



## Quality of work life of nurses in primary health care\*

*Qualidade de vida no trabalho do enfermeiro da Atenção Básica à Saúde*

*Calidad de vida en el trabajo del enfermero de la Atención Básica a la Salud*

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### ABSTRACT

**Objectives:** To understand the conceptions and experiences of nurses about quality of life and quality of work life in primary health care. **Methods:** A descriptive study using a qualitative approach, conducted in São Paulo state (Brazil), with eight nurses whose interviews were submitted to content analysis of a thematic manner. **Results:** The nurses presented expanded conceptions about quality of life and quality of work life, in general, showing that they were satisfied regarding these. However, barriers were identified that compromised the quality of life of the professionals studied in the context determined primarily by the lack / inadequacy of material, human and environmental resources, as well as the established work process. **Conclusion:** Although there is a recognition of satisfaction in working in primary health care, the problems highlighted reveal the importance of mobilizing greater attention of professionals and managers to the theme.

**Keywords:** Quality of life; Job satisfaction; Primary health care; Nursing staff

### RESUMO

**Objetivos:** Aprender as concepções e experiências de enfermeiros sobre qualidade de vida e qualidade de vida no trabalho na Atenção Básica à Saúde. **Métodos:** Estudo descritivo de abordagem qualitativa, realizado no interior paulista, Brasil, com oito enfermeiros cujos depoimentos foram submetidos à análise de conteúdo, na vertente temática. **Resultados:** Os enfermeiros apresentaram concepções ampliadas sobre qualidade de vida e qualidade de vida no trabalho, em geral, apresentando-se satisfeitos quanto às mesmas. Entretanto, foram apontados entraves comprometedores da qualidade de vida dos profissionais no contexto estudado determinados, principalmente, pela falta/inadequação de recursos materiais, humanos e ambientais, bem como pelo processo de trabalho estabelecido. **Conclusão:** Embora haja o reconhecimento da satisfação em trabalhar na Atenção Básica à Saúde, os problemas apontados revelam a importância de se mobilizar maior atenção dos profissionais e gestores para o tema.

**Descritores:** Qualidade de vida; Satisfação no emprego; Atenção primária à saúde; Recursos humanos de Enfermagem

### RESUMEN

**Objetivos:** Aprender las concepciones y experiencias de enfermeros sobre calidad de vida y calidad de vida en el trabajo en la Atención Básica a la Salud. **Métodos:** Estudio descriptivo de abordaje cualitativo, realizado en el interior paulista, Brasil, con ocho enfermeros cuyos testimonios fueron sometidos al análisis de contenido, en la vertiente temática. **Resultados:** Los enfermeros presentaron concepciones ampliadas sobre calidad de vida y calidad de vida en el trabajo, en general, presentándose satisfechos en cuanto a las mismas. Entre tanto, fueron señalados obstáculos comprometedores de la calidad de vida de los profesionales en el contexto estudiado determinados, principalmente, por la falta/inadecuación de recursos materiales, humanos y ambientales, así como por el proceso de trabajo establecido. **Conclusión:** No obstante haya el reconocimiento de la satisfacción para trabajar en la Atención Básica a la Salud, los problemas señalados revelan la importancia de mobilizar una mayor atención de los profesionales y gestores hacia el tema.

**Descritores:** Calidad de vida; Satisfacción en el trabajo; Atención primaria de salud; Personal de Enfermería

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## INTRODUCTION

According to the World Health Organization, quality of life (QOL) is defined as “individuals’ perceptions of their positions in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns”<sup>(1)</sup>. The concept has been related to individuals’ lives in society and at work – the quality of work life (QWL) – on the grounds that it is impossible to dissociate life and work.

The current notion of QWL encompasses physical, technological, psychological, and social dimensions of work corresponding to the ideals of a more humane and healthy organization<sup>(2)</sup>. QWL describes the satisfaction of workers in safe work environments that are characterized by mutual respect and opportunities to perform the required functions<sup>(3)</sup>. To achieve a satisfactory QWL, workers must be valued and considered in decision making and their needs must be satisfied, their creativity promoted, their work relationships humanized, and their working conditions improved<sup>(4)</sup>.

