

FAMILY HEALTH STRATEGY AND CARE INTEGRALITY: PROFESSIONALS' PERCEPTION

ESTRATÉGIA SAÚDE DA FAMÍLIA E A INTEGRALIDADE DO CUIDADO: PERCEPÇÃO DOS PROFISSIONAIS

ESTRATEGIA SALUD FAMILIAR Y LA INTEGRALIDAD DEL CUIDADO: PERCEPCIÓN DE PROFESIONALES

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Objective: to analyze the perception of professionals from Family Health Teams about integrality in daily care. **Method:** qualitative study carried out in four Health Strategy units. Data collection was performed through a focus group with professionals from different professional categories and counted with guiding questions about the understanding of integrality, as it is developed, the potentialities and the difficulties in its implementation. Data were analyzed through thematic content analysis. **Results:** two themes emerged: Basic Care Integrality clothed with the complexity and Challenges of integrality due to intersectoral and health care levels disarticulation. **Conclusion:** given the conceptual breadth of integrality, the professionals from Family Health Teams understand that this is of great complexity and face important challenges in its implementation.

Descriptors: Family Health Strategy. Unified Health System. Integrality in Health.

Objetivo: analisar a percepção dos profissionais das Equipes de Saúde da Família sobre a integralidade no cotidiano do cuidado. Método: estudo qualitativo realizado em quatro unidades da Estratégia Saúde. A coleta de dados foi realizada por meio de grupo focal com profissionais de diferentes categorias profissionais e contou com questões norteadoras sobre a compreensão de integralidade, como é desenvolvida, as potencialidades e as dificuldades em sua implementação. Os dados foram analisados por meio da análise de conteúdo, modalidade temática. Resultados: foram elaboradas duas temáticas: Integralidade na Atenção Básica revestida de complexidade e Desafios da integralidade devido à desarticulação intersetorial e dos níveis de atenção à saúde. Conclusão: dada a amplitude conceitual da integralidade, os profissionais das Equipes de Saúde da Família compreendem que esta se reveste de grande complexidade e enfrentam desafios importantes em sua implementação.

Descritores: Estratégia Saúde da Família. Sistema Único de Saúde. Integralidade em Saúde.

Objetivo: analizar la percepción de los profesionales de los Equipos de Salud Familiar en la integralidad en el cuidado diario. Método: estudio cualitativo realizado en cuatro unidades de Estrategia de Salud. La recolección de datos se realizó por medio de un grupo de enfoque con profesionales de diferentes categorías profesionales, utilizándose una

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guía de preguntas sobre la comprensión de la integralidad, como es desarrollada, las posibilidades y las dificultades en su aplicación. Los datos fueron analizados por medio de análisis de contenido temático. Resultados: se han elaborado dos temas: Integralidad en la Atención Básica vestida con la complejidad y Problemas de la integralidad debido a la desarticulación intersectorial y de los niveles de atención en salud. Conclusión: dada la amplitud conceptual de la integralidad, los profesionales de los Equipos de Salud Familiar comprenden que esta es de gran complejidad y enfrentan desafíos importantes en su aplicación.

Descriptores: Estrategia de Salud Familiar. Sistema Único de Salud. Integralidad en Salud.

Introduction

Seeking to implement the principles and guidelines of the Unified Health System (UHS), the integrality earns much relevance, since it is an “[...] articulated and continuous set of actions and preventive and curative services, individual and collective, required for each case at all complexity levels of the system^(1,2)”. In this way, its polysemic nature and complexity are perceived.

Integrality reveals itself as a social action resulting from the democratic interaction between subjects in their daily health practices, transposing the fragmented vision of the human being to an integral understanding, involving biological, cultural and social aspects of the user in individual, family and group dimensions⁽²⁾. To meet this paradigm, the health sector has as structuring base the Family Health Strategy (FHS), which considers the importance of the family in their social space, addressing their socioeconomic and cultural context, understanding that, within the family context occur the interactions and conflicts that directly influence the health-disease process⁽²⁾. The FHS is considered a privileged scenario of extended clinical practice to develop the attention and continuing follow-up, able to facilitate and enhance efforts to promote changes towards the construction of integrality⁽³⁾.

