WORKING IN THE FAMILY HEALTH STRATEGY: IMPLICATIONS IN PROFESSIONALS WORKLOADS*

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ABSTRACT: This study aimed to identify aspects of work in the Family Health Strategy that contribute to increase and / or reduce workloads of professionals. Eleven professionals from three teams of the Family Health Strategy from a state of southern Brazil participated in the study. Data were collected between December 2010 and March 2011, through individual interviews, focus groups and documentary study and were analyzed combining thematic analysis with the resources of the software ATLAS.ti. The main sources of increased workloads were aspects that hinder the implementation of the care model as recommended; and of reduced workloads, the affinity with the care model, the autonomy of the team and the guarantee of employment. In the work of the Family Health Strategy, some weaknesses that negatively affect satisfaction and health professionals predominated, but there are possibilities for intervention to reduce workloads and improve quality of care, especially those for better working conditions.
DESCRIPTORS: Occupational Health; Workload; Family health; Primary health care.

TRABALHO NA ESTRATÉGIA DA SAÚDE DA FAMÍLIA: IMPLICAÇÕES NAS CARGAS DE TRABALHO DE SEUS PROFISSIONAIS

RESUMO: Objetivou-se identificar aspectos do trabalho na Estratégia de Saúde da Família que contribuem para aumentar e/ou reduzir as cargas de trabalho dos profissionais. Participaram 11 profissionais de três equipes de Estratégia de Saúde da Família de um estado do Sul do Brasil. Os dados foram coletados, entre dezembro de 2010 e março de 2011, por meio de entrevistas individuais, grupo focal e estudo documental e analisados combinando a Análise Temática com recursos do *software* ATLAS.ti. As principais fontes de aumento das cargas foram aspectos que impedem a implantação do modelo assistencial como preconizado; e de redução, a afinidade com o modelo assistencial, a autonomia da equipe e a garantia do emprego. Predominaram, no trabalho da Estratégia de Saúde da Família, fragilidades que repercutem negativamente na satisfação e na saúde dos profissionais, mas há possibilidades de intervenção para redução das cargas e qualificação da assistência, especialmente aquelas para melhorias das condições de trabalho.
DESCRITORES: Saúde do trabalhador; Carga de trabalho; Saúde da família; Atenção primária à saúde.

TRABAJO EN LA ESTRATEGIA DE LA SALUD DE LA FAMILIA: IMPLICACIONES EN LAS CARGAS DE TRABAJO DE SUS PROFESIONALES

RESUMEN: Fue objetivo del estudio identificar aspectos del trabajo en la Estrategia de Salud de la Familia que contribuyen para aumentar y/o reducir las cargas de trabajo de los profesionales. Participaron 11 profesionales de tres equipos de Estrategia de Salud de la Familia de un estado del Sur de Brasil. Los datos fueron obtenidos entre diciembre de 2010 y marzo de 2011, por medio de entrevistas individuales, grupo focal y estudio documental, siendo analizados mesclándose el Análisis Temático con recursos del software ATLAS.ti. Las principales fuentes de aumento de las cargas fueron aspectos que impiden la implantación del modelo asistencial como preconizado; y de reducción, la afinidad con el modelo asistencial, la autonomía del equipo y la garantía del empleo. Predominaron, en el trabajo de la Estrategia de Salud de la Familia, fragilidades que repercuten negativamente en la satisfacción y en la salud de los profesionales, pero hay posibilidades de intervención para reducción de las cargas y cualificación de la asistencia, de modo especial aquellas para mejorías de las condiciones de trabajo.
DESCRIPTORES: Salud del trabajador; Carga de trabajo; Salud de la familia; Atención primaria a la salud.

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INTRODUCTION

Health care comprises the organization of actions that articulate with physical, technological and human resources, to intervene in the health-disease process, addressing and resolving health problems of individuals and groups[1]. It is constituted by dialogue and principles that reflect a particular epidemiological situation and certain design aspirations on healthy living[2].

