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Melhor no passado: a verdadeira saúde da família1

It was better before: the real family health[1]

Melhor no passado: a verdadeira saúde da família

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Abstract

The aim of this qualitative study was at evaluating the limitations of the Family Health Strategy (FSH) based on the daily work of its professionals. Individual semi-structured interviews were conducted with 16 professionals from the Family Health team of a municipality in the metropolitan region of Salvador, Bahia. Content analysis, as proposed by Bardin, and the references of the National Policy of Primary Care and the National Policy of Humanization for Primary Care were used. Two categories were identified: primary care (PC) of the Unified Health System (SUS), and co-management and humanization in PC. For the first category, the current context of the PC was emphasized, characterizing hardships present in the daily work of FHS professionals and the challenges in changing the health care model. For the second category, the concrete conditions wherein these practices take place in daily work were highlighted, going against humanization premises. The problems presented demonstrated lack of characterization in PC, contradicted the precepts of the FHS, and revealed challenges in the proposal for reorienting the health care model.
Keywords: Primary Health Care; Family Health Strategy; Humanization of Assistance.

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Resumo

Buscou-se avaliar os limites da Estratégia Saúde da Família (ESF) a partir do cotidiano de trabalho de seus profissionais. Neste estudo qualitativo, realizaram-se entrevistas individuais semiestruturadas com 16 profissionais da equipe de Saúde da Família de um município da região metropolitana de Salvador, Bahia. O exame dos dados utilizou a análise de conteúdo proposta por Bardin e os referenciais da Política Nacional de Atenção Básica e da Política Nacional de Humanização para Atenção Básica. Identificaram-se duas categorias: a atenção básica (AB) do Sistema Único de Saúde (SUS) e a cogestão e humanização na AB. Na primeira categoria, evidenciou-se o contexto atual que permeia a AB, caracterizando os desafios que se apresentam no cotidiano de trabalho dos profissionais da ESF e as dificuldades encontradas para mudar o modelo de atenção à saúde. Na segunda categoria, destacaram-se as condições concretas em que se realizam as práticas no cotidiano de trabalho, indo de encontro aos pressupostos da humanização. Os problemas apresentados evidenciam descaracterização da AB, contradizem os preceitos da ESF e revelam dificuldades na proposta de reorientação do modelo de saúde.

Palavras-chave: Atenção Básica à Saúde; Estratégia Saúde da Família; Humanização da Assistência.

Introduction

In Brazil, the traditional model focused on the private, hospital-centered, disease-based medical practice, with fragmentation and specialization of medicine, has been questioned by the Health Care Reform movement and has been changing (Costa et al., 2009; Scherer; Marino; Ramos, 2005). The historical milestones were the 8th National Health Conference in 1986, when the creation of the Unified Health System (SUS) was approved.

The Family Health Strategy (FHS) was implemented in 1994 by the Ministry of Health, first as a program and, as of 2006, as a proposal for a change and reorientation of the health care model based on primary care – PC (Brazil, 2010, 2012). Efforts and responsibilities are required by all levels of government to expand the FHS, offering greater assistance coverage to the population, seeking to improve health indicators, consolidate and qualify primary health care and transform its model. To reach this new paradigm, the FHS should be governed by the SUS principles, emphasizing actions to promote health and prevent diseases (Brazil, 2012).

HumanizaSUS, which pertains to the National Humanization Policy (PNH), seeks to put SUS principles into practice in the daily life of health services, changing the way management and caring is conducted. It consists of an ethical, political and aesthetic commitment of inclusion and communication between the three main SUS actors (workers, users and managers), so that they collectively act as co-responsible subjects in the care of themselves, the other, and the environment, with the aim to improve relations and processes.[2] Created by the Ministry of Health in 2003, the PNH defines humanization in SUS as a strategy for the democratization of health management and practices. It is a cross-sectional policy and, therefore, it must also overcome rigid barriers, such as those found in different fields of knowledge, as is the case of the FHS multiprofessional team. It is, above all, an ethical proposal, since it involves the attitude

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of committed and co-responsible users, managers and health professionals. The PNH is an expanded policy insofar as it is concerned not only with the user, but also with health workers - that is, clinic and management at the micro and macro political level are inseparable (Brazil, 2010).