There is no consensus on the best manner to assess QWL or the satisfaction of nurses<sup>(3)</sup>. Most studies in this field approach the QOL of patients and their relatives, whereas studies on the QWL of health care professionals are less common. Among the available QWL studies, there is an emphasis on the pathologic dimension of the diseases and the risk factors of health care providers as a function of the biological, physical, and chemical hazards to which they are exposed, particularly in the hospital setting<sup>(5)</sup>.

Primary health care is associated with several stressful and dissatisfactory working conditions for workers in different professional categories, including nurses<sup>(6-8)</sup>. In particular, workers often do not pay a sufficient amount of attention to their own health conditions. The basic health units (BHUs; unidades básicas de saúde) are the primary service for the Unified Health System (UHS; Sistema Único de Saúde). BHU environments are sources of constant stress for health care teams and users<sup>(9)</sup>. In this context, there is a constant stream of new and varied health problems that are difficult to solve. These problems involve assuming responsibility for the health care of users over time and caring for their countless needs and requirements.

However, care must also be provided to health care professionals, including community health agents (CHAs), doctors, dentists, and nurses; the individuals in these roles must be well prepared and provided with satisfactory biopsychosocial conditions to be able to work<sup>(10)</sup>. The work environment must be interesting

and humane, and health care professionals must be properly valued<sup>(11)</sup>.

Based on the importance that the active participation of professionals has for their own lives, health, and work, this study explored the conceptions and experiences of QOL and QWL among primary health care nurses. The study emphasized the unique conceptions and experiences that relate to nurses’ life histories and their sociocultural and occupational characteristics.

## METHODS

A descriptive analysis was performed of the social, demographic, and occupational characteristics of health care providers who are associated with the basic health care network in the city of Marília, São Paulo, Brazil. The investigated variables included age, gender, professional category, duration in the job, and type of BHU. The categories of health care providers in the basic health care network included registered nurses, nursing technicians and assistants, CHAs, dentists, and physicians.

To answer the primary questions that guided this study, a qualitative survey<sup>(12)</sup> was administered to nurses. Nurses were prioritized because they are often involved in the management of BHUs, correspond to several assistance models, direct other teams of nurses and CHAs, and have full-time schedules. Thus, nurses work in conditions that relate to their own QWL and health care teamwork. The participants were intentionally selected among several assistance models and county health care sector units. The inclusion criterion was that the nurses had more than one year of experience in primary health care; following the data saturation criterion, the sample size was established as eight<sup>(13)</sup>.

Data were collected using taped semi-structured interviews that used the following guiding questions: *What is quality of life and quality of work life? Speak about your quality of life and quality of work life. What do you suggest for improving quality of work life in primary health care?* Bardin’s thematic content analysis<sup>(14)</sup> was applied to the fully transcribed narratives. From an operational point of view, the analysis was performed in three phases: 1) Pre-analysis: a neutral reading of the transcribed data led to the formulation and reformulation of the hypotheses and study aims; 2) Exploration of the material: the data were categorized into groups of core meanings; 3) Treatment and interpretation of the results: the raw results were highlighted and correlated with the investigated themes using an inductive and interpretative analysis that was based on the theoretical framework<sup>(12)</sup>.

This study complied with the ethical requirements described in Resolution 196/96 on Guidelines and Regulating Norms for Research in Human Beings (Diretrizes e Normas Regulamentadoras de Pesquisa em Seres Humanos), and the study was approved by the Municipal Council for the Assessment of Research of the Municipal Health Secretary and the Ethics Committee of the School of Medicine of Marília (Protocol n° 396/09).

## RESULTS

The interviewed nurses included only one male; their ages ranged from 25 to 49 years old, and they had worked as nurses for between 1 and 21 years. Two nurses performed assistance tasks, two were managers of a BHU that was associated with the Community Health Agents Program (Programa de Agentes Comunitários de Saúde), and four performed assistance and managerial functions at Family Health Program (FHP) units. Two interviewees had a second job, and one had a second and third job; all of the jobs were related to the FHPs. Their narratives are presented below in a descriptive manner and are sorted according to themes and core meanings. The corresponding record units are individually identified by a number (N1-N8).

