

Work processes in the Family Health Program: crossings and transverses*

PROCESSOS DE TRABALHO NO PROGRAMA SAÚDE DA FAMÍLIA: ATRAVESSAMENTOS E TRANSVERSALIDADES

PROCESOS DE TRABAJO EN EL PROGRAMA SALUD DE LA FAMILIA: TRANSVERSALIDAD

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ABSTRACT

The study was performed with the objective to understand the ethical challenges of implementing the Program, using a qualitative approach and focal group discussion. The study included members from different FHP teams in the city of Campo Bom (Rio Grande do Sul, Brazil): three physicians, three nurses, two technicians, and four community health agents. Eight situations were created to discuss different aspects of the FHP. This article is an excerpt of the study, addressing the bottleneck effects in the FHP work process. The theoretical framework included concepts of crossing and transverse and the amplified clinic proposition. The results were categorized according to the individuals involved in the work processes: users of the health system, community health agents, professionals, administrators, and health system. The bottleneck effect in these processes originates in the repetition of primary care procedures and hospital practices, disregarding the subjective and social dimensions of the health/disease process. The amplified clinic proposition could be an answer since it holds that the therapeutic plans should result from an agreement between the health system user and the professional.

KEY WORDS

Family Health Program.
Personnel management.
Job satisfaction.
Primary health care.
Public health.

RESUMO

A pesquisa teve o objetivo de compreender os desafios éticos da implantação do Programa usando a abordagem qualitativa e discussão focal em grupo. A amostra foi intencional, com integrantes das diferentes equipes PSF do município de Campo Bom (RS): 3 médicos, 3 enfermeiras, 2 técnicas e 4 agentes comunitários de saúde. Foram criadas 8 situações de discussão sobre diferentes aspectos do PSF. O artigo é um recorte da pesquisa, tendo como objetivo específico os estrangulamentos nos processos de trabalho do PSF. O referencial teórico são os conceitos de atravessamento e transversalidade e a proposta da clínica ampliada. Os resultados foram classificados segundo os diferentes atores envolvidos nos processos de trabalho: usuários, agentes comunitários de saúde, profissionais, gestores e sistema de saúde. Os resultados apontam que os estrangulamentos nestes processos têm a sua origem na reprodução de procedimentos e de práticas hospitalares na atenção básica, levando a desconsiderar as dimensões subjetivas e sociais do processo saúde/doença. A proposta da clínica ampliada poderia ser uma resposta, porque defende que os itinerários terapêuticos precisam ser frutos de uma pactuação entre usuário e profissional.

DESCRIPTORIOS

Programa Saúde da Família.
Administração de recursos humanos.
Satisfação no emprego.
Atenção primária à saúde.
Saúde pública.

RESUMEN

La investigación tuvo el objetivo de comprender los desafíos éticos de la implantación del Programa usando el abordaje cualitativo y la discusión focal en grupo. La muestra fue intencional, con integrantes de los diferentes equipos PSF del municipio de Campo Bom (RS): 3 médicos, 3 enfermeras, 2 técnicas y 4 agentes comunitarios de la salud. Fueron creadas 8 situaciones de discusión sobre diferentes aspectos del PSF. El artículo es una parte de la investigación, teniendo como objetivo específico los estrangulamientos en los procesos de trabajo del PSF. El marco teórico es el concepto de transversalidad y la propuesta de la clínica ampliada. Los resultados fueron clasificados según los diferentes actores que participaron en los procesos de trabajo: usuarios, agentes comunitarios de salud, profesionales, gestores y sistema de salud. Los resultados apuntan que los estrangulamientos en estos procesos tienen su origen en la reproducción de procedimientos y de prácticas hospitalarias en la atención básica, llevando a desconsiderar las dimensiones subjetivas y sociales del proceso salud/enfermedad. La propuesta de la clínica ampliada podría ser una respuesta, porque defiende que los itinerarios terapéuticos necesitan ser fruto de un pacto entre usuario y profesional.

DESCRIPTORIOS

Programa de Salud Familiar.
Administración de personal.
Satisfacción en el trabajo.
Atención primaria de salud.
Salud pública.