The Basic Health Unit (BHU) should function as a gateway to SUS. The actions and services of the FHS happen within the territory assigned to the Family Health Unit (FHU), expanding and locating spatially and temporally the notion of the health-disease process, as well as enabling the bond between individuals (Brazil, 2010). For the implementation of the strategy, a multiprofessional team is necessary, having at least a group constituted by doctor, nurse, auxiliary nurse or nursing technician, and community health agents. The team can be increased by adding a dental surgeon, oral health auxiliary and/or technician, among others, such as professionals of the Support Center for Family Health (Nasf), a nutritionist, psychologist, physiotherapist, physical educator, speech therapist and social worker (Brazil, 2010, 2011).

Diversity during the work process in the context of the FHS is due to the fact that the work object of these professionals is the human being, whose health they seek to preserve or reconstitute, having as immaterial products the comfort, well-being and satisfaction of patients (Minayo-Gomez; Machado; Pena, 2011).

Discussing the dynamics of the FHS teams' work process as to their organization, physical space, work and interprofessional relations contributes to the understanding of their potentialities and weaknesses (Buchele; Coelho, 2010). To achieve the proposed objectives, the FHS requires a close personal relationship between the service user and health professionals, who should ideally reproduce this proximity to one another. In the case of teamwork, multiprofessional teams, by being closer to people, shift the focus from the individual to the family, in an attempt to guarantee the provision of integral health care with better resolution capability (Costa et al., 2009). The teamwork developed by the various FHS professionals should take place in an interprofessional manner. Interprofessionality, here, should be understood as the performance of different professionals, with individual authority and

respective codes of ethics and professional cultures, interacting in common areas wherein everyone has knowledge, regardless of specialty – involving knowledge integration and interprofessional collaboration (Ellery, 2012).

Understanding the actions of health workers and the limitations in the work process of FHS professionals from the perspective of the National Policy of Primary Care can contribute to remodeling the current care model of PC in SUS.

This study aims at evaluating the limitations of the FHS based on the daily work of its professionals.

Methodology

This study has a qualitative and descriptive nature and is aimed at the construction of meanings. With this approach, we sought to understand what certain experienced situations and daily individual experiences and meanings represent, and how they shape the individual or a group of individuals (Turato, 2005).

This study was conducted from February to October 2015, in a FHU located in a municipality of the metropolitan region of Salvador, Bahia, with a sample of 16 professionals working in the two FHS teams at that unit.

We included professionals who worked in this service for at least six months, in any of the teams or Nasf, regardless of employment, sex and age.

For data collection, semi-structured interviews were conducted with semi-structured script, with a nurse, a doctor, two nursing technicians, a receptionist, a psychologist, a social worker, a nutritionist, a dentist, an unit manager and six community agents, of which five women and one man. Their speeches were recorded and later fully transcribed (Rosa; Arnoldi, 2008). There was no need to increase the number of teams surveyed to achieve theoretical saturation of the data (Fontanella et al., 2008).

Considering the different professional perspectives of the subjects, the objective was to capture how they understood and interpreted the symbolic universe in which they were immersed, as well as to identify the personal values that brought them meanings amidst the socially constructed context of the FHS. Recording was facilitated by

the field observation, with fieldwork diary notes on the actions developed during the daily work of FHS professionals, as well as the interactions and relationships that occurred throughout the teamwork. According to Morin (2013), in order to understand what is sought, one must look at both the parts and the whole.

The content analysis method was used for the treatment and examination of the material generated by the interviews. One may define it as a set of communication analysis techniques that, through the use of systematic procedures and objectives to describe the content of messages, is able to allow the inference of knowledge related to the production of these messages (Bardin, 2009). Thematic category analysis covered three different phases, ranging from pre-analysis, material exploration and treatment of results, to interpretation and inference. The information contained in the messages was treated in such a way as to allow us to see beyond what was heard or read, working with vestiges, significants and signifiers behind the words, which gave rise to these categories (Bardin, 2009).

For each analysis category, subcategories emerged that contributed to a better understanding of the object of study.

To improve on this analysis, this research was grounded on the National Policy of Humanization (Brazil, 2010)[3] and in the National Policy of Primary Care (Brazil, 2011, 2017). It should be noted that these narratives were collected during the period in which the Ordinance No. 2,488/2011 that approved this latter policy was in force (Brazil, 2011).

This study was approved by the Research Ethics Committee of the Faculdade de Medicina of Bahia, Opinion No. 693,112, dated June 21, 2014. To ensure anonymity, fictitious names were given to the survey participants.

