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JOB DISSATISFACTION AMONG HEALTH PROFESSIONALS WORKING IN THE FAMILY HEALTH STRATEGY¹

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ABSTRACT

Objective: to analyze the aspects of the job process that generate dissatisfaction among professionals working in the Family Health Strategy.

Method: this was a qualitative study, conducted with 76 participants from five geographic regions of Brazil, and 27 Family Health Teams from 11 Basic Health Units. Data were collected using semi-structured interviews, observation and documentary analysis. The treatment and interpretation of the data were performed by means of thematic content analysis using the software resource, Atlas.ti 7.0, for analysis of qualitative data, supported by the Marxist theories of work process and job satisfaction, by Christophe Dejours.

Results: the aspects that generate job dissatisfaction are related to the categories: health work management, team and patient relationships, and overwork. Health work management gathered the following factors: inadequate physical structure, lack of material resources, salary deficits, work disorganization, management problems, and excessive work hours. In the relationships with staff and patients, the factors were: violence, lack of knowledge of the Family Health Strategy, patient attitude, lack of qualification of team members, and deficit in work organization. Finally, in the overwork category, the factors were: work overload, excess demand, and bureaucracy.

Conclusion: the manifestations of dissatisfaction among professionals working in the Family Health Strategy were significantly influenced by working conditions, management weaknesses, and problems in the scope of work relations.

DESCRIPTORS: Primary health care. Unified health system. Family health strategy. Job satisfaction. Qualitative research.

INSATISFAÇÃO NO TRABALHO DE PROFISSIONAIS DA SAÚDE NA ESTRATÉGIA SAÚDE DA FAMÍLIA

RESUMO

Objetivo: analisar aspectos do processo de trabalho geradores de insatisfação nos profissionais que atuam na Estratégia Saúde da Família.

Método: estudo com abordagem qualitativa, realizado nas cinco regiões geográficas do Brasil, com 27 Equipes de Saúde da Família, lotadas em 11 Unidades Básicas de Saúde, totalizando 76 participantes. Os dados foram coletados por meio de entrevistas semiestruturadas, observação e estudo documental. O tratamento e interpretação dos dados foi realizado articulando Análise Temática de Conteúdo e recursos do *software* para análise de dados qualitativos Atlas.ti 7.0 com suporte das teorias marxista de processo de trabalho e de satisfação no trabalho, de Christophe Dejours.

Resultado: aspectos geradores de insatisfação no trabalho estão relacionados às categoriais: gestão do trabalho em saúde, relações com a equipe e usuários e excesso de trabalho. A gestão do trabalho em saúde agregou os seguintes fatores: estrutura física inadequada, falta de recursos materiais, déficit salarial, falta de valorização do trabalho, problemas na gestão e jornada de trabalho excessiva. Na categoria relações com a equipe e usuários: violência, falta de conhecimento da Estratégia Saúde da Família, postura do usuário, falta de qualificação da equipe e deficiência na organização do trabalho. Por fim, na categoria excesso de trabalho consta: sobrecarga de trabalho, excesso de demanda e burocracia.

Conclusão: as manifestações de insatisfação dos profissionais que atuam na Estratégia da Saúde da Família são influenciadas significativamente pelas condições de trabalho, por fragilidades na gestão e por problemas no âmbito das relações de trabalho.

DESCRIPTORIOS: Atenção primária à saúde. Sistema Único de Saúde. Estratégia saúde da família. Satisfação no emprego. Pesquisa qualitativa.

INSATISFACCIÓN EN EL TRABAJO DE PROFESIONALES DE LA SALUD EN LA ESTRATEGIA SALUD DE LA FAMILIA

RESUMEN

Objetivo: analizar aspectos del proceso de trabajo que generan insatisfacción entre los profesionales que actúan en la Estrategia Salud de la Familia.

Método: estudio con abordaje cualitativo, realizado en las cinco regiones geográficas de Brasil, con 27 Equipos de Salud de la Familia, abarrotados en 11 Unidades Básicas de Salud, totalizando 76 participantes. Los datos fueron recolectados mediante entrevistas semiestructuradas, observación y análisis documental. El tratamiento e interpretación de los datos se realizó mediante análisis de contenido temático utilizando el recurso de software Atlas.ti 7.0 para el análisis de datos cualitativos, apoyado por las teorías marxistas del proceso de trabajo y la satisfacción en el trabajo, por Christophe Dejours.

Resultado: los aspectos generadores de insatisfacción en el trabajo están relacionados con las categorías: gestión del trabajo en salud, relaciones de equipo y usuarios y exceso de trabajo. La gestión del trabajo en salud agregó los siguientes factores: estructura física inadecuada, falta de recursos materiales, déficit salarial, falta de valorización del trabajo, problemas en la gestión y jornada de trabajo excesiva. En la categoría relaciones con el equipo y usuarios: violencia, falta de conocimiento de la Estrategia Salud de la Familia, postura del usuario, falta de calificación del equipo y discapacidad en la organización del trabajo. Por último, en la categoría exceso de trabajo consta: sobrecarga de trabajo, exceso de demanda y burocracia.

Conclusión: las manifestaciones de insatisfacción de los profesionales que actúan en la Estrategia Salud de la Familia son influenciadas significativamente por las condiciones de trabajo, por fragilidades en la gestión y por problemas en el ámbito de las relaciones de trabajo.

DESCRIPTORES: Atención primaria de salud. Sistema Único de Salud. Estrategia salud de la familia. Satisfacción laboral. Investigación cualitativa.