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INTRODUCTION

The purpose of the public policy called Family Healthcare Program— *Programa Saúde da Família (PSF)* – is to focus attention both on the social and the subjective dimension of health vulnerabilities. However, it has limits that hamper the intended changes due to work processes and management models organized according to the paradigm that has to be overcome⁽¹⁾.

This article is the result of a study performed by researchers of Universidade do Vale do Rio dos Sinos (UNISINOS) about the perception of the PSF staff in Campo Bom, a town in the metropolitan region of Porto Alegre, regarding the ethical aspects of their daily routine. The investigation yielded a few obstructions in the organization of the work processes and health management, which will be analyzed in this article as an excerpt of the aforementioned joint research.

The dynamics of the work processes are interpreted according to the theoretical references of crossings and transversalities, proposed by institutional analysis. Crossing means that any institution is always cross-influenced by other institutions. The hospital model, for example, crosses the basic unit. Transversality means that the institution is also the place where groups that integrate within the system to fight against such crossings are created⁽²⁾. The PSF represents an example of transversality in the system of the basic healthcare unit.

Crossings and transversalities occur because of the several authors that interfere in the work processes of the PSF: users, community agents, professionals (physicians, nurses, nursing assistants), managers and the system. They act according to their cultural representations of health, which serve as filters to accept or reject new organizational practices and structures. As medicine is always a historical and social construction, the biomedical model⁽³⁻⁴⁾ represents the scientific and cultural paradigm for most healthcare professionals, being a reference to mold the desires and interests of the users and to model the sanitary organizations. For this reason, crossings and transversalities present in the work processes use this model as a reference. The obstructions happen because old models are still present, crossing new healthcare proposals and strategies, coexisting with transversal articulations that attempt to propose new practices.

The theoretical references of co-management⁽⁵⁾ and broadened clinic⁽⁶⁻⁷⁾ will be used in the discussion of the specific crossings and transversalities in the healthcare area.

The social movement of collective health resulted in the creation of the Unique Health System (SUS), demanding a radical change in the healthcare model. The traditional biomedical model is based on a structure of competences and hierarchical management, considering the biological dimen-

sion to define health, disease, and its indicators, as they are considered objective. It is necessary to have real clinics in basic healthcare, but the typical hospital clinic cannot simply be transferred to basic healthcare because the contexts are different^(6,8).

With these theoretical references, the article intends to note certain obstructions in the impeditive work processes for the PSF transversality to be effective.

METHOD

The type of investigation was outlined as an exploratory study, using a qualitative approach and an intentional sample. The focal discussion technique was used for data collection, later analyzed according to the content analysis method.

Meetings were held with the state coordinator of the Family Healthcare Program in RS and with the coordinator of the First Regional Healthcare Division to select the town to be used as a study field. The selection criteria for the town were: 1) PSF implanted for over three years; 2) medium-sized town (> 50,000 inhabitants) in the metropolitan region of Porto Alegre; 3) the program coverage should reach over 40% of the population. The chosen town, Campo Bom, implanted the PSF in 2001. At the time, it had 55,310 inhabitants and the PSF reached 43.66% of the population (data provided by the regional healthcare coordination in 2004).

The studied group consists of professionals and community agents of the municipal PSF, intentionally chosen by the researchers after several visits to the seven teams, according to representative criteria of the local PSFs and the different members of the healthcare teams. At the time, the town had seven local family healthcare teams. When the members of the focal group were defined, the researchers insisted on including the community agents, as they do not take part in periodical team meetings, and their performance and qualification are only monitored by a nurse. The focal group consisted of three physicians, two nurses, two nursing assistants and four community agents. The testimonies will be referred to as M1, M2 or M3 (Physicians), E1, E2 or E3 (Nurses), T1 or T2 (Nursing assistants) and A1, A2, A3 or A4 (Agents). The project was approved by the UNISINOS Review Board through resolution # 029/2006.

The focal discussion guidelines addressed ethical aspects of the program itself, the professional practices, the relations among the professionals and with the users and the cultural traditions of the community. Eight research situations were created, lasting an hour and a half each, about the four themes. The discussions were recorded and later transcribed and analyzed.

