Cogitare Enfermagem

ORIGINAL ARTICLE

SATISFACTION AND DISSATISFACTION IN THE WORK OF MANAGERS IN THE FAMILY HEALTH STRATEGY*

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ABSTRACT

Objective: To identify and analyze the factors that generate satisfaction and dissatisfaction in the activities of managers working in the Family Health Strategy.

Method: Qualitative approach, supported by Dejours' theoretical framework of the work process, satisfaction and dissatisfaction. Seven managers of Basic Health Units from Florianópolis geographical regions were interviewed between September 2016 and July 2017. For data processing, the program Atlas.ti version 7.5 was used.

Results: Among the factors that generated satisfaction were the cooperation and good relations with the teams that provide assistance to users, the resoluteness of the assistance and the good relationship with the users; factors that cause dissatisfaction: Deficit/problems with the workforce; deficit/problems with the work tools and not be trained to be a manager.

Conclusion: Good working relationships and development of resolute practices have a positive impact. Deficit in working conditions and relationships are significant in job dissatisfaction.

DESCRIPTORS: Family Health Strategy; Job Satisfaction Health Manager; Worker Health.

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SATISFAÇÃO E INSATISFAÇÃO NO TRABALHO DE GESTORES NA ESTRATÉGIA SAÚDE DA FAMÍLIA

RESUMO

Objetivo: identificar e analisar os fatores geradores de satisfação e insatisfação nas atividades de gestores que atuam na Estratégia Saúde da Família.

Método: abordagem qualitativa, amparada pelos referenciais teóricos do processo de trabalho, satisfação e insatisfação de Dejours. Entrevistou-se sete gestores de Unidades Básicas de Saúde das regiões geográficas de Florianópolis entre setembro de 2016 e julho de 2017. Para o tratamento dos dados, foi utilizado o programa Atlas.ti versão 7.5.

Resultados: dentre os fatores geradores de satisfação, destacaram-se a cooperação e boas relações com as equipes que prestam assistência aos usuários, a resolutividade da assistência e o bom relacionamento com os usuários; fatores geradores de insatisfação: déficit/problemas com a força de trabalho; déficit/problemas com os instrumentos de trabalho e não capacitação para ser gestor.

Conclusão: boas relações de trabalho e desenvolvimento de práticas resolutivas impactam positivamente. Déficit nas condições e relações de trabalho são significativos na insatisfação no trabalho.

DESCRITORES: Estratégia Saúde da Família; Satisfação no Trabalho; Gestor de Saúde; Saúde do Trabalhador.

SATISFACCIÓN E INSATISFACCIÓN EN EL TRABAJO DE GESTORES EN LA ESTRATEGIA DE AS SALUD DE LA FAMILIA

RESUMEN

Objetivo: identificar y analizar los factores que generan satisfacción e insatisfacción en las actividades de los gestores que actúan en la Estrategia de Salud de la Familia.

Método: abordaje cualitativo, amparado por referentes teóricos del proceso laboral, satisfacción e insatisfacción de Dejours. Se entrevistaron 7 gestores de Unidades Básicas de Salud de regiones geográficas de Florianópolis entre septiembre de 2016 y julio de 2017. En el tratamiento de datos, se utilizó el programa Atlas.ti versión 7.5.

Resultados: entre los factores generadores de satisfacción, se destacan la cooperación y las buenas relaciones con los equipos que prestan asistencia a los usuarios, el carácter resolutivo de la asistencia y la buena relación con los usuarios; entre los factores que generan insatisfacción: déficit/ problemas vinculados con la fuerza de trabajo; déficit/problemas con los instrumentos de trabajo pero no con la capacitación para ser gestor.

Conclusión: las buenas relaciones de trabajo y el desarrollo de prácticas resolutivas impactan de manera positiva. El déficit en las condiciones y relaciones laborales son significativos para evaluar la insatisfacción en el trabajo.

DESCRIPTORES: Estrategia Salud de la Familia; Satisfacción en el Trabajo; Gestor de Salud; Salud del Trabajador.

