Comprehensiveness according to the perception of Family Health Unit workers*

INTEGRALIDADE NA PERCEPÇÃO DOS TRABALHADORES DE UMA UNIDADE BÁSICA DE SAÚDE DA FAMÍLIA

INTEGRALIDAD EN LA PERCEPCIÓN DE LOS TRABAJADORES DE UNA UNIDAD BÁSICA DE SALUD DE LA FAMILIA

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ABSTRACT

The objective of this study was to identify the perceptions of healthcare workers regarding the principle of comprehensiveness. To do this, a research was performed with five workers from a Family Health Unit located on the east side of São Paulo. This study was performed with a qualitative approach, using interviews and thematic analysis. Three categories emerged from the discourses: comprehensiveness as the profile and practice of healthcare professionals, focused on the humanization of care; comprehensiveness as the organization of the health service and working process; and comprehensiveness as the integration of the unit with other health services. In each dimension, it was revealed that the workers perceived the absence or presence of this principle as a guide for healthcare, problematizing the advancements and problems they experienced, as well as the challenges involved in changing the healthcare model.

DESCRIPTORS
Comprehensive Health Care
Family health
Health personnel
Public health nursing

RESUMO

O objetivo deste estudo foi identificar a percepção de trabalhadores da saúde acerca do princípio da integralidade. Para isso, participaram de uma pesquisa cinco trabalhadores de uma Unidade Básica de Saúde da Família da região leste da cidade de São Paulo. Optou-se pela abordagem qualitativa por meio de entrevista e análise temática. Emergiram dos discursos três categorias: integralidade como perfil e prática dos profissionais de saúde, com ênfase na humanização do cuidado; integralidade como organização do serviço e do processo de trabalho em saúde e integralidade como integração da unidade com outros serviços de saúde. Em cada dimensão desvela-se a percepção da ausência ou presença desse princípio como norteador da atenção à saúde, problematizando-se os avanços e entraves vivenciados e os desafios da mudança do modelo assistencial.

DESCRITORES
Assistência Integral à Saúde
Saúde da família
Pessoal de saúde
Enfermagem em saúde pública

RESUMEN

El estudio objetivó identificar la percepción de trabajadores de salud acerca del principio de integralidad. Participaron de la investigación cinco trabajadores de una unidad básica de salud de la familia de la región este de la ciudad de São Paulo. Se optó por abordaje cualitativo mediante entrevista y análisis temático. De los discursos, emergieron tres categorías: integralidad en cuanto a perfil y práctica del profesional de salud, con énfasis en la humanización del cuidado; integralidad en cuanto a la organización del servicio y proceso de trabajo en salud; e integralidad respecto de la unidad con otros servicios de salud. En cada dimensión se devela la percepción de ausencia o presencia del principio como orientador de la atención de salud, problematizándose los avances y obstáculos experimentados y los desafíos del cambio del modelo de atención.

DESCRIPTORES
Atención Integral de Salud
Salud de la familia
Personal de salud
Enfermería en salud pública

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INTRODUCTION

This study looks at the conceptions and perception of workers at a Basic Family Health Unit (UBSF) on how the comprehensive care principle is put in practice in health care, based on their professional experiences.

Comprehensive care is one of the principles of the Unified Health System (SUS), whose approval in the 1988 Federal Constitution marks the implantation of the public health policy in the country and promises health as a civil right and duty of the State, to be guaranteed through social and economic policies that aim to reduce the risk of illness and other problems and provide universal and equalitarian access to health promotion, protection and recovery actions and services[1].

The health chapter in the Federal Constitution results from the health reform movement – whose origins go back to the times of military dictatorship in Brazil and provided the conditions for the creation of the SUS and the approval of Organic Health Laws – Laws 8.080 and 8.142, issued in 1990 – which express the doctrinaire and organizational principles for the national health policy, including the comprehensive health care principle.