Results and discussion

After treatment and analysis of the interview speeches, two thematic units emerged as categories of analysis, "SUS primary care" and "Co-management and humanization in primary care". Based on these thematic units, the following subcategories emerged (Bardin, 2009).

SUS primary care

The narratives of the various professionals give their own meanings to the work that is developed in the FHS. Insertion in the PC of SUS and perceptions on the performance and limitations of the strategy are expressed in the field of action, during daily work. It is possible to note the tripod of accountability, in which the other always is the one responsible. Patients hold managers accountable; these hold professionals accountable, who, in turn, hold patients accountable. The patient blames the manager for mismanagement, for failing to meet his constitutional right to health; the manager blames professionals for lack of commitment to work and/or inefficient work process; it remains for professionals to hold patients accountable for the lack of popular participation and for not being autonomous agents and modifiers of their own health.

The insertion and meanings of working in SUS

The speeches reflect what is being done at SUS – a SUS that seems to be made "for the poor", under a "charity" or "volunteer" bias. These professionals are situated within this space and remain without consciously perceiving it. It should be noted that only one professional interviewed had sanitarist training.

> *I had some colleagues who were community agents and there they did volunteer work and I always offered to do that volunteer work. Then when they had a new bidding for CHA, they informed me that I had the profile.* (Cléo-CHA)

> *You start saying things like this: I'm going to change, I was good, now I'll start being mean [...]. When you get there at the table to ask me a favor, I'll think three times whether I do it or not, because you end up getting angry with certain situations. [...] I think like, there should be something to make it*

easier to motivate us to do more and more, because the more we do, the better for the municipality itself. (Vanessa-CHA)

Vanessa expresses the condition of "submission" to which patients must subject themselves in case the "motivations required" are not provided. She does not consider the sharing and exchange that must be experienced in the relationship between professional and patient.

To tell you the truth, this work doesn't fit my profile, I like the tranquility and safety that this job gives. (Robson-CHA)

Sometimes I get a bit stressed because of some of those who get this job by public bidding, because even if not all of them do that, there are some who, you know, want to make something and make things happen. (Michele-Health Manager)

Robson and Michele portray what they consider as the advantages offered in this public service, since, once working full time, the professional can enjoy the "tranquility and safety of work", that is, of the stability that guarantees them "to make something and to make things happen".

The literature records the erroneous idea that PC is related to the simple, minimum supply of actions aimed at an excluded and vulnerable part of the population without access to market medicine (Brazil, 2010).

Costa (2016) corroborates this idea when he proposes that the expansion of FHS coverage in municipalities is proportional to the prevalence of poverty in its population, which makes it difficult to develop and improve the FHS. In practice, this idea was assimilated by health managers, users of the service and, above all, health professionals who carry speeches such as Helen, who says: *I really like this closer relationship with the community and I think they are extremely in need* (Helen-Doctor).

So it is very, very good to work for the people, especially for the ones in most need, it's really nice to provide medicine they can't afford. This is more like social work, but I do it with a lot of love, I like to do it, you understand? (Michele-Health Manager)

The foundational text of the National Humanization Policy for Primary Care seeks to demystify the idea of the professional in the public service as a charitable, religious being with philanthropic attitudes that reveal goodness – someone who is doing a "favor" in performing this service for a community in need, reinforcing a submission relationship, making it difficult, if not impossible, to further develop citizenship and the right to health (Brazil, 2010).

Perception of health professionals on the performance and limitations of the Family Health Strategy

According to the National Policy of Primary Care, the FHS should be able to solve most of the population's health problems (Brazil, 2011). In these narratives, there is the limitation of macro-political performance of the FHS when professionals describe the increase of chronic diseases in the general population, the difficulty of articulation with other levels of care, the acquisition of medications, and the academic training still below curricular changes.

In my area, I've worked 8 years, never had a child die in childbirth, ever. So, there are cases of provoked and natural abortion, which the woman didn't want [...]. The vaccination index can safeguard a lot of children. (Silvana-CHA)

But that does not happen, because sometimes the doctor refers the patient to a cardiologist, a rheumatologist, and the patient has a delay for this care to occur since there are few professionals for a very large number of people, as these diseases [diabetes and hypertension] *are increasing in the community.* (Vanessa-CHA)

Of course we can't handle it, of course not [...]. It's a lot of people, they can't tend to everyone, we don't have that! (Angélica-CHA)

Some issues limit the effectiveness and perfection of the FHS, such as the organization of the work process in a unique format for the whole country and all teams, disregarding in part the local

differences and the management of spontaneous demand (Malta; Santos, 2003).