### Theme 1 – Conceptions of QOL

The nurses' conceptions of QOL were generic and complex. QOL was difficult to define for the nurses; however, QOL was directly related to feelings of wellbeing within several features of life:

#### A generic, complex, and subjective expression

*Quality of life, as I understand it, is a very generic expression; it generalizes too many different things. It is very subjective; that is, it depends a lot on the individual and his choices, his options, and the values that he takes into account. What are the values at stake? What is the ethical, moral behavior such an individual assumes for himself for quality of life to exist or not? (N1) Quality of life is physical, mental, and psychosocial wellbeing. (N2)*

The nurses also related QOL to the satisfaction of people's needs and alluded to various dimensions of their lives. The nurses emphasized the life dimensions related to work, thus indicating the importance they afford to the balance between their personal and work lives:

#### Being able to satisfy the various needs of people

*Quality of life means that you are in a condition to develop your potential in every way: in your emotional, financial, and professional lives. (N3) It is important to do what you like, within the proper boundaries and within the scope of what is allowed around you: work, environment, and everything else. It also means to be close to the people you like at the job and in everyday life, even when the environment is not nice. It means to be in peace, in harmony. (N7)*

The nurses also mentioned caring for oneself as a condition of QOL, thus indicating that professionals whose task is to care for others may not always care for themselves:

#### Caring for oneself

*To care for yourself as a person; not only caring for others but also for yourself. (N3)*

These professionals also acknowledged that when there is QOL, one lives better, works more calmly, and has more satisfaction:

#### Everything becomes easier and better

*Then, quality gets to improve what you do. You'll do things with more satisfaction and pleasure; it won't be an extra load, and you'll be more at ease when doing things, lighter. (N3)*

### Theme 2 – Conceptions of QWL

The nurses attributed much importance to work, which was considered to be a crucial factor for the actualization of one's QOL:

#### Work is important in the life of a human being

*Work is something very important in the life of a human being; it's something that strongly influences his life, influences everything. When a person isn't happy at his job, very rarely will he be happy at home; he'll hardly try to make other people happy. (N1)*

Although work was considered to be crucial for QOL, these nurses emphasized that health care workers and managers do not always acknowledge this fact:

*However, I don't think too much about it, no way. I just do my stuff. Only when one goes and discusses this stuff a bit does one feel its weight somehow. When one is working day after day, there's no time to think. (N7) Many managers don't see that as something important and serious... even though when a person has quality of life, she works better. (N2)*

These nurses related QWL to their daily work conditions:

*It means having a good work environment, conditions to perform one's tasks in a proper way. It means having a good physical space. It does not mean a lack of medications and employees. I think it is a series of factors. (N5)*

Other important factors for achieving complete QWL included having autonomy and responsibility in performing one's tasks according to one's abilities and skills and having respect from other people:

#### **Having autonomy and professional responsibility, to respect and be respected**

*To have a good QWL, both for nurses and other professionals, you have to have a little more autonomy and assume responsibility for what you do. I think that it's very important to respect and be respected. To fulfill your duties, know your rights, behave as ethically and morally as you can with others, and also get the same in return. (N1) It means that the employee has conditions to perform his work freely and calmly. (N3)*

Self-satisfaction with and at work was indicated as an essential factor for achieving adequate QWL:

#### **Having self-satisfaction with and at work**

*It means feeling well, to be a professional who feels well with what he does. It means being healthy, both physically and psychologically. It means liking oneself. It means being OK with what you do. It means feeling well with what you do at work. (N2)*

When alluding to the necessary conditions for achieving QWL, the nurses emphasized teamwork:

#### **The value of teamwork**

*I think that there are bonds, a liking for the job, because when one employee is missing, work becomes harder. When he doesn't tell anyone that he won't come and doesn't offer any justification, there'll be an empty "hole" in the unit, but when he tells not only the nurse but also the full team, everything is better, and the team will not feel so fragile. (N2) It means that the team is well integrated. (N8)*