In recent years, it has been observed that the universalization of care is expanding with the decentralization process of health management to the cities – organizational guideline of the SUS that establishes the amplification of primary care, since the 1990's, through the expansion of the Family Health Program (FHP) across Brazil. This amplification intends to universalize access, guarantee equity and change the care model – which should excel through comprehensive care.

The intended role of family health teams, whose multiprofessional activities serve to intervene in the determinants of the health-disease process, is coherent with the comprehensive care principle, underlining the principles of health promotion and surveillance, problem-solving ability, humanization and welcoming, which are fundamental for the model proposed to structure the SUS – departing from the FHP and permeating all other network levels[2].

In São Paulo City, the Family Health Programa (FHP) started in 1996 through a partnership between the Ministry of Health (MH) and the State Health Secretary (SHS), moving to the municipal area in 2001. Since then, the primary care service network has expanded all over the city, including the East and the Guaianases Technical Health Supervision Area, through the Family Health Strategy (FHS), probably improving access and furthering some degree of health care equity.

Departing from the premise that putting in practice the comprehensive care principle in the SUS represents a great challenge, it is important to take into account the need for an articulated service network, so as to guarantee the solution of the population's health problems, as well as to look at comprehensive care practice and work processes to make this proposal feasible.

Comprehensive health care results from the democratic interaction between actors in their daily care delivery practices in the different health care system spheres[3]. Thus, its operation implies changes in practices and individual and teamwork processes to produced humanized, ethical and problem-solving care. We believe that these changes demand all workers' efforts and commitments to review values, paradigms and construct more participatory and integrative practices.

Considering that, in their professional practice, workers perform their activities based on conceptions and values, it is important to capture what they think about this principle and what they perceive about its operation. When valuing comprehensiveness in professional praxis, they probably experience situations that entail satisfaction or anguish, depending on the facilities or difficulties met in daily multiple experiences. Some workers may not be committed to this principle. From a comprehensive care perspective, this affects multiprofessional integration or articulation processes with other services.

> Considering that, in their professional practice, workers perform their activities based on conceptions and values, it is important to capture what they think about this principle and what they perceive about its operation

The aim of this study was to identify health workers' perception at a Basic Family Health Action in the Guaianases Technical Health Supervision Area about the comprehensive care principle, apprehending both conceptions and perceptions on its operation in the service reality.

LITERATURE REVIEW

The text of the constitution addresses comprehensiveness in the organization of health services and actions, considering them as a *regionalized and hierarchized network* that is expected to guarantee *comprehensive care, prioritizing preventive activities, without impairing care services*[1]. It does not provide, however, a definition of the comprehensive care principle, whose current meanings result from the historical debate that started at medical schools, based on the notion of comprehensive medical practice, as opposed to Flexner's model that emphasizes the biological aspect and the cure approach[4].

In literature, different meanings have been attributed to the term comprehensiveness: a) comprehensiveness as an attribute of health professionals' practices; b) comprehensiveness in the organization of health services, internally, in each services, articulating different care levels

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and among different services; c) comprehensiveness in special policies, appointed as the governmental response to specific health needs or to the needs of a certain population group, so as to consider its context[4].

As an attribute of professional practices, comprehensive care involves a health work process interested in the production of effective and humanized care, centered on users' individual and collective needs[5] and should depart from the organization of work processes at any level in the system, including primary care, through guidelines like welcoming, bonding and the expanded health concept, considering users' needs as the "center of thinking and care production" in the team[6].

In this perspective, comprehensiveness incorporates the vertical dimension, considering the human being as a whole, unique and indivisible, which surpasses fragmented care that is only based on the biological aspect[7]. It presupposes a look at issues that involve the affective, biological, spiritual and sociocultural aspects, among others, of each person who receives care.

Comprehensiveness is related to health needs, which are classified in four sets: having good living conditions; having access and possibility to consume all health technologies; creating effective bonds with professionals and/or teams; and having autonomy to lead one's life[8]. In this perspective, for professionals and teams to deliver comprehensive practices, they should look at the subjects, the meanings they attribute to care and their autonomy in their way of being and leading their lives.

