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Perceptions of primary healthcare professionals about quality in the work process

Percepções dos profissionais de saúde da atenção primária sobre qualidade no processo de trabalho

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Abstract

This article describes the cores of social significance identified in the speeches of primary healthcare professionals regarding the quality of the actions performed. This is a case study carried out in two services organized according to different models: a "traditional" unit, with community agents, and one for family healthcare. The interviews and observations are analyzed based on the framework proposed by Vigotsky, dialogically with the literature on the working processes in health care. The results point as the main cores of quality in basic care: reception as interaction between professional and user of the Brazilian National Health System (SUS); diversity of multi-professional and intersectoral offers; community agents as a link between healthcare team and community; and teamwork and democratic management. Even though these aspects are socially understood as cores for quality in primary health care among professionals, there are tensions and contradictions between the legitimized and the instituted as practices.

Keywords: Primary Health Care; Health Services; Quality of Health Care.

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Resumo

O artigo descreve os núcleos de significação social identificados nas falas de profissionais de saúde da atenção primária com relação à qualidade das ações desenvolvidas. Trata-se de estudo de caso realizado em dois serviços organizados segundo modelos diferentes: uma unidade "tradicional", com agentes comunitários, e uma de saúde da família. As entrevistas e observações realizadas são analisadas a partir do referencial proposto por Vigotski, em diálogo com a literatura sobre o processo de trabalho em saúde. Os resultados apontam como principais núcleos de significação da qualidade na atenção básica o acolhimento como interação entre profissional e usuário do Sistema Único de Saúde, as diversidades de ofertas multiprofissionais e intersetoriais, os agentes comunitários como elo entre equipe de saúde e comunidade, e o trabalho em equipe e gerenciamento democrático. Ainda que esses núcleos estejam socializados entre os profissionais como significados de qualidade, observam-se tensionamentos e contradições entre o legitimado e o instituído como prática.

Palavras-chave: Atenção Primária à Saúde; Serviços de Saúde; Qualidade da Assistência à Saúde.

Introduction

The Brazilian National Health System (SUS) is recognized as one of the greatest achievements of Brazilian society. However, the still hegemonic assistance model tends to be focused on medical assistance, which is fragmented and specialized, and has healing actions as their privileged *locus* of attention, with still incipient articulation in relation to other therapeutic practices or not strictly biomedical rationalities (Cavalheiro; Marques; Mota, 2013; Duarte et al., 2015; Paim et al., 2011).

The transformation of this model towards the ideals proposed by SUS requires advancements in thought and elaboration of the production processes of care that have been performed by these services, i.e. it (re)defines the need to take health practices as a specific focus of analysis.

Within the area of primary health care (APS), the study of health practices as work has been conducted under different perspectives, the approaches regarding work process in health being a privileged view of analysis (Merhy, 2000; Peduzzi, 2001, 2002; Schraiber et al., 1999). In this approach, it is possible to state that the concept of quality is directly related to the concrete modes with which actions are carried out, and to how the working process is conducted, which depends on, among other things, the performance of professionals and the way these agents internalize the concept of quality and express it in actions in their services routine (Dalla Vecchia, 2012; Nemes et al., 2004).

In the health work process, the subjects of action, i.e. the health unit professionals, are set as the agents responsible for the active integration of the constituent elements of this process, intermediating the relations between instruments and the subject-objects of intervention and, thus, conducting a project that is both socially defined and mediated by the intersubjectivity of the subjects involved. In this sense, approaching the conceptions of health professionals on the quality of their actions can provide elements for critical thinking on the project that drives the articulation of material and immaterial instruments on the part of these subjects.

As part of a set of studies on quality in APS (Cunha; Giovanella, 2011; Giovanella et al., 2009; Starfield, 2012), this study aims to determine the conceptions of quality incorporated in the routine of these services. In other words, what are the guidelines that direct the actions conducted in health services and that delimit quality standards, according to the perception of the subjects that carry out these actions themselves? Are there different conceptions among professionals of organized services based on distinct models? How is the work process in APS organized and conducted? Are the guidelines of SUS for organizing primary health care taken as quality standards, such as bond, humanization, co-responsibility, among others, present in the perception of the agents directly involved in these actions? Better understanding these issues can assist in constructing institutional processes that recognize and dialogue with different concepts that guide the practices of those directly involved in the production of care in APS, increasing the introduction of new practices (Camelo et al., 2000; Carvalho et al., 2004; Conill, 2002; Giraldo, 2015; Hartz; Contandriopoulos, 2004; Schimith; Lima, 2004).