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INTRODUCTION

In Brazil, with the promulgation of the 1988 Constitution, health becomes a universal right. In 1990, the Unified Health System (SUS) was created by Laws 8080 and 8142. In 2006, the National Primary Care Policy (NPCP) is promulgated, which establishes guidelines to reorganize the care model, based on the principles of SUS and the principles of the Primary Health Care (PHC). The Family Health Strategy (FHS) has been incorporated as a priority within the NPCP, providing for universal access to services, comprehensive care and equity, focusing on families and communities.

The NPCP was modified in 2011[1] with alterations that reinforced the PHC perspective and the search for access universality. Recently, there have been changes, and the provisions of Resolution No. 2436, from 2017[2]. It should be noted that the implementation of this policy has always been a field of dispute of understanding and health care projects, being influenced by the macro policy in force in the country. Thus, the future fertility of NPCP/FHS/PHC, in view of the changes registered in the new Resolution, may be analyzed after its implementation, in a longer time period.

The implementation of models involves both those who do the work, as well as the scope of collective work coordination, work planning and decision making regarding work environments. Managers are responsible for performing an important and full work of challenges for the feasibility and operationalization of health care, especially in the case of the FHS, which can be understood as a technological innovation of work reorganization, a new care model in relation to the hegemonic classic model of biomedicine[3].

Rescuing Karl Marx's theorization of the work process, it can be said that work plays a fundamental role in people's history. Marx presents human labor as a process where men initially idealize and mobilize their forces, to act upon resources of nature (or objects resulting from previous works) and then to transform them in order to meet the need that mobilized them[4]. For him, man, through his work, was able to control in part the forces of nature, putting them at his service.

Transformative action, including the way the worker acts, the activities performed, the objects and instruments used to obtain a given product, constitutes the work process. It also observes that the accomplishment of the work can generate human satisfaction, attending to the desires for a processualistic where it modifies the human being and object - this one, when performing a creative activity, to meet needs, is seen in their creation, in their work[4].

In this perspective, in general terms, the work of the health manager in Basic Health Units (BHU) involves the idealization of the work, the use of existing means to develop it and the transforming action of the reality. The BHU manager who works with the FHS exercises, within the units under their responsibility, the role of a leader and a coordinator of the collective work of the multiprofessional teams and other workers working in the referred care area. The said manager articulates the work of the BHU with the other SUS instance management; monitors and coordinates administrative activities, team care activities and educational activities, as well as evaluates results and performs corrective actions.

The manager's being and doing are no easy task and are far removed from the absence of individual and collective tensions, as they involve aspects of power, conflicting interests, disputes, individual, professional and institutional. Thus, satisfaction and dissatisfaction arise from this challenging activity in PHC/FHS. Job satisfaction and dissatisfaction of managers generate various behaviors, as well as impacts on the organizations. There are few found studies on the subject of job satisfaction and dissatisfaction of managers in PHC/FHS[5-8]. Most studies on the theme of satisfaction and dissatisfaction in health work are international and some national studies, but they address the satisfaction and dissatisfaction of health professionals and workers.

Worker' satisfaction is in tune with their emotional state, their relationship with other

professionals, values and perspectives about the work environment, and may interfere with the professional's quality of life and well-being. The concept of job satisfaction, or "job satisfaction", Is an emotional response of the worker to the work they develop. However, this degree of satisfaction is subject to worker expectations about the issues at work and their preferences[9-11].

Job satisfaction comes to be the many positive feelings that workers expose about it, and the greater the number of satisfaction factors, the better the professional's effort to provide quality care, reflected in a qualified service. Conversely, dissatisfaction at work is characterized by negative factors that may also affect the quality of the activity, leading, in addition to dissatisfaction at work, to physical and emotional distress of the team[12].

Job satisfaction involves the way a person does it, as well as the relationship between what one wants and what one achieves from work, plus the value attributed to it[13].

Given the importance and complexity of health work and the manager in the FHS, the following question arose: Which factors/elements in the work of managers of the Family Health Strategy in the city of Florianópolis generate satisfaction and dissatisfaction?

Therefore, this study aims to identify and analyze the factors/elements that generate satisfaction and dissatisfaction in the work activities of managers working in the FHS.

METHOD

This is a descriptive, exploratory and qualitative study conducted with seven managers in a UBS in Florianópolis. For defining the participants, an intentional sampling was used. This type of definition of participants is applied in qualitative research and seeks to choose the events or types of events that will contribute to the study[14].