The crossings impeding the fluidity and success of the teams' activities and the transversalities that attempt to

Crossings and transversalities occur because of the several authors that interfere in the work processes of the PSF: users, community agents, professionals, managers and the system.

pave the way are analyzed according to the perception of the family healthcare workers and classified according to the actors involved in the work processes.

RESULTS AND DISCUSSION

In order to understand the work performed in the PSF^(1,9), it is necessary to know the protagonists who interact in these processes. The *user* is the central focus of the services, receiving care from the *community healthcare agents* and the *healthcare professionals*, supported by the *managers* and the *integrated healthcare system*.

Users

The professionals note two main crossings caused by the users that obstruct the work processes: spontaneous demand and dependence/independence in relation to the healthcare team members.

The spontaneous demand clashes with the PSF's scheduling proposal and the offer of healthcare education initiatives⁽¹⁰⁾. Scheduling does not work because the person says, *How do I know if I'll be sick that day?*, and there is no awareness on the importance of healthy habits. As such, the team merely responds to progressively increasing demands. Therefore, the participants in the focal group collectively state: *[...] the more demands you have, the more patients you have. [...] as the medical records increased in number, so did the number of patients.*

This statement is a factor of stress for the team, according to one of its members:

It is terrible having to meet a demand as high as that. You get stressed... there is not even time to tell the patient to have a seat because there are already ten forms in front of you and there's a schedule to be followed (M3).

Basic care is more likely to become aware of this unnecessary demand than the hospital suffering from cultural iatrogeny, where the users become dependent on the medical services (8). This is not a repressed demand, but it simply responds to the social imaginary created by biomedicine. For this imaginary, cure does not depend only on the active principle of the medication, but also on its symbolic efficiency provided by a medicator who, in a way, produces the cure, like in the case of the physician. As access to them is facilitated, this symbolic medicator of health is then consulted. At the PSF,

people have more freedom to come and go. It's like this, I have no obvious reason to do it, but the door is open, let's go there and see what they have to offer. That's what the demand is like [...] you know that they won't even buy the medication, they fold the prescription and put it away, they just dropped by to hear what the doctor had to say, because that's what you have to do (M2).

This dependency on the professional can also be encouraged by the bonds that characterize the PSF:

Of course we want to establish bonds, but we don't want those users to become dependent on the unit [...] we want them to become agents of their own health. We want them to be independent (E1).

The professional, however, understands that the cause for this dependency may stem from the discouragement and social despair people have to live with:

Everybody feels discouraged, and they see a little solution or a beacon of hope at the unit, because they can't financially, they're socially terrible, they're politically terrible... at least there's something at the unit, because nothing else works (E1).

The clinical vision of the old family doctor, in general, lies behind the bonds, so that the person can say *That's my doctor*. Ideally, the bonds would have to be established with the team instead of the physician, although the user may feel a stronger identification with a member of the team. If the bond is established exclusively with the physician, a dependency is created and the social imaginary of the biomedical model is corroborated. Therefore, the team should develop a broader clinical perspective that will help overcoming dependency.

If, on the one hand, the professionals are aware of such dependency, on the other hand, they express the frustration and despair they feel with the users' autonomy:

Not being able to change the habits of hypertensive or diabetic patients. [...] but I can't force someone to do something they don't want to. Still, it's really frustrating [...] That causes a lot of despair: knowing that certain things can be avoided, but they are not because we can't rule over the lives of other people [...] We reach a point where you don't know what to do anymore. Everything has been said, the whole team is burned out. It's funny, but you have to live with the problem, because they're always there at the unit with the same problem, the same complaints (E2).

The professionals are aware of the interference in the issues of user subjectivity and autonomy, but are unable to insert them in the therapeutic itinerary, or even to provide moments of interaction to reach an agreement about the values of use for the production of health the users seek at the unit. It is also difficult to work with the production of the subjectivity of both users and professionals in this relation.