For an approximation of the conceptions of quality available in the APS work process, and as a way for further understanding the values internalized by the agents in the production of care, the theoretical framework presented in the studies by Vigotsky (2007) was applied, while trying to articulate the concepts developed by this author and his followers with the concepts guiding the analysis on health practices at work, particularly from the concept of social significance.

Aguiar and Ozella (2006), based on Vigotsky and on the realization that men transform nature and themselves during activities, indicate that meanings must be regarded as constituent elements of cultural, social and personal production processes. Human activity is always signified, that is, man, during human action, performs an external and an internal activity, both of them operating with meanings.

> Thought is [then] subjected to many transformations before it is expressed in words, in such a way we can arrive at the conclusion that the transition from thought to word passes through meaning and sense. In this way, it is possible to argue that the understanding of the relation thought/language undergoes necessary understanding of the categories of meaning and sense. (Vigotski, 2001, p. 226)

To Vigotsky (2001), meaning corresponds to the relations under which the word can be understood and mean something to people; in the psychology field, it is a generalization, a concept. The meanings of words evolve and transform, as they are constructed throughout the history of humankind, based on the relations of individuals with the social world wherein they live. To him, meaning is a social construct of conventional origin, relatively stable, in which man, at birth, finds a system of meanings already historically prepared, to be internalized, reproduced and transformed by their actions.

In this sense, it is possible to state that all human activity produces meanings, defined by Aguiar and Ozella (2006, p. 226) as:

> social and historical products. They enable the communication and socialization of our experiences. Hence, meanings refer to instituted content, more established, shared, that are appropriated by subjects, and configured based on their own subjectivities.

In this study, we attempted to articulate the Vigostkian methodological approach to the health work theory, both for the formulation of an instrumental framework for data collection and analysis and as a reference to identify cores of social significance in the speech of subjects and through the observation of the actions conducted. The tensions and contradictions between the legitimated and the instituted as quality practices in APS are described. In this approach, it was decided not to further capture personal senses assigned or constructed by the subject individually, but rather grasp socially imposed meanings in a whole, as a dimension that in principle directs the elaboration of sense and reflects moments in

concretely performed practices. Although meanings and senses are typically discussed together in socio-historical psychology analyses, they are distinct categories, which allows for apprehending the social meanings attributed to quality in APS.

Methods

This is a case study conducted in two primary care services organized according to different models: one being a "traditional" unit, with a Program for Community Health Agents (Pacs), and the other organized according to the Family Health Strategy (ESF). These services are located in a medium-sized municipality in the state of São Paulo, with approximately 400,000 inhabitants. Choosing these services was based on the results of prior research that assessed the healthcare network of this municipality by means of a structured questionnaire (QualiAB) answered by managers of all the units of the healthcare network in July 2007 and that defined a quality ranking between services (Bizelli; Castanheira, 2011; Castanheira et al., 2009, 2011, 2014).

Assessing the quality of the organization of work processes in basic care through structured and self-response instruments, as proposed by QualiAB, allows the simultaneous inclusion of a set of services and the acquisition of results that become instruments both for local teams and managers in the planning and monitoring of actions that increase quality, allowing to characterize the organizational base that defines the operating model of care. However, this type of assessment does not advance in deep explanatory analyses, especially when referring to relational and intersubjective aspects of health work, which are constituted as social practice and cannot be seized by means of organizational indicators (Castanheira et al., 2014).

This study seeks to advance in the explanatory model of evaluation previously performed in the services studied through qualitative research of type case study, aiming to understand how quality is expressed in the speech of the subjects who operate the actions carried out in routine of these services (Yin, 2001).

Rey (2013, p. 108) states that

> quantitative research has historically been guided by an analytical logic based on the decomposition of the problem into its elements [...]. Going towards a qualitative representation on what is studied is always a construction of thought, which is impossible to ground based on inductive processes.

During the study period, the healthcare network was composed of 19 basic health units, 2 of those being family health units, 12 traditional basic units, 1 basic unit with Pacs, 1 basic unit with specialties, 2 integrated units of outpatient care and emergency, and 1 basic unit with emergency medical service and specialties.

The units chosen for this study were the two most well-evaluated, according to structure and process indicators, and that corresponded to the criterium of being organized according to different models – a "traditional" basic unit with Pacs and a family health unit (Carrapato, 2011; Vasconcelos, 2011).

The services studied had a similar total number of secondary and higher education professionals. The traditional unit was a former Health Center of type I, i.e. of higher complexity and having community health agents (ACS), a unit which we will call "UBS". The family health unit had four teams which, all together, constituted the service, and will be called "USF".