The overload of work caused by high demand, especially curative, prevents the accomplishment of educational activities and health promotion, something that appears in the speech of nurse Camila:

Since we end up missing a bit in the schedule, because our schedule is already tight, five days is practically nothing, the community is big, so I wanted to take a little more time to be able to do an educational activity. (Camila-Nurse)

This finding coincides with the reality of the study by Trad and Rocha (2011), in which work overload was shown to limit educational activities and, consequently, the consolidation of a new health care model based on health promotion.

The idea that intervention of the professional in the family environment is capable of changing the hygiene profile of the population, in an attempt to change the patient habits (Malta; Santos, 2003), appears in the imaginary of the respondents, as described by this community agent:

Like I mentioned just now, last month, I pointed this out during the meeting, since the staff was in a circle, which in turn became a vicious circle, just exchanging prescriptions, prescriptions. [...] People not coming to consultation for more than six months, only due to this addiction to exchanging prescriptions. [...] So like, it isn't easy, since this addiction, this habit, is difficult, very difficult to deal with. You telling that to that mother who used to leave her children barefoot, all day long, the youngest one already on the floor anyway, which spends all day without taking a shower and you say: hey lady, why didn't the child shower yet? – Ah! Later this afternoon. But in the afternoon, that's a different shower. So, I try to be firm and all, joking and such, but making her understand that this is important, I always try to explain why this is needed. (Angélica-CHA)

The attitude of the health agent is like a subtle confrontation that imposes other bio-social values. That is, the agent has an interpretation and this gives meaning to their experiences with the residents of the neighborhood on the same surrounding reality. The sociocultural dimension is depicted in the interaction between the community agent and people, enabling shared meaning in its plurality. In this process, one observes the force of dialogue or inter-subjectivity as a result of the agent's work, in which subject and object are not separate. Singularity in each case and plurality in the community are related dimensions, as if individual and society were permanently intertwined.

The narratives below show some of the problems of ineffective management, such as the turnover of professionals, which limits the performance of the FHS.

As for nurse women, we don't have as much support anymore, since in here, nurse men come and go very quickly, they don't have the same permanence. Sometimes we can't even create a bond with that nurse woman; when you get time, another one comes. (Robson-CHA)

There is a lot in the human being that is psychosocial and I think primary care has to be focused on it. [...] The managers still don't believe us, they want the number of patients served. (Helen-Doctor)

These speeches are examples of the turnover problem, which sometimes seems contradictory, since the FHU studied was distinguished by the long permanence of doctors – which, since they got the job per bidding, had already been working for more than seven years in both teams of the unit.

Obstacles to current family health practice

Although not included in the interview script, the term "outpatient care" emerged in the speech of most professionals investigated and allowed to proceed with other interpretations. Professionals who have been working on family health for six years have portrayed a past that differed greatly from the current context. The proposal of a "comprehensive and expanded view", due to its ties to operationalization, has been replaced by a schedule full of prescriptive consultations; they

use the expression "outpatient care" to refer to this. Angélica, a community agent, signifies her work as she says:

> We, the oldest ones, were lucky. The doctor, she was a person who conducted FHS while enjoying it, with much love [...]. No, there is no more family health, it does not exist. What has been done here is outpatient care, going quickly outside, since we're on the street. So, even we [CHA] are sometimes doing outpatient care out there, handing out drugs, prescriptions. (Angélica-CHA)

> Not this way, people keep covering for absences, they put a doctor to work twice a week since they're lacking doctors, that is outpatient care. The guy [doctor] invents the home visit. So he doesn't take it seriously. (Helen-Doctor)

The expression "outpatient care" was emphatically used by Nasf professionals. Although they recognize the support matrix as a methodological proposal to develop interdisciplinary work in health, they cannot act using this logic, often feeling compelled to return to the previous individual care, which they call outpatient care.

