the cities of the RHC by courier, along with an explanatory note and two copies of the free and informed consent form. It is highlighted that prior telephone contact was established with the coordinators of the FHS teams to communicate the sending of the data collection instrument. In total, 479 questionnaires were sent out, of which 126 were answered and sent back.

Data analysis

Data were analyzed based on thematic analysis[4]. This analysis occurs through the organization, reading and discussion of the collected data, consisting of three stages: pre-analysis, careful examination of the material, treatment of the obtained results and interpretation. No statistical test was used for data analysis, only comparison between relative frequencies.

RESULTS AND DISCUSSION

This section presents the data related to the characterization of the participants and their perception concerning the work process in the family health teams.

Characterization of the research participants

The analysis of the questionnaires enabled the identification of the characteristics of the FHS teams, as analysis of data from the first section of the questionnaire is presented in Table 1.

Table 1 - Characterization of the workers who compose the FHS teams and managers, 15th Regional Health Coordination unit - Palmeira das Missões, RS - 2007-2008

Variable	Number (n = 126)	%
Age (years)		
19 – 30	48	38.1
31 – 40	38	30.1
41 – 50	34	27.0
> 51	06	4.8
Gender		
Male	27	21.4
Female	99	78.6
Profession		
Physician	11	8.7
Nursing Technician	09	7.1
Nursing Auxiliary	07	5.6
Nurse	26	20.6
Dentist	11	8.7
Nutritionist	01	0.8
Custodian	01	0.8
Health Secretary	01	0.8
Health agent	50	39.7
Agriculturist (manager)	01	0.8
Agriculture technician (manager)	01	0.8
Public worker (manager)	01	0.8
Did not specify	04	3.2
Dentistry auxiliary	02	1.6
Time of graduation (in years)		
< 1	3	2.44
1 – 5	25	19.8
6 – 10	16	12.7
11 – 20	13	10.3
21 – 30	7	5.6
Did not answer or does not have	62	49.2

As to the characterization of the FHS teams, the predominant age group of the professionals was from 19 to 30 years (38.1%), which shows a young representation of the professionals acting in the FHS. Recent professional training, varying from 1 to 5 years, was also observed. These characteristics can contribute to the accomplishment of the Strategy, considering the possibilities of change shown in the new Curricular Guidelines of the undergraduate Health Programs.

Health teaching is adapting its training structure as it approaches students early to pre-professional activities, through extra-classroom activities. With this opportunity, professionals under training can understand and discuss the current structure of public health policies, among them the Primary Health Care National Policy, focused on Family Health. Most undergraduate programs have a generalist training that enables students to develop their competencies and abilities to intervene in several situations in the health-disease process of individuals, families and communities[5].

Knowing that the participants in the study have recent training puts at issue the characteristics of teaching, the expectations concerning graduates' professional behavior and the policies of health work, once these are the main sources that base the actions of the health workers.

Addressing professional training is important to understanding the context of health practices, considering the historical mark left by the biomedical-centered teaching and the current trial by training institutions to put into action the indications of the new Curricular Guidelines[6].

As to specialization, regarding higher education professionals (nurses, physicians, dentists and nutritionists), the main reported areas of activity were Collective Health (16.7%), Public Health (12.5%) and Hospital Management (8.3%). Data demonstrated the workers' desire to improve their professional practice in important areas of knowledge for implementation and consolidation of the FHS proposal. On the other hand, a study carried out with nurses working in the FHS in the city of Marilia, in the state of Sao Paulo, showed that none of them had specialization in the area of Collective or Public Health[7].

Considering gender distribution, the professionals on the teams were predominantly female (78.6%). Most research subjects were health agents, nurses, physicians, nursing technicians and auxiliaries, corresponding to the composition of the minimum team recommended by the Ministry of Health for FHS work[2].

As to the type of work contract, most were employees hired according to the Labor Law Consolidation (38.1%) and on temporary contracts (32.5%). These types of contract can make the establishment of a professional bond with the service and the population who receive care difficult. Studies by the Pan-American Health Organization[8] demonstrated that most health workers in the SUS were hired under the above-mentioned contracts, causing instability in their professional careers. The instability of professional bonding is pointed out as one of the main factors responsible for the high turnover of professionals working on the FHS teams[9]. Research developed with physicians from the FHS showed the uncertainty of the contracts and the lack of guaranteed labor rights as the most frequent complaints among partici-

pants[10] . Another form of contract for FHS professionals is by political-partisan appointment, which is common and evident in small cities, and can contribute to the insertion of professionals with nonspecific knowledge in the family health area. This form of labor contract interferes directly in the services delivered. It should guarantee stability and strengthen labor bonding, in addition to enabling professional/user bonding and social responsibility[11].