INTRODUCTION

Health work can be a source of satisfaction, but also dissatisfaction, with direct repercussions on health care and one's professional life. Currently, in addition to the increase in unemployment and underemployment, dissatisfaction is identified among those who continue to work.¹⁻⁴

Studies demonstrate factors that cause dissatisfaction in health work, as well as within Primary Health Care (PHC). Among these are: working in a place that was not their choice, work overload, violence,⁵ conflicts in work relations, problems in the organizational structure;⁶ insufficient salaries, excessive workload, lack of a career plan;⁷ situations that limit professional autonomy; and, problems in co-operation with co-workers.⁸⁻⁹ This latter study concluded that physicians working in PHC were more satisfied than those working in the hospital.

The Family Health Strategy (FHS) is based on the PHC principles and those of the Brazilian Unified Health System (UHS), and is currently part of the National Primary Health Care Policy (PNAB).¹⁰⁻¹¹ Almost 41 thousand Family Health Teams (FHTs), are distributed in most Brazilian cities, representing more than 15% of all Brazilian health care facilities, which are among the main services of the health area, and one of the main places of employment for health professionals,¹²⁻¹³ showing relevance for studies focused on those who work in these facilities.

Among Brazilian studies addressing health professional dissatisfaction, few include dissatisfaction in the PHC, and even less in the FHS. Studies

consider the dissatisfaction with workload, job instability, low wages, and the lack of defined job responsibilities.¹⁴⁻¹⁶ Other studies indicate increase in the workload of health professionals working in the FHS, which can result in physical exhaustion and illness, and contribute to professional dissatisfaction.¹⁷⁻¹⁹

Despite a significant number of studies on the subject, this study has a different approach by centralizing the research object exclusively in the FHS, addressing multiprofessional teams from the five regions of the country.

Thus, the objective of this study was to analyze the job aspects that generate dissatisfaction in the professionals who work in the FHS.

METHOD

This was a qualitative study,²⁰⁻²² based on the theoretical precepts of Marx and Dejours.^{1-4,23} Participants and the place of study were selected according to one of the criteria used in qualitative research, namely, intentionality, which consists of the researcher's decision to choose "cases or types of cases that can better contribute to the information needs of the study".^{21:354}

The inclusion and exclusion criteria incorporated aspects related to the place and participants. The study included the BHUs with Family Health teams in the five geographic regions of Brazil: South (S), Midwest (MW), North (N), Southeast (SE) and Northeast (NE) including at least one municipality and state in each region; FHTs of good quality, ac-

cording to management information, professionals or leaders from different regions; professionals from different categories that constitute the FHTs; and FHTs that presented all the components of the minimum team, as recommended by the PNAB.¹⁰ The exclusion criteria were: BHUs in which the two care models coexist, that is, the traditional care model and the FHS; workers who were not health professionals, excluding community health agents (CHAs); and administrative, cleaning and support staff.

The sample was considered sufficient by the data saturation criterion,²⁴ and was composed of 76 participants from 27 FHTs and 11 BHUs from six municipalities, distributed in the five geographic regions of the country. Data collection occurred between November of 2010 and April of 2014, by means of instrument triangulation,²⁰⁻²¹ involving: semi-structured interviews (76) as the main instrument; non-participant observation, materialized by observation notes (44), conducted in the 27 FHS, totaling 142 hours and 30 minutes; and documentary analysis of different documents that guided and recorded the work of professionals in the FHS (32), as a complementary tool. For data collection, previously developed scripts were used.

The data were uploaded into the software for analysis of qualitative data, Atlas.ti 7.0.²⁵⁻²⁶ The analysis process was based on thematic content analysis associated to the software resources, and guided by the chosen theoretical framework. Thematic content analysis has three phases: pre-analysis, material exploration and treatment of the obtained results, and inference and interpretation.²⁷

The first phase (pre-analysis) consists of selecting the "documents to be submitted for analysis, the formulation of hypotheses and objectives and development of indicators that support the final interpretation."^{27:125} In this phase, 76 interviews and five observation notes totaling 81 primary documents were uploaded, and grouped into families by geographic region. The first memos (reminders that aim to make an association with the theory) were also written. The data obtained in the documentary study were uploaded in the software in the form of comments, and combined for analysis.

Then, the material was exhaustively read and the significant portions, that is, the *quotations*, were selected and a *code* was assigned to each (word or set of words), according to the objective of the research and the supporting theory, and then these were grouped into *families*.

In the third phase (interpretation), the "gross results are treated in a way that is meaningful and valid", allowing one "to establish results tables, diagrams, figures".^{27:131} In this stage, associations were made using software analysis tools, establishing relationships between *quotations*, *codes* and *memos*, as well as completing the synthesis of the results, using the *network* formation feature.

Data collection complied with all internationally recommended ethical standards regarding research involving human beings, as well as respecting all Brazilian legislative guidelines and received the ethical protocol process 971 FR: 366844 and certificate of presentation number for ethical assessment: 25557614.0.0000.0121. The anonymity of the participants was guaranteed by means of an alphanumeric code consisting of the professional's initials and the geographical region, followed by a cardinal number. The observation notes were identified by the abbreviation *Obs*, followed by the respective geographical region, for example: Obs. SE is the observation related to the southeast region.

RESULTS

The results demonstrate the existence of factors that generated dissatisfaction in the professionals who work in the FHS, which are summarized in the Table 1.

Table 1 - Distribution of quotations (n=171) according to codes (14) of dissatisfaction in the work of professionals in the Family Health Strategy, in Brazil

<i>Codes</i>	<i>Quotations</i>	
	n	%
Lack of material resources	26	15.2
Inadequate infrastructure	22	12.9
Management problems	21	12.3
Undervaluing the work	18	10.5
Salary deficient	14	8.2
Patient posture	12	7.1
Excessive demand	11	6.4
Excessive work hours	10	5.8
Lack of knowledge of the FHS	9	5.3
Bureaucracy	8	4.7
Violence	5	2.9
Work overload	5	2.9
Work organization	5	2.9
Lack of team qualification	5	2.9
Total	171	100.0

The *codes* were structured in three categories: health work management, work overload, and re-

lationships with staff and patients. Figure 1 shows the synthesis of the results.

