ORIGINAL ARTICLE

Family health Strategy in the Supplemental Health System: convergences and contradictions*

ESTRATÉGIA DE SAÚDE DA FAMÍLIA NO SISTEMA DE SAÚDE SUPLEMENTAR: CONVERGÊNCIAS E CONTRADIÇÕES

ESTRATEGIA DE LA SALUD DE LA FAMILIA EN EL SISTEMA DE SEGURO DE SALUD: CONVERGENCIAS Y CONTRADICCIONES

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ABSTRACT

A qualitative research shows the convergences and contradictions at the implementation of the Family Health Strategy (FHS) at the Supplemental Health System at São Paulo city-Brazil. Identify the concept of family health by upper formation professionals of a self management company and understand the performance ways of these professionals at FHS and to identify the possibilities and the limits lived by these professionals at the implementation of the FHS at the company. There were made interviews with 14 professionals and the content analysis was made. The results show that the concept of family health seems to transit between the hegemonic model and the idealized model of integral attention to health, with its bases at health promotion actions, however always linked with illnesses prevention, multidisciplinary work, and the logic of the reduction of the costs of the system. Despite the search for new forms of customer service, contradictions had been identified that make it difficult the implementation of proposals based on the Health Promotion. There are necessary investments of politic kind, organizational, financial, and fundamentally, at the formation and permanent education of the professionals.

KEY WORDS

Family health.
Primary health care.
Health promotion.

RESUMO

Pesquisa qualitativa que evidencia as convergências e contradições na implementação da Estratégia de Saúde da Família no Sistema de Saúde Suplementar no município de São Paulo. Identifica o conceito de saúde da família de profissionais da saúde de nível superior de uma empresa de autogestão; identifica as possibilidades e limites vivenciados pelos profissionais na implementação da ESF na empresa. Foram realizadas entrevistas com 14 profissionais e feita análise de conteúdo. O conceito de saúde da família parece transitar entre o modelo hegemônico, curativo, e o modelo idealizado de atenção integral à saúde com bases nas ações de promoção da saúde, porém vinculadas sempre à prevenção de doenças, ao trabalho multidisciplinar, à lógica da diminuição dos custos do sistema. Foram identificadas contradições que dificultam a implementação de propostas baseadas na Promoção à Saúde. São necessários investimentos de ordem política, organizacional, financeira e, fundamentalmente, na formação e educação permanente dos profissionais.

DESCRITORES

Saúde da família.
Atenção primária à saúde.
Promoção da saúde.

RESUMEN

La investigación, de naturaleza cualitativa, se ha basado en las evidencias de las convergencias y las contradicciones en la puesta en práctica de la estrategia de la salud de la familia (ESF) en el sistema suplementario de la salud en la ciudad de São Paulo (Brasil). Identificación del concepto de salud de la familia de los profesionales de formación superior de una institución de autogestión y identificación de las maneras del funcionamiento de estos profesionales en el ESF; identificación de las posibilidades y los límites que han sido vivenciados por estos profesionales en la puesta en práctica de la estrategia de salud de la familia en la institución. Han sido hechas encuestas con 14 profesionales y los análisis del contenido de las contestaciones. Los datos demuestran que el concepto de salud de la familia parece estar ubicado entre el modelo hegemónico y el modelo idealizado de la atención integral a la salud, con sus bases en las acciones de la promoción de la salud. No obstante la estrategia se la tenga como uno de sus rasgos la prevención de las enfermedades, el trabajo multidisciplinario, así como la lógica de la reducción de los costes del sistema. Han sido identificadas contradicciones que hacen contradictoria la puesta en práctica las acciones basadas en la promoción de la salud. Se concluye que hacen falta inversiones del orden político, societário, monetario y, sobre todo, en la formación y la educación permanente de los profesionales.

DESCRIPTORES

Salud de la familia.
Atención primaria de salud.
Promoción de la salud.

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INTRODUCTION

This article presents results from research that was aimed at demonstrating how the Family Health Strategy was implemented into the Supplementary Health System in the city of São Paulo, as well as the perception of professionals involved in the implementation.

Changes have been occurring in the health sector regarding scientific-technical development, computerized information and the technology that has enabled differentiated treatments, although there are still concerns regarding service costs, demographic transition, population aging, and the increase in chronic-degenerative diseases[1]. Instituting neo-liberal policies in the 1990's has encouraged transformations in regards to the decrease in the State's responsibility for reducing basic services offered to the population, mainly impacting the areas of education and health[2-3] in Brazil and other countries, in addition to enabling the actions of the private sector in the area of health care and the organization of a private care system[2].