Proper care for employees was related to a satisfactory QWL, denoting the interviewees' concerns for their work tasks:

#### **Providing proper care to users**

*It means helping the community satisfy its needs, within the UHS, primary health care boundaries. (N5)*

### **Theme 3 – Experiences regarding the QOL and QWL of primary health care nurses**

Initially, most nurses reported being satisfied with their QOL and QWL:

#### **I'm satisfied with my QOL**

*My life is good, both at home and at work. Although conditions aren't favorable, I think I have a good quality of work life. (N7)*

To ground such perceptions, the nurses emphasized the relationship between primary health care providers and their work, and they also emphasized teamwork:

#### **The team is essential in the job**

*Here, we become one member of the team and work together, so we grow. (N4)*

However, these nurses also implied that the teamwork conditions sometimes negatively interfered and affected their QOL:

#### **Teamwork problems affect QOL**

*Even when I think that this team is quite united, there are some situations when one feels one is working more than others. In primary health care, I notice that the work process is too centered on the nurse, both at the health units and the FHP. (N1) I'm not having a high quality of life because of the work; it's too tiresome. (N2) One isn't well when one gets home, doesn't eat well at lunch, and starts pondering one's life context. (N5)*

Other problems that were mentioned as being unfavorable for QWL in primary health care were related to the nurses' characteristics and the disorganization of the assistance model. The assistance model prioritizes healing diseases over prevention and the promotion of health, and it fosters stress at work, absenteeism, and a lack of material, physical, and human resources:

#### **QWL is affected by problems in the primary health care setting**

*There is no quality of work life because our environment is too stressful due to the work conditions and the patients themselves. They have little education and no patience. Additionally, it's difficult to deal with the population because of the way the service is built. Prevention and promotion get little attention; the emphasis falls on healing. (N2)*

To face the problems and difficulties at work and improve the QWL for the health care team in the pri-

mary health care setting, the nurses indicated several measures that have already proven to be successful. They also indicated other potential interventions encompassing a wide scope of possibilities, ranging from giving attention to workers' mental and physical health to managerial features of work organization and continued education in health:

### **Interventions are needed to improve QWL in the primary health care setting**

*I think it'd be interesting to work in continuing education. To survey the team's needs, see what needs to be changed, and discuss; run a theoretical search on this to find out what needs to be improved, and have room to do it. The team's meetings are the only occasion we have to think, talk, fix what's wrong, and praise what's right. (N5) I believe that both the managers and the nurses lack the initiative to improve the quality of work life. (N8)*

## **DISCUSSION**

The choice to include eight nurses in the study corresponded to the diversity of characteristics that were verified by a quantitative study on nurses associated with primary health care in Marília in 2009. The sample size was sufficient for providing information about different dimensions of the investigated phenomenon, and it favored the deeper analysis<sup>(13)</sup>. However, while the inclusion of these nurses served the aims of this study, the exclusion of other members of the health care team, whose perspectives may have contributed to the investigated subject, must be considered as a limitation.

This study showed that most of the interviewed nurses initially had difficulty defining QOL and QWL but related these notions to their own worldviews and life experiences. The abstract and subjective nature of these expressions, particularly in the case of QOL, implies that different individual and collective meanings are attributed to knowledge, experiences, and values. Such meanings depend on the particular historical time, social class, and culture to which the individuals belong. Thus, QOL may be approached from different perspectives and may concern several facets, potentially leading to conceptual debates<sup>(4)</sup>.

In the course of the interviews, further meanings were added to the initial conceptions of QOL and QWL, and these meanings have also been reported in the scientific literature on health<sup>(3-4)</sup>. QOL was related to the satisfaction of workers' and users' needs within their bio-psycho-socio-spiritual dimensions of life. More specifically, QOL was related to the balance among those dimensions. A variety of needs were mentioned that demanded satisfaction, including

professional, family, and social relationships, as well as leisure, health, nutrition, and education. QOL was also linked to the feeling of wellbeing that resulted from having satisfaction with these many dimensions of life, indicating that QOL is correlated to a wider perspective of the health-disease process, particularly with regard to the dimensions that favor the development of citizenship. It is worth stressing that as a function of the dynamics of living, life satisfaction and the feeling of wellbeing may be transient feelings<sup>(4)</sup>.

