

## Conception of workers in a municipal health network about the service-management relationship

Meyrielle Belotti<sup>1</sup>  
Paloma Pereira Andreatta<sup>1</sup>  
Teresinba Cid Constatinidis<sup>1</sup>  
Andrea Thamiris Barbosa Dias<sup>1</sup>  
Luciana Bicalbo Reis<sup>1</sup>  
Alexandra Iglesias<sup>1</sup>

<sup>1</sup>Universidade Federal do Espírito Santo (UFES), Vitória, Espírito Santo, Brasil

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### Abstract

The objective of this work was to understand the conceptions of health professionals about the relationship between management and the different services that constitute the public health network of a municipality in the southeastern region of Brazil. It used the Focus Group (FG) technique for data collection. Three FG were held with an average of 12 participants per meeting, totaling 38 participants. The Lexical Descending Hierarchical Classification analysis was applied with the support of the Iramuteq software. The results outlined four classes: Management-Service Relationship; Daily challenges of services; Sustainability of work in the territory and Prioritization of the user. The relationship between health services and management was marked by hierarchical practices. However, it was possible to verify that there are expectations regarding the establishment of a transversal relationship. Collective spaces and user participation in care management are considered as important elements for co-management.

*Keywords:* Unified Health System; Public policy; Health Management.

### Concepção dos Trabalhadores de uma Rede Municipal de Saúde sobre a Relação Serviço-Gestão

#### Resumo

Objetivou-se compreender as concepções de profissionais de saúde sobre a relação de uma gerência com os diversos serviços que compõem a rede de saúde pública de um município da região sudeste do Brasil. Utilizou-se da técnica do Grupo Focal (GF) para a coleta de dados. Foram realizados três GF com a composição média de 12 participantes por encontro, totalizando 38 participantes. Seguiu-se com a análise lexical do tipo Classificação Hierárquica Descendente com o auxílio do *software* Iramuteq. Os resultados delimitaram quatro classes: “Relação Gestão-Serviço”; “Desafios cotidianos dos serviços”; “Sustentação do trabalho no território” e “Priorização do usuário”. O estudo indica que a relação serviços-gestão é marcada por práticas hierarquizadas. Contudo, foi possível verificar que existem expectativas em torno da instauração de uma relação transversalizada. Pondera-se os espaços coletivos e a participação dos usuários na gestão do cuidado como elementos importantes para a cogestão.

*Palavras-chave:* sistema único de saúde, políticas públicas, gestão em saúde

### Concepción de los trabajadores de una red de salud municipal sobre la relación servicio-gestión

#### Resumen

El objetivo de este trabajo fue comprender las concepciones de los profesionales de la salud sobre la relación entre la gestión y los diferentes servicios que componen la red pública de salud de un municipio de la región sudeste de Brasil. Se utilizó la técnica de Grupo Focal (GF) para la recolección de datos. Se realizaron tres GF con un promedio de 12 participantes por reunión, totalizando 38 participantes. Un análisis léxico de Clasificación Jerárquica Descendente fue aplicado con el apoyo del *software* Iramuteq. Los resultados distinguieron cuatro clases: “Relación Gestión-Servicio”; “Retos cotidianos del servicio”; “Sostenibilidad del trabajo en el territorio” y “Priorización de usuario”. El estudio indicó que la relación entre los servicios de salud y la gestión está marcada por prácticas jerárquicas. Sin embargo, se pudo constatar que existen expectativas en cuanto al establecimiento de una relación transversal. Los espacios colectivos y la participación de los usuarios en la gestión de la atención se consideran elementos importantes para la cogestión.

*Palabras clave:* Sistema Único de Salud; Políticas públicas; Gestión de la salud.

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## Introduction

Historically, guided by theories in the field of administration, it appears that the emergence of health management signals, mainly, to reduce the autonomy of workers on the task to be developed, favors the

separation between the moment of conception and the execution of activities related to work (Matos & Pires, 2006). Hence, it can be said that the the Unified Health System (SUS), despite signing democratic commitments, has not managed to detach itself from certain patterns of traditional managerial rationality, marked

by the exercise of control, a quantitative productivity, fragmentation, discipline and the reduction of the subject to an object (Campos, 2010). In the same direction, other studies (Pimenta, 2012; Campos, 2010) showed that traditional administrative rationality creates important obstacles to the realization of SUS assumption, which converge to shared management, anchored in network, interdisciplinary and intersectoral work, with fostering social participation, health promotion and comprehensive care.