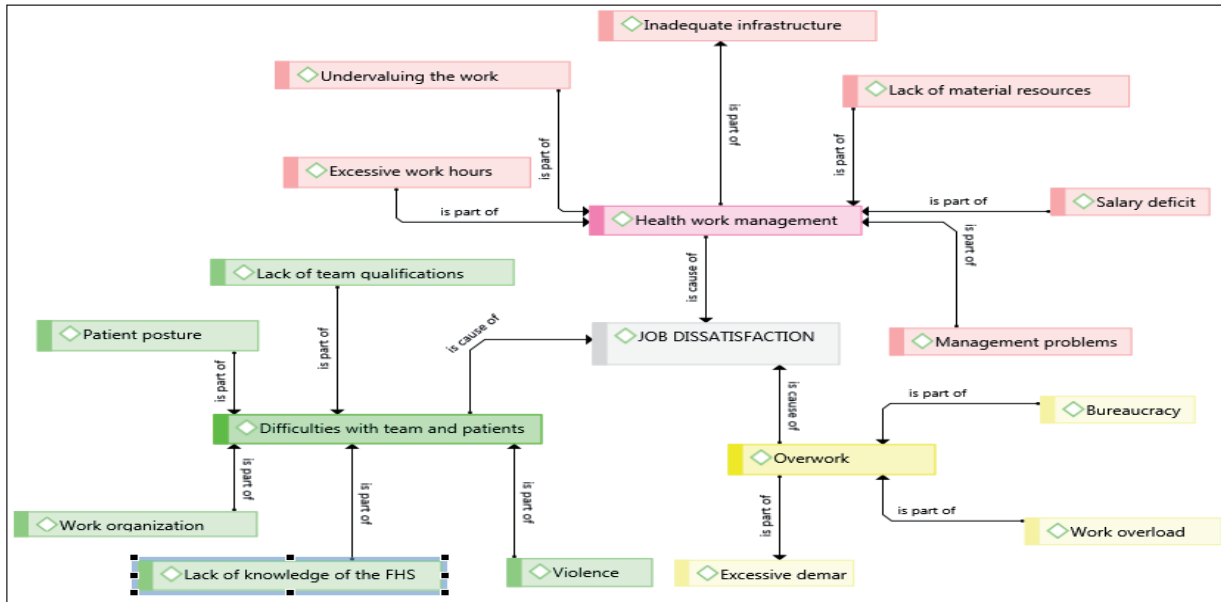


Figure 1 - Relationships of the factors generating dissatisfaction in the work of the professionals of the Family Health Strategy

Health work management

This category represents more than 64.9% of the *quotations*, and adds the following reasons for dissatisfaction among FHS professionals in Brazil,

synthesized by the *codes*: inadequate physical structure, lack of material resources, lack of management, excessive work hours, lack of appreciation for work and deficient wages. Figure 2 summarizes this category.

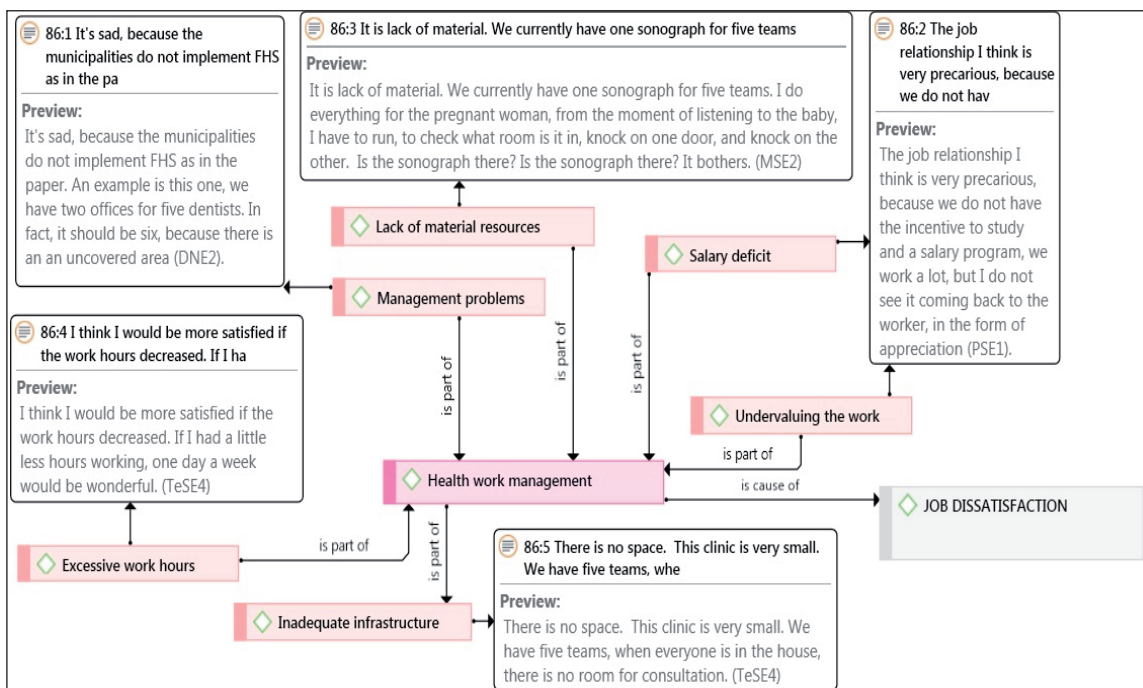


Figure 2 - Health work management as a dissatisfier of Famili Health Strategy professionals

Relationships with staff and patients

This category represents more than 21.1% of the quotations, and adds the following codes: patient attitude, lack of knowledge about FHS, lack of quali-

fication and preparation of team members, problem in team and PHC organization, and violence. Figure 3 summarizes the relationships between codes and quotations.