The interviewed nurses emphasized that work is an important component of QOL. QOL was depicted as being linked to the ability to distinguish between work and everyday life and to having time to rest and participate in leisure activities. Consequently, many interviewees observed that these were absent from their lives. To them, the ideal QOL construct involves nice and quiet family and professional environments that are free from emotional conflicts. Initially, their conceptions sounded naïve and removed from reality; however, when they alluded to their actual lives and work experiences, the nurses acknowledged more realistic dimensions that are inherent to the notion of QOL and manifested by the potential to accomplish a satisfactory QOL and QWL<sup>(11)</sup>.

QWL in the primary health care setting was related to being satisfied with work conditions, such as the availability of human, material, and environmental resources; the organization of work processes; approaches to health care; and the results and recognition of the work they perform. Payment was mentioned as an important factor for QWL. Payment is an important motivation for work, but it is not the primary motivation. When work is performed under favorable conditions, it promotes a feeling of wellbeing that favors human relationships and work processes. This feeling has a positive effect on the QOL of health care professionals and improves the quality of their assistance<sup>(3,15-16)</sup>.

Autonomy and professional maturity were related to an adequate QWL within the investigated context. From the perspective of workers' satisfaction with work, QWL studies have pointed to the importance workers assign to work relationships and work processes<sup>(3-4)</sup>. Adequate teamwork was considered to be necessary for a satisfactory QWL. Multi-professional teamwork was considered to be an important basis for the organization of work processes in the primary health care setting and, especially, in the FHP to achieve a more integral and effective approach<sup>(17)</sup>.

For their own QOL and QWL experiences, the nurses noted several positive features, including the engagement with and responsibility of the team with regard to nursing tasks. Nevertheless, they also men-

tioned negative experiences, such as work overload, overtime that results from the lack of collaboration among team members, and the centralization of work processes. A study performed in the FHP setting found that nurses attributed work overload to the poor distribution of bureaucratic tasks<sup>(17)</sup>. FHP nurses with second or third jobs emphasized the incoherence of the governmental discourse regarding full-time positions for professionals in the primary health care setting<sup>(9)</sup>. Having more than one job and working weekends and holidays eliminates leisure time, which is rated as a necessary aspect of a healthy lifestyle.

Interviewees mentioned another factor that leads to work dissatisfaction: it is not always possible to rationally manage relationships with primary health care users. Although it is recommended that professionals establish links with the assisted population<sup>(9-10)</sup>, the family and sociocultural contexts of the users are often diverse, and it can be difficult to solve problems. Distortions in the adopted assistance model also impaired QWL. In particular, priority is given to assisting users with spontaneous demand rather than preventing health problems and promoting action. A recent characterization of FHP teams in Marília showed that they are currently proposing strategies that align with the UHS goals. Such actions must be applied on a larger scale and emphasize multisectorality and popular participation<sup>(18)</sup>.

The nurses suggested several possible measures for improving QWL in health care units, ranging from specific actions for promoting the mental and physical health of the health care team to changes in the professional structure, such as sharing the responsibility for the work processes and purposes. At the county level, the nurses suggested stronger involvement of health sector managers with the actual conditions of the population and QWL. Nurses frequently men-

tioned the need for effective educational actions that focus on primary health care workers, which are currently performed in some FHP units. In such units, according to the interviewees, the FHP improved the work processes and user assistance and widened the perspectives on health care needs and the provision of opportunities for improving QWL. Further discussion and research on this subject may improve the work conditions of health care professionals. In this regard, future studies must seek to overcome the problems identified in this study by applying a wider perspective and including other members of the health care team.

Finally, it is worth stressing the nurses' acknowledgment of the importance of self-care, even though they sometimes neglect it while caring for others, as a factor of QOL and QWL. From an institutional point of view, strategies must be implemented to enhance interpersonal relationships with actions and programs that consider the expectations of workers, how workers can care for themselves and execute their professional health care tasks and how the organization<sup>(4)</sup> can ensure that the workers are cared for.