Concerning the comprehensiveness attribute as health service organization with internal articulation, at each service, with different care levels and among different services[4] – this is also considered fundamental to achieve comprehensiveness from the perspective of this study. At each service, needs-based comprehensiveness results from a team's effort and knowledge combination. This is called focused comprehensiveness – in which, when the user meets with the team, the commitment prevails to listen to his/her needs as good as possible, which does not always coincide with the actions the service offers[8]. The complexity of this care demands a double challenge – each professional's approach and multiprofessional articulation in solidary teamwork, with its multiple knowledge and practice to achieve the highest possible level of comprehensiveness.

As to working in a team, two modes exist that can happen in work processes, furthering comprehensiveness or not: a) group team, when actions happen side by side and professionals' grouping hampers interaction; b) and integration team, characterized by the articulation of actions and interaction among the agents. This mode demands: communicative and technical action, permeated by the participatory and intervention process; lesser inequality among different activities and professionals; greater flexibility of work division; complementariness of different specific activities; and joint construction of a care project to cover the complexity and multidisciplinary nature of each patient's health needs. This can enhance the materialization of focused comprehensiveness in the singular space of each service at any system level[9].

In view of the multiple and complex needs of each person who seeks health services, the insufficiency of each singular service should be admitted with a view to fully accomplishing comprehensiveness, no matter how good professionals and the articulation of local teams are. Each health service needs to articulate with a more complex network, comprising other health services and/or other social institutions[7]. Comprehensiveness also needs to be considered in a *broader dimension* or at the macro-level the *focused dimension* articulates with[8]. In this perspective, comprehensiveness imposes the construction of care networks that join services, admitting interdependence among the stakeholders and organizations involved, considering that none of them concentrates all recourses and competences needed to solve the population's health problems[10].

In a broader sense, comprehensiveness represents a network aim, requiring articulation between *micro and macro-policies.* It depends on an articulation between services and sectoral and intersectoral actions. In this perspective, it presupposes overcoming the rational pyramid-shaped service organization, ranked by increasing complexity, whose entry door is the basic (primary care) health unit, which forwards users with more complicated health problems to the other levels, in which each level is responsible for a punctual aspect. The care network can present multiple entry doors and the possibility of *focused comprehensiveness* in each situation and each space in which the users accessed the system. *Thus, expanded comprehensiveness results from the institutional, intentional, process-based network articulation among multiple focused forms of comprehensiveness[8].*

Comprehensiveness should be part of managers' concerns in the three government spheres, who need to take charge of service organization, so as to guarantee all people's high-quality access to the care network. To organize health services in this sense, changes in the management form are needed, so as to share planning, execution, regulation and assessment processes of actions and services among managers, workers and users, with a view to communication, integration and flows among different services. Network organizational arrangements require communication strategies and relations, in which an adequate information system represents a facilitator of different work processes[11].

Thus, operations are needed at different levels, which increases challenges, one of which is institutional – the restructure the organization of of distinct health establishments that still work disarticulated from one another; and the other refers to professional practices, with a view to good meetings in their relations with the users[2].

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METHOD

A qualitative research was accomplished. This approach allows researchers to perceive how the study participants signify their experiences related to a given phenomenon they intend to understand[12], in this case how the comprehensiveness principle is put in practice in health care.

The study took place between June and August 2009. Subjects were five workers from a Basic Family Health Unit (BFHU) in the Guaianases Technical Health Supervision Area of the Eastern Regional Health Coordination – one of the five regional health departments in São Paulo City. This Health Supervision Area consists of six Basic Health Units (UBS), seven Basic Family Health Units (UBSF), one Psychosocial Care Center (CAPS), one Specialty Outpatient Clinic (AE), two Outpatient Medical Care Units (AMA), one Municipal Emergency Unit (PSM), one STD/AIDS Test and Counseling Center (CTA) and one General Hospital (HG), besides the Health Surveillance Supervision (SUVIS). Among these units, the General Hospital is administered by the state; the CAPS, PSM, CTA and SUVIS are directly administered by the Municipal Health Secretary and a Social Organization administers the other services.