In this scenario, the Family Health Strategy (FHS) is a model of care development in Brazil since 1994. This has been recognized as the main intervention for the reorientation of Primary Care, by seeking to approach the precepts of the Unified Health System (UHS/SUS) of universal and continuing access to high-quality and problem-solving health services, based on the definition of the territory, planning and decentralized programming[3].

This new model recommended by the Ministry of Health provides a look at the community, focusing on the family and the multidisciplinary care. Studies visualize the FHS as a strategy that strengthens PC and health promotion, as a way to improve the health condition and reduce costs[3-6].

It is understood that the characteristics of the work process in this model have implications for satisfaction / dissatisfaction and workloads of teams, understood as elements of the work that interact among themselves and with the worker's body, potentially triggering biopsychologic changes, possibly expressing fatigue and illness among professionals [7]. Thus, workloads have strong influence on the work conditions and directly interfere with worker fatigue and can result in illness[8-9].

Accordingly, this study sought to identify aspects/characteristics of work in the FHS that increase and reduce the workloads of their professionals.

METHOD

This is a qualitative study carried out in the 7th Regional Health District, located in the Southwest of Paraná, in Southern Brazil.

The research population was composed through intentional sampling, including teams referenced by the head of the 7th RH (53 teams distributed among 17 cities), who play a prominent role in relation to quality of care, in the sense that the approximation is recommended by the MH. Three teams of FHS were included, totaling 11 health professionals, with 3 doctors, three nurses, three nursing technicians, one dentist and one dental office assistant.

To collect data, conducted from December 2010 to March 2011, the triangulation of instruments involving documentary study, semi-structured individual interviews and focus groups was used. We sought to: identify the socio-political and institutional scenario where the teams' work was performed and the teams' composition; characterize healthcare practices, organization and division of labor in teams; and identify the characteristics of the family health care model in its relation to the workloads of professionals who make up teams.

The data collection process was initiated only after the consent of the involved Municipal Health Offices; approval of the Federal University of Santa Catarina (n. 971/2010) Research Ethics Committee and followed the ethical aspects recommended by National Health Council Resolution.

The documentary study identified the rules/ routines of the institutions, medical records, characterization of the labor force, wage policy, division and forms of organization and management.

The interviews were pre-arranged with the participants, preceded by explanations about the research and conducted in the workplace, in a location and time chosen by respondents so as not to intervene in the dynamics of the health center's activities. At the time of the interviews, the consent of each participant and signing the informed consent was requested. The interviews sought to characterize the work of healthcare professionals, the healthcare model of FHS and its influence on workloads.

For the purpose of further exploration, a focus group was formed, with three sessions of about an hour and a half each, guided by a semistructured script. The focus group sessions took place after the end of the team meetings. Five to ten participants participated in the sessions. They discussed topics such as work in FHS, sources of (dis)satisfaction, elements that contribute to reduce and increase workloads. The number

of interviews and focus group sessions was satisfactory as data saturation occurred.

The information collected was organized with the help of the Atlas.ti software and analyzed based on content analysis[10]. Two core categories emerged: the sources of increased and of reduced workloads [7].

RESULTS

The subjects had, on average, 32 years of age (between 24 and 39 years). Nine were female, with an average of 8 years of experience in the profession and 3.5 years at FHS. Also, three professionals had finished high school, an incomplete college education and seven college education. Regarding graduate degrees, two had professional expertise in family health and two in clinical surgery.

All professionals had a 40 hours per week contract, but 54.54% had another job. Among the complementary activities, some stood out: private practice; teaching; activity in the hospital emergency room. The average weekly workload was 68 hours, ranging from 40 hours to 76 hours per week.

Board 1 shows the categories that emerged as sources of increased and decreased workloads in the FHS.

The findings above show the main aspects mentioned as causing increased workloads, especially the excess demand in the face of the insufficient physical structure of the units/health centers, the number and training of teams to meet the needs expressed by patients.