The care effectuation, in the perspective of integrality, gains relevance mainly in the scenario of Basic Health Care for constituting the entrance door to other care levels, which articulates the whole process of connection and access to the health care network, which not always occurs, due to the lack of involvement of professionals and managers to promote integrality in practice, to the restricted concept

of sense of integrality and scarce structural resources for its operationalization⁽⁴⁾. In this way, health professionals should walk the path constantly seeking to offer care on a continuous, articulated and coordinated basis with views to the principle of integrality.

Care integrality is built into the praxis of different professionals inserted in different health care modalities, imposing as a challenge the need for a new form of organization of the work process, as well as the ways of acting and interacting among the different actors involved. Therefore, this construction implies breaking with the fragmented and decontextualized knowledge and establishing a health practice based on health needs of people, family and community, which are influenced by values, beliefs and ways of life, according to the political, economic and social context⁽⁵⁾.

Thus, in view of the role of integrality in the organization of the UHS and the orientation of services and everyday health care practices, it is essential that such principle route professionals consciously and intentionally, with a view to meet the health needs of the population⁽⁶⁾.

In this context, in which the principle of integrality is fundamental when aiming to improve the quality of health care at different care levels, and primary care constitutes the structuring axis of the care network, this study begins from the following question: What are the potentialities and limits identified by them to carry out care promotion towards integrality?

The present study aims to analyze the perception of professionals from Family Health Teams (FHT) about integrality in daily care.

Method

A study with a qualitative approach, which aims to capture the representations, beliefs, perceptions and opinions resulting from interpretations of people about how they live, feel and think. Therefore, this approach enables unveiling social processes related to specific groups and allows constructing new approaches and new concepts in the course of the research process⁽⁷⁾. The development of the study followed the recommendations of the Consolidated Criteria For Reporting Qualitative Research (COREQ) of the EQUATOR Network, whose purpose is to ensure the reproducibility of health research⁽⁸⁾.

The study was conducted in a mid-sized county in the countryside of São Paulo, whose estimated population is of 238,882⁽⁹⁾. The county basic care service, on the occasion of the survey, counted with 36 Family Health Units (FHU) and 12 Basic Health Units (BHU), which constitute the entrance door to the healthcare system.

The county organizes the primary health care (PHC) units in four regions (north, south, east and west), and each one has both Family Health Units (FHU) as Basic Health Units (BHU), considering the diversity of the process of living and illness of people in these territories. In this way, the study scenario defined was one FHU of each region in order to represent this heterogeneity.

The participants were four professionals from FHT. Two of them were chosen by convenience, since they are units where one of the authors developed activities during the period of Multiprofessional Residency in Collective Health. The two other units were chosen by simple random sampling. In order to maintain the anonymity of the selected teams, they received the numbering from one to four according to the sequence of the beginning of data collection.

One professional of each category that composes the FHS teams were invited to participate in the research: Nurse, Dentist, Doctor, Nursing Assistant, Community Health Worker (CHW), Dental Assistant (DA), Writing Assistant

and Cleaning Assistant. For the categories with more than one professional, such as nursing assistants and CHW, the participants were defined by simple random sampling.

In total, there was the participation of 29 professionals, being eight from team one, eight from team two, seven from team three and six from team four. There are four doctors, two nurses, four dentists, five nursing assistants, four dental assistants, three writing assistant and seven community health workers. In this way, the sample contemplated the representation of each professional category that composes the FHS teams, and there was no refusal of the invited professionals.

Data collection was performed through focus groups, bearing in mind that it allows grasping the object complexity, through the dynamics of the interaction among their members.

The focus group consists of a dialog in small homogeneous groups – from 6 to 12 participants – in order to obtain information, enabling the interaction between the participants in order to foster consensus and or differences. The technique should be operationalized through a guide of questions and the researcher should be able to ensure the participation and acquire the perspectives, thoughts, concepts of all and each one⁽⁷⁾.