Perceptions of workers of the FHS teams concerning their work process

The study's participants were asked about the existence or non-existence of difficulties in the work process of the FHS teams. The results were categorized and are presented in Table 2.

Table 2 - Main difficulties faced by professionals and managers in the process of work in the FHS* teams, 15th Regional Health Coordination - Palmeira das Missões, RS - 2007-2008

Difficulties	Number*	%
Lack of infrastructure	42	26.1
Difficulty of team work	27	16.8
Answered having no difficulty	17	10.6
Difficulty of the population understanding the proposal of the FHS	15	9.3
Lack of specialization	14	8.7
Mistaken understanding of managers	13	8.1
Professionals without appropriate profile	10	6.2
High number of families per team	07	4.3
Lack of integration by managers, teams and community	05	3.1
Professional valorization	04	2.5
Form of contract	03	1.9
System bureaucracy	02	1.2
Answered having difficulty, but did not specify	01	0.6
Did not answer	01	0.6
TOTAL	**161**	**100**

* some individuals reported more than one difficulty

Concerning the difficulties reported by participants, lack of infrastructure in the basic health units was the most frequent one. The lack of transportation for home visits was highlighted, as it renders the appropriate accomplishment of the daily tasks unviable, especially in rural areas. There is also lack of materials and equipment to carry out the work, mainly medication, material for wounds and cleaning. Data from the literature confirm that the lack of or deficiency in infrastructure compromise the planning and execution of the FHS proposals, interfering directly in the work of the team and in the care delivered to users, causing a lack of motivation and responsibility in the execution of the activities[12-14]. Thus, the research carried out in the state of Minas Gerais found in the work of the FHS the lack of transportation, infrastructure, equipment, medication, support from the institutions responsible for the FHS, human resources, political desire, passing on of budgets from the municipal government and the improper use of budgets to be main difficulties[11]. These problems were also faced by graduates from the State University of Campinas/ UNICAMP when they joined the public health system as professionals[15]. This shows that these problems are not exclusively present in the FHS, but are part of the context of Brazilian public health, demanding the construction of broader governmental projects[11]. However, community participation, social control and commitment by the agents involved, either users, managers or professionals, is essential for the consolidation of the system.

Regarding teamwork, approximately 17% of the participants reported difficulties, among them the lack of planning by members for collective work, lack of sensitivity and interaction of people for teamwork, individualization of work characterizing a division of activities, and difficulty in the flow of information, among others. The concept of teamwork can be understood as a kind of collective work, with a reciprocal relationship between the technical interventions and agents' interaction. Interaction is a communicative practice characterized by the search for consensus and aiming to build a common work project[16]. These difficulties pointed out by the participants concerning teamwork are opposed to the understanding of health work as something collective. The absence of a collective planning of action cause the care provided by professionals to be parceled out, not considering the many facets of users' health needs, depriving care of the characteristics of the proposal recommended by the FHS.

A study carried out with nurses working in the FHS in Marilia, state of São Paulo, showed that, concerning teamwork, 62.5% of the interviewed nurses reported interaction difficulties with the team and considered these difficulties to be both personal and professional. They also reported that teamwork promotes the superposition of functioning with other health professionals. Another interesting aspect revealed by this study was the suggestion about work given by the nurses themselves, including knowing how to work in groups and being prepared, while still in undergraduate training, to work on teams[7], thus agreeing with the findings in the present study.

The participants' answers that they did not have difficulties in their work process were a result that captured the researcher's attention. However, data from the literature show that the difficulties are present in most studies carried out with FHS teams in their work process[10,14,17]. One possible explanation of the current data is that professionals may be having difficulty to analyzing and expressing the daily problems in their work micro-spaces. Other possibilities for this result include adopting a passive posture concerning their work process, a practice of non-criticism by professionals and a distancing from the framework that supports the FHS actions.