> When there's outpatient care, it's a lot of pressure, it's a lot of individual care, I used to provide outpatient care and now because of this work process having changed, there isn't this understanding on the part of the team. Because there is a lot of pressure for us to meet individually. (Roberta-Nutritionist)

> Because we're from NASF, our role is not to do outpatient care here, although a lot of people don't understand this NASF process. I don't know if NASF is still new, anyway. (Luíza-Psychologist)

Natália's narrative thus reaffirms what the PNH discusses about PC not fitting biomedical logic, focused on curative/care assistance, where the individual exposes their complaint and merely expects the prescribed medication (Brazil, 2010).

> Here the token-based queue system is bad, since it depends on a number the doctor defines. Sometimes

there are 20 tokens, but then there are two or three left, so I just: Oh my God! [...] today I see the FHS as an emergency call, it is no longer the same FHS as before, from when it first started, it is more like a consultation, outpatient care, [the patient] arrives and wants his prescription and does not know that they need to come for consultation. Group activities worked a lot, and now nothing. (Natalia-Receptionist)

For Angélica, who has been working for 16 years at the FHS, the current training does not change anything:

> We're standing still today, stagnant. But then today when I see these short courses, forgive me, they're dumb, repetitive. Every year dengue and tuberculosis is all you hear. Dengue and tuberculosis. Not even the transmission method changes. We already know what the next speech will be like, for example, the nurse who will talk about tuberculosis. It's because not even the methodology changes. No, nothing changes, same thing, same way. (Angélica-CHA)

She speaks and interprets the words she listens to in the same scene of the worldly relationship in which she is immersed. Thus, the professional speaks of herself and of what she experiences, seeking to explain and understand, because the professional accepts what makes sense to support their own experience in the midst of the difficulties they report and perceive. For her, the current information is insufficient to continue the explanatory health model.

One of the main bottlenecks that have culminated in retrogression for the implementation of FHS is the transfer of the classic biomedical model to PC, reflecting a new practice that is at the same time in crisis and under construction (Junges et al., 2009; Trad; Rocha, 2011).

What if I could choose?

The professionals demonstrated little credibility in the FHS. When questioned, there were doubts as to the choice of building more health units with the strategy or of a hospital in the municipality, which reinforces the idea and valuation of the hospital-centered model.

Andrade et al. (2018) shows practical evidence on the expansion of the FHS during the consolidation of PC. They emphasize the magnitude of this expansion in a country with inequalities, where often, in small municipalities, the provision of primary services constitutes the majority, if not the only way to have access to health.

Even when opting for the strategy, this was based on a possibility: *So I think if there were more units in the municipality there would be more doctors in the municipality* (Robson-CHA).

We are also lacking an ambulance. There is no use creating a municipal hospital and the person has no way to get there. [...] *So I prefer the health units because they are convenient, aren't they?* (Silvana-CHA)

If we were to look at the broader aspect of health, I would opt for the hospital. Because the larger hospital we have here is very precarious for serving patients, lack of beds, all of that stuff, you understand? (Vanessa-CHA)

Since this way, in terms of municipality, I think the PC is well assisted, whereas the hospital is lacking a lot. (Camila-Nurse)

I would prefer a hospital since the demand is too high [...]. *It's because people don't really understand what the FHS is, then they see it as an urgent matter.* (Natalia-Receptionist)

Priscila's speech is the only one that reflects an academic training consistent with the model established for the FHS operation.

It's much cheaper to prevent it than just thinking about the rehabilitation part. So, in fact it is extremely important, but it is also important that the professional included in this FHS is able to work using this logic, or else they will only reproduce the old care model and it will simply be called FHS, while in actuality not acting using this logic. Then there is professional training that came from a different model, that of specialties, those little boxes, but I think this has changed. (Priscilla-Dentist)

The narratives transcribed reveal how fragile such a change has been in practice, despite all efforts in an attempt to reorient health care models. It is understood by health model "the organization of service production based on a certain arrangement of knowledge from an area, as well as specific social action projects, such as political strategies of certain social groups" (Merhy; Cecílio; Nogueira, 1992, p. 91). These professionals reproduce their daily actions, strongly focused on physicians and hospitals and on the disease, in detriment to the determinants of health and the collective (Faria et al., 2010). It has been notably challenging the proposal of the FHS to incorporate biomedical issues and involve them in a new model of health care that seeks to share professional knowledge, strengthening SUS and transforming the health system (Malta; Santos, 2003).

Professional identities versus exchange of professional category roles

The narratives highlight the role played by professionals in the context of the FHS when they are "lost" within the limits defined by their codes of ethics and professional performance.