From this movement, Brazil began to regulate the private health sector [11], which was then known as the Supplementary Health System. Its services are financed by companies, common people and the Unique Health System. It comprises a broad, diversified and conflicted group of interests from various sectors, represented by five types of organizations: group medicine, medical cooperatives, private companies' own health plans (self-management), health insurance, and philanthropy[12].

Regulating the direct action of the private sector in the health system presented, among other consequences and challenges, a direct demand increase for new ways of providing services in an effective and self-sustainable way.

This study was developed from this structuring process of new health care models within the private company scope. One of the researchers, who worked in one of these companies and knew their dynamics well, experienced firsthand the implementation of the Family Health Strategy (FHS). The company was innovating due to its desire to initiate changes in its predominantly curative model. Also, the company proposed actions with a view to promoting health that is understood to be the process that enables individuals and the community to enhance their control over certain health determinants, paving the way to health improvement. These actions represented a new paradigm in thinking regarding the methods needed to deal with health problems[13].

A search of the database MEDLINE was carried out by associating the following keywords: *health model, private sector, family practice*, and *comprehensive health care*. Experiences regarding health care model restructuring in the private sector were identified, and the need to invest in Primary Care and to integrate the diverse and complex levels was highlighted. However, these were limited to the actions of family doctors or general physicians, and to the availability of primary health care clinics. This search did not find information on the experiences of Family Health Teams in the private sector.

OBJECTIVES

- Identify the concept of family health as defined by upper level professionals of a self-management company of the Supplementary Health System;
- Learn about these professionals' actions within the Family Health Strategy;
- Identify possibilities and limits as experienced by professionals in regards to the FHS implementation into the company.

METHOD

This is a qualitative study. The case study strategy was chosen due to its unwritten feature and the ability to bring the object of study into context[14].

The research was carried out with upper level education professionals from four Family Health Teams of a self-management private company in the city of São Paulo, which first implemented the FHS in Brazil in 2005. These teams, spread throughout East, West, North and South regions of the city, were composed of a family doctor, a nutritionist, a nurse, a psychologist and a social worker, in addition to nursing assistants. Each region also had a local manager.

Professionals from each of the categories from the four teams who had been working for at least six months in the company's FHS were randomly drawn. An instrument was developed to characterize socio-demographic features and to learn about the professionals' concept of family health, the description of their working day, the perception of professional's actions in regards to the Strategy and the implementation of the Strategy in the company. Data saturation was considered the criteria to end collection. The project was authorized by the Ethics Committee of USP Nursing School (Process No 629/2007/REC-EEUSP) and by the company. Regarding data analysis, content [15] analysis of the transcripts from the interviews was done and categories were built as follows. In order to better illustrate the categories, some statements are presented immediately following some categories. Data were discussed under the scope of health promotion reference and the reviewed literature.

RESULTS

Fourteen professionals who worked in the FHS were interviewed: three nurses, three Module managers (two psychologists and one social worker), two social workers, two family doctors, two nutritionists and two psychologists.

The majority of them were females (71%). An age bracket between 31 to 40 years old and older than 50 years old (36%) was predominant, followed by 41 to 50 years old (21%). Six professionals had graduated more than twenty years ago, six between 10 and 19 years ago and two had graduated six years ago. Only two professionals had previous experience in Family Health and one had completed a residency in Family Health, confirming academic and internship experience. All others (79%) had hospital care, clinic and home health care experience. Eight subjects had expert education in specific areas such as hospital administration, health services management, intensive care, and home care, among others, including four in Public Health and Collective Health. From all training performed within the company, eleven had participated in the Family Health Strategy Awareness and six had taken the Basic Course in Family Health.

Content analysis of the professionals' answers enabled the construction of categories related to the *Family Health Concept, the Methods of Professional Work in the Strategy* and the *Implementation of the Strategy into the Company: Limits and Possibilities.*

The Family Health Concept of the participating professionals in this research is based on a hegemonic, curative health model, supported by disease prevention, individual and isolated work in the unarticulated team, and in the focus on the individual and on the disease.

> [...] His education is more old fashioned […] he is very into bodily things, just diseases […]. He makes the rounds with me, he does the medical part and I do the emotional...

However, there are statements that demonstrate that there is also a concept that is under construction and is supported by health promotion, multidisciplinary work and a focus on the individual, the family and its life context.

> I do understand it is a care model that aims not only at caring for the individual, but also the family and the environment the individual lives in, with various principles of caring for the individual throughout his life, of being close, following up, knowing the environment where he lives, and also the interventions specific to him.

