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Clinical and Care management in the assistance of users of the Family Health Strategy

Gestão do cuidado e da clínica no atendimento aos usuários da Estratégia Saúde da Família

Gestión del cuidado y de la clínica en el atendimiento a los usuarios de la Estrategia Salud de la Familia

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The aim of this study was to analyze the clinical practice and management of care in the daily life of the Family Health Strategy with emphasis on limits, potentials, and challenges for the consolidation of the Unified Health System. It is a qualitative study, carried out with 42 users and 31 health workers of the Municipality of Fortaleza, CE, Brazil. The results show that the health actions in the territory are governed by the productive efficiency of the health care team. The following categories emerged: limits and tensions in the assistance, daily potential, and challenges for care and clinical management. The structural and operational limitations for health care are overcome by the inter-subjective relations between the team and community. The management of care is vertical in the work processes and demonstrates frailties in reaching an adequate health conditions. It is considered that the clinical practices and health care touch on the policies and institutional guidelines of the Unified Health System and the legal right to health is still partially guaranteed in daily care.
Descriptors: Practice Guideline; Family Health Strategy; Primary Health Care; Integrality in Health; Unified Health System.

O objetivo do estudo foi analisar a prática clínica e a gestão do cuidado no cotidiano da Estratégia Saúde da Família com ênfase nos limites, potencialidades e desafios para a consolidação do Sistema Único de Saúde. Trata-se de estudo de natureza qualitativa, realizado com 42 usuários e 31 trabalhadores de saúde do Município de Fortaleza, Ceará. Os resultados evidenciam que as ações de saúde no território são regidas pela eficiência produtiva da equipe de saúde. Emergiram como categorias: os limites e tensões no atendimento, as potencialidades cotidianas, e os desafios para gestão do cuidado e da clínica. As limitações estruturais e operacionais para o cuidado em saúde são superadas pelas relações intersubjetivas entre a equipe e a comunidade. A gestão do cuidado se verticaliza nos processos de trabalho e se demonstra frágil no que diz respeito ao alcance de condições de saúde adequadas. Considera-se que a prática clínica e o cuidado em saúde tangenciam as diretrizes político-institucionais do Sistema Único de Saúde e o direito à saúde ainda é parcialmente garantido no cotidiano assistencial.
Descritores: Guia de Prática Clínica; Estratégia Saúde da Família; Atenção Primária à Saúde; Integralidade em saúde; Sistema Único de Saúde.

El objetivo del estudio fue analizar la práctica clínica y la gestión del cuidado en el cotidiano de la Estrategia Salud de la Familia con énfasis en los límites, potencialidades y desafíos para la consolidación del Sistema Único de Salud. Se trata de un estudio de naturaleza cualitativa, realizado con 42 usuarios y 31 trabajadores de salud del municipio de Fortaleza, CE, Brasil. Los resultados demuestran que las acciones de salud en el territorio son regidas por la eficiencia productiva del equipo de salud. Emergieron como categorías, los límites y tensiones en el atendimiento, las potencialidades cotidianas y los desafíos para la gestión del cuidado y de la clínica. Las limitaciones estructurales y operacionales para el cuidado en salud son superadas por las relaciones intersubjetivas entre el equipo y la comunidad. La gestión del cuidado se verticaliza en los procesos de trabajo y se demuestra frágil al alcance de condiciones de salud adecuadas. Se considera que la práctica clínica y el cuidado en salud se valen de las directrices político-institucionales del Sistema Único de Salud y el derecho a la salud aún es parcialmente garantizado en el cotidiano asistencial.
Descriptores: Guía de Práctica Clínica; Estrategia de Salud Familiar; Atención Primaria de Salud; Integralidad en salud; Sistema Único de Salud.

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INTRODUCTION

To consolidate the principles of universality, integrality and equity of the Unified Health System (SUS), there should be a care network that prioritizes Primary Health Care (PHC) and solves problems through the integration between the levels of complexity of the system. In this process, the Family Health Strategy (FHS) becomes relevant for its assistance, which is more sensitive to the demands and health needs of the population[1].