The professionals' frustration with the interferences in subjectivity is linked to the crossing of the hospital model in primary care. Hospital work is centered on the appropriate procedures, exams and medications for each disease, but such practices are not adequate to primary care because there is no submission of the subject like in the hospital, and the action depends on the subjects themselves instead of the professionals. In basic care, the power of the professionals is much smaller, and the therapeutic route becomes impossible if there is no participation and dialogue with the users. The frustration of the professionals is explained by the lack of awareness regarding this difference⁽⁸⁾.

The hospital clinic developed by the biomedical model demands a certain detachment from daily life, creating an artificial situation of control in order to face a given pathology. It is characterized by the concentration in the diagnosis, short hospitalization times, total dependency on the professionals (heteronomy), focus on the physical symptoms and short-term assessment of the results. This situation dims the desires and interests of the patient's subjectivity.

If this disregard for subjectivity is a problem for the hospital service itself, it is totally counterproductive in basic care, since people there are inserted in the real situations of their routine, where subjectivity is continuously produced by the relationships and challenges they have to face. In this situation, care needs to be focused on the therapy, on longitudinal time, on the subjects' autonomy when faced with the proposed procedures, on long-term results and, especially, on the incidences of the health-disease process in the constitution of the users' subjectivity.

The users' social imaginary about healthcare was built by the biomedical model imposed on Western society, creating demand for and consumption of medical procedures and products as a symbolic medication of health. For this imaginary, cure depends on the use of medical procedures and products that are not merely technical instruments, but realities provided with health-producing, symbolic effectiveness, provided by its mediators, the professionals. The same professionals educated in this model⁽¹¹⁻¹²⁾, whose maximum expression is the hospital, mistake the clinic for the hospital procedures. When the professionals transfer practices learned in hospital care to basic care, they feel frustrated, because they do not work as they should and, on the other hand, by acting like that, they unconsciously encourage the users' demand.

Community Healthcare Agents

The community healthcare agents are indispensable actors for the PSF. They represent the link with the community, one of the bases of the program. However, this new figure is not exactly clear in the healthcare world⁽¹³⁾. The first question is about whether they belong in the healthcare team. The focal group is not unanimous:

I'll include the CHA in the multiprofessional team as well. But that's my opinion [...] I also think that the community agents should be considered as any other professional in the team (M1).

This divergence is manifested because the agents do not take part in the team meetings, but have periodic meetings with the nurse instead⁽¹⁴⁾.

Another issue is granting access to the medical records and information to the agents. The prohibition is justified, according to some group members, because

they are members of the community, they should belong in the community [...] they have often been neighbors of a patient for years, or could even be related and, for some

reason, they end up knowing things that the person wasn't willing to share (E1).

Conversely, other professionals believe that this depends on the orientation, since

when you qualify someone, you guide them according to which is the right thing to do (M1).

Another professional states that

there's no reason they shouldn't be granted access to the medical records to update data, so they obviously will be able to see the patient's history (E1).

The agents in the focal group replied to the confidentiality issue by saying that

we end up knowing about things when we visit the patients, sometimes they tell us things that they don't tell the nurses or the doctor (A1).

Other topics discussed by the group included the qualification and professionalization of the agents:

they have to be better prepared, since the CHA face things they can't solve, even personal things related to suffering [...] (E3).

Concerns with qualification are an ongoing issue, and are related with the issue of regulating the profession in order to reduce the conflict of competences with the nursing assistants.

You have to regulate the unregulated profession of the CHA, so that it doesn't clash with the staff within the unit, the assistants because, in the near future, the nursing assistants will bring it to light and they will be justified in doing so (E2).

This lack of preparation and clarity about the function makes the agent vulnerable and causes grief⁽¹⁵⁾. One of the group members proposes that the agents be considered as the old nursing attendants. Such concern with the desired qualification for the agent shows that it is characterized as being closer to nursing or social work, or as a mix of both. This definition of the agents' identity is indispensable in order to define their profile and the necessary qualification.

Again, it is important to present the reference of the broadened clinic. Several crossings related to the presence and action of the agents in the teams would be solved with the introduction of a broader clinical perspective. They are the result of thinking within an outlook of hospital procedures. At the core, this is the cause to exclude the agent from the family healthcare team. They are not competent to develop the practices demanded by the biomedical model. If health production is considered as the production of subjectivity, as the broadened clinic defends, the presence of the agent is requested as a mediator of the community the services are provided to, since the subjectivity is built upon the relationships that exist within a given sociocultural context.