The community agent Vanessa refers to difficulties in performing her duties because she takes other duties as well, not belonging to her category. Helen fills the reference role doctor that should be developed by the coordinator/manager of the unit. Michele, on the other hand, abdicates from her coordinator role to the detriment of a favoritism regime and ends up selecting and prioritizing patients, contrary to the accessibility and universality proposed by SUS.

During an appointment marking, they [patients] *struggle to sleep in a queue but can't, because you know there's this regulatory problem.*
I go there, take their request [patient], *I go towards the regulation section swiftly, I get what I asked for, and they come the next day to thank me, this is very gratifying.* (Michele-Health Manager)

So when I started working I thought it would be so that I could pave an easier access to them [patients], *that I could be defining consultations, scheduling examinations, since I have to be in*

the Unit everyday, it would make things easier. (Vanessa-CHA)

I feel valued, like, problems in the unit, I have to solve problems with patients and other things, I'm the one who must solve them, so the manager comes to look for me, the CHA come [...]. It is valuation nonetheless. It overloads [...] but it's not bad, it's not bad. (Helen-Doctor)

There is a lack of clarity, regardless of the level of schooling, as to the tasks and the role that must be played by the various professionals. Another study has pointed out that, in the multiprofessional work of the FHS, the identity of the subjects is not as clear as in other health services (Silva et al., 2006). The profession of community health agents (CHA) remains without ethical guidelines, since its code of professional ethics is still in the works. Although their attributions are well-defined and described in the National Policy of Primary Care (Brazil, 2011), the CHA ends up experiencing a dichotomous praxis between the conduct adopted in the accomplishment of the work in these families and the preconization of the law, between having knowledge and knowing how to do it (Siqueira-Batista et al., 2015; Vidal et al., 2015).

I wanted to have more freedom as a health agent in order to improve my work. Not being too dependent on the other, since despite being in a team, sometimes you are thinking ahead and the other is behind. Because there are things for which I'd like to have that power, you know? (Angélica-CHA)

There are many difficulties found by the CHA in their daily work, such as the attitude of some of these professionals to privilege access to people close to or related to the BHU, their lack of previous training, and the devaluation of their knowledge (Siqueira-Batista et al., 2015).

In the narrative below, a community health agent, without any other professional training, feels hurt because he is no longer allowed, as he was in the past, to carry out the blood pressure measurement of users under his responsibility. Although, for him, weighing a child is important, he wants to do it at the user's residence and not within the health unit, in the

Bolsa-Família Program. He wants to offer something more than is prescribed; his discourse and daily practice shows itself as an antagonistic action subject to disorder, interfering in the quality of care offered.

It is noteworthy that the narratives, although divergent with the Primary Care Act of 2011, find subsidies in the new ordinance of 2017. According to this, the CHA is allowed to "perform other duties attributed to them by specific legislation of the category, or other regulations established by the federal, municipal or Federal District administrator" (Brazil, 2017). This has caused discussion and the fragilization of the work process for FHS professionals.

The program Bolsa-Família, instituted by Law No. 10,836 of January 9, 2004, and regulated by Decree No. 5,209 of September 17, 2004, aims at serving poor and extremely poor families in the provision of basic actions (health, education and social assistance). For such, beneficiary families should be assisted by an FHS (Brazil, 2015).

For example, today we go to people's homes and we don't have much to offer besides information, chatting and lending an ear to people. [...] Nowadays we can't even gauge a person's pressure, we can't. Nowadays we can't weigh the child, nor do we have a weighing scale anymore. [...] But we have to weigh Bolsa-Família, which totally depends on our role. (Robson-CHA)

Robson, in saying that he "lends his ear," refers to qualified listening and reception that is offered by the health professional, regardless of his professional category; this indicates bond and the strengthening of the relationship between professional and user.

The respondents get confused in the borderline between care completeness and the co-responsibility of care, with "hard work" that does not end after the consultation or application of a vaccine, ultimately assuming responsibilities that go beyond what is prescribed:

And it turns out that we are a psychologist, a psychiatrist, a caring therapist, all of this we do a little bit. Because we work with people, after all. When we go to their home, there's no way we're staying with only health topics, there's even a little

gossip. Ah, my husband is like, toasted! (Silvana-CHA)

The doctor chats, also takes the role of psychologist a bit, since some users arrive very sad, they arrive with several problems and then he sees the doctor as a trusted person to tell their story. (Michele-Health Manager)

Co-management and humanization in primary care

Things here don't go forward: the inadequacy of physical work space

All speeches were unanimous in denouncing the inadequate physical structure of the health unit in which the respondents work, having an insufficient number of offices, absence of room for procedures such as nebulization or application of injectable drugs (these are performed in the vaccine room) and lack of privacy due to partitions between offices – instead of masonry walls –, among others. Physical space was considered the biggest obstacle in the interviews.