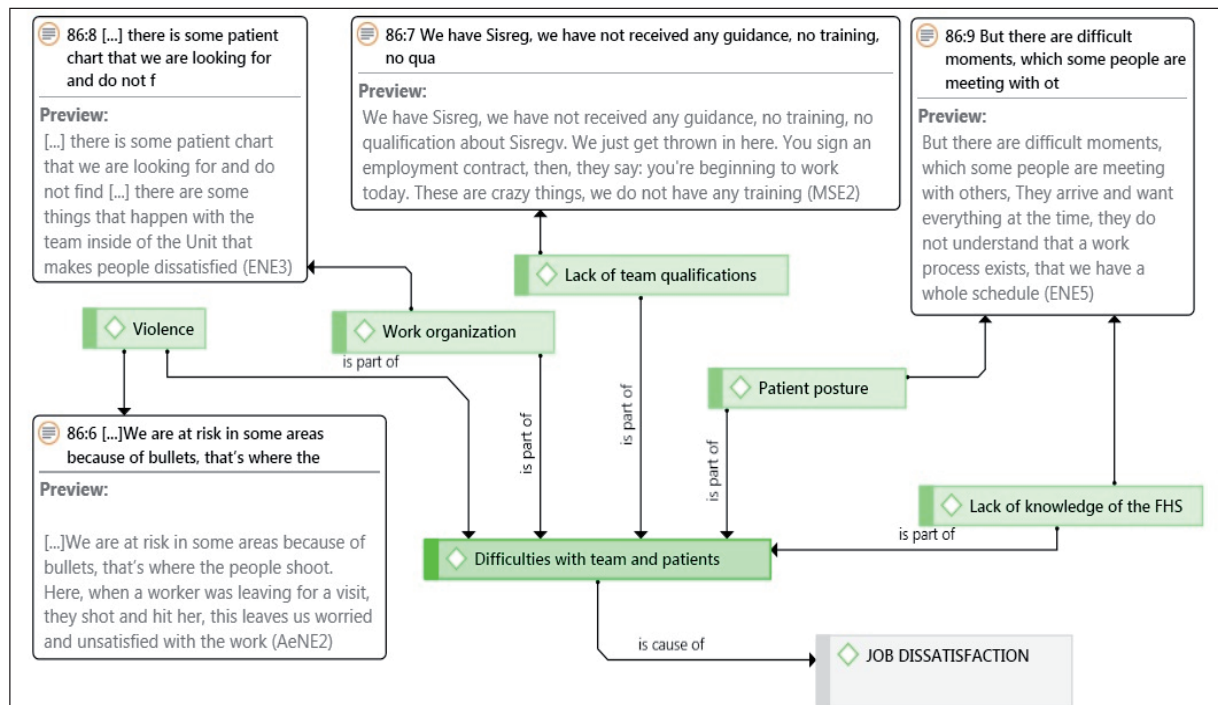


Figure 3 - The relationships with the staff and patients as a dissatisfier for the Family Health Strategy professionals

Work overload

This category represents more than 14% of the quotations and adds the following codes: work over-

load, excessive demand, and bureaucracy. The following figure illustrates the relationships between codes and quotations as well as an observation note.

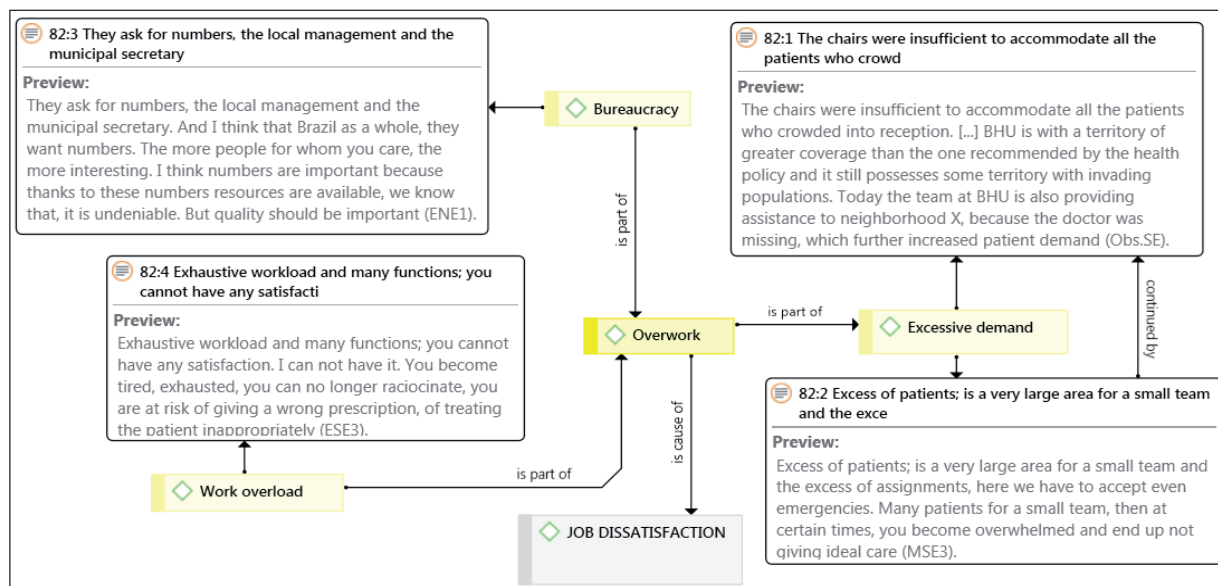


Figure 4 - Work overload as a dissatisfier for Family Health Strategy professionals

DISCUSSION

The results indicate the professional dissatisfaction that those in the FHS associated to three aspects: management problems, relationships established in the practice environment of care, and work overload.