The confidentiality issues acquire another perspective, as they are designed according to a classic understanding of the clinic, where explicitly asymmetric relations between physicians and patients occur. In these relations, the subjectivity of both users and professionals is particularly disregarded. Confidentiality is based on the exclusive accountability of the physician in relation to an infantilized patient. This is an asymmetric comprehension, in which no subjectivity is produced.

However, changes are necessary in the management model so that the agent can take active part in the team, both in the sense of making the professional relations more horizontal and differentiating competences according to the production of health. The agents' competences are defined, but it is not clear how they converge with the other competences of the team for the production of health. This convergence is the necessary result of an interaction between the subjectivities of the different workers, made possible by co-management of health collectives. Otherwise, the competences would be fragmented, and this would make the collective production of health for the family and the community impossible.

Healthcare professionals

The healthcare model proposed by the PSF is based on a multiprofessional team. One of the assistants states:

it's much stricter in the hospital, we have little access. Not in the PSF. We talk to doctors and nurses often. At least we can decide together there (T1).

The joint decision-making is the objective of a group with multiple multiprofessional competences. That demands horizontal relations and interactions between the actors and the comprehension of co-management processes in order to reach the decisions that were agreed upon. In this interaction, the exchange of knowledge overcomes the biomedical model, characterized by exclusivist competences and standardized procedures.

One of the physicians understands that the team is a place to share knowledge:

In a little while you will be with the assistants, someone from the nursing staff, the experience exchange is among the professionals, and we learn from that. Knowledge has no value if it's kept for yourself. Some day you may need it, and you're with someone who knows more about a given topic (M2).

The multiprofessional approach allows for the broadened clinic. In addition to the ontology of the diseases, it integrates knowledge linked to the context and the implied subjectivities, allowing for a truly hermeneutic clinic.

This broadened clinical perspective demands overcoming the tradition of applying standardized procedures and creating therapeutic itineraries that are adequate to the personal history of a given subject. This necessary creativity in

the broadened clinic demands teamwork that involves all health production actors, always to produce the subjectivity of these same actors. The method of interactive construction of subjectivity in the social healthcare context is named *paideia*, inspired on the ancient Greeks, for whom education is always identified with the construction of the citizenship of the actors involved in social projects⁽⁶⁻⁷⁾. In other words, subjectivity is always the result of an educational interaction among all actors involved in healthcare processes. This subjectivity means considering ethical responsibility and political agreements in their context, resulting in continuous and permanent education for the actors involved.

The worker's knowledge of how to deal with the incidence of subjective questions in the health-disease process depends on the incidence of their own subjectivity in the work processes. That is why one of the nurses stresses team cohesion:

It is very important for the team to get along well. Otherwise they couldn't stand working together for eight hours. Working in harmony, as a group. If I make a decision, the team has to know about it. Working with clarity, being open and frank. Not omitting things (E2).

This *getting along well* does not happen spontaneously. It must be a management policy, so that conflicts, interests and desires in the processes can be discussed and agreed upon, regarding their incidence in the subjectivity of the workers themselves.

In a multiprofessional team, the matter of competences is always a topic for discussion, as they can either cause conflict or contribute towards creative solutions. One of the nurses reports:

This thing of knowing how far the other can go, what he can do, is very important, as we cannot overburden the doctor, because the community thinks that it all has to do with the doctor... we have to develop these instances so that the team can work in harmony, or even an affinity so that you can delegate or assume things (E1).

Multiprofessionality demands, on the one hand, a clear definition of each competence but, at the same time, spaces for interchange and intermingling of competences. This definition cannot be based on a delimitation of geographic or market-based borders – instead, different types of knowledge should always be interlinked. This is the basis of the broadened clinic, which goes beyond the positivist limits defined by the biomedical model.

Another crossing observed by the professionals is work-related stress. The cause that is usually reported is the lack of response from the users:

I really feel that we are guided by... we always try to do something expecting something in return. What would this something in return be? That they change (E2).