The unit was chosen in function of the researchers' activities as participants in the Multiprofessional Residency Program in Family Health, which *Faculdade Santa Marcelina* organized in partnership with the Brazilian Ministry of Health between 2007 and 2009. The unit comprises four teams and covers a population of 4,062 families and 15,494 people. The purchasing power of this population is low, occupying a territory on the outskirts of the city. As some professionals are missing from the unit, the team that is considered complete was chosen for the study – consisting of one physician, two nursing auxiliaries, 5 Community Health Agents (CHA) and one administrative aid. Only the Community Health Agent and the nursing auxiliary were drafted, as more than one of them took interest in the study.

After obtaining approval from the Research Ethics Committee at *Faculdade Santa Marcelina* and the São Paulo Municipal Health Secretary, data were collected through interviews, using a semistructured script, which contained data on the participants' demographic profile and the following guiding questions: a) what do you consider as comprehensiveness? c) describe a situation you experienced in which the comprehensiveness principle took place; c) describe a situation you experienced in which the comprehensiveness principle did not take place; d) talk about the comprehensiveness principle in the organization of the service where you work. The interviews were recorded with the participants' consent, fully transcribed and then submitted to them for approval of the transcriptions. The researchers wrote down the demographic data.

To analyze the interviews, thematic content analysis was used[12]. Therefore, after the transcription, the interviews were read repeatedly to apprehend the meaning expressed in the contents and the identification of emerging themes. Next, these themes were organized, interpreted and analyzed, including the respective excerpts of the participants' discourse that revealed the workers' meanings and perceptions regarding comprehensive health care. The theoretical-philosophical conceptions expressed in the literature review supported the analysis.

RESULTS AND DISCUSSION

Five workers were interviewed from a UBSF: one community health agent, one nurse, one nursing auxiliary, one physician and one administrative aid. The mean time of professional activity in the Family Health Strategy at other units is eight years, ranging between four and 13 years. At the unit under analysis, the mean work time is approximately five years. In three cases, the work time in the strategy coincides with the work time at the unit. Except for one worker, all participants are married and ages vary between 33 and 45 years, with a mean 40.2 years. The lowest education level is secondary education and, among higher education professionals, only one declared a postgraduate degree.

The interviewed workers perceive that the comprehensiveness principle involves the following dimensions: health professionals' profile and practices, with an emphasis on care humanization; organization of the health service and work process; and integration of the UBSF with other care levels – with an emphasis on system organization. In each of these comprehensiveness dimensions, the perceived absence or presence of this principle is revealed as a health care driver. The advances and bottlenecks experienced are problematized, revealing the challenge the task of changing the care model imposes through the Family Health Strategy.

Comprehensiveness as health professionals' profile and practices, with an emphasis on care humanization

The interviewed workers perceive that the comprehensiveness principles involves a welcoming and respectful approach in user care, highlighting: the range of a holistic look on the patient – in the physical, psychological and social dimensions; the importance of capturing the needs the patient brings, which are not always expressed as a disease or biological alteration, and the dialogue established between worker and user to construct bonding and welcoming. Each worker's availability for humanized care is underlined, even when the resource the user is seeking is absent, which is often the medical consultation.

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(...) Comprehensiveness means treating the person as a whole! As a human being and his needs… Because people come to the Basic Health Unit and, sometimes, they just want to be welcomed! Sometimes the problem is not the disease. So the person wants you to welcome and understand what is happening. Half of the problem is already solved!(...) Because, today, you go to a public service and care is very cold, due to the rush and people's bad mood! That also happens at the UBS (...) (E 05).

Comprehensiveness emerges in humanized care and in the holistic approach of human beings, who do not admit being reduced to the disease or physical complaint[7]. This approach is often absent in the unit's reality, as a result of the professionals' profile – who are not always committed to good care delivery – in the interviewees' opinion – depending on listening, a respectful attitude or interest in solving small situations within the professional's reach. In the statements, a lack of *focused comprehensiveness* is perceived in the health micro-policy sphere, due to the professionals and/or the team's lack of commitment and effort to apprehend and attend to the needs of the people seeking care[8].