The PHC generates modifications in the assistance that lead to a significant impact on health and care indicators[2]. The public policies that offer incentives to the municipalities to expand the coverage of their FHS are institutional mechanisms that establish the implementation of practices aimed at the promotion of health and prevention of diseases. However, the teams work processes, the creation of care flows, and the full participation are what is directly related to the recognition of citizenship and to the health of the population[3].

In this context, for the FHS to legitimize its strategic objective, which is the inclusion of segments of the population to health services, it should support a work process based on a real scenario. The health policy was implemented in the reality of health care through a range of conditions: greater availability of financial resources for the health sector, allocation of resources between spheres of government, and the local organization of the network of health services, aiming to ensure a universal, integral, and equitable access to the population[4].

In large and medium-sized urban centers, tensions at the gateways to health services become relevant. Primordially, the understanding about the demands in health units and their causalities, indicate the possibility of innovation, in the public management practices, of social policies consistent with the needs of the population and the reduction of the prevalent iniquities in the territory.

Changes in the way health professionals deal with people in need of care are necessary every day. The massive contribution of a prescriptive care logic comes from the health professionals themselves and from the population. Determined by tense service conditions, a clinical process guided towards curing damages weakens the care provided for acute and/or chronic conditions. The consistency between care and clinical assistance requires the search for practices of health promotion and the empowerment of users.

In this context, this study aims to analyze the clinical practice and management of care in the daily life of the Family Health Strategy, with emphasis on limits, potentials, and challenges for the consolidation of the Unified Health System.

METHOD

This is a qualitative study with a hermeneutic approach, based on critical and reflective interpretations of the daily routine[5]. The research was conducted in the Municipality of Fortaleza, capital of Ceará in the Northeast region of Brazil. In 2013, the population covered by the SUS was 5.733.859 inhabitants of an estimated total population of 8.530.155 in the State of Ceará. The coverage of the FHS at the state level was approximately 67.22%, where the capital had only 33.15%[6].

The study participants were 31 health professionals from two FHS teams, and 42 registered users of the service. Participant selection occurred during the approach to the field of study. The teams were previously selected, with the support of the municipal management center. Sample composition was defined by the relationship of the teams with the users and by an expanded and meaningful discussion about the object of this study.

For data collection the following techniques were used: semi-structured interviews, focal groups, and systematic observation. The application of the instruments was carried out from April 2011 to January 2012.

After the approval of the research, the interviews were conducted through a script

on the topic of the study. The focal groups were performed with multiple participation, including users and the health care team. The groups had from six to eight participants, were previously scheduled and met for an average of 45 minutes. The systematic observation was guided by questions about the capacity of problem-solving of the health unit, as well as its actions for health promotion, and its operation.

Data analysis was guided by a comprehensive and interpretive process based on critical hermeneutics[5]. Convergences and divergences were presented according to complementarities and differences depicted by discourses and observations of the participants and discussed in the light of relevant literature. The division of the descriptions according to the areas assigned to each of the teams was suppressed to avoid the recognition of the participants.

The study was approved by the Research Ethics Committee, Protocol No. 10724452-7 as guided by Resolution 466/12 of the National Council of Health[7].

RESULTS

31 health professionals from two FHS teams and 42 registered users participated.

In the process of interpretation, this research analyzed narratives and observations that cross the guidelines for the consolidation of the SUS and the form of assistance to the population offered by the FHS. Three thematic categories emerged from the 1st analyses: *everyday limits and tensions*, daily *possibilities* and c*hallenges to care and clinic management*.

Everyday limits and tensions

The daily operational actions of the FHS in the territory are driven by the productive efficiency of the health care team. Care practices converge to the outpatient care of the recurrent demand:

The system does not stop. Every day there are people to attend. And it is not just a few things. It's people needing people. If we stop a lot to talk, people will not be attended. So, what really matters day-to-day is what we do. If it is promotion, or if it is integrality, that is decided later. What matters is to give a good assistance. And with quality. (Physician)

The difficult thing is to get a chance to be attended. I arrive early. To be attended early. Sometimes the doctor is late. But he must have his reasons. But when he arrives, he begins attending right away. Does what he has to do. This is a good thing. I have nothing to complain about. (User)

In the territory, situations can be observed where the users in the process of illness and seeking for the maintenance of their health, come across an insufficient coverage of assistance due to an extensive geographic and demographic dimension of the urban space. At the same time, prevalent risky and vulnerable conditions add up to the need for a universal and equitable health care between the health team and users:

The health service is very far away. I am sick. Walking up there, I'll become sicker. My son, when he is off work, takes me by car. It is very far away. I think that it is time for us to have a unit closer to us. (User, Elder)

It is difficult to give a good and effective attention because the area is very big and populous. It is a lot of people, and the worst, the area is also very big. People found a way and seek aid, rides, company, but even so it is complicated to come to the health unit because of the distance. (Community Health Agent)

It stands out that PHC is responsible for the elucidation of most clinical cases among the users of a territory. Otherwise, the clinical act in the superficiality of care undermines the service and, over time, will lead the population to conditions of illness, that is, the assistance becomes limiting regarding therapeutic resolution:

It is too difficult to maintain health. For us to get some improvement, we have to know a person. In the health unit there are too much people. Today, if you do not have a person that helps, it is difficult. (User)

My case is very complicated. If I don't take care, I'm going to die. Because in this world, it is every man for himself. The difficulty that we find in this SUS is the lack of attention. The person attends you and doesn't even look at you. My problem is very serious! [...] *It is too much people, there is not enough time for the doctor to even look at us.* (Users)

During the observations, difficulties for the staff of FHS add up, making the resolution of the problems and situations of sicknesses and ailments difficult. Situations of excessive delay, low network communication and discontinuity of care add up:

Neurologist, orthopedist, pediatrician, neurologist, otolaryngologist, and gastroenterologist are referrals that we will hardly be able to get. Large and small surgeries too. Because there are no vacancies in the system. I do not know why the system is precarious, you know? This appointment central control, I think it

should pass through an urgent reform, because patients will die if they don't change. (Community Health Agent)
Team work is necessary, in networking. If I refer a patient to another service it is because I cannot solve that situation. The other service needs to know our reality to understand why I sent someone and continue the treatment. This often does not happen, and the patient is the one who is mainly harmed due to this fragmentation. The SUS still does not work in a network system. (Physician)

In urgency and clinic complication situations, the narratives of the users in the focal group, as well as in the discourse of health-care workers, shows the hospital as a place of immediate care:

[...] *when something more serious happens, we rush to the hospital.* [...] *None of the two services are good. The hospital at least works better.* [...] *It takes longer, but we know that we will be attended. The health unit is as an "escape". We try to see if it works.* [...] *If your child, or a person you care about got sick, what would you do? Anything that can help is good. I would pay for a car to drive me so I get [hospital] attention, but I won't let a relative of mine die without trying.* (Users)
They usually go to the hospital in cases of urgency and emergency. There are people who take children with fever, and now with Dengue fever, and they also take the more serious adult cases. And, mainly, people with high blood pressure. (Community Health Agent)
The hospital is very important to our work here on the health unit. Unfortunately, there is not a strong communication between us. We refer the most urgent cases, but we do not have a continuous return. And there are also people who go straight to the emergency without even passing through the health unit. (Physician)

Daily potential

Differently from the situations analyzed, the structural and operational weaknesses in the offer of health care are overcome through initiatives from the FHS team. Their search for assistance that can solve the problems stands out, strengthened by the interaction between those who need and the action needed to alleviate the pain and/or suffering of the population:

The PHC, the way it is today, it cannot be the way the population enters the system, because of the demands and conditions of work. The only good thing we have at work is the integration of our team. Here everyone tries to help each other. (Physician)
We try to schedule exams that are more urgent – to find other solutions – trying to solve. (Nurse)
I do what I can, in a difficult context, but I maintain the sterilization of the material, and I try to find a solution and not leave the user without service. (Dentist)
Anytime that there is something more complicated – we make a task force for help – one helps the other. That's how it is. (Community Health Agents)

The operation of healthcare that is closer to the patients converges with the relations of the staff of the FHS. The expansion of the relationship and the sharing of knowledge regarding the approaches and techniques used make the service unique. Thus, it is possible to obtain positive results through mutual co-responsibility:

[...] *when we are attended, they give us a lot of attention. The doctor here in the unit, even went to my home to know if my exams had worked, if my surgery had been good.* [...] *if it was not for these angels* (HCA). *Our health was bad. But they do everything they can. If it was not for him* (HCA), *I would never have managed to get my treatment right.* (Users)
Whenever we can, we try to pay more attention to the more serious cases, to the pregnant women, the more complicated hypertensive patients, the smaller children. The number of appointments and examinations is small and we have to prioritize, when we can. (Nurse)
Things only work when the teams give their all to do well what it is needed. And also when the patients cooperate and seek to take care of themselves. The ones who make things happen here are the people that commit themselves to do right. (Physician)

In the areas of risk and vulnerability, the dynamics of work complement a subjective expansion contextualized by the social situation of users during FHS work. The therapeutic protocols, although still guided by priority programs, are adapted or subdued by the life conditions of the population:

Every month we check if they are being accompanied, if they did the exams and if they are taking the medicine right. It is all controlled by the team. (Nurse)
It is important to add that the lack of assistance goes beyond health care policies and is influenced by the deficient supply of drinkable water, basic sanitation, garbage collection, eating habits, among others. (Observation)
You need to find a way to guide the population based on what they have. (Physician)

In a resolutive sense, the regular schedule of preventive activities of the FHS avoids problematic situations in the life of the users:

With this monthly consultation, we avoid delaying the vaccines, common problems in this age and, especially, that they get sick often. (Nurse, attending a child and mother on the day scheduled for child care in the FHS)

A confluence of assistance meanings emerges in the FHS, involving prescriptive actions and controlling risks and harm. The

health promotion recovers conducts that are superficial and distant from a broader sense of health. The network of primary care maintains its profile assistance, effecting prevention activities, with emphasis on collective mechanisms, home monitoring and health education:

The promotion activities are basically lectures and the health groups that we do with the pregnant women, especially. We always have some activity in the waiting room, we guide them before the consultations. (Nurse)

We have the endemic diseases staff that helps a lot on the prevention of diseases. When we have some campaign for the prevention of dengue fever they always help, they are very helpful in the guidance of the community, visiting them with us (Community Health Agent).

We know that it is necessary to take care before the disease comes. Eat right, avoid salt and fat. All this we learn here on the unit. They teach us right (User).

Care and clinical management challenges

The management process of health units is still vertical, mainly in the operational issues related to the demand for health care in the territory. The circularity of decision-making power and governance is over when problems arise involving the higher levels of management, as expressed:

The problem is that we are in a period in which the system lacks credibility. The professionals lost the belief in the SUS due to unsuccessful attempts of transformation. With this, they prefer not to try something, and to do it the way that offers results. In a way, the daily clinical practice is what solves the problems of the population, but to do this, you must encourage the patient to seek their rights, claim their correct treatment, etc. On the other hand, it is not what the political and management levels of SUS always want. It is easier for the management to have a professional that solves the problem and does not make the patient aware of their needs. (Physician)

It is necessary to improve the assistance in the unit. We have the monthly famous big conversation meeting, which is with the coordinator of the unit, right. Every month. I participate every month but have a colleague that does not because he does not see results. [...] *The conversation, we gather, many issues are discussed, but nothing comes of it! Things are said, are spoken, but the answer that we want does not exist. (Community Health Agents)*

It was observed, among the users, the extensive and almost always desperate situation of people who come to the health units with the utmost needs and few options for solving their problems or cases of illness. The management control is insufficient, according to the reports of the team:

The organization is the one that you [the researcher] *saw that day. The staff is all mixed in. There are times that it is worse. There are times when there are even fights.* (Community Health Agent)

Every day a person comes complaining. There are a lot of diseases and very few doctors to attend (Physician)

These people are looking for medical attention and many of these people are in waiting lines and wait a long time for their turn. But we only have permission to distribute 25 tickets. (Administrative Assistant – Reception)

I'm here every day, trying to do my best, chatting, and checking if the whole team is attending. (Coordinator of the Unit)

DISCUSSION

The assistance provided by the FHC teams still prioritizes actions directed to procedures and immediate care. The access to health services follows a social role, guided by the needs, demands and supplies. However, it is necessary to establish a reflexive process about the care practice that recognizes the social conditions, health determinants, and citizenship[8].

In the organization of the FHS, the location of Health Unit is also of strategic importance to the accessibility of the population. For a resolutive planning of actions and services, and, for the promotion of collective health, an appropriate spatial distribution is required, focused on the conditions of life of users and close to their contexts. At the expense of universality, a restricted and disproportionate access to health services in the SUS becomes an obstacle to the consolidation of the health attention[3,8,9].