As can be seen, there is evidence that challenges in the transition health model adopted exist and they influence the concept of family health in these professionals, who express themselves through overcoming initiatives of the curative (hegemonic) model, and through enhancing of the professional's view of the person as a citizen, with a personal and cultural background and a history to tell.

> for me, the strategy is a counter health culture movement.
>
> [...] It is a job that requires you to be inside…you are not alone, always with a team that is concerned about this citizen, with a view to also integrating him[…] By observing the environment he lives in, what he does, his background is brought in, as well as his history. The work in this strategy is to attain this overall vision, which I find very difficult.
>
> it actually contemplates the overall care of the individual, both the individual and the family […] We utilize a care practice logic where we do not see the person in fragments; we look within a systemic approach to understand what type of system it is, what are its concepts, the culture brought by that person, disregarding the individual as we see him in the hospital environment.

Regarding the Manner of Professional Work in the Strategy, although some team work experiences were reported, the subjects' statements demonstrate that the work process, to a higher or lower degree, is organized under a spontaneous logic demand, by individual and fragmented care delivery, providing only care delivery quantity statistics indicator targets. Seldom has the team answered user's demands based on actions focused on the disease or the cure, exhausted by adhering to unsuccessful promotion proposals.

> The team is talking about the strategy and all the time there is someone that is talking about something they don't do. They say they don't believe in it and so they don't do it. The multi-professional thing, the interdisciplinarity, everyone does their own work. The result is an adding of aspects; however, it is not an exchange yet. Each individual has their own knowledge.
>
> Well. I think like this, each professional in this work, we are still a little focused on our own work development. So I still see the professional as being a little alone inside the strategy, we are still not able to actually perform team work, […] So I think that each one of them, the nutritionist, the psychologist, the doctor, the nurse, the social worker, are still like this: '- I'll do this because I know, so I do my tasks.' [...] […] I see isolated actions […] because we were not yet able to develop, perhaps, this ability to work in a multidisciplinary way […].
>
> Well, the team itself, as I said, is a nuclear team, which is a nursing assistant and the doctor. Therefore, this nuclear team, during the day, delivers care, the care delivery 'recall' of this registered population, because inside the company plan there are indicators that can be reached.

On the other hand, research participants exposed favorable aspects of this work that have been developed since the implementation of the FHS. These aspects constitute progress in this work when performed in teams, a fact that can only be seen in a favorable context, including maintaining the continuity of the original team, locally participative management and personal development through the participation in continuing education and permanent education activities.

Regarding the *FHS Implementation into the Company* category, *limits* and *possibilities* were identified as *limits* regarding *team work* and the *management* and *policy of the company.* Regarding *Team Work*, statements were identified indicating that the work seems to still be centralized in the doctor who, in his turn, is isolated from the rest of the team. Also, there seems to be professional role non-specificity related to the difficulties in defining and clarifying what each professional needs to develop to contribute to the team work, causing a centralizing reaction and maintaining the focus on each individual's expertise. In addition, the lack of team planning and care coordination is another limiting factor for team work development. The team sees that they cannot cope with care delivery coordination and their activities end up being focused on disease.

> The proposal of having a multi-disciplinary team is extremely important, but the doctor still has a very important role… I understand that the role of this professional is important, but even regarding other professionals, there is some condescendence. So, if I am discussing a case and a doctor brings his perception - *Look, this case has this problem and that problem, he takes this and that medication, we propose this kind of procedure*, there is an acceptance from the other areas, in a way that... the doctor's opinion always prevails.

Regarding *limits* related to the *company's management and policies*, the following aspects were presented: a) time reduction on health professionals' initial care delivery; b) bureaucratic barriers and management changes; c) political context; d) the curative model culture; e) ambivalence in health care models; f) a feeling of uncertainty surrounding the model to be developed; g) centering decisions in the programs to be implemented and its ways of implementation, which does not always provide for local needs and reality; h) communication and disclosure breach in the Strategy by the company itself; i) low financial investment; and j) absent salary and career planning policies.

Regarding *Possibilities of FHS Implementation into the Company*, the following were mentioned: the need for compound construction of the work, where the same team begins registering and connecting with users and the local community, planning, implementing and evaluating health actions guided to that public; b) the need for the team to be able to provide continuity of care, allowing for a clinical follow-up on the person that receives the care, a necessary condition for the success of the actions proposed; c) a more homogeneous users' socio-economic profile that connects risks and external conditions to the health system that negatively influence people's health; d) home care delivery and pharmaceutical policies support actions which decrease team intervention limits and enable more possibilities to solve health issues that go above and beyond FHS acting scope; e) the company is considered by the research subjects as being in a differentiated position in the country's health market, due to its organizational structure and the processes it holds; f) the pre-set budget for structuring the company's own services enables disclosure and implementation of planned actions, providing more credibility to decision making; g) availability of concrete guidelines for team work linked to the population profile enables more agility, evaluation and results; h) action planning on care delivery for the population by organizing spontaneous demands and previous appointments; i) Basic Family Health Course proposed by the company and included in the minimum training provided to team members was also mentioned as an important reflection and support instrument for actions; and j) the articulation of the FHS team is fundamental for putting into practice the planned and proposed actions.