The work was developed through direct and systematic observation of how assistance was organized, semi-structured interviews with managers and professionals with higher education, and focus group with the technical and administrative support teams and ACS. All university-level professionals were interviewed, 13 of the UBS and 11 of the USF, being conducted four focus group interviews, two in each unit, addressed to professionals with secondary education and the ACS, totaling 88 subjects, 39 professionals of the traditional UBS and 49 of the USF.

The observations followed a script focused on the organization of work and were recorded in field notes. The care service conducted in both health units was analyzed for twenty days, ten days for each service, being attentive to the work of health

professionals and the way in which the population was welcomed, in addition to monitoring home visits of the ACS and the participation of educational activities, such as hiking.

The interviews and focus groups were recorded and transcribed, later being skimmed and comprehensively read, seeking to identify in the speeches the cores of significance that indicate the understanding from subjects about quality of health care. In this construction, initially we used the records of the field notes and subsequently conducted the interviews with professionals with higher education, managers, and focus groups.

The analysis sought to understand the attributes of quality and the obstacles to its effectiveness by identifying the meanings given by the set of professionals, singularity of the voice of subjects from an initial thematic approach, then organized into **cores of significance** and grasping of the constitution of **senses** implicit in the lines and, consequently, with emotional content of professionals related to the quality and organization of the work process in basic care.

According to Aguiar and Ozella (2013, p. 301), the singularity is built from the conception

> of man in a dialectical relationship with the social aspect and history, which makes him at the same time unique, singular and historic. This man, constituted within and by activity, when producing his human form of existence, reveals - in all its expressions - the social historicity, ideology, social relationships and mode of production. At the same time, this same man expresses his singularity, the new that is capable of producing social meanings and subjective senses.

Vigotsky (2001, 2007) states that signs structured in linguistic representation systems acquire the value of psychological instruments due to converting, through practical activity, into bearers of certain meanings. In this process of appropriation of reality through consciousness and of constitution of a conscious psychic reflex, meanings stabilize themselves as representations of reality and, by being communicated socially in the form of speech, acquire an objective, intentionally guiding the conscious activity of the human being, giving meaning to it. Hence, we seek to find the meanings attributed by health professionals to quality through analysis of the speeches of the research subjects.

According to Aguiar (2009), research with a socio-historical approach seeks to grasp the meaning of speech while unit of thought and language, with **the word with meaning** as the unit of analysis. In this process, it is possible to identify cores of significance that express forms and contents of senses performance by individuals based on their concrete practice and their historical and social insertion.

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Results and discussion

The cores of social significance seek to reflect the conceptions of **thinking and feeling** prevalent in the set of subjects from each of the services analyzed on quality of primary care, while social understanding of the group. Four cores of social significance concerning quality in the APS were identified.

Welcoming as interaction professional/user is a quality attribute, but its execution is limited in function of users' lack of understanding and the high demand of medical consultations

> *Welcoming is not medical care. A feeling of trust between staff and time for welcoming is necessary.* (Family Doctor)

On several occasions, health professionals express that the interaction between health professional and user constitutes one of the main determinants of quality in the APS, defining this mechanism as "welcoming" and relating its expression to work organization mechanisms.

They point out that, in the USF, there is always a nursing scale posted in the waiting room that identifies the professional who will be treating in a specific room all users that were not scheduled and seek care in the unit. In the UBS, it is the Reception that identifies an available professional to meet and listen to the patient in a room or, when there is no private space available, in the reception itself. Both units value "open doors" for spontaneous demand and the referral to a responsible professional and a physical space as defining of welcoming, i.e. as indicators of the development of practices committed to the interaction between professionals and users.

Welcoming is a peculiar form of humanization in the APS. However, this is often performed poorly due to the lack of a specific project in different local contexts to guide the professional's work in this matter (Camelo et al., 2000; Teixeira, 2005).

More than being valued as the team's attitude with regards to the community, the intention of developing actions that allow for the interaction between professionals and users is mostly a guideline of how to organize reception to spontaneous demand. The priority given to the reception mechanisms of spontaneous demand, in addition to representing the partial incorporation of a humanization policy, points both to the importance given by the team to equating care to this demand as well as its valorization with regard to work in its entirety.

> *On the other hand, respondents report that users perceive welcoming as immediate healing care, with prescription of medication, and as a moment prior to What people are seeking as welcoming are medical consultations. A huge part of them ends up coming for nursing consultation, often for lack of medical consultation. Sometimes we solve this, because they are often requests for exams, which reduces the burden on the doctor. We make an evaluation,* [and] *depending on the exams,* [the request] *is done by us.* (UBS Nurse)

> *We welcome this patient, listen, see what their problem is and try to guide them: If they are in pain, we give medications and orient them on what must be done - make an appointment or something else.* [...] *As soon as I walked in to work, patients wanted medical consultation. This is cultural and happens a lot.* (UBS Nurse)

Hence, in addition to considering the welcome a specific moment of the organization of work, we can identify the existence of a tension between how the welcoming process is characterized and the way the demand is expressed by these users, making them responsible for requesting a doctor-centered care.