Before this scenario, of contradictions and ambiguities between the principles of SUS and the management practices governed by the logic of traditional administrative rationality, the Ministry of Health (MS) instituted the National Humanization Policy (PNH), characterized as a transversal policy, which groups a set of ideological foundations that seeks to favor the organization of health work within the democratic logic, emphasizing the inseparability between care and management. Among its foundations, PNH highlights co-management as a valuable device that encourages participatory culture, with the promotion of the role of users in their care process (Brasil, 2009). Its potential lies in building a commitment to the creation of shared spaces of power, knowledge and practices, aiming at the democratization of relations between users, workers and managers, with a view to overcoming hierarchical models.

However, for the realization of the co-management guideline, Galavote et al. (2016) underscore the need to create new channels of dialogue, which implies civilizing borders, dissolving existing barriers between managers and workers, specialists and generalists, between clinic and management, among those who formulate and those who execute (Iglesias & Avellar, 2017). In this same direction, Dorici (2018) points out that one of the factors that favors co-management is correlated with the way health teams relate to users and the community. The author highlights the importance of horizontality in the relationships, the bond, the inclusion of different knowledge and the co-responsibility of all the actors involved with the health issues that emerge in the territory.

Based on the above considerations, as well as on the study carried out by Iglesias (2015), it can be seen that the integration of management with services has been built with numerous clashes and challenges, since a hierarchy among these workers prevails, which produces barriers to health, carrying out effectively joint work and building relationships compatible with the

practice of co-management. Therefore, despite the advances produced with the promulgation of PNH, Guizardi et al (2010) emphasise the need to reinvent health institutions and their “ways of organizing work, an objective that confronts subjects with the need to analyze and share situations they face, building, in function of them, co-responsibility with the formalization of collective commitments”(p.1254).

In the midst of these necessary relations with co-management, the problematization stands out: how does the health professional in the services of a municipal network perceive their relationship with the management? It is a cut in the midst of the variety of relationships that this worker experiences, in addition to his contact with the user and the other social actors that make up SUS. Therefore, the goal was to understand the conceptions of health service professionals about the relationship of the management with the various services that make up a health network, within the scope of a municipality in the southeastern region of Brazil.

The differential of this study is highlighted, which encompasses the understanding of health professionals of different levels of care (Primary Care and Secondary Care) and several professional categories, as presented in the method. Furthermore, it is worth mentioning that such conceptions can guide practices, both in the sense of maintaining verticalized power relations, as well as enabling the reinvention of work collectively, by the certainty that the management process involves all the actors involved in the production of health, as brought by PNH (Brazil, 2010).

## Method

### *Participants*

A health professional, representing each of the services in the municipality, participated in this research: 29 Basic Health Units (UBS), four Psychosocial Care Centers (CAPS II, CAPS III, CAPS for children and adolescents, CAPS alcohol and drugs), a Reference Center for Elderly Care and one for the treatment of Sexually Transmitted Infections, an Attention Service for people in situations of violence, two Emergency Services Units (PA) and a Municipal Specialties Center (CME). Altogether there were 39 workers who participated, so that each focus group (FG) contained, on average, 12 participants. Among these participants, different professional categories were present: a community health agent, an art therapist, a social worker, a

pharmacy assistant, a nurse, a pharmacist, a physiotherapist, a speech therapist, a doctor, a physical education professional, a psychologist, and also an occupational therapist. They are mostly women aged between 35 and 53 years.

#### *Instrument*

This is a qualitative research made in a municipality in southeastern Brazil. Such research was used as a data collection technique the Focus Group (FG), which aims to gather information on a specific subject, from the communication and interaction of a group of people who received appropriate stimuli for the debate (Kinalski et al., 2017).

#### *Procedures*

Three FGs were performed with the representatives of all health services in the municipality. Each FG session was moderated by a trio of researchers who, in line with the objectives of this study, had the intention of understanding these actors' conceptions about the relationship between a Health Management (from the Municipal Health Department - SEMUS) and the services of this municipal network.

The FG started with the arrangement of figures cut out at random from magazines, followed by the request that the participants chose the image that they considered to represent the management-service relationship. Based on this choice, each participant presented his/her figure to the group and commented on the association made between the image and the management-service relationship. This strategy was a trigger for the next discussion, guided by a script with questions about: daily management-service relationship; expectations of services in relation to the management; challenges and potentialities found in the service-management relationship.

The average duration of the FG session was 90 minutes. The sessions were recorded in digital audio files and later transcribed, following the protocol of free and informed consent by the target population of the research (Resolution No. 466/12 of the National Health Council).

#### *Data analysis*

Subsequently, it followed with the lexical analysis of the textual data, which allowed describing the material produced by the participants. For this purpose, IRAMUTEQ software (Interface of R pour les Analyses Multidimensionnelles de Textes et de

Questionnaires) was used as a tool for data exploration, which consists of a "free computer program that allows different forms of statistical analysis on textual corpus and on tables of individuals by words" (Camargo & Justo, 2013, p. 513).