Another difficulty pointed out by participants regards the lack of understanding by the population of the FHS proposal. This data was also reported in a study carried out in the FHS in two cities in the state of Minas Gerais[14]. One possible explanation for this finding could be the lack of political concern of the population, their lack of knowledge of their rights as citizens, the lack of participation of users in the process of making health decisions, the shortage or absence of activities for health sensitization and education regarding the proposal of the strategy, professionals' anxiety over user complaints in biomedical procedures and also the lack of flexibility on the part of management.

One difficulty reported by the workers was the lack of professional qualification. Professional qualification is essential for worker education and the improvement of the health services, besides the social relationships established inter- and intra-teams and with users, which would permit an improvement in the quality of the care provided[15]. The implementation of a strategy for promoting the value of qualified professionals on the FHS teams should promote workers' intellectual autonomy, the domain of technical-scientific knowledge and a capacity for planning, managing their action time and space, the exercise of their creativity, team work, interaction with services' users, consciousness of the quality and of the ethical implications and greater humanization of the primary health care activities[2].

Managers' mistaken understanding of the FHS, itself, was another difficulty reported by the participants. It is possible, in certain situations, to perceive a divergence regarding the work process of the family health team and the management model. A study has demonstrated the presence of centralized and authoritarian managerial practices, based on management theories with excessive standardization and bureaucratic control of the health practices, depriving workers' of autonomy[17]. A study carried out with FHS teams in Juiz de Fora, the state of Minas Gerais, found similar characteristics in the management model, such as vertical power relations among managers and secondary and higher level professionals[18].

The presence of professionals without the appropriate profile to work in the FHS was also reported as a difficulty, expressed under the description of a lack of commitment by them and, consequently, a lack of resolution of the health actions. The work of these professionals in the FHS requires them to be able to plan, organize, develop and evaluate actions that meet a community's needs[15]. The lack of the appropriate profile negatively influences the change of the health care model proposed by the FHS.

The elements that constitute the work process include objects, instruments and aims. The practice and the instruments to be used to achieve the work aim are defined by knowledge of the objects in the work process[17]. When the work object is the family in its life context, professionals from the FHS teams should be able to respect the cultural, social and economic differences therein, using listening, welcoming, bonding and the setting of responsibilities as a means to meet individual and collective health needs. The work process in the FHS demands these abilities and their absence can be a factor that contributes to the presence of professionals who have difficulty in using this framework in their professional activity.

As to the high number of families per team, a study carried out in the interior of the state of São Paulo reported an attempt to restructure the excessive number of families receiving care[17]. However, there was no support by the managers to solve this problem, showing the tendency of a centralized and non-democratic practice. According to the Ministry of Health[2], one family health team should be responsible for delivering care to around 1,000 families in order to be possible to accomplish the activities proposed by the strategy and establish bonding with the community.

The form of contract was also pointed out as one of the difficulties due to instability at work and was previously discussed.

One study performed with five physicians of the FHS from a city in the Northeast region of Brazil showed that the difficulties faced by them regarding working conditions are similar to the ones reported in this study. Besides work instability, the inadequate work facilities (there were frequent complaints concerning the lack of appropriate physical space, human and material resources and medication), the excessive work generated by the high number of families per team, the distances crossed to go to rural areas, the bad condition or lack of vehicles for transporting the professionals, the maintenance of the same level of income and payments in arrears were considered tiring. The situation is worse in rural areas, where the conditions of the Family Heath Units are more precarious and combined with communication difficulties with the headquarters of the city, as well[10].

This study demonstrates that difficulties identified by the health workers and managers are related to several factors such as work instability, precarious working places, and an excess of work due to the high number of families receiving care by the teams, among others.

CONCLUSION

The results presented and discussed in this study corroborate previous research and show that the practical experience of the FHS strategy reveals different weak points – related to infrastructure, working conditions, team work, among others – that clearly influence the professionals' motivation and certainly limit the accomplishment of the objectives of the FHS.

Among these weaknesses, the present study highlights the lack of perception of difficulties by the workers concerning their work and the lack of understanding by the population regarding the FHS proposal. These findings re-

ceive little attention in other studies, but are relevant aspects to be considered in the work of health teams and in the implementation of the FHS, which aims to change the care model through the exercise of citizenship.

It is believed that the improvement of working conditions supports the motivation for health work, as the valuing of workers can enable the development of a qualified and effective health care. The importance of knowing the work process of the FHS teams to (re)think and reflect on the organization and production of health care is highlighted. Thus, the findings of this study enable the improvement of more effective actions by workers, managers and social control in the work process of the primary health care.

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