On the other hand, the nurse is set as having a secondary role and without specialties, who "facilitates" medical work, contrary to the idea of interaction between professionals.

The guidelines for welcoming, according to the National Humanization Policy from SUS (Brasil, 2003), orient changes in the organization of the work process by promoting bonds with users, co-responsibility and resolutivity. Thus, they advocate the welcome of patients, listening and providing a positive response for the health complaints of the population. The welcoming process held in many basic health units does not follow what is advocated, with a tendency to occur divergence between the welcoming practice as defined by health policies and the practice effectively performed in these services (Camelo, et al., 2016; Girão; Freitas, 2016). This divergence is expressed in the interviewed professionals' speech, who recognize what is advocated on welcoming, but do not practice it fully.

Thus, the main tension that is established is between the "must be" embedded in the speech and in the efforts of unit reorganization, and the simultaneous identification of impediments in advancing to a new model based on "the other", the user being pointed as resisting to the decentering of medical consultation as the best answer to any need, which leads us to question of how much the "welcome" fulfills the role that is expected.

Users expect that the relationship between them and the health professional is capable of creating a welcoming that allows action over their suffering and problems. There is a great expectations on the part of the user that the

worker – individually or collectively – responds with the aim of solving their problem. It is expected that the full set of health actions to which the user is willing to undergo will bring them benefits, that is, that they be able to change their situation. Hence, their highest expectation is that health actions be effective and satisfy them (Lima et al., 2014; Schimith et al., 2011).

In fact, it is possible to say that the USF and UBS present difficulties in conducting a welcoming process for the spontaneous demand that is not centered on medical care, since health professionals state manifold that, for "cultural" reasons, users seek the unit as a place to "cure" their disease, where the expected response is immediate medical attention, conduction of exams, and access to medicine.

> *Here, we work with a mischaracterized model. In the sense of excess of people and the way in which it is welcomed this excess of people. There is the welcoming process that goes much more overboard than what is established, so* ***it's like it was the first-aid post of the family.*** [...] *This hinders the other activities we must do, such as educational groups, meetings, home visits – we often can't do them because of the excess of patients.* [...] *The model is mischaracterized because the part about prevention would have to be done more, with more visits, but we don't have time to do that.* (Family Doctor)

The large demand is also presented as an expression of "misuse" of the service by the user population, reinforcing the responsibility of "the other".

The welcoming performed in the routine of the services studied, according to the record of observations and regardless of the organizational model, both in the UBS and USF, often assumes the character of reception service and screening of the "door", although in the speech of the various actors the welcome is referred as a practice that comprises all spaces of health services, i.e. as being present wherever there is an encounter between workers and users.

Diversity of multiprofessional and intersectoral offers confer quality, but compete with the centrality of medical consultation at work

> *You must have the profile, you have to enjoy working with the community, because the goal has more to do with the community, with prevention and promotion, than with consultation and medication themselves.* (UBS Nurse)

A second core of significance that emerges in the speech of the professionals refers to the importance of work being organized in diversified manner in relation to the biomedical approach, and for such it is valued the strategic presence of community workers.

There is effort and valuation of a diversified offer in both UBS and USF. Thus, daily, the health team seeks to create therapeutic groups, groups of pregnant women, hypertensive and diabetic patients, and, aside from these internal activities, there is interest and commitment to the development of outside activities such as hiking, promotion of excursions, celebration of festive dates, and occupation of spaces to conduct partnerships with universities and other municipal departments.

> *I was able to develop an intersectoral work, in which I mobilized and articulated the community* [and] *the health managing council. We were able to show to this community the need for partnerships and, together with competent bodies, seek the possibility of bringing equipment to use the space that was idle.* [...] *at night with the Sports Department, with Capoeira, also used as an intern space by the Law School of Anhanguera every Tuesday morning for legal assistance to the user population.* (UBS Manager)

A wide program of "extramural" actions means the effort of articulating health promotion, disease prevention and assistance, thus further constituting practices of integral health care. However, these activities "compete" with each other through the work time of those that take responsibility for them, and the individual medical assistance remains as the main response to great demand.