Some interviewees problematize the professionals' profile, which should be more adapted to the Family Health Strategy – issuing a perception that the proposed care model requires more committed people. They question the medical professional's profile, which is not always compatible with the recommended proposal to change the care model.

(...) People are not willing at all. (...) Sometimes I feel outraged because everyone belongs to the same system (...) And when we arrive, people make an ugly face at you because you brought them more work, you know?(...) Sometimes it's not the error of the system, but of the professionals who are acting in the system. And, because of that, this comprehensiveness happens. First the professionals' quality (...) Second, the willingness! Sometimes they are apt but not willing, which is essential (E 03).

(...) We have to be realistic. Some people are here just to be here. Do things just for the sake of doing… Some people are really interested, they come with you and accompany you. (...) Because so many questions are asked about us workers to enter... And the physician? What question is asked? (E 01).

The interviewees reveal a perception that comprehensiveness involves user-centered care and the professionals' profile, including technical-scientific competences and skills and availability to dialogue. This refers to one of the sense of comprehensiveness as an attribute and value of care practices[4]. Comprehensiveness in this perspective is not just the professionals' attribute, as attitudes can result from processes that affect them. In that sense, health policies and training/education policies can result in benefits or not for the desired changes in values and care practices[4].

Comprehensiveness as the organization of the health service and work process

The second dimension of the comprehensiveness principle in the interviewees' perception refers to the internal organization of the health service and its work processes. Some issues emerge from the discourse, like the hegemony of the biomedical, cure-oriented and fragmentary model, seen as one of the bottlenecks to put in practice comprehensiveness. Both the team's and the population's emphasis on medical professionals' activities is noteworthy, evidencing that the predominant care model, focusing on the disease and the medical solution, is part of the unit's internal culture and of the users' expectation. As this professional is not always available for numerical, and perhaps also for other reasons, this ends up raising limitations and arouses users and teams' dissatisfaction. In one of the statements, it stands out that users are somehow blamed for demanding medical care and curative action – ignoring the burden of the heritage medicalizing health practices produced throughout history, in professionals' way of thinking and acting as well as in the way the population in general perceives the disease.

(...) This physician is God, it's the Almighty, that still exists (...) You go there, give advice, do the group, do the active search. But if the physician is not present the group does not function. So they still see the physician as the center of everything. And, as there's a lack of physicians at the unit, many things go wrong. Often you start a group, the physician participates (...) Then the physician leaves and it seems things break down a bit. The whole value of what was constructed is lost. Because the population has this view. They want to see results now. He gave a prescription, there's the result. They're unable to see the result of prevention (...) (E 01).

This reveals a perception that comprehensiveness is hampered by the posture of the population that seeks a medical solution to its problem. The insufficiency of this professional in the proposed model and the population's dissatisfaction with the service package offered appear though – demonstrating that *focused comprehensiveness*[8] does not happen satisfactorily at this unit. This represents a challenge for comprehensive care, demanding that health teams and their work processes go through transformations, so as to expand the ability to perceive the users' needs[4]. The following discourse highlights important aspects of teamwork, appointing the need for communication and dialogue among professionals, which contribute to achieve comprehensive care.

(...) The profile and willingness of the professionals who are working, need to correlate and interconnect. I think that these are two situations, a priori, because many other situations, like a lack of resources and others, we manage to find a way around. But this, I think it's essential. (...) Some people are kind of individualistic in their work. It's not that they're not apt and do their work badly. But there's not this cooperation. This lack of communication, sometimes it's complicated (...) (E 03).

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The workers perceive that comprehensiveness does not reflect in system management, showing dissatisfaction with the charges they receive from the hierarchical levels, whose concern is characterized by quantitative targets, to the detriment of collective and multiprofessional actions. This discloses a hardly participatory management form, which can generate alienating work processes that do not produce satisfaction and motivation for comprehensive care.