Considering that in Florianópolis all BHUs operate in the FHS modality, the following criteria were defined for choosing the managers participating in the study: Inclusion of representatives from the different geographical areas of the municipality with a view to including the management in different socioeconomic contexts, with at least one manager from each Health District; BHU managers considered to be of good quality, for this, two criteria were associated - information provided by authorities of the Municipal Secretariat of Health (MSH) about the BHU considered successful, and the data provided in the first phase of the evaluation of the National Program for Access Improvement and Quality (Programa Nacional de Melhoria do Acesso e da Qualidade - PMAQ), accessible in 2012. Also, being the manager responsible for coordinating the work of the Family Health Teams (FHT) that work in the entire area covered by the BHU; having at least one year of management experience in the FHS; and to be fully employed in the role of the FHS at the time of the interview.

Exclusion criteria for services and managers were: Services that are part of the Sanitary District and are not Health Centers/BHU, such as the Emergency Care Units (ECU), Psychosocial Care Units and others; managers with less than one year of experience in the FHS; managers on sick leave or disabled during the data collection period.The number of participants in qualitative research does not follow a statistical pattern in relation to the population and there is no requirement for a large number of participants, since it aims to find meanings, facts, and not prevalence[15]. In this sense, the number of participants was considered satisfactory by the data saturation criterion.

For data collection, triangulation was chosen as a resource: Interview using semi-structured script, documentary study and observation. Observation and documentary study were used as a support for better understanding of the manager's work and also the data obtained in the interviews.

The interview was scheduled with each participant and in person, with an average time of thirty minutes. As a documentary study, we used the data available in PMAQ, accessible in 2012 and specific documents of the municipal secretary. The transcript of each interview was returned to the participant for validation, and care was taken to ensure the confidentiality of the information.

The collection took place from September 2016 to July 2017. Semi-structured interviews were developed in the interviewees' work environment, audio recorded, transcribed and later organized with the support of the Atlas.ti, version 7.5 (Qualitative Data Analysis), where the search data were entered.

Data were arranged in two major macro categories (Satisfaction Reasons and Manager Work's Dissatisfaction Reasons), categorized and analyzed, considering Marx's theoretical dialectic of historical dialectical materialism and Christophe Dejours' theory of job satisfaction and dissatisfaction.

The analytical process began by selecting significant passages identified in each document (quotations in the denomination of the software), which have been assigned codes (codes). To guarantee the anonymity, the lines are identified as G1, G2, successively.

When the highlighted excerpt was from an Observation Note, it is identified as OBS, followed by the order number.

The approval of the research was issued by the Research Ethics Committee of the Federal University of Santa Catarina, opinion number 1.547.952.

RESULTS

The sets of work aspects and situations considered as generating satisfaction or dissatisfaction were organized into two macro categories: Reasons for job satisfaction of managers in the FHS and Reasons for job dissatisfaction of managers in the FHS.

Reasons for job satisfaction of FHS managers

In the FHS care model, the study participants reported several reasons for job satisfaction, as described in Table 1.

Table 1 - Manager Satisfaction Reasons, Florianópolis, SC, Brazil, 2017 (continues)

Satisfaction Reasons (Codes)	Total Citations (Quotations)	%
1. Team	12	26
2. Assistance resoluteness/Quality Improvement	10	22
3. Good Relationship with Users	5	13
4. Like what you do	4	8
5. Autonomy	4	8
6. Work with the PMAQ	4	8
7. District and Municipal Health Department Support	3	6
8. Appropriate Physical Area	2	4

9. Remuneration	1	3
10. Work at the FHS	1	2
Total	48	100

Source: Created by the author from data extracted from Atlas.ti 7.5

The team appears as the most significant reason for satisfaction for managers. The sense of cooperation among teams and managers, and the involvement of professionals with users and families who seek the BHU, contributes to better care resoluteness, being identified as a generator of satisfaction. The expressed by the managers indicates that the relational aspect is determinant for job satisfaction.