Here's what happens: we have patients who are scheduled, but there isn't a stipulated number for welcoming per day; whoever comes, we treat. This hinders the other assistance activities that we have to do, such as educational groups, meetings, home visits. We often can't do it, due to the excess of patients. (Family Doctor)

Despite the diverse and intense attempts to transform the space of assistance action with educational activities, emphasizing a vision of expanded clinic and considering relevant the subjective aspects and the social determinants of the "disease", there is the predominance of biomedical assistance, which seeks as a main focus the clinical diagnosis and medical treatment, without articulating the disease with other aspects, such as psychological and social ones.

On the other hand, it is pointed out that the diversification of assistential offer incorporating different alternatives to respond to the complexity of demand is acknowledged by users, who then start searching for these alternatives.

Nowadays, it is all complete. Nowadays, they want a nutritionist. In the old days there were no social workers, it's a fight for the social worker, because she has so many meetings in various places. Today the demand is great for other professionals, such as social worker, nutritionist, not only the doctor. Today is a bit different, the Pap smear is performed by the nurse. Today there's this demand, previously there wasn't, the patients' view was exclusive to medical care. (UBS Administrative Employee)

I see it as a multidisciplinary team for meeting the patients' needs, so whenever I need I'm there along with the nurse discussing the case, asking for help. Even with the doctor we have a very good relationship, we can have this access, discussing the patient's situation as a whole. One knows what the other does, sometimes we sit down to discuss a case. Depending on the case that appears, I turn to the doctor, the nurse, the social worker for discussing and seeing how we can solve it as a team. (UBS Nutritionist)

The demand for other professionals can be seen as indicative of the recognition of the incorporation of new needs by the user population and a result of the effective offer of multiprofessional care.

It is then determined an evident tension between the initiatives of intersectoral approach and multiprofessional work, and even interdisciplinary, as implied in the effort of team construction of alternatives to answers for the cases, and the loss of priority of these practices due to the time required for "consultation", in the words of Schraiber, Nemes and Mendes-Gonçalves (2000).

The community agents are the link between team and community, they face complex problems and find more difficulties when they cannot have an organic integration with the team

You gotta know how to work in teams, you cannot impose things, you have to ask everyone's opinion. Here, the doctor isn't the only focus, if he were we would not have the monitoring of a community agent. These agents, for instance, most of the time I know that the patient is not well because of their information. (Family Doctor)

A third core of significance that illustrates the quality determinants of APS attributed by the professionals refers to the attendance made by ACS, as these professionals are pointed out as the main link between the social and family realities of patients and the staff, given the proximity to the community defined by their job.

ACS is presented as a mediator between the service and the community and different knowledge. Through this mediation, the role of the ACS is valued by users of SUS, because it is built an egalitarian bond for which the user demonstrates ease in speaking about their life (Placideli; Ruiz, 2015; Queirós; Lima, 2012).

In both units studied, the presence of ACS is valued as a factor that adds quality to the actions conducted and as one of the determinants for decentralizing the work of the biomedical core.

Respondents emphasized that ACS enables other health professionals to know the location where the user lives, how families survive, and their relational,

emotional and social difficulties. The technical team reveals that ACS brings the problems encountered at home for discussion and participates of decisions, presenting strategy suggestions for acting in the community in order to generate improvements and create overcoming scenarios.

The professionals of the medical staff of the USF appreciate ACS more. There is daily interaction among them and a greater sense of belonging to a same team. At the traditional UBS, some team members present more difficulty in understanding the role of this professional, but still believe that interventions on families cause positive changes in peoples' lives, although they do not feel as being participants of this process.

It is pointed out that because the ACS carries out visits to households and lives in the region, they have greater proximity to the reality where the nearby population live, which enables a stronger bond between the health service and the life context of the users.

Although the ACS exercise the role of mediator between the health service and the user population, many times they feel frustrated for not being able to perform all the functions proposed for their work. They identify complex problems they seek to "resolve" in the best possible way.

> *Everything we see within the residence, we have weekly team meetings, and we hand it to the team for them to try and solve it. Sometimes you know [the patient] is a drug user or has HIV, but the person does not speak, so you try to acquire the confidence of the family and the patient ends up saying. When they give this opening, then you see what can be done.* [...] *Sometimes I feel discouraged when I can't solve a problem.* (Family ACS)

Teamwork and democratic management as attributes that extend the responsiveness to patients' needs and promoting changes at work and in the care

> *Another differential is the team's autonomy. The whole team decides, everyone gives opinions and suggestions.* (UBS Nurse)

The fourth core of significance present in the speech of virtually all respondents is teamwork - characterized as able to solve problems presented by users and having autonomy to suggest changes, in a very connected manner to the democratic and horizontal management, while enabler of integration in work relations.