## FINAL CONSIDERATIONS

In general, the nurses reported being satisfied with their QOL. However, they also disclosed several features that must be taken into account for improving QWL in the primary health care setting. These features relate to their professional category and general features of health care assistance. Based on nurses' wider perspectives on QOL and QWL, there is a need for managers who can implement actions and improve the daily activities in BHUs. In the process, these managers should ensure the active participation of nurses and other members of the health care team.

## REFERENCES

1. World Health Organization. Quality of Life Assessment (WHOQOL): position paper from the World Health Organization. *Soc Sci Med*. 1995; 41(10):1403-95.
2. Cunha KC, coordenador. *Gestão de pessoas: foco na enfermagem atual*. São Paulo: Martinari; 2008.
3. Schmidt DR, Dantas RA, Marziale MH. Quality of life at work: Brazilian nursing literature review. *Acta Paul Enferm*. 2008; 21(2):330-7.
4. Felli VE, Tronchin DM. A qualidade de vida no trabalho e a saúde do trabalhador de enfermagem. In: Kuregant P, coordenadora. *Gerenciamento em enfermagem*. Rio de Janeiro: Guanabara Koogan; 2005. p. 89-107.
5. Campos JF, David HMSL. Abordagens e mensuração da qualidade de vida no trabalho de enfermagem: produção científica. *Rev Enferm. UERJ*. 2007;15(4):584-9.
6. Gehring Junior G, Corrêa Filho HR, Vieira Neto JD, Ferreira NA, Vieira SVR. Absenteísmo-doença entre profissionais de enfermagem da rede básica do SUS Campinas. *Rev Bras Epidemiol*. 2007; 10(3):401-409.
7. Camelo SHH, Angerami ELS. Symptoms of stress in workers from five family health centers. *Rev. Latino-Am. Enfermagem*. 2004; 12(1):14-21.
8. Camelo SH, Angerami EL. Formação de recursos humanos para a estratégia de saúde da família. *Ciênc Cuid Saúde*. 2008; 7(1):45-52.
9. Brasil. Ministério da Saúde. Portaria n. 648/GM, de 28 de março de 2006. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica para o Programa Saúde da Família (PSF) e o Programa Agentes Comunitários de Saúde (PACS). *Diário Oficial da República Federativa do Brasil, Brasília (DF)*; 2006 Mar 29.
10. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização.

- Trabalho e redes de saúde: valorização dos trabalhadores da saúde. 2ª ed. Brasília: Ministério da Saúde; 2006. (Série B: Textos Básicos de Saúde).
11. Martins JT, Robazzi ML, Bobroff MC. Pleasure and suffering in the nursing group: reflection to the light of Dejour psychodynamics. *Rev Esc Enferm USP*. 2010; 44(4):1107-11.
  12. Minayo MC. O desafio do conhecimento: pesquisa qualitativa em saúde. 10a ed. São Paulo: Hucitec; 2007.
  13. Fontanella BJB, Ricas J, Turato ER. Amostragem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. *Cad Saúde Pública*. 2008; 24(1):17-27.
  14. Bardin L. Análise de conteúdo. São Paulo: Edições 70 Brasil; 1998.
  15. Talhaferro B, Barboza DB, Domingos NA. Qualidade de vida da equipe de enfermagem da central de materiais e esterilização. *Rev Ciênc Méd. (Campinas)*. 2006; 15(6):495-506.
  16. Batista AA, Vieira MJ, Cardoso NC, Carvalho GR. Fatores de motivação e insatisfação no trabalho do enfermeiro. *Rev Esc Enferm. USP*. 2005; 39(1):85-91.
  17. Silva IZQJ, Trad LAB. O trabalho em equipe no PSF: investigando a articulação técnica e a interação entre os profissionais. *Interface (Botucatu)*. 2005; 9(16):25-38.
  18. Marin MJ, Morro E, Higa EF, Lias M. Caracterizando as ações das equipes da estratégia de saúde da família do município de Marília. *REME Rev Min Enferm*. 2009; 13(4):492-8.