The dissatisfaction of the professionals working in the FHS has a strong connection with the health work management in the PHC. This category of analysis presented the greatest number of factors generating dissatisfaction in the work of professionals of the FHts.

The factors related to work management are closely associated with working conditions, involving several elements related to the environment in which the work is completed, which includes the workforce, considering the amount, qualification and role played in the production process, contractual relationships, salary, work day, labor benefits, and rules related to job protection. The working conditions also include the instruments of work in terms of quantity and quality, in addition to the institutional conditions, and the knowledge to develop them.²⁸

The 40-hour work week, considered excessive, was highlighted as an unsatisfactory element for professionals working at the FHS, contributing to an increase in workload. It should be noted that for some participants, the working hours are even greater due to double and even triple employment. That is, the time dedicated to work occupies a great space in the life of these professionals.

The balance between the time spent at work and in one's personal or family life is intrinsically related to the possibility of a satisfactory job, and affects the quality of the life of the professional and the people around him/her.³⁻⁴ Other authors also emphasize the relationship between overwork and overload, and the impact on the care and on one's personal life.^{17,29-30}

Most of the research participants have a secure job relationship, which is in line with studies that support a decrease in the practice of precarious work found with direct contracting within the FHS.³¹ Even when facing this situation, deficient wages, and especially the absence of a career and salary plan, considering their time in the profession and their level of education, was another important aspect that contributed to professional dissatisfaction in the FHS.

The incorporation of the career and salary plan for health professionals in the FHS in Brazil is still

fragile. Only 21% of the professionals have this,³² which indicates the need for investments by the municipal administrations related to political decisions, so that this proposal of professional valuation becomes effective.

Other aspects of dissatisfaction related to working conditions are related to deficits in the physical structure and working tools found in the Basic Health Units where the FHts work.

Regarding the physical structure, issues included: the absence of BHU enlargements in places with extreme structural need; delays in BHU structural reforms; dental office closed for more than three years; lack of bid planning for acquisition of supplies and medicines; and structural difficulties that interfere in the accomplishment of necessary exams for patients of specialized care services; along with other problems that have direct repercussions on the effectiveness of the care provided.

One of the main objectives of the management oriented to the FHS is the functionality of the services. So that the actions of the FHS happen according to the PNAB guidelines, it is necessary to guarantee essential elements, such as: availability of adequate physical structure, and supplies necessary for health care under favorable conditions of use.

The concept of environment, adopted by the Ministry of Health as a prescription for the construction of FHS units, means the construction of a welcoming and humane physical space for health care, both for workers and health professionals, as well as for patients;¹⁰ this was not found in most of the units participating in this study. The absence of supplies interferes with the adequate provision of care, resulting in prejudice of care and, in some cases, interruption of caring.³³

The deficits in this set of factors related to working conditions contribute to the patients' dissatisfaction and, consequently, to a professional who cannot provide the desired response. These aspects make it difficult for the professional to see himself in his work,²³ as "working is not only intended to produce, it is also about transforming oneself [...] it is an opportunity offered to the subjectivity to test itself, in order to be successful".^{1:30}

This aspect also includes the factors related to work management that cause dissatisfaction in the professionals of the FHts, the lack of professional appreciation by the team, managers or even by patients. This valuation implies actions related to salary policies, but also recognition for the work done. The valuation of work is of fundamental importance for a satisfactory job, and must consider

the efforts, doubts, disappointments and dismay of the professional.²⁴

Valuing is not only about framing the professional based on quantitative results, but also about the quality and intensity of his/her actions. Valuing includes recognizing the professional as a person, with unique abilities and contributions in the actions that s/he performs. It also requires “ the recognition of what is done by adding to the one who benefits from it, a collective belonging to a team or a business, and should not consist of judgments of the person who works, but rather about doing, about working”.^{1:33}

Considering the importance of the category “health management” to the dissatisfaction of FHS professionals, it should be emphasized that management in the sector has been a recognized problem in the literature and within the health systems, in the country and in the international scenario, and that these problems are presenting consequences for patients and professionals. The reality of the Brazilian health sector presents scarce resources, with unprepared managers with little knowledge of health policies, and even those who lack a commitment to professionals and the population.³⁴ Given these problems, the capacity to produce different things and even to create different patterns is something exclusively human, and it is not possible to be individually exercised; however this is possible in part by sharing the work. However, this leads to a change in the management role to one of process control regarding the workforce, and the expropriation of the staff from the product of his work.²³

The high turnover of committed and trained managers due to merely political issues is another aspect, hampering the continuity of good practices and better quality care.³²

The lack of commitment and planning of managers to continue health actions, coupled with the political influence on the services, hinder the implementation of the PNAB guidelines. This is reflected in the day-to-day care within the FHS, and compromises its ability for resolution.

The second category that aggregates the factors of dissatisfaction concerns the “relationships” that happens at the *locus of care*, between the professionals themselves and between professionals and patients.