> *Everyone always tries to solve the patient's problem, one knows what the other does. Every week we have a minimal team meeting, and in this minimal team everybody says what's going on, what the patient needs, and then we can improve his life.* [...] *Everyone always interacts a lot, that's cool. The dentist is not isolated in their office, you stop seeing the patient as a tooth, and can then see other problems.* (USF Dentist)

> *So whenever I need I'm there along with the nurse discussing, asking for help. Even with the doctor, we have a very good relationship; we have this access, discussing the patient's case as a whole. One knows what the other does, sometimes we sit down to discuss a case. Depending on the case that appears, I turn to the doctor, the nurse, the social worker for discussing and seeing how we can solve it as a team.* (UBS Nutritionist)

Respondents from both UBS and USF emphasized the importance of teamwork, referring to it as interdisciplinary work that should be focused on the user.

However, both in speech and observations, we realize that, in the UBS, work is organized in such a way that fragmentation and difficult integration tend to occur. Each professional stays in a room treating patients, and when necessary, there is referral to another professional. The difficult cases are discussed without a formal space for this - just barely, in a room and/or hallways of the health unit. No periodic meetings are held with the purpose of discussing cases and elaborating projects articulated towards acting, despite respondents mentioning great team integration.

In the USF, team meetings occur weekly, in a set period, with the participation of nurses, manager, and general coordination of Family Health

Units, being discussed topics such as welcoming organization, project creation, conduction of clothes bazaars used to collect financial resources, Bolsa Família and discussion of difficult cases, among others, also being emphasized that the office/room is not the doctor's, but of the team.

It is pointed out that, in order to get good results and interfere directly in the quality of services provided, teamwork requires the exercise of professionals' autonomy, whose limits are given by the common project that unites them. Thus, teamwork is pointed as essential to the quality of care, but its feasibility is directly related to an integrative local management.

Conclusions

The use of the vigotskian referential foundation enabled identification of cores of social significance on the quality of primary health care attributed by professionals directly responsible for the development of care actions in the daily routine of the services.

Analysis of the material allowed for the reading and understanding of its cores of significance, based on an approach from socio-historical psychology, dialogically with the organization of health work. Through field observation, focus groups and interviews were performed, and tensions and contradictions were identified in the conceptions of the agents, representing **social significances**, depicting the ongoing movement in health practices of primary healthcare. The tension arises from the moment the health professional presents a speech with updated scientific technical knowledge, but executes the opposite in daily routine.

The practices of the professionals of the APS are closely related to previous accumulations represented by prior aspects of training and experiences, both formal and informal, in constant transformation due to their routine activities and their historic and social insertion. The actions developed by the professionals are often automated, setting a gap between them and the social and culturally accepted concepts regarding quality embedded in speech, expressing contradictions and tensions.

The approach used demonstrates that, on the one hand, the quality of the actions in APS depends on policies of support and encouragement, which also define the current assistance model; on the other hand, one should not underestimate the determination power of the working process concretely operated in the services as a result of the "live work in action" and the social meanings incorporated by its agents.

Returning to the issues initially placed, it is possible to identify in the speech of both USF and UBS professionals a discourse that is consistent with the guidelines of SUS and the National Healthcare Policy (Brasil, 2012) on quality, with distinct contradictory points between them and related to the concrete organization of actions. The "official discourse" that assigns to the ESF and the APS the role of primary strategy for the reorganization of the assistential practice with new bases needs to be deepened, both in political and technological terms. Observation of these experiences indicates a discrepancy between the "discourse" already incorporated by the services and the assistential practices they implement, which most times have not achieved the "promised objective".

In a first level, for the subjects interviewed, quality is related to the way the service conducts welcoming for the user, how the work process and development of teamwork are organized, and to the understanding of the reality experienced by the user, aside from an "horizontal management", in which all professionals are considered important and capable of promoting changes at work and in peoples' lives. The limitations for implementation of quality is expressed themselves in their own speeches, with differences between the services analyzed.

USF tends to present a work process organization that allows greater approximation with the ethical-normative principles of SUS than the UBS. That is, the USF aims to perform actions that improve entirely through a teamwork that values the proximity with the community and that has local autonomy for defining of the best care strategies for the population.

Although the cores identified are socially understood among the professionals as meaning quality, the tensions and contradictions between

the legitimized as "desirable" and the established practice represent concrete limits for effective "should be", not only of political and institutional nature but also defined by the senses that the agents effectively internalize and reproduce in health practices.

Referências

AGUIAR, W. M. J. Consciência e atividade: categorias fundamentais da psicologia sócio-histórica. In: BOCK, A. M. B.; GONÇALVES, M. G. M.; FURTADO, O. (Org.). *Psicologia sócio-histórica*: uma perspectiva crítica. 4. ed. São Paulo: Cortez, 2009. p. 95-110.