(...) There are only duties here... No rights! Lately, there have only been duties. It's more like that now, every man for himself and God for all, right! But there has been comprehensive work... Partnership (...) Now, we're working under pressure a lot. So, every man looks after his own back! Nobody wants to meet anymore (...) "Let's have an integration let's make the team. Now it's each... Pulling one's hair out to reach 100% of visits, write one's reports (...) It's like that, either you do it or you're out, right? (E 02).

They emphasize the lack of information democratization and the need to change work processes, so as to guarantee effective communication – a condition for teamwork and, consequently, for care comprehensiveness to take place. This reveals the perception that it is not enough to join professionals with distinct goals – *group team*[9], leaving aside the construction of a common care project, which does not enhance integrative care practices.

(...) Even in here with this new team, from the NASF (...) I'm having some difficulty. Because we don't get feedback. Only when we ask for it: "Hey, how's it going? Then we get some feedback. After starting to charge a lot, I'm feeling that the return is better. In team meetings, things are being transmitted, there's being more comprehensiveness (E 03).

The lack of information makes it difficult to put in practice comprehensiveness (...). Comprehensiveness is when you unite forces for a common sense. It's very difficult here, because there's something here called partiality and not comprehensiveness (...) When you talk about comprehensiveness, you look at a whole! At a single good (E 04).

On the other hand, some workers give successful examples of team integration in daily work. They consider situations as positive when: professionals get involved and seek solutions to problems jointly; higher-education professionals commit to solving demands other secondary-level professionals present (nursing auxiliary, community health agent); knowledge is exchanged and the other person's knowledge is respected in case discussions. In these situations, the professionals believe that teamwork was developed and comprehensiveness was exercised. When the health teams are able to establish a therapeutic project for the service users, they are practicing the *integration team*[9] – which results in greater user and team satisfaction.

I think that, in here, there are people who participate in what's happening to the patient, seek an answer (...) And the nurse or the physician, the community agent, everyone seeks this answer (...) Look, several times, we presented a situation inside the team and got a return. I have worked with many physicians who gave this return. The nurse gave this return (...) So it was teamwork (E 01).

The Family Health Program is a strategy proposed to change the care model and one of its prerogatives to reach this goal is teamwork. This represents yet another challenge through, as it demands overcoming values and paradigms gained throughout one's education and health work experience, besides intentionally established spaces in management that enhance collective work practices. This complexity of teamwork is underlined, which needs to be constructed every day through more dialogical, democratic and solidary relations among its members, especially to construct a holistic care project based on different knowledge and practices. Understanding the importance of diversity and actions that are not limited to each category's specific tasks comprises the potential to practice comprehensiveness[13]. The following discourse evidences situations that do not permit teamwork, characterized by unequal relations and lack of interaction.

(...) Sometimes there's criticism, just that you don't have room to talk, you want to talk, but you end up getting isolated and give up saying many things. So we end up just observing and keeping quiet (E 01).

(...) This work is horizontal work, it's a job that you have to do in the blind, without mistrust. That's comprehensiveness! Construction and credit. And not destruction. (...) Nobody can feel that he owns power, knows everything! Everyone's constructing. That's why every day there's a new document, a new protocol, people bringing things and new information. If it's not like that, this program doesn't evolve. And, here, at this unit, this program does not stand a chance! (...) (E 04).

As observed, considerable emphasis is put on issues related to work organization, to teamwork, to interpersonal relations – unveiling some people's satisfaction and others' dissatisfaction – reflected in care production. It is interesting to observe that the importance of working together with the community only appeared in one of the statements. In that sense, the health service users do not usually play a paramount role in the production of their care and their own life, as only the workers make decisions, leaving the population aside, whom the actions target[14].

(...) Once, there was a garbage can in the street, right… Then I thought that that garbage can was causing health problem, it was polluting the environment. So I talked to some users that, if we managed to get rid of that can things would get better for everyone! When I arrived the other day the can was no longer there (...) They integrated in that thing, cleaned it up and let everyone know... That each person had to put the garbage outside his door, as it was harming health and the environment, you know? That seemed like a job in which they integrated everything! (...) *(E 02)*.