Other studies have already mentioned that facility precariousness negatively affects the performance of activities recommended by the FHS, dehumanizing work and health care (Nora; Junges, 2013; Trad; Rocha, 2011).

A unit that would need a change for yesterday, for it to be able to have a better reception, a better screening, a better curative part. […] You work in an environment where you're sitting in a room and out of nowhere you feel a bad odor, until you get sick, you're working in this kind of environment. (Vanessa-CHA)

The ambiance, seen as an improvement in working conditions and servicing, is one of the guidelines proposed by HumanizaSUS: "to create healthy, welcoming and comfortable spaces that respect privacy, that allow for changes in the work process and are spaces for people to meet".[4] The problems related to ambiance, as previously pointed out in the literature (Nora; Junges, 2013), compromise the entire work process in the FHS since they cause demotivation in professionals and managers, as well as discomfort to users, especially regarding lack of privacy. *Because of the very structure of the center itself, right. […] Because if you speak too loud, whoever is in the other office can listen. So, for that matter, there are patients who end up talking about the discomfort they have with this.* (Cléo-CHA)

The absence of a nebulizer appeared in the speeches, which is contrary to the one proposed in the manual of physical structure for family health units (Brazil, 2008).

It isn't enough to make a unit and when you get here you don't have nebulization. […] Gee, no one is bound to have a nebulizer at home, and they don't even have the money! (Silvana-CHA)

We can't solve it here; for example, for PC we don't see nebulization for children […]. We could be applying benzetacil, we can't, we can't do that here. (Camila-Nurse)

The respondents' discourse on the concrete conditions in which they perform their daily work practices denounces the lack of rooms for performing health education, as well as for the application of medicine such as benzetacil and team meetings; there is poor harmony between the work process and the premises of humanization. Home visits, team meetings and health education were being left in the background, to the detriment of an schedule full of consultations that were set for a single day of the week, generating long queues.

Nurses have a close relationship with us, things here do not go accordingly since we don't have enough room to work, there are room problems, difficulty to make groups, but this is not an management fault, it is the place where they are. (Eliana-Social worker)

Here it was supposed to be only one team, and even then it would lack space […]. Today we can't just make a team meeting; we do it in the leisure area,

every time someone knocks on the door. The physical structure does not allow us to… a waiting room yet to have, this is terrible! (Angélica-CHA)

Camila, with a controversial discourse, explains the lack of medication as due to the great user demand, an aspect also pointed out in other studies (Nora; Junges, 2013; Trad; Rocha, 2011). The use of diminutives expresses a perception that minimizes the violation of the constitutional right to health.

Sometimes there aren't contraceptives, sinvastatina, things like that, but little things, if one doesn't have it, the other certainly has, and what ends up missing is a lot cheaper and you can afford to buy, the ideal situation would be to not to lack anything, but you know… the demand is high. (Camila-Nurse)

Angélica points out the various difficulties that distanced her everyday work from the principles of humanization in health and, in a highly sensible manner, speaks of the "weight" to be able to move on:

I feel like we carry this unit in the back. What managers need to understand about what is lacking in the FHS is that the structure of the unit has to be much better, it has to be much better. […] the files keep sickening the receptionist and the people, the archives are broken, the drawers are falling, everything is full, there is no air conditioning in the room, the stretcher is broken… (Angélica-CHA)

The major challenge of the SUS is political since none of the governments, after the sanitary reform, compromised to SUS in accordance with what was established in the Constitution, given the underfinancing of the public system – suggesting a not very optimistic scenario for its sustainability (Paim, 2013).

Doniec et al. (2018) point out the likely practical consequences of Constitutional Amendment No. 95/2016, with a lack of investment in strategic areas of health care (Brazil, 2016). The SUS, which is still under construction, is also in a state of crisis and regression, revealed by the increase in social inequalities, the strengthening of the private sector and the reduction in the quality of public services.