In coexistence with a multiprofessional team and a varied number of patients, problems in relationships commonly occurs, and it is part of this collective work environment to experience conflicts. For work in the FHS, a multidisciplinary team is required, which has specific assignments. This

team should work with the objective of caring for an assigned population, offering actions of health promotion, disease prevention, and cure and health recovery.¹⁰

In this context, conflicts emerge once again from the share of work, which separates the conception and execution of the work, separation of the tasks between different staff members, fragmentation of the work, with the responsibility falling to the manager to control the phases of the process and the method of execution, aiming toward greater productivity.²³

The patient’s attitude, which is sometimes disrespectful of the professionals, may not respond positively to the proposed treatment, and generates professional dissatisfaction when they do not understand the precepts established in the model of FHS care. It also generates dissatisfaction with the manner in which colleagues and managers implement the FHS, sometimes contradicting the model of care designed for PHC.

The participants’ dissatisfaction regarding the patient’s attitude and the manner of work organization in the FHS implies the need to face these difficulties, to renounce their individual subjective potential in favor of a collective,¹ namely, the team. To reduce dissatisfaction with these relationships, it is necessary to overcome the optics of work production and learn to live together in work, because it is in the real work within the collective that dissatisfaction will be overcome.³ Marx contextualizes another aspect present in the work that reinforces the demands on staff members, the exclusive recognition of productive work, as exclusively that which produces user value.²³ This aspect is complex in the scope of health work, considering that the final product of work is immaterial.³⁵

On the other hand, it is fundamental that professionals know the principles and guidelines that regulate their work within the FHS, and cooperate to reverse the curative logic that still prevails in professional practices and organizations, and also in the patient’s expectations. Changing this situation requires proactive action by professionals and patients to reverse this logic of care.

Another unsatisfactory aspect in this category is the absence of security for exercising professional practice, either inside or outside the BHU. The work skills in the FHS require working outside the unit, in places with a higher incidence of crime. These reasons lead, sometimes, to a fear of working.

The advance of crime has been a matter of concern to the most diverse sectors. Criminal actions that

were once more restricted to the outskirts, today do not have specified locations, social classes or groups, so society as a whole lives with the fear of insecurity. This fear of insecurity generates a conduct of self-defense, impairs the organization of work, provides loss of satisfaction, and generates suffering.²

In health, the struggle for a safe place is understood as an aspect that can provide quality of life for people, and has been the subject of discussion in the sector since the first conference on Primary Health Care, held in Alma Ata, in 1978. The Brazilian national health promotion policy also supports the need to stimulate the adoption of nonviolent ways of living and the development of a culture of peace, which is also a responsibility of the FHS.³⁶

The last aspect of dissatisfaction is "work overload". The FHS is conceived as one of the most important places to guarantee universal access in health. The team members need to manage this access, scheduling and defining work schedules; however, the existence of poorly defined geographical areas of the FHS, seasonality, and the curative culture also present as increased demand from the population. This lack of control of the demand generates professional dissatisfaction.

The reception of spontaneous demand is one of the activities foreseen in the FHS, with a view to favoring access to the attached population. It involves actions that must be conducted across all aspects of health care, including PHC services, especially in the FHS.^{10,37} However, this flow management is difficult to administer in many situations, requiring a broader action by managers and professionals so that patients can be welcomed by team members. The actions can consist of the resizing of the geographical area, construction or expansion of new BHUs within Family Health, and hiring of more professionals.

The results also indicate that bureaucratic aspects of the FHS functions cause dissatisfaction. In the FHS, work time is not only dedicated to care actions, but also to administrative activities, such as statistical consolidation of production, completion of reports, updated maintenance of medicines and supplies requested, among others. Although these activities are recognized as important for the good functioning of the services, the participants' perception of the research does not rank these as high of a priority as the caring practices, and consequently they generate dissatisfaction.

The bureaucratic activities in the FHS are numerous, and have increasingly decreased the time available to provide care, increasing the dedication

to administrative actions, based on concern for quantity, target and numbers, with little emphasis on quality of care. Bureaucracy makes sacred the rules and regulations. Most often, between solving a situation and following a norm, the bureaucracy-based organization opts for the second. The big problem does not necessarily exist within the norms and rules, which must be respected in the FHS, but is found within their temporal rigidity, inadequacy for reality, and abusive implementation.³⁸

Considering the interests of the organization, which is based on the tightening of norms, the professional is often punished for his desires, and forced to act according to the organizational desires. This expropriates the professional from his competence, and also disregards a more flexible care practice, generating dissatisfaction.⁴ On the other hand, health care work is performed in the relationship between the established and the real, and must be frequently reinvented by the professional, aiming to achieve the target of health care, as well as to generate more satisfactory work, because "so, for the work process function, the prescriptions must be adjusted and the work organization must be effective"^{1,32}

Another unsatisfactory aspect of this category is work overload as a consequence of excessive demand, and the several bureaucratic activities that surround the FHS. The work overload, and the forms of organization, can be detrimental for health care and even for aspects of the personal life of the worker.^{3,17,30}

When discussing overload, out-of-office work must also be considered, such as the commuting, the housework after formal work, and also the time that workers think about working, outside the work environment. This means that the dedication to work occupies much of a person's life. The work is not only the time that the professional stays in the FHS, it goes beyond any limit imposed by time, and mobilizes a commitment of all subjectivity. The BHU has closed its doors, but the professional has not stopped working, he thinks, plans and structures his demands for the next day.

Overload means that the work is not completed at the end of the shift, but extends to the external environment of professional practice. To confront these situations experienced in the work environment, Dejours.^{4:364} sustains the need to "to make oneself be inhabited by the experience of the real and the failure, the suffering, not being able to sleep at night, even poison the domestic space relationships, even dream about this experience",

because he understands that it is in meeting the real work adversities that overcoming these situations can turn into satisfaction.

The methodological precepts used in this study are described to allow for replication or expansion. The interpretation of the results can be a limitation, as the results correspond to those identified in a given historical moment, and each social reality is conceived by subjects that, while being influenced by macro social determinations, are also agents of change.