The aspects that increase workload are related to the organization of the team's work and the distance between the current model and the new care model, FHS. As described here:

[...] *it is not easy because the logic of the people is still the medical consultation, they want to talk with the doctor, come out with their medicine and the prescription under their arm, that's the hard part*. (Focus Group)

The lack of counter-referral [...] *you monitor a patient and refer him to a specialist but there is no counter-referral. I do not know what to do* [in

Board 1 - Sources of increased and decreased workloads in the Family Health Strategy. Paraná-Brazil, 2011

Sources of increased workload in FHS	Sources of decreased workload in FHS
Excessive demand	The FHS care model
Lack of staff training	Teamwork
Absence or deficient implementation of user embracement	The proximity of professionals with the reality of patients and families
Focus on the medical consultation	The presence of the community health agent (cha)
Verbal abuse by patients	Organized work with previously scheduled activities
Lack of understanding among patients and managers regarding the care model	Flexibility in work organization
Difficulty in establishing link between professionals and users	Employment by public tender
Daily contact with urban violence	Less exposure to biological loads
Failures in referral centers and absence of counterreferrals	
Weaknesses in management and strong political party influence in everyday services	
Lack of incentives and investment in professional training	
Dissatisfaction with salary, workload, and the lack of the career and salary plan	
Problems with interpersonal relationships within the team	
Deficits in the physical structure of the units/health center	
Unequal division of quantitative activities among team members	

this situation]. *There is no feedback, this makes me tired, very irritated, it is like an unfinished bridge.* (Nurse 2)

It is understood that the verbal assaults of users/patients are related to their difficulties and the managers understand the meaning of the new care model of FHS, so that situation complicates the implementation of the recommended model, as seen in the following:

[...] *what makes it difficult is the lack of knowledge the families have about what the FHS is. They know that there is a health center here, but they do not know that the FHS teams intend to promote health and prevent* [illness]*, they still have the curative vision* [...]. (Nurse 3)

Assistance to families experiencing domestic violence, marginalized individuals exposed to licit and illicit drugs, sometimes with poor living conditions, increase the health risks of these professionals from exposure to situations of urban violence and intense exhaustion, as checked in the records of users/patients at the units/heath centers surveyed.

Highlighted characteristics related to poor working conditions are: low income (inconsistent with the responsibilities assumed and team productivity); lack of job and salary plans and 40-hour workweek. A phrase with this feature was:

The pay is poor, which greatly increases the load, we leave here very tired, because there are many people, a lot of contact, a lot of demand and little recognition. (Dental Office Assistant)

Interpersonal conflicts in teamwork, lack of material resources, poor division of labor and when it is very bureaucratic, have repercussions in increased loads. Also, the shortage of trained professionals to work in this care model and the lack of incentives for improvement through graduate work are highlighted.

We identified weaknesses in the management and strong partisan political influence in decision-making processes, staff turnover in commissioned positions, the lack of continuity of projects and actions during and after the elections. In addition, there is a lack of work tools, in particular electronic medical records, seen as helpful in increasing dialogue between services.

Professionals mentioned the lack of care protocols and the truncated and restricted access to hospital services, which is reduced and permeated by the public-private mix in the region, and the lack of specific services.

Regarding the sources that reduce workloads, the main reason was the identification of the professional with the form prescribed for the FHS. Among the aspects of FHS identified as facilitators of work are the implementation of the admittance, teamwork, proximity to the reality of users/patients and families and the presence of CHAs. A story relates this aspect:

[...] *in the residence program, the philosophy of family medicine is very cool,* [...] *it's different work based on prevention and health promotion, you go beyond health, see the factors that affect their health* [...] *this community has sports, has leisure, has a nursery, places to work, it's all health.* (Doctor 2)

The proximity to the reality of families and users/patients, through the description of the clientele, home visits and strengthened links between teams and families, especially the work of CHAs, contribute to reducing workloads.

In terms of organization, most professionals said that the schedule of admittance fosters equitable division of labor among the team members and the more efficient planning of actions, reducing the physical and mental burden. Respondents emphasized the importance of autonomy to organize work with flexibility, which enhances professional creativity. In addition, labor rights and job security nurtured by public tender, are identified as a source of satisfaction. The following report indicates this:

Public tender gives me confidence to fight for what I think is right. (Nurse 3)

Fewer invasive technical procedures in relation to other labor realities are emphasized, which consequently generates less exposure to biological loads.