Thus, the textual materials obtained through the transcription of the three FGs were brought together to build a single corpus. With this as a starting point, with the help of IRAMUTEQ, the Descending Hierarchical Classification (CHD) technique was used for textual analysis, which classifies the text segments (ST) according to their vocabularies, in order to obtain the classes of text. ST who, at the same time, have a vocabulary similar to each other, and a different vocabulary from the ST of the other classes (Camargo & Justo, 2013).

## **Results**

The corpus containing the transcripts of the three GFs was submitted to CHD, with a use of 79.27%. There was a partitioning of the material into four classes, which are divided into 825 text segments. At first, there was a division into two sub-corpus. In this first partition, class 1, called "Management-Service Relationship", was created, so that it is separated from all the others. Class 4 was obtained from a second partition, named "Daily challenges of services". Finally, there was a third partition, resulting in classes 2 and 3, respectively: "Sustaining work in the territory" and "Prioritizing the user". The following figure (figure 1) shows the partitions of the corpus and sub-corpus for the construction of the four classes.

Class 1, called "Management-Service Relationship", represents 32.7% of the content analyzed, so that the words with the largest chi-squares ( $\chi^2$ ) are: "relationship" ( $\chi^2 = 71.93$ ) and "management" ( $\chi^2 = 81.79$ ). The segments of this class, in general, refer to the relationship between services and management, including the expectations of each other. The service-management relationship is described not only as: difficult, distant, indirect, vertical, careless, enigmatic and fragmented, marked by a lack of dialogue, resoluteness and a careful eye towards the worker, but also as something that is under construction.

The participants bring in their speeches a virtualization of this service-management contact, as it can be seen in the excerpt: "My relationship with SEMUS is only virtual, distant, things just arrive, messages. People who are here, I think I don't know anyone,

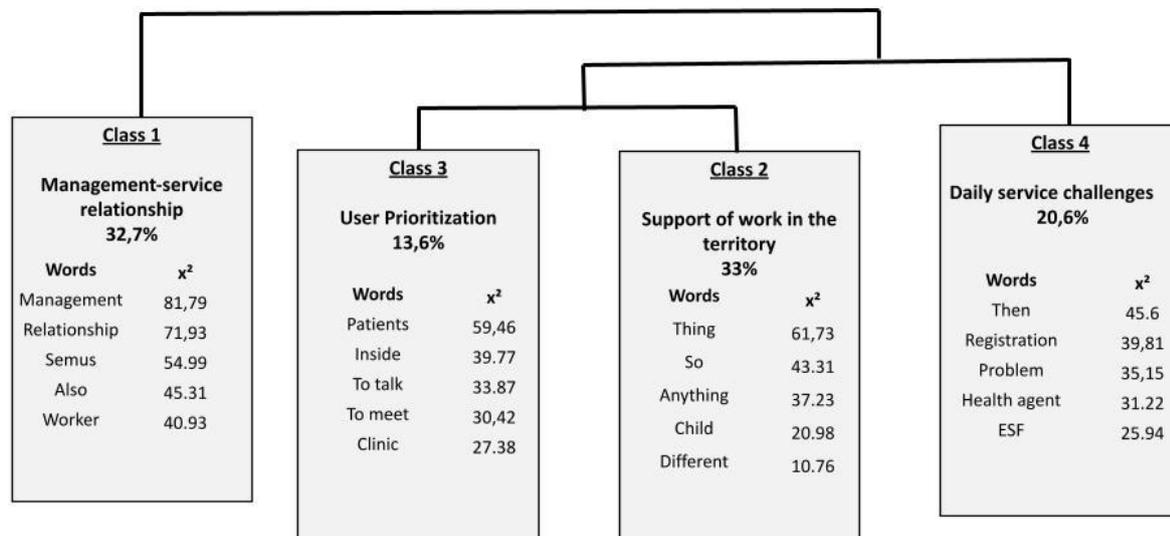


Figure 1. CHD dendrogram of the “Management-Service Relationship” corpus

the relationship is very virtual, each one in their own square”. In this sense, the existence of several sectors in management is demarcated and a noticeable disconnect between them, marked by a difficulty in communication, since the service receives several demands at all times and it is not known where they came from, which makes it difficult to search for guidelines for performing these tasks:

*“SEMUS seems to have a lot of management sectors, when you want to ask for information, you want to talk to someone, you are very redirected to various places without an answer, I think it's a bit labyrinthine. We have a lot of bosses for little Indians” (P.10).*

For the participants, these labyrinthine and fragmented relationships among services and the management reflect on the relationship of services with each other, and on the relationship of services with users: “(...) we talk about management, but the thing is much bigger than that, one service does not know what the other does (...) we are dissociated, from those who are in management and from our own patient. Perhaps, he also perceives himself as well as we do”.