Clinical care that requires specialized attention has to deal with a logistics of referral regulations that is not sufficient[10]. The FHS incorporates in its assistance routine the scheduling of activities and interventions in a network system, in their various levels of complexity.

Longitudinal care becomes effective with the follow-up of the user by the health care team over time. In the PHC, the continuity of care is considered a central aspect to ensure a full access to procedures, services, and specialized consultations, required for solving the health problems[11,12].

Historically, In Brazil, the hospital protagonism is hegemonic in operational

assistance. However, the policies aim to provide incentives for the expansion of the FHS in different direct and cross-sectional actions (health education, Nuclei of Support to Family Health, participatory management, and humanization). It stands out that the inversion of the logic of hospital prominence requires the qualification of primary health care, associated with problem-solving capabilities and effective integration with specialized and hospital care[13,14].

The relations between health team and users affect the people involved in order to stimulate solidarity and motivation in health care. Aware of their responsibility, the teams that recognize operational problems and trigger movements for their resolution promote transformations in the work processes[15].

The consolidation of health care happens through actions of assistance and in the relationships between the people involved with care. The problem-solving capacity of the clinic is built by the conditions offered by the assistance and in the planned provision of materials, drugs and procedures. Therefore, it is possible to experience a cross-sectional daily routine guided by a comprehensive, regular and resolutive caregiving practice[16,17].

In attempts to deal with the problems, the FHS sets out priorities for monitoring, controlling, and accompanying the health situation of the population. However, everyday actions must recognize the social determinants as guidelines for the effectiveness of their interventions[18].

Regarding illnesses, considering the living conditions of the population and implementing different ways of care is to guarantee equal possibilities for maintaining the health-disease process[18-20].

When considering the shared management proposal, an active participation is expected from those involved and from the recognition of their subjectivity. The power dissolves and, at the same time, is strengthened by the participatory elucidation of those involved in the dialogue around a common problem. If the process differs in part or in whole, it will result in a method that is not in accordance to the reality being transformed[21].

The demands presented in the waiting rooms and receptions are only the "tips of the iceberg", which indicate a basis for the determinants of health problems for the maintenance of a healthier life. Dealing with the demands on a superficial level is to achieve only a semi-basic level of care with, mainly, recurrent problems in the territory[22,23]. The care planning is a continuous challenge for consolidating the FHS as the leader of the care network.

Situations that cross the line that separates supply and demand in the FHS need, on one hand, to harmonize the reduction of the care deficits, and on the other, to focus on new ways to mobilize the territory for a healthier life process. This is a continuous risk of the intensification of the evaluation of health practices considered resolutive only in the final stages of more serious processes of acute or chronic illness, in detriment of an efficient care.

CONCLUSION

The present study is limited by the territorial focus required by a deep interpretation of the relations happening in the FHS. However, the thematic arrangements discussed expose situations experienced by family health teams in different contexts.

The analytical, critical and reflective involvement broadens the dimensions and views about the subject of study, offering subjective evidence for the management of the clinic and of care in the dynamic, unique and diverse territory.

In summary, the FHS still has a long road between the institutional policy of the SUS and the everyday reality of care and clinical practice.

On one side there are incentives for implantation, expansion and financing of the FHS activities, and on the other, there is a clinical care still fragmented in its assistance flow. This shows that healthcare is limited by its insufficient universality, as well as due to the fragmentation of care and to social inequalities.

Since it is possible to implement PHC strategically to invert the logic centered around hospitals and broaden the territorial care, the planning should support the participation of the subjects with their needs and demands.

Inter-subjective relations between the health team and users have to integrate the collective planning and the participation in health activities. The effectiveness of health care refers to the real solutions of urban coexistence and integral access to health care.

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CONTRIBUTIONS

Antonio Germane Alves Pinto contributed in the conception of the object of study, in the collection and analysis of data, writing and revision. **Maria Dayanne Luna Lucetti, Kelly Fernanda Silva Santana, Adriana de Moraes Bezerra and Maria Corina do Amaral Viana** participated in the writing and revision. **Maria Salete Bessa Jorge** participated in the methodological design and data analysis.

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