On the National Humanization Policy (PNH)

When questioned about the PNH, it was possible to observe a lack of knowledge on the part of most professionals. Even those who claim to know politics, under a reductionist view of the scope of guidelines and actions, refer to it only in the context of welcoming.

No, not yet, not here. Only the other unit has the reception, 20 tokens [sic] are provided every day in the afternoon from Monday to Thursday, where an CHA is chosen to work at the welcoming of those people. (Michele-Health Manager)

I see welcoming like so, for example: some days there are two urgent cases, I can't tend to everyone, but once I hear the patient's complaint, at least I prescribe and orient them on what place they must go, that there is a 24 hours unit and such, I already consider this welcoming but I still think it's very incipient. (Priscilla-Dentist)

In the aforementioned perceptions, HumanizaSUS is reduced to the reception practiced in an incipient way since it obeys a token distribution format. This is still performed without a pre-established parameter, disregarding all professionals involved in health care, which is opposed to the concept defined by the PNH. For such,[5] this welcoming must be collective, recognizing what the other has to offer as a legitimate and unique need for health through qualified listening, giving priorities based on the evaluation of vulnerability, severity, and risk, building a relationship of trust, commitment and bond between teams and services, the worker and the teams, and the patient with his/her social network.

We got the course, we did the humanization course in health, but […] I think the person at the gates, he should have received this course, he didn't receive it, I don't even remember if the receptionist

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5 BRASIL. Ministério da Saúde. *Política Nacional de Humanização*: HumanizaSUS. Brasília, DF, [s.d.]. Available at: <https://bit.ly/2NwlnGK>. Accessed on: 8 Jan. 2019.

received it, since it starts with the person at the gates and the reception. Simply from looking, I know that this course was not implemented here. (Fabiane-CHA)

Everyone knows how to listen to a no. The problem is how this no is said. [...] Sometimes someone comes to the front desk: "Ah! I have a doctor's appointment. Ah, they didn't come today" [...]. The person misses work, sometimes their boss doesn't even want to hear, you can't have a sickness certificate, the person misses a day, it is far, the child missed school. (Cléo-CHA)

Oh, I don't really know much about Humaniza-SUS, but from what I know, I don't think so. Starting with this lack of dialogue that we don't have with the team, right? (Luíza-Psychologist)

A recent review study pointed out an operational complication in the organization of services, with harm to the welcoming and integrity of care-work (Barbosa et al., 2013). Thus, in order to implement the PNH, it becomes imperative that workers be able to transpose and produce new ways of shaping their work.

An illness without treatment: the barriers of referral and counter-referral

These narratives reveal the reality of counter-referral within the PC context and characterize it as an obstacle towards humanized care. Robson summarizes: *There is no counter-referral. There may even be a referral, but it does not return* (Robson-CHA).

But this is like a disease, ever since we started with this. We've repeatedly gone over that. I already had a patient like that with the [referral] *file. They did not even read what the colleague wrote! After the assistance, he wouldn't even write his conclusion for the doctor to continue from there.* (Angélica-CHA)

I refer them, I'm the one who writes the file, the referral, and I send it, when it is a case we can't solve here. But we never get the counter-referral back; we send it, but never receive it. (Camila-Nurse)

They speak directly with the patient, for them to come and talk here, but they won't come back, no they won't. (Natalia-Receptionist)

The absence of an effective system for referral and counter-referral to other levels of assistance, especially regarding specialized examinations and/ or consultations, was already pointed out by other authors (Nora; Junges, 2013; Trad; Rocha, 2011).

Final considerations

This study identified the pains and joys of working in SUS and the obstacles to developing health actions in PC. According to the professionals interviewed, despite being the main entrance door to the health system, the current FHS experiences difficulties and limitations with regard to changing the health model. The stories narrated by these professionals show that, although they pointed out their activity in daily health practices, they are lost in the midst of an infinity of attributions and reinforce the limitations faced in order to carry out their actions. For these professionals, the FHS that is currently being performed decharacterizes PC and is no more than outpatient care with previously scheduled appointments. The performance of the professionals that develop the FHS still does not fully reach what is recommended for humanization in health as the guiding principle of PC. The care provided at the health center analyzed still meets the biomedical model and has been distancing itself from the FHS proposal. It is necessary that the professionals of the FHS recognize their work in health and remodel their practices in order to contribute to the effective transformation of health care models and management of SUS services.

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