The group proposition to answer the questions should provide relaxation, generate possibilities contextualized by the study group itself, in order to facilitate the formation of new ideas and enable the strait understanding of the theme in the everyday life of the people involved in the process⁽¹⁰⁾.

The collection was carried out in the months from October to December 2017, in their respective work units, in the times when the team meetings occurred, because this is a moment in which the units are closed to the public service, not interfering in the care with the population.

Before starting the works, the participants introduced themselves, and then one of the researchers presented the problem, the objectives, the scenarios and the participants of the study. The focus groups were conducted by the research advisor, Professor at the Famema,

who holds the PhD degree in Public Health Nursing and has experience in conducting focus group. This researcher led the group through guiding questions, prompting the participation of all. This work had the involvement of the intern, who made notes about the group development, recording them.

The development of the focus groups included the following guiding questions: What is your understanding of integrality-based care?; How is integral care developed by the team?; Talk about the potentialities/facilities for promoting integrality-based care; Talk about the limits/difficulties for promoting integrality-based care.

The groups were developed with a coordinator, Professor of the Nursing Course and with experience in this area, in addition to an observer who performed the recording. The dialogs, which lasted an average of 50 minutes, were recorded and fully transcribed. The data were submitted to content analysis, thematic modality, understood as a set of strategies to extract the senses and meanings from the diversified speeches. This type of analysis leads to search for "meaning cores" inserted in a communication, confronting them with the objective of the study and theoretical reference⁽¹¹⁾.

In this trajectory, after the fieldwork and transcription of the dialogs that emerged from the focus groups, the data underwent the steps of planning and organization of empirical material, followed by the understanding of this material, in order to provide with value, emphasis, space and time. Subsequently, there was the transition moment between the empirical and theoretical elaboration, also aiming to grasp the maximum of information obtained, already in an effort to overcome the level described in the material. After that moment of material impregnation, there are the elaboration of meaning units and the correlation with the theorization and, finally, the preparation of the final text⁽⁷⁾. Two researchers initially made the elaboration of the themes, and, as a result, the other authors made the validation.

The interpretation of the results was based on health care integrality, understood as a priority of the current National Health Policy⁽¹²⁾.

This research was approved by the Research Ethics Committee (REC) of the proponent institution, in accordance with Resolutions n. 466/2012 and 510/2016 of the National Health Council, which regulate researches involving humans, REC opinion n. 2.291.819 and CAEE n. 73033417.5.0000.5413. Participants who agreed to participate in the study signed an Informed Consent Form (ICF).

Results

The data analysis processing identified seven meaning cores that were grouped into two themes: Basic Care Integrality clothed with the complexity and Challenges of integrality due to intersectoral and health care levels disarticulation, as described below:

Basic Care Integrality clothed with complexity

The meaning cores articulated to this theme are: Challenges of understanding oddities involved in the promotion of care integrality; Professional training focused on the biological model hinders the promotion of care integrality; Lack of involvement of users with health care hinders the promotion of care integrality; Lack of involvement of users with health care results from the medical-centered model and its social construction.

In relation to the care operationalization towards integrality, there emerged, between the teams, the confirmation of the complexity to promote care, bearing in mind that people are different, because their values, desires, expectations were built by different life conditions. The following speech reveals this meaning core:

There are so many things, "Look, you need to take the poop of those chickens, you can't leave many chickens on the table [...] 'Look, she is the detainee's wife', both of her children are addicted; then you go to another family, 'Look, unfortunately the girl is a prostitute because she has no other way to earn money' [...] a daughter who is married to a young man that is in prison, is a drug dealer". So, the criterion she uses to be married to a drug dealer, do you think she will take care of herself? You know, very complex. (DENTISTRY 3).

There is also a professionals training based on the hegemonic biomedical model, which hinders the promotion of care integrality.