On the other hand, some participants perceive that these relationships are under construction, aiming at highlighting the services and management as complementary to each other: “I see myself as part of this structure and each of the pieces of this puzzle. Having SEMUS this structure, we just complement it here. I see this relationship as one complementing the other”. For

another participant: «This relationship is a construction that we need to be involved in and not give up».

This Class also brings these workers' understanding of what management expects from services and what services expect from management. For the participants, the management area expects partnership, exchange, willingness to work, local problem solving, compliance with health policy, service and user satisfaction. In the words of the participant: «I believe that what the management wants from this relationship with the service and what the service wants from this relationship with the management is in the health policy: who the main one is the user».

In addition, the participants claim that they expect the management to be involved in the work in the territory and thus understand and participate more in the daily life of the service. There is a desire to build a knowledge exchanging process, aiming at a relationship based on horizontality, as illustrated in the segment: “I think that an ideal management, a co-management, should be based on the exchange, but the direct manager of that area technique needs to be more humane and know the process more closely, even the reverse, someone from the top go to management too. An agreement, no imposition, unilateralism, vertical relation, only horizontal relation”.

An investment from management in the collective spaces of encounter between it and the services is also expected. These spaces are pointed out by the participants as being of great importance, being a way to

discuss the issues that permeate the daily work, making it possible to establish bonds between the workers of the service itself and this one with the management, a way for a collective construction. In the participant's report:

*"I believe that this collective space is important. It is the place where you can talk, especially when we are inside the health unit, if it is empowered and well conducted, it helps a lot to resolve and face what we have inside the unit, it is always good to talk. Because, then, you explain, we give solutions to each other, we ask for a solution to another difficulty that you are experiencing in your sector. Because otherwise everything gets too much in the imagination of the other" (P.32).*

Class 4, named "Daily service challenges", represents 20.6% of the content analyzed and concerns the difficulties faced by professionals in their daily work. The word "problem" ( $\chi^2 = 35.15$ ) appears in this class as one of those with the highest chi-square. Then, the segments bring the problems that hinder the functioning of the service and the performance of the management in these matters, which contributes to these impasses. In this context, overload is one of the most frequent scores in workers' reports. They point to a high demand for activities on a daily basis, added to tasks that constantly arrive from the management. It is also emphasized how exhausting to deal with all these duties in the face of the recurring lack of materials, absence of professionals and overlapping of functions it is. Here is the report:

*"[...] sometimes, the person has a lot of functions, and the Technical Reference, sometimes, requires the professional to do more of this, or that: smoking, women's health, children's health and so on. So, the person that has his / her role within the unit, and he / she has to take on all the work and there is a lot of demands, and sometimes there is a lack of time to do the proper thing and perform all the functions properly" (P.05).*

In this same direction, the participants talk about the crossing of the norms of the Health Ministry, supported by the management. In the words of the participant: "whoever is on the edge, not always will be able the one to follow the Ministry's norm that the management brings; unfortunately, there are times when we have to do the famous "Brazilian way", because if we follow exactly what is in the law, you do not work! This is a fact".

Hence, the participants stress the high demand for tasks ends up hindering the smooth functioning of the service, mainly because many times a professional

has to perform functions of positions in addition to the one he occupies, due to the lack of those who do them. They also ask that all this overload does not only affect the work, but also their quality of life and mental health, which results in many sick leaves, generating more positions without personnel and consequently more overloading. It is a kind of "snowball" that, according to the participants, could be resolved if there were a greater attention from management with the importance of keeping these spaces always occupied. Participants also indicate that the high turnover of professionals also interferes in the consolidation of the ties with the territory.

Still with regard to a certain lack of professionals, the participants point this out as detrimental to the operationalization of other resources available in the service, for instance, online scheduling: "my area does not have a doctor. How am I going to make this appointment online?". For other participants, this scheduling mode is conceived as another challenge, because of the plastering of work processes:

*"It is more in a cast, because it has a technological system that needs a break. We, who work with the public, are very sorry for the implementation of this system, but no one says that; why? Because it wins a prize, it has another value. The needy population who does not have access to the internet, do not have a smartphone, they always have to go to the clinic, they make an appointment and do not know that they have to go back to confirm it" (P.23).*

Another aspect that appears in the segments is the question of "registration" ( $\chi^2 = 39.91$ ), so that this word appears as the second with the largest  $\chi^2$  in the class. The issues raised are: the accumulation of registrations to be carried out, the recurrence with which users from neighboring regions try to register in units that are not their reference and the difficulties of access for people on the street, for example, on behalf of the requirement the requirement of this record. In the words of the participant:

*"In my unit, there is a lot of wanting to register a domestic employee. So, to register the employee is possible only if she actually lives in the residence. We ask for three vouchers, for example, a health insurance account, a credit card bill ... If you don't have that, there must be a statement from the employer with a notarized signature; otherwise, we will not register them, because the maid sometimes does not reside there. In my own area, I used to see the person every day leaving and taking the bus; I said: no, then you unsubscribe them" (P.34).*

With regard to Primary Care (AB), the participants affirm that the difficulties intensify when it is not a Family Health Strategy (FHS). This is also related to the lack of collective spaces to tackle conflicts, as illustrated in the report: “so you don't have a forum to discuss, for you to expose problems, situations, disagreements, what can happen is that many sometimes a disagreement between two employees can cause problems that hinder the functioning of the health unit”.