He didn't satisfy you, so you get frustrated with that [...] But why did I get frustrated? Actually, because she didn't corre-

spond to my expectations. And what were my expectations? I'm telling you, but you have to answer me. Because she didn't answer me, so I'll get frustrated over it (E1).

The professionals educated within the hospital dynamics understand the therapeutic proposals as prescriptions instead of offers, a condition that is more appropriate for basic care. They have difficulties in having a shared decision and subjective responsibility with the users about the therapeutic itinerary. Instead of having the user's subjective autonomy as an ally in the therapy, it is a source of frustration for the professionals. They lack the perspective of the *paideia* method.

Because of work-related stress, many people note the necessity of a caregiver:

We need someone to look after us. As there is nobody to provide care to us, you end up creating mechanisms to deal with certain things (E2).

Often, these mechanisms of escape or deviation strengthen the stress. Therefore, one of the participants suggests that it would be necessary to focus on the relationships and subjectivities of the workers themselves:

Whenever we have a team meeting to plan, to get together, to have moments of exchange or collective experiences, at least. Otherwise we'll only look at the schedules (T1).

Another participant thinks that, at moments of conflict,

it is vital for the group to look up to a leader [...] Someone to pull the group up, who feels the thermometer of the situation. Because there will always be conflict. Someone has to help things move along smoothly (T2).

The importance of moments of exchange and collective experiences points to the necessary construction of subjectivity in the work processes, according to the *paideia* perspective⁽⁶⁾. This interaction, however, is only possible if the local manager, by feeling the thermometer of the team and with a co-management outlook, helps things move along smoothly and tries to have an agreement between the values of the healthcare institution and the interests and desires of the people who work there.

The Taylorist management perspective⁽⁵⁾ often dissolves the necessary atmosphere of trust for interaction, due to the introduction of an administrative agent in the unit:

We know that there is an administrative agent in the unit who will take control of everything. So, up to what point, can we trust [...] because I don't know if I'll be able to say everything I used to (E2).

The function of this agent is to oversee compliance with the schedules and the attainment of results, identifying efficiency with control, a typical premise of Taylorist management. The co-management collective model proposes another way: the emergence of subjectivity and agreed-upon accountability of the workers. This model does not work as supervision, but as *co-vision*, constructed interactively with them⁽¹⁶⁾.

Another problem identified is the high turnover of professionals. The focal group had both favorable and unfavorable opinions about the changes of professionals in the teams. The opinions were based on bonding. For some, changes make bonding difficult and displease the community; for others, it helps overcoming dependence and brings new blood for the team. In general, the changes occur to solve the problem of lack of bonding for a new team member. This is not the only cause of turnover. The lack of stability makes the workers seek other towns where the PSF offers better salaries and work conditions.

The managers

In order to make the *paideia* method feasible, along with the consequent broadened clinic, it is necessary to change the management models, criticizing the Taylorized management model that rules over the healthcare institutions, characterized by vertical decisions and disregard for the subjectivities of the workers, focused only on control and encouraging competition. To make this paradigm change possible, we propose the *wheel method*, based on a horizontal approach and the co-management model, favoring the creation of agreements between the values of usage of the institutions, i.e. the ends to which they exist – in this case, production of health. Also, the desires and interests of the different actors involved in this relation, factors that influence the constitution of the subjectivities⁽⁵⁾.

This perspective is denied by a crossing that was often mentioned by the focal group when talking about the managers: demands for quantitative results. One of the nurses reports that

the coordinator demands that, if there are 200 families, the Healthcare Agents should make at least 200 visits that month. Those who have been working for some time and follow the Healthcare Agents know that this is impossible. The quality has really slumped. How can we produce health in such a hurry [...] They demand quantity over quality (E2).

One of the agents adds:

To meet the production quotas, you end up going to the gate, talking to that person and asking them to sign the docs. I don't think it's right. I'll be honest, I never got 100%, because I don't think it's right to get there in a hurry to talk to people. If you do that, you can't bring anything back to the unit (A2).