AGUIAR, W. M. J.; OZELLA, S. Núcleos de significação como instrumento para a apreensão da constituição dos sentidos. *Revista Psicologia: Ciência e Profissão*, Brasília, DF, v. 26, n. 2, p. 222-245, 2006.

AGUIAR, W. M. J.; OZELLA, S. Apreensão dos sentidos: aprimorando a proposta dos núcleos de significação. *Revista Brasileira de Estudos Pedagó*gicos, Brasília, DF, v. 94, n. 236, p. 299-322, 2013.

BIZELLI, S. K.; CASTANHEIRA, E. R. L. *Saúde na roça*: expressões da qualidade das práticas de atenção primária. São Paulo: Cultura Acadêmica, 2011. v. 1.

BRASIL. *HumanizaSUS*: política nacional de humanização. Brasília, DF: Ministério da Saúde, 2003.

BRASIL. *Política Nacional de Atenção Básica*. Brasília, DF: Ministério da Saúde, 2012.

CAMELO, S. H. H. et al. Acolhimento à clientela: estudo em unidades básicas de saúde no município de Ribeirão Preto. *Revista Latino-Americana de Enfermagem*, Ribeirão Preto, v. 8, n. 4, p. 30-37, 2000.

CAMELO, M. S. et al. Acolhimento na atenção primária à saúde na ótica de enfermeiros. *Acta Paulista de Enfermagem*, São Paulo, v. 29, n. 4, p. 463-468, 2016.

CARRAPATO, J. F. L. *Qualidade e organização do processo de trabalho na atenção básica:* percepções e significados atribuídos pelos profissionais de saúde. 2011. Dissertação (Mestrado em Saúde Coletiva) – Faculdade de Medicina de Botucatu, Universidade Estadual Paulista, Botucatu, 2011.

CARVALHO, A. I. et al. Concepts and approaches in the evaluation of health promotion. *Ciência e Saúde Coletiva*, Rio de Janeiro, v. 9, n. 3, p. 521-529, 2004.

CASTANHEIRA, E. R. L. et al. Avaliação da qualidade da atenção básica em 37 municípios do centro-oeste paulista: características da organização da assistência. *Saúde e Sociedade*, São Paulo, v. 18, p. 84-88, 2009. Suplemento 2.

CASTANHEIRA, E. R. L. et al. QualiAB: desenvolvimento e validação de uma metodologia de avaliação de serviços de atenção básica. *Saúde Sociedade*, São Paulo, v. 20, n. 4, p. 935-947, 2011.

CASTANHEIRA, E. R. L. et al. Avaliação de serviços de atenção básica em municípios de pequeno e médio porte no estado de São Paulo: resultados da primeira aplicação do instrumento QualiAB. *Saúde em Debate*, Rio de Janeiro, v. 38, n. 103, p. 679-691, 2014.

CAVALHEIRO, J. R.; MARQUES, M. C. C.; MOTA, A. A construção da saúde pública no século XX e início do século XXI. In: ROCHA, A. A.; CESAR, C. L. G.; RIBEIRO, H. *Saúde pública*: bases conceituais. 2. ed. São Paulo: Atheneu, 2013. p. 1-18.

CONILL, E. M. Políticas de atenção primária e reformas sanitárias: discutindo a avaliação a partir da análise do Programa Saúde da Família em Florianópolis, Santa Catarina, Brasil, 1994-2000. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 18, p. 191-202, 2002. Suplemento.

CUNHA, E. M.; GIOVANELLA, L. Longitudinalidade/continuidade do cuidado: identificando dimensões e variáveis para a avaliação da atenção primária no contexto do sistema público de saúde brasileiro. *Ciência e*

Saúde Coletiva, Rio de Janeiro, v. 16, p. 1029-1042, 2011. Suplemento 1.

DALLA VECCHIA, M. *Trabalho em equipe na atenção primária à saúde*: fundamentos histórico-políticos. São Paulo: Cultura Acadêmica, 2012.

DUARTE, L. S. et al. Regionalização da saúde no Brasil: uma perspectiva de análise. *Saúde e Sociedade*, São Paulo, v. 24, n. 2, p. 472-485, 2015.

GIOVANELLA, L. et al. Saúde da família: limites e possibilidades para uma abordagem integral de atenção primária à saúde no Brasil. *Ciência e Saúde Coletiva*, Rio de Janeiro, v. 14, n. 3, p. 783-794, 2009.

GIRALDO, A. F. El rol de lós profissionales de la salud en la atención primaria em salud (APS). *Revista Faculdad Nacional de Salud Pública*, Medellín, v. 33, n. 3, p. 414-424, 2015.