Class 2, called “Sustainability of work in the territory”, represents 33% of the content analyzed and says about the organization of work in services, and how those who work in these spaces deal directly with the reality of users, with the singularities of the territory and with the unpredictabilities that arise in everyday life. The word “thing” ( $\chi^2 = 61.73$ ) appears with the largest  $\chi^2$  in this class, relating the difficulty in naming the diversity of situations that cross this territory. Followed by the words “like this” ( $\chi^2 = 43.31$ ) and “nothing” ( $\chi^2 = 37.23$ ).

To talk about the work in the territory, the participants present the service as the one that is “below” living with the community and with the various crossings of this routine and the management as the one who is “up there” giving orders, without understanding the peculiarities and demands of that space. In this sense, the participants bring some case reports to illustrate the dynamics of the work in the territory, highlighting unexpected situations that interfere with the progress of the activities planned to be carried out.

*“Many times, we don't know what to do, just like today, for example, a grandmother went there with an autistic child who was extremely aggressive, and who already was cared there. The grandmother said that she no longer wanted to take care of the child and she arrived there with the boy with the suitcase and stuff and said: «he is here, I came to bring him and I will not take him home». [...] We had to make a way to hold the grandmother and try to call somewhere to see if the city car was coming, she called the nurse to help put the boy in, because the boy also didn't want to leave, but the mother to take him; the service is already missing everything” (P.27).*

Participants also speak of the anguish of not being welcomed in their proposals to change these work processes: “What frustrates us most is knowing that you thought about it, you talked to your team how to improve, you deliver things and the thing is shelved. You think, Gee, but it was of no use!?”.

Class 3, called “User prioritization”, represents 13.6% of the analyzed content and refers to the

centrality of the “patient” ( $\chi^2 = 59.46$ ) in the daily service, so much so that this word appears with the highest qui class square, followed by the word “inside” ( $\chi^2 = 39.77$ ) and “talk” ( $\chi^2 = 33.87$ ). According to the participant: “(...) the priority is the patients (...) I have to satisfy the user during these visits, I have to meet his needs and when he is seen inside the office, it has to be satisfactory. He [the user] has to give a grade that satisfies this management”.

On account of the priority given to the “patient”, the challenges of this centrality are approached in the face of busy schedules, shortage of material, lack of rooms to perform appointments, deficit of employees, among other routine situations; which leads some professionals to think if the interest is really in ensuring effective care for this user or if the interest is in the number of procedures performed. According to the participant:

*“When I enter my room, there is already a patient who missed an appointment hitting the door to reschedule or asking if there is a vacancy. How do I do it? My agenda, I have nowhere else to put the patient (...). They say that the patient is important, everything is up to the patient, so we work with the patient. So, we solved it by putting out the fire, if the problem arose is to try to solve it the way we can't, you know, the way we can and thus, overloading it.” (P.20).*

Participants say this scenario has favored the emergence of situations of user aggressiveness towards the worker, as they do not understand the faults that the service experiences to guarantee care. In this discussion, health professionals also verbalize the lack of time for the creation of spaces for discussion / conversation among the team's professionals: “I was talking to her, I don't have time to talk, to know what the one my side does, because it is very busy, we care for many patients”. Then, participants find that these spaces have become less and less common, with considerable difficulty in establishing them. Therefore, they perceive a patient care process hampered by this same logic that wants to prioritize the user “at any cost”.

## Discussion

It is noteworthy that despite the initial objective referring to the conception of health professionals about the relationship of services with SEMUS management, the participants approach management as a single block, which, certainly, makes it difficult to direct the demands of services to the competent management

of that Secretariat. Thus, since the role of each management area that makes up the Secretariat and of what is addressed to the local manager is not clear, the participants ended up dealing in this study with their relations with the municipal health management in general and their repercussions in other relationships, including with users.

In this context, the results found in the present study, suggest that the participants have experienced hierarchical relationships, characterized by the distances between the management and the service and the fragility of communication. Although there are movements in favor of shared management and horizontal relations, as presented in the "Management-Service Relationship" class, the current management logic is still guided, in technical-specialized knowledge, in the separation between those who plan and those who execute it, that is, in traditional administrative rationality. This scenario is also reproduced, in the relationship between the services existing in the network and in the care process with the user, who has, at times, been sustained in fragmentation, placing himself in opposition to the democratization of relationships, compatible with the ethical guideline. and co-management policy.