Team, this year, I went to the cabinet for three times, meeting with the assistant secretary, to take over the coordination of another unit [...], which is on the side of my house I can go on foot and I didn't want [...]. We are resolute, our team is like that. (G7)

I talk quickly to a doctor and he tells me that he loves working there, which is very rewarding, that the teams help each other. When a colleague is missing, another will attend urgent patients [...]. (OBS3)

As for the professionals who work here, the CHA report tells me that they are a great, close-knit team who have a unique language, they understand why a certain "colleagueship" takes place [...]. (OBS1)

The second most important reason for satisfaction was the resoluteness of the Care:

See people's happiness, see their health restored, and even practice health promotion, before seeing the disease itself. (G6)

Resoluteness of the team, as for the provided assistance, be resolved you know? (G3)

During the observation period it was possible to notice that everyone who comes to the BHU with any demand is welcomed and checked for their needs. If you have an appointment you are already referred to doctors/dentists and nurses. (OBS5)

As a third reason for satisfaction, the good Relationship with the Users stood out.

Health Center conflicts are well mediated because we have a good relationship with the community.... As I said, we have an excellent relationship, both between workers and between users and their families. (G3)

I talked to a CHA who informed me that the work there is great, but very rewarding, because the population is helpful and cooperative. (OBS1)

Other satisfaction reasons mentioned by the participants were having the autonomy to do the work, enjoying what they do and working at the FHS, having the support of other management bodies, working conditions, remuneration, and having adequate working means (highlighting the physical area and having a care assessment instrument such as the PMAQ).

Reasons for job dissatisfaction of FHS managers

Regarding the factors of dissatisfaction that emerged in the speech of managers, one identified ten reasons given in Table 2.

Table 2 - Manager Dissatisfaction Reasons, Florianópolis, SC, Brazil, 2017

Reasons for Dissatisfaction (Codes)	Total Citations (Quotations)	%
1. Deficit/Problems with the Workforce	14	21.21
2. Deficit/Problems with the Work Tools	12	18.19
3. No Training to be a Manager	7	10.6
4. Problems with the Central Management	6	9.10
5. Vulnerability/Violence	6	9.10
6. Misunderstanding of the Population	5	6.05
7. Increased Demand	5	6.05
8. Little Autonomy as a Manager	4	5.7
9. Low Care Resoluteness,	4	5.7
10. Accumulation of activities - manager and assistance	3	4.5
Total	66	100

Source: Created by the author from data extracted from Atlas.ti 7.5

Among the causes for the dissatisfaction cited by the managers, we highlight the Deficit/Problems with the Workforce (21.21%) and the Deficit/Problems with the Work Instruments (18.19%), illustrated in the excerpts from the interviews that follow:

We have difficulty maintaining equipment, which greatly interferes with your work process. Our equipment is old, so it gets in the way. (G5)

What else comes out being trouble [...] (it is) the lack of medical consultation, which is one of the things that knocks a lot on the coordinator's door; Sometimes we don't have much to do. Without a pro you know it's complicated. Unit (BHU) problems are usually HR (Human Resources) issues. (G4)

A CHA talks to me and tells me that there is a lack of nurse and CHA, because the manager is very overwhelmed with everything. (OBS4)

"No Training to be Manager" is also noteworthy, which was mentioned by 100% of the interviewed managers, and identified by some as a generator for dissatisfaction. This finding is illustrated in the following statements:

No, I did not receive any course. I got the job unprepared and started working as a manager, I learned as I developed the activity. (G3)

I wanted that the part of having a managerial training, for those who assume management position, who had a preparation would be encouraged … because everyone get the job unprepared and such things, what do I have to do now? [...]. No one ever told me what I had to do here. (G7)

The mention of problems with higher instances of management was also very significant.

Lack of support from the municipality for health facilities (G5).

The question of these impositions from top to bottom without an assessment. It is very common, now in the campaign season promise several things, then when will put into

practice, we were not asked if we can afford this demand that they want. These are all annoying things. (G4)

The following were mentioned as reasons for manager dissatisfaction: The situations of vulnerability and violence, the misunderstanding of the population in relation to the problems of deficit of instruments and workforce and the increasing population increase in the areas covered by the BHU. In addition, aspects related to the manager's poor autonomy, the low resoluteness of the care and the accumulation of activities, especially those of management and care provider, are added.

DISCUSSION

The results of this study indicated that the job satisfaction of the managers participating in the research is strongly influenced by the teams that work at the BHUs under their responsibility, especially the FHT responsible for attending the enrolled population. The accomplishment of a collaborative and integrator work for different knowledge and doings was positive for the satisfaction of the managers.