CONCLUSION

This study demonstrated that several factors contribute to professional dissatisfaction while working in the FHS, interfere in the work process in health, and also in the life of the professionals themselves. These factors are centered in three aspects: the management, relationships with staff and patients, and the work overload.

To reduce the unsatisfactory work aspects of FHS professionals, it is necessary to have: better physical structures and guarantees of availability of materials and supplies for health care; improvements in the processes of professional evaluation, contemplating more the qualitative than the quantitative elements of the work process in health; and qualify the development of administrative actions focused on efficiency and effectiveness, aiming to reduce bureaucracy. Also, aiming to reduce work overload, the demands of reducing the working day must be adjusted, whether looking for ways to implement them or acting in the legislative sphere; strengthening secure employment relationships; developing professional valuation practices, including the development and implementation of a career and salary plan.

Relationships between professionals also generate dissatisfaction, either due to the lack of knowledge of the precepts recommended by the FHS, the patient desire for quick and curative health care, or the professionals' fear regarding violence in the areas covered by the FHS. The work in the FHS requires the establishment of congruent relationships for a more resolute health.

The results of this study can contribute to health management in setting priorities for action, with a view to reducing unsatisfactory factors. Additionally it can support professionals in the development of coping strategies; and for teaching, especially for education of future professionals who will work in the FHS, by aiming for better prepa-

ration of the professionals in the face of possible factors of dissatisfaction.

REFERENCES

1. Dejours C. Subjetividade, trabalho e ação. *Rev Produção* [Internet]. 2004 [cited 2014 Apr 10]; 14(3):27-34. Available from: <http://www.scielo.br/pdf/prod/v14n3/v14n3a03.pdf>
2. Dejours C. *A banalização da injustiça social*. Rio de Janeiro (RJ): FGV; 2006.
3. Dejours C. Entre o desespero e a esperança: como reencantar o trabalho? *Cult* [Internet]. 2009 Sep [cited 2013 Jul 20]; 139:49-53. Available from: <http://revistacult.uol.com.br/home/2010/03/reencantar-o-trabalho/>
4. Dejours C. Psicodinâmica do trabalho e teoria da sedução. *Psicol Estud* [Internet]. 2012 [cited 2014 Mar 11]; 17(3):363-71. Available from: <http://www.scielo.br/pdf/pe/v17n3/a02v17n3.pdf>
5. Munyewende PO, Rispel LC, Chirwa T. Positive practice environments influence job satisfaction of primary health care clinic nursing managers in two South African provinces. *Hum Resour Health* [Internet]. 2014 [cited 2015 Apr 23]; 12(27):1-14. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4024627>
6. Khamlub S, Harun-Or-Rashid M, Sarker MA, Hirosawa T, Outavong P, Sakamoto J. Job satisfaction of health-care workers at health centers in Vientiane capital and Bolikhamsai province, Lao PDR. *Nagoya J Med Sci*. 2013; 75:233-41.
7. Shi L, Song K, Rane S, Sun X, Li H, Meng Q. Factors associated with job satisfaction by Chinese primary care providers. *Prim Health Care Res Dev* [Internet]. 2014 [cited 2015 Apr 09]; 15(1):46-57. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23388523>
8. McCrae N, Banerjee S, Murray J, Prior S, Silverman AM. An extra pair of hands? A case study of the introduction of support workers in community mental health teams for older adults. *J Nurs Manag* [Internet]. 2008 [cited 2014 Apr 24]; 16(6):734-43. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/18808468>
9. Korac V, Vasic M, Krstic M, Markovic R. Job satisfaction among health care workers in Serbia. *Cah Sociol Demogr Med* [Internet]. 2010 [cited 2015 Jul 20]; 50(3):319-43. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/21086768>
10. Ministério da Saúde (BR). *Política Nacional de Atenção Básica (PNAB)*. Brasília (DF): MS; 2012.
11. Mendes EV. *O cuidado das condições crônicas na atenção primária à saúde: o imperativo da consolidação da estratégia da saúde da família*. Brasília (DF): OPAS; 2012.
12. Ministério da Saúde (BR). *Histórico de cobertura da atenção básica e saúde da família*. Brasília (DF): MS; 2016.