The research participants showed aspects/ strategies, not present in the current reality, that could reduce exhaustion. These include: better disclosure of care model; investment in vocational qualification; care organization merging with the scheduled service demand; implementation of the electronic medical record, a plan for jobs and wages consistent with the specifics of the care model, including incentives for training and reduction of working hours.

DISCUSSION

By analyzing the profile of the research subjects, it was observed that the sample studied is composed of young adults. The short time work experience was also found in another study as a factor that interferes with the availability of resources for coping with situations that increase job wear at FHS[11-12].

It was found that the aspects/characteristics that contributed most significantly imply in predominantly increased physiological, psychological and cognitive loads of the health professionals surveyed. Among the many difficulties to work in this new model, excess demand stands out and weakens the humanization of these services[13]. Furthermore, the focus in the demand for medical consultation interferes with the possibility of change in the organization of work and hinders the implementation of the guidelines proposed by the ESF.

Another aspect observed was the effect of inappropriate professional training, hindering the development of practices to meet the challenges present for the implementation of the UHS and the ESF, resulting in increased cognitive and mental burden.

Considering all the teams, it was found that only 18.2% of the sample had some training in graduate work in this care model. Nevertheless, there should also be concern with propagating in schools training that honors specialist knowledge[14].

It is understood that the difficulty to implement and consolidate the teams also relates to the training process, which allows little or limited access to primary care services. Many health professionals receive training still associated with private medicine, hospital care and the denial of the non-biological aspects that impact on health[14-16]. In this sense, the FHS should build a basis for the development of new health practices, focusing on bonding, reception and care in the context of a humane and humanistic health care[3-6,15,17].

Changes in production processes, in technical, organizational, political and cultural terms, have a strong impact on vocational training and lifelong learning is necessary[16-17]. In the Brazilian scenario, however, the adoption of public policies to qualify as a right is something new and is still at a stage of shy formulation and implementation. The Ministery of Health has formulated various strategies to promote professional qualification in the FHS, highlighting the University of SUS, the In-Service Education Program in Health (PET-Health), etc[17]. These strategies can contribute to skilled labor and address the problems experienced by teams.

Regarding work conditions, dissatisfaction with wages and excessive working hours were identified to increase the mental burden, contributing to exhaustion. Different categories of health professionals have legally conquered the regulation of work hours and discuss its implementation in services. This scenario highlights the struggle of nursing professionals seeking the approval by the Brazilian Parliament of Bill 2295/2000, which regulates their working hours to 30 hours per week[18].

It is also worth questioning the size of the minimum staff. The findings reveal that the number of responsibilities is incompatible with the number of professionals available to guarantee the quality of care, increasing the physiological and psychological burdens. One strategy could be the expansion of the staff, however the problem is complex, which requires the search for creative solutions in order to enhance health promotion and coordination of actions focused on offering comprehensive and humanized care.

Regarding the difficulties in the organization of work for the consolidation of FHS, the results showed the need to implement the user embracement. In the literature, it is mentioned that this helps to increase the problem-solving ability of services, expanding access, reducing demand and improving user/patient satisfaction(19-20). It should be reminded that the recognition of teamwork stood out as a source of reducing workload.

There are many obstacles in the exercise of the user embracement[13] including the mismatch between demand and available resources, problems regarding the organization of work, which have predominantly focused on medical care. These findings suggest the persistence of strong features of the biomedical model in the work of the FHS teams surveyed. Nevertheless, the study subjects studied were aware of the need to redirect the actions offered, with the purpose of adapting them to better listen to users, encouraging greater autonomy of individuals, noting their individual and collective needs and rescuing interdisciplinary work.

The various problems the teams mentioned evidenced in the care network certainly influence the quality of primary care, undermine the consolidation of FHS and increase physiological and psychological workloads of professionals. These endanger the security of the guidelines and principles provided by the UHS/SUS, such as access, equity and comprehensiveness in public health care. Therefore, the non-accomplishment of the referral system and cross-referrals, for example, undermines the principles of equity, universality and offering solutions to inequalities in health needs.