DISCUSSION

Results demonstrate that the socio-demographic profile of this study's participants are different from some research studies that address doctors and nurses' professional profiles who work in the Unique Health System (SUS) Family Health Program (FHP). The participants in this study are mainly younger people who have recently graduated[16].

Investments in professional and permanent education geared towards working within the Strategy, with a view to going above and beyond the hospital-centered vision and focused in expertise, are needed. Other studies found agree with this idea[17]. Therefore, the important role of the company in enabling professional development and promoting partnerships with teaching institutions with a view to educating professionals and constructing policies and innovations in the health area[18] cannot be overstated, since changing operations depend on building and obtaining new practices.

Although professionals hold the concept of family health in the curative model as reference, they also presented a health promotion theoretically-based concept without presenting the needed conditions to put the technique into practice in the company's Family Health Strategy. We can infer that they are probably internally mobilized to change; however, they do not find concrete conditions to effect the necessary changes. This may be due to the formation of the curative model. The family health concept, therefore, seems associated with disease prevention and health promotion focuses on changing behaviors[19].

In the true formation of concepts, a concept gains acceptance only when the features extracted are, once again, synthesized and the abstract synthesis, which may have met with resistance previously, becomes the accepted way of thinking [20]. These research participant's statements identified that there are influencing elements in the elaboration process of concepts by professionals. In this case, these elements are characteristics of the two health care models with which they live; the curative model and the health promotion model, although the curative model is still idealized.

Findings related to change challenges for the health model transition that considers the subjects' full care agree with other studies found in literature[17,18]. Inappropriate professional training is one of the main limitations for putting the primary care reorganization strategy techniques into practice[17]. The authors[21], when analyzing the challenges of FHS implementation into São Paulo's public network, acknowledged that the desired professional profile training programs are not promptly and easily found and should be constructed throughout the process.

Data in this research support findings that health practice changes do not occur automatically as innovating proposals and programs are implemented [22]. Subjects involved in the process must be included in the process, both users and professionals, in a way that promotes a changing environment that enables the desired changes[23].

The interface between management, planning and change process is explained by the author[24], who considers planning to be an important tool for mediating change processes and the management adopted and practiced in the organization and its teams. It directly influences the planning regarding needs and expectations of the people involved in the health care process. When analyzing managers' competency profiles from the Basic Health Units of São Paulo, there was evidence that the

> unprepared manager directly influences the way strategies are put into practice and the dynamics of the team involved, contributing to its inefficiency and processes' ineffectiveness[25].

The authors[26] point to the importance of clarity regarding local managers' roles regarding health projects, so they can effectively contribute to the construction of the necessary changes.

Regarding the indicators used to measure FHS team work results, with a view to increasing efficiency and effectiveness, we must consider that many authors and organizations do not have the same resources, interests or competencies to commit to the cooperation projects in the system[27].

Regarding the market context where the Supplementary Health stands, in addition to an organizational history and actions guided to the curative, the National Health Agency (NHA) has stimulated changes and qualifications for the sector. In 2006, the NHA released a guiding manual[28] for company's actions; however, it neither comprises guidelines regarding the minimum organization to carry out those actions nor regards the issue related to the accredited network.

FINAL CONSIDERATIONS

The results of this research show a movement that can be identified, although incipient, by the Supplementary Health System of the company. It holds a view to implement new ways to provide care to its users that are distinguished from those already performed. However, in order to profoundly understand this process, analyses that are not superficial and abrupt are necessary due to organizational interaction complexity when related to the Brazilian Supplementary Health System functioning structure. Also, we can state that none of the companies, whether self-managed or not, will be able to handle a consumption use culture of the offered products in the current health market. There must be regulating institutions that hold higher governability, providing support for actions that agree with a full health care model.

Higher teaching institutions provide the primordial function in this process. They need to prepare and train future health professionals to answer the demand of this disassociation between educating for a practice based on a biomedical paradigm and the demand for a full care model for the subject focusing the health promotion model.

Therefore, only a compound action from the society's sectors - teaching institutions, management companies and governmental institutions - will converge for a practice that will overcome the contradictory movement that sometimes is seen in innovating actions in the Supplementary Health System.

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