[...] and I think that, within the team, there is too much unawareness o integrality. It was so good to have this theme addressed here. (MEDICINE 1).

I think one of the missing things is the look at the social question. We think of the biology, even in of the emotional issue, but I think that the social issue is left aside too much. (NURSING 2).

[...] when the team tries to also work prevention, despite that other issue, all professionals were trained within the curative model, you know, it is a real issue for everyone. (NURSING 1).

The lack of involvement of users with health care hinders the promotion of care integrality, aspects that emerged from the teams:

[...] the education of users and the co-responsibility. Because nobody wants to change the food salt, the diet, nobody wants to exercise, they just want their pressure to be lowed that time [...] we search or offer, explain. Sometimes he doesn't have enough knowledge, you explain everything to him but he remains reluctant [...] you move the whole team to solve the problem. Then when everything is right, everything referred, the person does not accept the aid, I mean, that's the aggravating factor, because everyone is involved, mobilized. (MEDICINE 1).

[...] there is no way, we do, but they don't change. They ask for help, but also do nothing to help themselves [...] Sometimes you think it is due to lack of knowledge, it is such a complex context [...] So you don't know if it is "laxity", because the mouth is already so precarious, there is no guidance, there is no care culture, and they have no idea of how much it costs, that it is expensive to lose such a place, they don't appreciate it, but some aren't like this, they just don't have the money to go. It is very complex. (DENTISTRY 3).

It is necessary to consider, however, that difficulties arise in changes in life habits, requiring paying attention to the singularities of the subjects, as well as their surroundings and socio-economic reality.

There is no point in talking to someone that he needs to eat meat and dark green vegetables every day, when he is starving and has not even rice to eat, got it? There is no point in prescribing her a medicine that will cost 120, 150 bucks, when he lives with the minimum income program of the government. (NURSING 2).

The professionals believe that the lack of involvement of users with health care results from the cultural question established by a model still hegemonic in Brazil, i.e., the model focuses on the medical and curative actions, excessively specialized, high-cost and with low

problem-solving ability, i.e., a fragmented care and not centered on the subject.

The professional indicates the treatment. But not always he continues it or he is no longer in crisis and stops the treatment, "I'm feeling well". So, we have to always search for him and stuff[...] without considering that, sometimes, you may even lose the bond [...] due to the that culture issue, it is the cure, the curative. [...] The curative issue is very intense. Not only of professionals, but also of the population, the population has this issue and they have difficulty listening to the team, when the team tries to work the prevention. (CHW 1).

Challenges of integrality due to intersectoral and health care levels disarticulation

The meaning cores articulated to this theme are: Difficulty of access to the secondary care level; Impaired referral and counter referral process; Articulation with other sectors is the responsibility of the county health management.

In general, professionals show the development of integral care. However, this care is restricted and weakens when the health needs surpass the unit "walls". Faced with these situations, its governability is believed to be restricted, pointing to the limits of networking.

Both the secondary as the tertiary sectors are in the same situation, a chaos if you think [...] some opthbalmology specialties that the network doesn't even have, we have to fit in another specialty [...] does not meet that need identified by the service. This frustrates a little, because it is the support network issue that we should have[...] and then the integrality, I feel it is a little impaired. (CHW 1).

The greater difficulty is to give continuity in treatment, because when they get here, you try everything, but when you depend on other forces, it is a great difficulty. Let's say, when the patient needs a test, a very expensive test, this test gets stuck, it takes a year or six months to do it. And we depend on this test to give continuity in her problem, so it is a very great difficulty for us, we suffer along with the patient. (CHW 4).

Among the teams, there stands out the non-accomplishment of the referral and counter referral process, considered essential tools for the health care integrality.

[...] we hardly have counter referral, this follow-up gets lost. Then with the teamwork, we manage to retrieve the history with the patient. Then, the attempt to make integrality, I think it gets fragmented in this sense, when you depend on other levels and on other areas too. (MEDICINE 4).