With regard to inequality in access to health services, the articulation of the FHS with other levels of care is needed. The expansion of health coverage brought the creation and expansion of the FHS is insufficient to overcome the inequalities in access to different services of the UHS/SUS[21]. Thus, this gateway to the health care network appears quite fragile, which affects the health of its employees, revealing the complexity of this level of care in their current organization.

Another challenge is the lack of recognition/ knowledge of the importance of this care model. Despite the expansion of the teams in the country, users and managers show little knowledge of how FHS functions. Managers sometimes privileges care in the traditional biomedical model. Also, there is the difficulty of managers in evaluating the quality of health services, as discussed in other studies[21].

In relation to violence in the daily work of the teams, authors[22] show that macro-social factors in health, such as urban inequality, are important, as is the relationship between access to education and employment, as well as the contingent nature of influential factors like the increased needs and the impossibility of meeting them, and the cultural changes in the structure of families and the reduced capacity of civil society organizations in promoting social inclusion. Moreover, the increased density in poor areas and urban segregation, the cult of masculinity, easy access to drugs, impunity, increasing the number of firearms and the difficulty of verbal expression of emotions, contribute to increased violence.

Concerning the health of the professionals, studies show a range of everyday situations that expose the FHS to illness and require intervention[8-9,11-12]. Among the useful tools available, there is the construction of collective strategies for addressing the problems and workloads[11] and increased scrutiny of working conditions.

With regard to aspects / characteristics that contributed to reducing workloads, it was revealed that the identity of the teams with the assistance of the FHS model allows better resolution and quality of care, as well as a more collaborative and satisfying work for teams.

It was observed that teamwork is able to decentralize the care from the medical doctor, favoring collective decision-making, autonomy of the various professionals and greater visibility of their activities[13-14].

Scheduled patients, as a source of reducing workloads, also raise questions and assume the need for studies on the organization and management form of the FHS services. The UHS/SUS introduced the guideline of social control, however, the idea of shared management depends on a large-scale reformulation of the mentality and legislation and requires the creation of collective spaces, in which teams share the preparation of management plans and therapeutic projects with users, as the humanization policies have sought to expand the power of the everyday users of health services.

Also, the need for new management strategies to ensure the quality of public health services, including the creation of teams for matrix support to FHS, needs to be remembered[4,23-24].

The FHS is surely an innovative strategy, with great potential to contribute to universal access, but needs to overcome numerous difficulties that have emerged throughout the implementation process and development. It should be reminded that inequalities in

health are not likely to be equated only within the health sector, as political, economic, social and environmental determinants exist.

In the Brazilian social reality, with its perverse levels of inequality, with its still fragile social protection system despite advances, among other problems, the FHS can be a tool to strengthen community participation and health awareness. Therefore, it is necessary that its expansion is done together with the proper logistics for the teams, giving them the ability to effectively overcome the hegemonic medical care model and assume its social function, turning to the construction of projects, actions and programs that interfere positively and effectively in the social and political determinants of health and thereby assist the effective implementation of public policies advocated by UHS/SUS.

CONCLUSION

The study reveals that, in the FHS, there is a predominance of increased workloads, arising from problems in the effective implementation of this care model, especially because of the distance between the prescribed model and the implemented form. However, identification with the proposal of the FHS, the belief that it can provide better care outcomes and greater user satisfaction reduce workloads. In this regard, they emphasized the proximity with the reality of families, the presence of community health agent in teams and greater autonomy in work organization.

It was possible to identify the weaknesses of the teams and the need for urgent investments in quality of care and workload reduction. The study reveals aspects of the relationship between working in the Family Health System in only one of multiple regions of the country, however, the results contribute to the understanding of aspects that increase the loads, and consequently increase the wear of health professionals in the FHS and aspects that should be strengthened, allowing for greater protection against exhaustion and reduced workloads, favoring the work done by professionals.

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