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Comprehensiveness as the unit's articulation with other health services, with an emphasis on system organization

The discourse reveals a conception of comprehensiveness related to the dimension of the health service's organization as an integrated network with different services and actions that should add up to attend to the population's needs. The importance of information systems is highlighted, which enhance communication among different network levels and services. Facilitators and obstacles for comprehensiveness to take place also emerge from the discourse. The workers understand that the hierarchized care network is not enough as, without cooperation among the services involved, the practice of comprehensiveness is compromised. When talking about network, authors suggest two readings, one as organizational structure, focused on service production, and the other as a permanent renegotiation of roles among the actors (managers, workers, users) involved, so as to provide new solutions to existing problems, taking into account a *context of changes and mutual commitments*[10].

(...) Comprehensiveness would be the junction and cooperation among services in the health system. At primary, secondary and tertiary level… And also cooperation, which should exist among these levels... Which we sometimes see that it does not exist. Sometimes you leave somewhere, supposedly with everything well organized, contact made, hospital waiting and you get there and nobody knows anything (...) (E 03).

The lack of communication among health services is put forward as one of the bottlenecks for comprehensive care as, although forwarding takes place, mainly in case of referrals, counter-referral does not seem to happen. Users attended by different services receive fragmented care, similar to information about their health/disease conditions. Primary care professionals face difficulties to access information about what has been done at the secondary and/or tertiary levels and vice-versa. The family health network is being created without articulation with the rest of the system, and little relation with specialized services and hospitals[15].

(...) Often, we also face the lack of communication among institutions. We don't have a computer system. Sometimes, you need a patient's medical file. The physician needs some information from the hospital, but this information is not that easy. There is not much comprehensiveness between the unit and other health services! The following happens: patients are always received and we always try to solve things. But there's not much feedback, there's a lack of interaction and communication (...) (E 03).

The lack of communication in the health system hampers comprehensiveness in progressive user care delivery, as service work on their own distinct logic, ignoring users' needs as the axis of their organization[7]. According to some interviewed workers, referral exists and they perceive improvements in the availability of places for medi-

cal specialties and more complex tests. They attribute this improvement to the organization of the regulation system and to the better allocation of human resources, thus guaranteeing the continuity of the work the primary care level started.

(...) There are some people who open doors for us. The specialties, the referral units. In this respect [medical specialty] things improved a lot (...) It seems that the specialty thing is much better organized. They are training people who like to do this kind of work. Trying to get places for that specialty (...) I think that improved a lot (E 01).

(...) I think that facilitators are regulation, including the availability of places for tests, meetings where we get to know each other and facilitate contact. Because it's not just formal, there are informal things as well! (...) (E 04).

CONCLUSION

Different meanings are attributed to comprehensiveness, among which those related to care and health service organization are highlighted, whether internal to organizations or among different care network services.

The study unveiled the workers' perception that comprehensive care involves issues like humanization, welcoming and bonding, that is, person-centered care, in a holistic perspective. That is not always what happens in daily practice though, as it seems that some professionals do not have the expected profile, nor availability to seek the ideal of comprehensiveness. As for the professionals' profile, education cannot be ignored, which is still based on the biological, cure-oriented, fragmentary and medicalizing model, quite distant from an education process that prioritizes interdisciplinarity, teamwork, comprehensive care and problematization of health work processes.

Great emphasis was put on the unit's internal organization and the alienating way in which health work processes happen sometimes. The dissatisfaction established power relations, charges for targets that prioritize individual activities and expected medicalizing solutions – by the users - generate emerge from the discourse as examples of situations that are considered bottlenecks to put the comprehensiveness principle in practice. Teamwork, recommended by the family health team, varies between moments of *integration team* and *group team*.