Furthermore, this weakness in the system can generate unnecessary costs:

The person goes to UPA [Emergency Care Unit] and does two, three tests, sending to the central hospital, does another test and sends to Santa Casa, and then he gets back here without the test result, there is no electronic communication, which is so easy [...] Then we ask for God's sake, and the person has to go back there to ask for a copy [...] (MEDICINE 3).

[...] it gets hard from the moment it leaves here, not always you manage to get a support. After going to the mid, high complexity, it is hard to make the right follow up, you know? Also because they can't pass, and the professional there sometimes also fails to send to us a communication, even a discharge letter, you get lost. (NURSING 4).

Between the teams, many actions involve instances that are “outside” the health sector, fleeing completely from its governability, being the institutional support responsible for establishing networks and linkages with other sectors.

The support should be the bridge between one sector and another [...] lack of basic sanitation, down there in the community, no basic sanitation, a thing that is still very serious in Brazil and here we have this reality [...] so many needy people. (NURSING 4).

Sometimes you are having difficulty to talk with another service, let's say, the flow is not working well [...] then this would be a role of support [county management], and then when we seek this support, “Ah, you go there and call them, speak with what's her name” you know? This is very difficult, because sometimes we end up getting upset with the professional from another sector. (NURSING 3).

Discussion

Considering the complexity of care promotion in the integrality perspective and, in the case of PHC, the construction of care integrality is conceived in the redefinition of actions, to create bonds, reception and autonomy that appreciate the singularity of subjects as starting points for any intervention⁽²⁾.

Health practices are supposedly driven by individual concepts, which jeopardizes the effectuation of changing the care model. There is need for further studies and debates aiming to develop a theoretical framework to guide public policies, actions of workers from FHT and processes of training and permanent education⁽¹³⁾.

In addition, one states⁽¹⁴⁾ that the understanding of health concept is essential to develop strategic, interdisciplinary and intersectoral actions with actions of promotion, prevention of risks and health problems. There is a successful strategy

developed in Portugal in relation to the reform of the PHC. Investments such as trials and pilot experiments to assess the viability especially in terms of training and appreciation of doctors focused on primary care and PHC as a priority in the policy of State⁽¹⁵⁾.

One denotes⁽³⁾ that, for care promotion in the perspective of integrality, there is need to look towards the social issues, since the situations of life and health differ in each case and for each person. The health needs may be of a more comprehensive character, including the various care levels and/or other sectors of society.

In general, in the international literature, the integrated care has been defined as the functional set of practices of attention, articulated around the health needs of each citizen by fixing the clinical responsibility in a professional capable of having a broad overview of the health/disease process⁽¹⁶⁾.

In the practice of health care, there is an expressive interference of the hegemonic biomedical model. The conformation of a given care model involves values that guide the concept of health and the right to health, which is influenced by the accumulated knowledge and by the hegemonic paradigm of science⁽¹⁷⁾.

There are difficulties in the implementation of a model that breaks with this paradigm and, thus, for the construction of a new model, it is important to consider the daily routine of practices and the health needs of people⁽¹⁷⁾.

Considering the needs of the subject to organize, plan and execute the FHT work is a strategy to change the health care model. On a hegemonic basis, practices are constructed based on the disease, focused on the individual and outside his/her reality. When associating the unique needs of users with the sociocultural context in which they are inserted, the FHS breaks radically with the hospital-centered health care model⁽¹³⁾.

A study⁽¹⁸⁾ highlights the weaknesses in communication among professionals in the various care levels. The studied mechanisms – referral and counter-referral form, discharge summary, telephone and tickets, protocols of the Ministry of Health and joint clinical sessions – are

underutilized and, when used, differ between levels, suggesting the compartmentalization of the tool and not its sharing. This scenario contributes to the care fragmentation, hindering the implementation of public policies⁽¹⁸⁾.

In this sense, the secondary care points and the support system act apart from primary health care, due to deficiencies in the flows and communication or lack of information among professionals and/or services, which jeopardizes care integrality⁽¹⁹⁾.