Therefore, in spite of the advances achieved with the implementation of SUS, it is still possible to verify, within this system, that the culture of institutions, the training of professionals, the organization of health services, continue to feed and support practices guided by the hegemonic model of health, characterized by the curative, fragmented and physician-centered logic (Belotti, 2019). The democratization of policies, knowledge and practices are in confrontation with this reality, which hinders creative work, which may reduce health action to a productivist rationality. Then, the challenge is to conduct this relationship between management and service in order to encourage the autonomy of the worker's creation, so that the technical-ethical and political project at the service of health care is also a project of the working worker, in contrast to serialization of protocol practices (Franco, 2015).

Yet, as highlighted by the participants, the achievement of this reality, permeated by the construction of joint work and the establishment of shared management, depends on readjustments in the daily work of health services and investments in the management and service relationship, especially considering that shared work is not limited to "being together" and also needs certain material and organizational conditions to be effective. It is important that teams from

the same service collaborate with each other, and also with professionals and teams from other services and other sectors, favoring operation in networks (Peduzzi & Agreli, 2018). In this composition of networks, the management is included as essential in this process of fostering the creation of partnerships, not only with services with other points of care, but also as users and the territory itself, with a view to producing comprehensive and consistent care with the community demands.

In this discussion on the role of the management in the consolidation of care networks, the class "Daily challenges of services" stresses the crossings of management in this daily life as one of the important challenges in health work, in which management "requires professionals to do more of this and that (...)" . Or even, when this management passes on the various norms of the MS to the services, and the professionals are not always able to follow or understand their senses.

At this point, it corroborates with Cecílio and Reis (2018) about the need to overcome the logic of normalization, standardization and homogenization operating in the Ministry, in the direction of the composition of "singular management projects". The importance of regulations for guiding health practices is undeniable, however, they must be sustained in flexibility, to recognize the different models of teams and the different territories for possible adjustments to different realities (Brasil, 2016). In this discussion, the studies by Galavote et al. (2016) show that the difficulties of working in health care in PHC are also related to management interferences, which, in the majority, are carried out against the background of the political leaders' mandates. The authors also add the difficulty of fixing the medical professional at this level of complexity, the ineffectiveness of the Health Care Network, the bureaucratization of the public service and the lack of in-service training.

Specifically, regarding the bureaucratization of the public service, mentioned by Galavote et al (2016), it was observed that this reality also appeared in this study, related to the user's registration in the health service. The apparent solution to the high demand for registration in the health service by people from other municipalities, is a bureaucratization of the registration process, requiring more than a proof of residence and verifying the veracity of people's households. Although such registration of the user by the health region is indicated as favorable to the processes of regulation of the health system and the rationalization of human, physical and financial resources (Andrade et al., 2015),

the rigidity of this procedure can mean an obstacle to the user access to SUS services and, consequently, the implementation of the principle of universality. This way, it is crucial to promote the debate on how to favor and guarantee an efficient and equitable offer in the health system without promoting inequities in the population's access to services.

Regarding work overloading, enunciated by the participants as a challenge of the daily service, it appears that this reality is attributed mainly to the absence of professionals and the overlapping of functions, with the participants stressing the importance of management to keep vacancies / existing positions held, in order to strengthen the work in the territory and the bond with users. It is also noteworthy, the influence of this work organization in the worker's health, which corroborates the discussion brought by Brotto and Dalbello-Araujo (2012), that, possibly, the ways in which this work is structured and managed keep a disruptive character in terms of worker health; in other words, the illness linked to health work would not come from work, but from the mode of organization that the work process acquires, which are linked to the management models adopted.

In general, the participants report that they work in isolation, with no communication, reproducing a productivist logic, in which the performance of procedures is said to be a priority, then, hampering the creation of collective spaces. It is worth mentioning that the relevance of these collective spaces was a point of discussion present in the four classes, these spaces being characterized as opportune for the promotion of communication and the exchange of knowledge and, consequently, for the overcoming of hierarchical relationships.

The results also underscore that the little investment in collective spaces is intensified in BA, when there are no FHS teams. In spite of the emphasis of ESF's work organization on those services that require quick and urgent solutions, it is verified, through the results of this research, that the configuration of the ESF, when compared to the traditional model of AB organization, can favor the meeting between workers and, consequently, the resolution of conflicts that emerge in the work setting. It is corroborated by Faria, Leite and Silva (2017), when they affirm that the effectiveness of collective spaces, governed by dialogue, allow the construction of a relationship of trust between the different actors that make up health work. For the authors, being part of the production process,

being listened to, exchanging knowledge and proposing solutions, enhance team work in a collaborative way, beneficial to the health of the worker and the user served. It is important to emphasize the need for these spaces to be governed by the logic of co-management, with a deliberative character, involving health professionals, managers and users.