It is highlighted that practices that involve users in their care production are still incipient, as well as the articulation of intersectoral actions – important aspects to achieve comprehensiveness. Finally, the organization among different health services appears, which according to the workers should cooperate mutually, besides having efficient information systems that permit communication among the levels. Advances were observed in the availability of places for medical specialties, attributed to the better organization of the system and human resource training. The main error, though, is due to deficient com-

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munication and articulation among the services – evidencing that comprehensiveness in the region lacks a properly organized network.

It seems that all ingredients needed to put in practice comprehensiveness are like pieces of a large puzzle, which are placed in our daily lives to fit in the best possible way. The challenge is exactly to find out what is the *best way*.

In view of such diversity, one single way of doing things probably will not be enough. Instead, a wide range of ways needs to be considered and constructed. It is a fact that a rupture is needed with practiced that have been crystallized for so long and with the current care model – which demands political commitment from managers, workers and users in this construction.

REFERENCES

1. Brasil. Constituição, 1988. Constituição da República Federativa do Brasil. Brasília: Senado Federal; 1988.

2. Campos CEA. O desafio da integralidade segundo as perspectivas da vigilância da saúde e da saúde da família. Ciênc Saúde Coletiva. 2003;8(2):569-84.

3. Pinheiro R, Luz MT. Práticas eficazes x modelos ideais: ação e pensamento na construção da integralidade. In: Pinheiro R, Mattos RA, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. 6ª ed. Rio de Janeiro: IMS/UERJ/ABRASCO; 2001. p. 7-34.

4. Mattos RA. Os sentidos da integralidade: algumas reflexões acerca de valores que merecem ser defendidos. In: Pinheiro R, Mattos RA, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. 6ª ed. Rio de Janeiro: IMS/UERJ/ABRASCO; 2001. p. 39-64.

5. Silva JPV, Tavares CMM. Integralidade: dispositivos para a formação crítica de profissionais de saúde. Trab Educ Saúde. 2004;2(2):271-85.

6. Fontoura RT, Mayer CN. Uma breve reflexão sobre a integralidade. Rev Bras Enferm. 2006; 59(4):532-37.

7. Mendes EV. Os grandes dilemas do SUS. Salvador: Casa da Qualidade; 2001.

8. Cecílio LCO. As necessidades de saúde como conceito estruturante na luta pela integralidade e equidade na atenção. In: Pineiro R, Mattos RA, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro: v; 2001. p. 113-26.

9. Peduzzi M. Equipe multiprofissional de saúde: conceito e tipologia. Rev Saúde Pública. 2001;35(1):103-9.

10. Hartz ZMA, Contandriopoulos AP. Integralidade da atenção e integração de serviços de saúde: desafios para avaliar a implantação de um "sistema sem muros". Cad Saúde Pública. 2004;20(2):331-6.

11. Brasil. Ministério da Saúde; Secretaria de Gestão do Trabalho e da Educação na Saúde. Curso de Formação de Facilitadores de Educação Permanente em Saúde: unidade de aprendizagem – análise do contexto da gestão e das práticas de saúde. Rio de Janeiro: FIOCRUZ, 2005.

12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 10ª ed. São Paulo: Hucitec; 2007.

13. Duarte ED, Sena RR, Xavier CC. Work process in the Neonatal Intensive Care Unit: building a holistic-oriented care. Rev Esc Enferm USP [Internet]. 2009 [cited 2011 May 14];43(3):647-54. Available from: http://www.scielo.br/pdf/reeusp/v43n3/en_a21v43n3.pdf

14. Matumoto S, Mishima SM, Fortuna CM, Pereira MJB, Almeida MCP. Family discussion in the family health strategy: a working process under construction. Rev Esc Enferm USP [Internet]. 2011 [cited 2011 Aug 14];45(3):603-10. Available from: http://www.scielo.br/pdf/reeusp/v45n3/en_v45n3a08.pdf

15. Campos GWS. Reforma política e sanitária: a sustentabilidade do SUS em questão? Ciênc Saúde Coletiva. 2007;12(2):301-6.

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