Authors⁽¹⁴⁾ reveal major weaknesses in communication for networking, restricted to referrals without opportunity for dialog with the professionals of different services. In addition, many times, they only become aware of the process of referrals and calls conducted in other services by the patients themselves, corroborating what is seen in the present study and in others.

Regarding the access to specialized services, one highlights⁽²⁰⁾ the thesis that the mid-complexity care is currently the main challenge of the UHS. The financial burden borne by counties, the lack of specialists and the consequent shortage of supply of consultations in various specialties, as well as the dependence on the private sector, contribute to the magnitude of the problem.

It is crucial to recognize the importance of coordination to accomplish the referral and counter referral system. Moreover, the tension between doctors in primary and specialized care is evident. As a hypothesis of this situation, there are the factors related to the labor market, education and values that define the social representation about the generalist and specialist⁽²¹⁾. These are major challenges that require analysis and solution to allow the articulation between the different care levels.

The deployment of unique and computerized records across the care network represents an important contribution to the articulation between the different services of the care network, besides the need to create spaces for meetings among the professionals that enable the construction of bond of trust and sharing of knowledge. There is also the importance of investing in continuing education that regards

the different profiles and needs of workers, with the implementation of active and participatory methodologies that stimulate the involvement between these actors⁽¹⁸⁾.

In the FHS context, the work must be able to articulate in order to promote intersectoral actions and strengthen bonds with the social equipment. The actions must consider the association between social inequality and health. One highlights the high degree of complexity that guides this work, once it should be based on the social determination of the health-disease process and its family-community relationships. Based on this look, there emerges the need for a comprehensive approach of the population assigned to the FHS, UHS user, and the establishment of intersectoral partnerships for health care⁽¹³⁾.

There are two assumptions about the intersectoral action for health promotion. The first is of political character and proposes that the intersectorality allows seeking more integral interventions, and the second is of a technical nature, because the integration of various sectors allows implementing the differences between them productively to cope with social problems⁽²²⁾.

A study^(17:1876) mentions that “The theoretical and political perspectives to implement a new health care model in Brazil are challenges that need to be assimilated in the routine of health services, by healthcare professionals, users and their instances of social control and by health managers.”

A limitation of the present study is its approach of a specific moment and scenario; however, it provides information that contributes to reflections on the existing care model and the one desired.

Conclusion

The study analyzed the conception of workers from Family Health Teams in a city in the countryside of São Paulo about the promotion of care in the perspective of integrality.

Between teams, there lies the complexity to operationalize the care under the perspective of

integrality, considering that people are different, since their values, desires, expectations were built based on different life conditions.

There are limits in care promotion in this direction, namely: the professional training is still based on the biomedical model, the non-compliance and the lack of responsibility on the part of users, as well as the articulation between the different health care levels, and the inexistence of intersectorality.

Given the conceptual breadth of integrality, the basic care workers understand that this is of great complexity and face important challenges in its implementation.

Therefore, to achieve integrality in the health care system, there is a need for county, state and federal managers to prioritize this principle, observing if the goals are being put into practice in the daily management of the system.

This research has allowed elucidating the experience of professional practice, and it is possible to say that the efforts for implementing the UHS have been occurring. However, there is a need for investment in training of health professionals in educational and service scenarios, as well as of managers, because paradigmatic change is necessary to achieve the principle of integrality. To do so, it is necessary to implement the strategy of Permanent Health Education.

The research is important to the health practice in general, and of nursing in particular, in view of the importance of the nurse's role in the PHC, acting in the perspective of integrality.

Collaborations:

1 – conception, design, analysis and interpretation of data: Aline Pereira de Souza and Kátia Rezende;

2 – writing of the article and relevant critical review of the intellectual content: Aline Pereira de Souza, Kátia Rezende, Maria José Marin and Silvia Tonhom;

3 – final approval of the version to be published: Aline Pereira de Souza, Kátia Rezende, Maria José Marin and Silvia Tonhom.

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