13. Ministério da Saúde (BR). Datasus. Cadastro Nacional de Estabelecimentos de Saúde. Consultas, estabelecimentos por localização geográfica. 2016[cited 2016 May 05] Available from: http://cnes.datasus.gov.br/Lista_Tot_Es_Estado.asp
14. Buciuuniene I, Blazevičienė A, Bliudziute E. Health care reform and job satisfaction of primary health care physicians in Lithuania. *BMC Fam Pract* [Internet]. 2005 [cited 2014 May 23]; 6:1-6. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC555592/>
15. Ferrer MS, Benedicto AS. Working conditions of public health workers in the primary care in Catalonia, Spain. *Gac Sanit* [Internet]. 2007 [cited 2014 Mar 30]; 21(3):261-3. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/17565904>
16. Teles MA, Barbosa MR, Vargas AMD, Gomes VE, Ferreira EF, Martins AMBEBL, et al. Psychosocial work conditions and quality of life among primary health care employees: a cross sectional study. *Health Qual Life Outcomes* [Internet]. 2014 [cited 2015 Nov 19]; 72:1-12. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4122097/pdf/1477-7525-12-72.pdf>
17. Pires DEP, Bertoncini JH, Trindade LL, Matos E, Azambuja E, Borges AMF. Inovações tecnológicas no setor saúde e aumento das cargas de trabalho. *Tempus Actas de Saúde Coletiva* 2012; 6(2):45-59.
18. Trindade LL, Pires DEP. Implications of primary health care models in workloads of health professionals. *Texto Contexto Enferm* [Internet]. 2013 [cited 2014 Feb 10]; 22(1):36-42. Available from: http://www.scielo.br/pdf/tce/v22n1/pt_05.pdf
19. Trindade LL, Pires DEP, Forte ECN, Medeiros F. Job satisfaction and dissatisfaction of primary health care professionals Esc Anna Nery [Internet]. 2014 [cited 2014 Apr 30]; 18(1):17-24. Available from: <http://www.scielo.br/pdf/ean/v18n1/1414-8145-ean-18-01-0017.pdf>
20. Minayo MCS. *Desafio do conhecimento: pesquisa qualitativa em saúde*. 12ª ed. São Paulo (SP): Hucitec; 2010.
21. Polit DF, Beck CT. *Fundamentos de pesquisa em enfermagem. Avaliação de evidências para a prática da enfermagem*. 7ª ed. Porto Alegre (RS): Artmed; 2011.
22. Morse JM. Critical analysis of strategies for determining rigor in qualitative inquiry. *Qual Health Res* [Internet]. 2015 [cited 2014 Apr 30]; 25(9):1212-22. Available from: <http://journals.sagepub.com/doi/10.1177/1049732315588501>
23. Marx K. *O capital: crítica da economia política*. Livro I. 30ª ed. Rio de Janeiro (RJ): Civilização Brasileira; 2012.
24. Fontanellas BJB, Ricas J, Turato ER. Amostragem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. *Cad Saúde Pública* [Internet]. 2008 [cited 2014 Apr 30]; 24 (1):17-7. Available from: <http://www.scielo.br/pdf/csp/v24n1/02.pdf>
25. Friese S. *Qualitative data analysis with ATLAS.ti*. 2nd. London (UK): Sage; 2014.
26. Atlas.ti qualitative data analysis. Version 7.5.10. Atlas.ti Scientific Software Development GmbH: Berlin; 2015.
27. Bardin L. *Análise de conteúdo*. São Paulo (SP): Edições 70; 2011.
28. Pires DEP, Lorenzetti J, Forte ECN. Condições de trabalho: requisito para uma prática de enfermagem segura. In: Vale EG, Peruzzo SA, Felli VEA, organizadores. *PROENF. Programa de Atualização em Enfermagem: Gestão: Ciclo 4*. Porto Alegre (RS): Artmed Panamericana; 2015.p.35-67.
29. Silva AA, Rotenberg L, Fischer FM. Jornadas de trabalho na enfermagem: entre necessidades individuais e condições de trabalho. *Rev Saúde Pública* [Internet]. 2011 Dez [cited 2014 Apr 30]; 45(6):1117-26. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102011000600014&lng=pt&nrm=iso
30. Battaues MRB, Dalri RCM, Lelis CM, Brienza AM, Robazzi MLCC. Repercussões da jornada de trabalho para os enfermeiros: revisão de literatura. *Rev Enferm UFPE online* [Internet]. 2012 [cited 2014 May 21]; 6(1):212-22. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/2056/pdf_779
31. Girardi S, Carvalho CL, Der Mass LW, Farah J, Araújo JF. O trabalho precário em saúde: tendências e perspectivas na Estratégia da Saúde da Família. *Divulg Saúde Debate* [Internet]. 2010 May [cited 2014 Out 08]; 45:11-23. Available from: https://www.academia.edu/401484/O_Trabalho_Precario_em_Saude_tendencias_e_perspectivas_na_Estrategia_Saude_da_Familia
32. Seidl H, Vieira SP, Fausto MCR, Lima RCD, Gagno J. Gestão do trabalho na atenção básica em saúde: uma análise a partir da perspectiva das equipes participantes do PMAQ-AB. *Saúde Debate* [Internet]. 2014 [cited 2014 Out 08]; 38(Spe):94-108. Available from: <http://www.scielo.br/pdf/sdeb/v38nspe/0103-1104-sdeb-38-spe-0094.pdf>
33. Liu C, Zhang L, Ye W, Zhu J, Cao J, Lu X, et al. Job satisfaction and intention to leave: a questionnaire survey of hospital nurses in Shanghai of China. *J Clin Nurs*. [Internet]. 2012 [cited 2014 Out 08]; 21(1-2):255-63. Available from: <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2011.03766.x/pdf>
34. Lorenzetti J, Lanzoni GMM, Assuít LFC, Pires DEP, Ramos FRS. *Gestão em saúde no Brasil: diálogo com gestores públicos e privados*. *Texto Contexto Enferm* [Internet]. 2014 [cited 2015 Nov 20]; 23(2):417-25. Available from: http://www.scielo.br/pdf/tce/v23n2/pt_0104-0707-tce-23-02-00417.pdf
35. Soratto J, Pires DEP, Dornelles S, Lorenzetti J. *Estratégia Saúde da Família: uma inovação tecnológica em saúde*. *Texto Contexto Enferm* [Internet]. 2015

- [cited 2015 Nov 19]; 24(2):584-92. Available from: <http://www.scielo.br/pdf/tce/v24n2/0104-0707-tce-24-02-00584.pdf>
36. Buss PM, Carvalho AI. Desenvolvimento da promoção da saúde no Brasil nos últimos vinte anos (1988-2008). *Ciênc Saúde Coletiva* [Internet]. 2009 [cited 2014 Oct 20]; 14(6):2305-16. Available from: <http://www.scielo.br/pdf/csc/v14n6/39.pdf>
37. Garuzi M, Achitti MCO, Sato CA, Rocha AS, Spagnuolo RS. Acolhimento na Estratégia Saúde da Família: revisão integrativa. *Rev Panam Salud Publica*. 2014 Feb; 35(2):144-9.
38. Rego A. *Kafka e o estranho mundo da burocracia*. São Paulo (SP): Atlas; 2010.

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