Such environments do not seem to be strengthened in this municipal reality, which appears when participants present the mode of regulation of consultations by online scheduling, understood by the worker as not favorable to the work organization, since some users, for example, do not have resources to use the system, making it difficult to access services. Still, this analysis is not placed on the agenda for discussion among health professionals, managers and users, because of the awards provided by such configuration of schedules.

This search for the improvement of forms of scheduling appointments is related, for managers, to the idea of optimizing services and access and reducing costs, however, as brought by Cunha and Campos (2011), it is important to pay attention to the possible effects of this organization in the care process, which may also result in a devaluation of the territorial logic, with the appointment of consultations and exams without territorial criteria; absence of co-responsibility of the teams, since, for the most part, the user is only responsible for looking for ways to access the other services; the fragmentation of care, insofar as there is no appreciation of the relationship between the team and the user.

These discussions are in line with the results displayed, with regard to the emphasis given to the distancing of management in relation to the demands of the territory, besides the devaluation of the contributions of workers in the work process, as brought up in the class "Sustainability of work in the territory", causing the professional to occupy a position of alienation to the activity he performs, as emphasized in the traditional administrative rationality. It is worth noting that the alienation of the work process is contrary to the PNH proposal, which advocates encouraging the protagonism and autonomy of the subjects and the collectives. In this context, it is coherent to affirm that there is a tension in "letting oneself be carried away" by the alienating tendency, in which work takes on a mechanical, deadly character, devoid of its power, or to put itself in a position of resistance, from their position as reflective subjects, producers of meaning for health work.

Finally, the last class, called «User prioritization», says the centrality of the «patient», who appears, apparently, passive in the process of promoting their health, being exclusively the health professional to satisfy the patient and the user a note that satisfies management. In relation to this debate, Brotto and Dalbello-Araújo (2012, p.12) discuss the potential of this configuration to be sickening for workers, “insofar as they are unable to build limits in their involvement with the user and their demands”. In a way, this debate seems to contrast with the idea defended by collective health and by inter-professional education that the actions in the health services must be centered on the user, which would benefit all the actors of this system.

Accordingly, it is worth problematizing the way in which this user is understood, if the professionals are to satisfy him at any cost, without including him as co-responsible for this system (Rinaldi, 2015), and without sharing relative information as well, the shortages and challenges experienced daily by the services, possibly, the result of this relationship will come accompanied by the user's aggressiveness towards the worker, as pointed out in the data above mentioned. This is related to the fact that one is unaware of the other's reality and in the case of workers, this reality is also permeated by faults that are beyond their governability and directly interfere in the care offered. The shortcomings / challenges highlighted by the service professionals must be seen as a barrier to the realization of the relational dimension of health work, preventing this worker from directing his activity in the application of relational technologies in favor of establishing a connection that will revert to benefits. users and the worker himself (Brotto & Dalbello-Araújo, 2012).

It is important to highlight the legitimacy of the user's place in this construction of the health care and production process, which is not limited to being a mere consumer of the service's offerings. But also, it is necessary to provide the material and organizational conditions that are indispensable for the construction of this care.

Otherwise, an important paradox is affirmed, as brought up in the results, the “patient” is considered central to this system, but the material conditions announced as indispensable to promote quality care to this user are not provided, which leads participants of this research to the question about whether the interest really is in guaranteeing effective care to this user or if the interest is in the number of procedures performed, which may point, as mentioned by Merhy (2002), to the

validity of a model of competitive management and the notion of a consumer user of this system. This notion places professionals and users in antagonistic fields, as a game of strength, which, as outlined in the data, generates relationships built on the basis of aggressive situations, preventing the construction of solidary bonds, determinants for health care.

### Final considerations

This study aimed to understand the conceptions of health professionals about the relationship between management and the various services that make up a municipal health network. The results reveal that the management-service relationship is marked by hierarchical, distanced practices and weakened communication processes. It was observed that, in part, these difficulties are due to a mode of health management that is still permeated by the managerial practice derived from traditional administrative rationality, which feeds into the hegemonic model in health. Nevertheless, despite the relationship between management and services being characterized as hierarchical, the participants conceive it equally, as procedural and bearer of the possibility of the new and of creation, pointing to the expectation that it will give rise to more transversal relationships, with shared and co-responsible decisions.

Furthermore, the outputs highlight some impasses that contribute to the vertical relationship between management and network services, such as: the lack of material resources; work overload; bureaucratization of services; the absence of professionals and overlapping functions; the ineffectiveness of collective spaces with a view to fostering shared and joint work; the crossing of norms linked to macropolitics that appear disconnected from the demands of the territory; the devaluation of workers' contributions in the work process and, finally, the demand for quantitative productivity.