Dejours[10,16] reports that the work, being a source of satisfaction, enables the relief of the psychic burden for the worker, in our case, the manager. If the work is organized, it is balancing and structuring.

The second reason for satisfaction for managers is associated with the available resources and the professional's technical capacity, as well as the professional/user relationship.

A health services' resoluteness is a way for assessing how health services are being provided, based on the results achieved in providing this assistance[17].

Marx[4] reported the importance of the worker to recognize themselves in the product of their work, to obtain satisfaction. Being the work developed by a group that gets involved, that has objectives and efforts combined, as a consequence it reaches better resoluteness and quality. The mentioned satisfaction is linked to the quality of the service provided. For this, it is necessary that the institution strives to find out what the user needs to develop the right product for him[18].

The third item of satisfaction is the relationship with the users. Establishing healthy proximity to the user can ensure that all goes well throughout the health work process. To ensure a good relationship, the FHS model has been collaborating, articulating spaces for users and their families, as well as their physical and social environments, allowing greater clarity about the health-disease process, with actions that go beyond curative practices[1].

Regarding the dissatisfaction at work, it was found that the main reasons are: Deficit/ Problems with the Workforce and Deficit/ Problems with the Work Tools. The deficit or problem with the workforce puts a burden on the manager, hinders the development of activities in the BHU and generates suffering. Health work is highly dependent on the workforce, so any action in this field requires looking at who does the work[19].

Ideally, activities should be shared among the professionals; and not occurring, will cause discomfort and suffering. The working relationships that are established in the teams influence the care outcome[20].

The instruments of labor are, according to Marx[4], what is between the worker and their work object and their function is to direct the activity towards that object. The work instruments are all the material conditions necessary to carry out the work process; without them, the process is totally or partially unable to be completed[20].

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In health, the work tools are varied: Equipment, instruments of various kinds, medications, knowledge and technologies, the physical space of the institutional environment, etc. Deficit and problems with work tools are a health problem in Brazil, negatively affecting the health of those who run the sector, as well as the result of the provided care.

Amid all the reasons for dissatisfaction, the lack of preparation of managers to act as such deserves to be highlighted, as it was a unanimous report, in which all reported not having received training from the public agency, in this case, the MSH, to perform their managerial duties. The literature describes that there are no professionals prepared to act as managers in SUS[21].

The professional who will develop the role of manager needs to receive professional training, being a prerequisite for the implementation of changes and reforms in all fields of public policy. Therefore, it is a challenge to establish training programs engaged in the policy of valorization and professionalization of health management activity, as well as the daily practice of managers. The NPCP, with its reformulation that took place in September 2017, establishes the qualification of managers for PHC[2].

Approximate research and study of this new legal requirement is required and its actual implementation observed, with a view to giving the manager better working conditions.

In this perspective, it is worth mentioning the importance of a Permanent Education Policy that has as its methodological axis the process of health work, the problematizing teaching and, as a consequence, the significant learning, since it is known that specific and decontextualized skills of the process of work are less effective.

Qualitative research seeks to understand individuals in their own context and, therefore, can be performed with an intentional sample, which can be characterized as a study boundary, besides being carried out in a single municipality. In this sense, studies involving multiple scenarios and a larger number of participants can reaffirm or modify the results herein submitted.

FINAL CONSIDERATIONS

According to the collected data, it can be concluded that the managers participating in this study have as their main factor for job satisfaction the cooperation and good relations with the teams that assist the users of the BHU under their responsibility. The resoluteness of care and the good relationship with the users were also noteworthy.

In this study, managers considered that job dissatisfaction is strongly related to the workforce, including deficit and problems in work relationships. In addition to these two aspects, the issue of lack of management skills mentioned by all study participants was highly significant. These three elements trigger dissatisfaction in the manager, generating psychic burdens and stress, which can cause damage to the worker and also negatively influence the quality of the performed work.

The present study makes it possible to identify that the job satisfaction and dissatisfaction duality are elements that do not occur in isolation. The presence or absence of certain factors is what determines them and gives meaning to this ambiguity.

The study on job satisfaction and dissatisfaction of the managers is a contribution to scientific knowledge and also has the potential to impact practice by shedding light on aspects that can be reinforced or corrected for better PHC implementation and better qualification for the care being provided to the users.

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