One of the physicians remembers that "in the last PSF qualification, we had the following: you don't have a target number to reach and there's no time limit. However, today, there's a document telling us to see a patient in 15 minutes at most [...] This 100% thing is not exclusive to the agents (M2).

Quantitative demands are possible in hospitals, since the perspective is centered on the diagnosis, the procedures have already been defined and the results are expected in the short term. In basic care, the clinical outlook is broadened by listening to the subjectivity, making its transfor-

mation in figures difficult. On the other hand, the broadened clinic focuses on the therapy and works with the long term, which makes it more difficult to quantify results that are essentially crossed by the subjectivity.

The impossibility of transforming the interferences of the subjectivity in the health-disease process into figures and the demands for quantitative results are one of the main obstructions for the PSF. It leads to a problem of sanitary comprehension of the system itself, which simply transfers clinical and epidemiological hospital criteria to evaluate the PSF. The broadened clinic proposal⁽⁶⁻⁸⁾ could be an answer, since it is not centered on procedures, but on the therapeutic subject, defending that the itineraries of cure will be the result of agreements between the user and the professional. This practice is based on the principle that every production of health is always the production of the users' and the workers' subjectivities, demanding work processes to be agreed upon and system organization changes.

The healthcare system

The system is not an actor alongside the others. It represents the environment where those actors interact. The system is understood as the secondary- and tertiary-level structure which the actors resort to when they have to respond to necessities that demand another type of relation between the different levels of the system. The participants in the focal group consider that the issue of referral and counter-referral, when related with the principle of equity, is an obstruction.

I think that equity is being able to do something. If you can't solve the problem of a patient in primary care, refer him to the secondary or tertiary levels but, at the same time, monitor him from afar. Know that he's going to another service, but that he gives you feedback. They have to be linked. Equity is having the three levels work as one (M1).

The resulting problem is that

you play the role of referral and counter-referral, but you don't receive the counter-referral (M3).

The cause is the prejudice of the hospital towards the basic unit, as it does not accept a referral with an accompanying diagnosis:

the doctors cannot send patients with a diagnosis on paper, because the hospital would call back saying: who does the doctor at the basic unit thinks he is to provide a diagnosis? You couldn't diagnose the patient, only refer him [...]

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the hospital would call back swearing at the doctors who already had the diagnosis (E2).

This hospital vs. basic network / PSF prejudice is clearly based on the predominance of the biomedical model, which does not accept a diagnosis that has not gone through more sophisticated technological means, which do not exist in the basic unit. Lacking the competence to be effective in basic care, the medical hospital corporation tends to state that primary care practices lie outside its responsibility, disregarding the diagnosis provided by PSF professionals. Although the basic care clinic is very complex due to the interferences of subjectivity and the necessary negotiation of therapies, the medical corporations tend to deny this complexity and neglect basic care, since it differs excessively from the classic hospital biomedicine⁽⁸⁾.

The matter of referral and counter-referral and the relationships between the different levels of the system would follow another course if the reorganization of services were proposed through integration between the local reference teams and the matrix-based specialized support groups. This integration would make it possible to build shared therapeutic projects between the base team and the matrix-based specialization service⁽⁷⁾.

CONCLUSION

The Family Healthcare Program has the purpose of changing the basic care model. This transformation demands a conversion in the healthcare paradigm, which is not easy as it depends on changes in the comprehension of the health-disease process and in the form of organizing the healthcare practices.

Data show that one of the main obstructions for the effectiveness of the program is the unconscious transference of hospital procedures from the classic biomedical model to basic care. This transference produces crossings that hinder the efficacy of therapeutic practices, because their result mostly depends on the incidences of subjectivity. Its effects tend to appear in the long term, which is not the case of hospital procedures.

The broadened clinic model could be an answer to this obstruction, as it defends that basic care needs to perform a true clinic, but not the one performed by hospitals. This clinic provides attention to the subjective and social dimensions of the health-disease process and the work process that it triggers. This means building therapeutic itineraries agreed upon by users and professionals.

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Funding

CNPq under Notice 372004 Unique Health System/Healthy Systems and Policies – quality and humanization at the Unique Health System and by Universidade do Vale do Rio dos Sinos (UNISINOS)