Notably, regarding the collective spaces, the need for their sustainability in the daily life of the services is considered, configuring themselves as spaces governed by the logic of transversality, that is, enabling the constant dialogue between the different actors that make up the SUS. It is argued that the promotion of these spaces can contribute to the construction of collaborative and co-responsible work, stimulating the emergence of new patterns of inter-relationship between managers, workers and users, thus favoring the effectiveness of the co-management guideline.

In addition, the importance of achieving active participation of users with regard to the management of health care in the territory is emphasized. Based on the results found in this study, it is bet that sharing with the users / community the challenges experienced in the day-to-day services for coping with health problems in the territory, can be a way to «remove» the user from his / her role exclusively. demanding consumer for reflective subjects engaged with the proposal of health work in SUS.

It is hoped that the results found in this research may favor the improvement and effectiveness of the co-management guideline, as well as promoting the establishment of work processes capable of replacing the traditional bureaucratic and hierarchical relations still existing in the health field, strengthened both by rationality traditional administrative model and the hegemonic health model.

It is understood as the limit of this study to approach only the conception of workers on health relationships, for this reason, it is indicated the continuity of research in the sense of investigating also the understandings of managers and users on the construction of these more transversal relationships among the various public health actors, especially considering that co-management takes place with health professionals, managers, and SUS users.

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About the authors:

**Meyrielle Belotti** is a PhD in Psychology at the Federal University of Espírito Santo (UFES). Master in Institutional Psychology from UFES. She has a degree in Occupational Therapy from Faculdade Integrada São Pedro. Adjunct Professor in the Department of Occupational Therapy / UFES. She has experience in the field of public health, working mainly on the following themes: mental health, primary care, matrix support, intersectoral and network.

ORCID: <https://orcid.org/0000-0003-3901-4656>

*E-mail:* [meyrielle.belotti@ufes.br](mailto:meyrielle.belotti@ufes.br)

**Paloma Pereira Andreatta** is an undergraduate student in Psychology at the Federal University of Espírito Santo (UFES). A trainee in Collective Health in Primary Care and Humanist Clinic at the Applied Psychology Center; a Member of the Co-management as a way of working in health research group. She has an interest in the field of public health.

ORCID: <https://orcid.org/0000-0002-3232-7978>

*E-mail:* [palomaflores000@hotmail.com](mailto:palomaflores000@hotmail.com)

**Teresinha Cid Constatinidis** is a PhD in Psychology from the Federal University of Espírito Santo (UFES). Master in Social Psychology from the University of São Paulo (USP). She has a degree in Occupational Therapy from the Federal University of São Carlos- UFSCar. An Associate Professor at the Department of Occupational Therapy at UFES. A professor of the Graduate Program in Psychology at UFES.

ORCID: <https://orcid.org/0000-0001-9712-3362>

*E-mail:* [teracidc@gmail.com](mailto:teracidc@gmail.com)

**Andrea Thamiris Barbosa Dias** is a Psychologist of the Municipality of Vila Velha – ES, and majored at the Federal University of Espírito Santo (UFES). She has experience in the areas of mental health and drug addiction. She has an interest in the field of mental health, hospital psychology and public health.

ORCID: <https://orcid.org/0000-0002-6248-0770>

*E-mail:* [andrea.thamires@hotmail.com](mailto:andrea.thamires@hotmail.com)

**Luciana Bicalho Reis** is an adjunct professor at the Department of Psychology / UFES. Master and a PhD in Psychology from the Graduate Program in Psychology at UFES. A Psychologist at UFES. She has experience with Health Psychology in Primary Care, Children's Mental Health and Hospital Psychology. A member of the CNPq Psychological Processes and Health Research Group..

ORCID: <http://orcid.org/0000-0001-6173-7514>.

*E-mail:* [luciana.b.reis@ufes.br](mailto:luciana.b.reis@ufes.br).

**Alexandra Iglesias** has a major in Psychology from the Federal University of Espírito Santo (UFES). Master in Collective Health from the same University. A PhD by the Graduate Program in Psychology at UFES. An adjunct Professor at UFES / Department of Psychology. She has experience in the areas of Collective Health, mental health and health psychology, working mainly with the following themes: health promotion, matrix support, mental health and primary care.

ORCID: <https://orcid.org/0000-0001-7188-9650>

*E-mail:* leiglesias@gmail.com

Contact:

Av. Fernando Ferrari, 514, Goiabeiras  
Prédio Professor Lídio de Souza, CCHN – UFES  
Vitória-ES, Brasil  
CEP: 29075-910  
Telefones: (27) 3337-8855/ (27) 98172-0115.