GIRÃO, A. L. A.; FREITAS, C. H. A. Usuários hipertensos na atenção primária à saúde: acesso, vínculo e acolhimento à demanda espontânea. *Revista Gaúcha de Enfermagem*, Porto Alegre, v. 37, n. 2, p. 1-7, 2016.

HARTZ, Z. M. A.; CONTANDRIOPOULOS, A. P. Integralidade da atenção e integração de serviços de saúde: desafios para avaliar a implantação de um "sistema sem muros". *Cadernos de Saúde Pública*, Rio de Janeiro, v. 20, p. S331-S336, 2004. Suplemento 2.

LIMA, C. A. et al. Relação profissional-usuário de saúde da família: perspectiva da bioética contratualista. *Revista Bioética*, Brasília, DF, v. 22, n. 1, p. 152-160, 2014.

MERHY, E. E. Um ensaio sobre o médico e suas valises tecnológicas: contribuições para compreender as reestruturações produtivas do setor saúde. *Interface: Comunicação, Saúde, Educação*, Botucatu, v. 4, n. 6, p. 109-125, 2000.

NEMES, M. I. B. et al. Avaliação da qualidade da assistência no programa de aids: questões para a investigação em serviços de saúde no Brasil. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 20, p. S109-S118, 2004. Suplemento 2.

PAIM, J. et al. O sistema de saúde brasileiro: histórias, avanços e desafios. *The Lancet*, Amsterdam, p. 11-31, 2011.

PEDUZZI, M. Equipe multiprofissional de saúde: conceito e tipologia. *Revista de Saúde Pública*, São Paulo, v. 35, n. 1, p. 103-109, 2001.

PEDUZZI, M. Mudanças tecnológicas e seu impacto no processo de trabalho em saúde. *Trabalho, Educação e Saúde*, Rio de Janeiro, v. 1, n. 1, p. 75-91, 2002.

PLACIDELI, N.; RUIZ, T. Educação continuada em gerontologia para agentes comunitários de saúde. *Revista Brasileira de Medicina de Família e Comunidade*, Rio de Janeiro, v. 10, n. 36, p. 1-10, 2015.

QUEIRÓS, A. A. L.; LIMA, L. P. A institucionalização do trabalho do agente comunitário de saúde. *Trabalho, Educação e Saúde*, Rio de Janeiro, v. 10, n. 2, p. 257-281, 2012.

REY, F. L. G. *O pensamento de Vigotsky*: contradições, desdobramentos e desenvolvimento. São Paulo: Hucitec, 2013.

SCHIMITH, M. D.; LIMA, M. A. D. S. Acolhimento e vínculo em uma equipe do Programa de Saúde da Família. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 20, n. 6, p. 1487-1494, 2004.

SCHIMITH, M. D. et al. Relações entre profissionais de saúde e usuários durante as práticas em saúde. *Trabalho, Educação e Saúde*, Rio de Janeiro, v. 9, n. 3, p. 479-503, 2011.

SCHRAIBER, L. B.; NEMES, M. I. B.; MENDES-GONÇALVES, R. B. (Org.). *Saúde do adulto:* programas e ações na unidade básica. São Paulo: Hucitec, 2000.

SCHRAIBER, L. B. et al. Planejamento, gestão e avaliação em saúde: identificando problemas. *Ciência e Saúde Coletiva*, Rio de Janeiro, v. 4, n. 2, p. 221-242, 1999.

STARFIELD, B. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. *Gaceta*

Sanitaria, Barcelona, v. 26, p. 20-26, 2012. Suplemento 1.

TEIXEIRA, R. R. Humanização e atenção primária à saúde. *Ciência e Saúde Coletiva*, Rio de Janeiro, v. 10, n. 3, p. 585-597, 2005.

VASCONCELOS, R. D. *Avaliação da qualidade da atenção básica no município de Bauru/SP*: desafios para um processo de mudança. 2011. Dissertação (Mestrado em Saúde Coletiva) – Faculdade de Medicina de Botucatu, Universidade Estadual Paulista, Botucatu, 2011.

VIGOTSKI, L. S. *A construção do pensamento e da linguagem*. São Paulo: Martins Fontes, 2001.

VIGOTSKI, L. S. *A formação social da mente*: o desenvolvimento dos processos psicológicos superiores. 7. ed. São Paulo: Martins Fontes, 2007.

YIN, R. K. *Estudo de caso*: planejamento e métodos. 2. ed. Porto Alegre: Bookman, 2001.

Authors' Contribution

Carrapato was responsible for the design of the study and data analysis. Both authors contributed to the writing of this article.

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