

MANAGEMENT OF THE WORK PROCESS IN HEALTH CARE ORGANIZATION: WELCOME IN PRIMARY CARE

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Abstract: **OBJECTIVE:** To describe the welcoming process in primary health care as a strategy for managing the work process. **METHOD:** The research was conducted through an integrative review, using the LILACS, SCIELO, and BDNF databases, with the descriptors welcoming, primary health care, work process management, people management, and multidisciplinary team. **RESULTS:** It was found that the actions conceived as welcoming are carried out in specific shifts and times, by a professional category, considered as triage of acute complaints that would determine medical care. **CONCLUSION:** Most professionals have little understanding or are unaware of the guidelines of the National Humanization Policy and the expanded concept of welcoming, generating work processes incompatible with the policy, resulting in several challenges to be faced by the team. Thus, they must believe in the organization of welcoming as an indispensable practice for improving work management in primary care, enabling more humanized and effective care.

Keywords: Reception. Primary Health Care. Work process management. People management.



Multiprofessional team.

INTRODUCTION

There are a variety of conceptions about what welcoming is. Among the meanings pointed out, listening to the patient, listening to their complaints and trying to solve them stand out; properly welcome the user, considering cordiality as something important. In addition, listening to the complaint followed by the classification of the demand that will immediately produce a conduct. Another conception is the identification of the complaint and referral to the physician or the receipt of a demand that is directed to a specific professional. These views are simplistic and do not consider the complex and impactful view of user embracement in health practices (Vale et al., 2022).

Embracement, as one of the main guidelines of the National Humanization Policy, is characterized, according to the Ministry of Health, as the “constitutive process of health production and promotion practices that implies the responsibility of the worker/team for the user, from their arrival to their departure”. Thus, user embracement considers active listening, an expanded analysis of demands and needs, as well as the guarantee of comprehensive, problem-solving and responsible care. Embracement needs to be understood in its expanded conception, making it possible to conduct planning, health education, and the implementation of actions that meet the fundamentals that determine it (Santos et al., 2023).

Even after the implementation of user embracement through the National Humanization Policy, there are still practices that are not consistent with it in Primary Health Care services in Brazil, and studies are needed that seek to reflect and know these practices (Dato; Silva-Filha; Spolidoro, 2019).

The present study deals with user embracement as a strategy for managing the work process in primary health care, in order to improve health care by providing more humanized care. The welcoming of the community in the Basic Health Unit favors the strengthening of the Unified Health



System and Public Health Policies.

Thus, the following research problem arises: How can welcoming in primary health care be a strategy for managing the work process? Taking this context into account, it is understood that user embracement is inserted in the face of these practices in the unit, being considered a structuring of health care with the participation of users in daily life. In this sense, the general objective of the present study is to describe user embracement in primary health care as a strategy for managing the work process.

METHODS

The research was conducted through an integrative review. The articles were selected from the databases of the Latin American and Caribbean Health Sciences Information System (LILACS), Scientific Electronic Library Online (SCIELO) and Database (BDENF).

The inclusion criteria for the selection of articles were studies with abstracts available in the databases; with full text; published in the period from 2014 to 2024; articles in Portuguese, English, Spanish; and that they dealt with the theme addressed in this study. Irrelevant articles that were off-topic were excluded; those who did not have an abstract and full text available in the databases; duplications; Articles written in languages other than Portuguese, English, Spanish.

The bibliographic survey was developed between March 2025 and October 2025, from secondary databases. For data collection, an instrument validated by Ursi (2005) was used with the following information: article identification data (title, authors, journal name, year of publication, volume and number), type of study, place of study, study objective, thematic axis, Qualis/Capes classification, journal of publication, level of evidence, outcomes, among others. The selection of articles was carried out independently by the researchers, and the divergences were resolved using the validated instrument.

The descriptors used were “Reception”, “Primary Health Care”, “Work Process Management”,



“People Management” and “Multiprofessional Team”, using the Boolean operator “and” for combination. From the selection of the texts, floating reading was applied to the organization of the corpus of analysis, according to the objectives of the present study.

RESULTS AND DISCUSSION

Initially, 300 potential references were identified for this review; of these, 70 articles were selected for critical reading in full, and then, 56 articles were excluded due to duplicity or for not answering the guiding questions of the study; In the end, 14 articles were chosen for analysis.

The development of Primary Health Care (PHC) in Brazil began in 1924, with the Health Centers that were developed at the University of São Paulo (USP), with an extensive trajectory of creating health services and public health awareness (BRASIL, 2015).

At the end of the 1970s and during the eighties with the imbalance of capitalism, the chance of a sense between states and classes was drastically replaced by the logic of the market, emerging movements that culminated in the first International Conference on Health Promotion, which made it possible to sign the Ottawa Charter of 1986, claiming the ideals of the Declaration of Alma Ata, being considered as a precursor event of holistic health (Alves; Cueto, 2017).

In this context, the creation of coverage extension programs was established, agreeing on PHC as a guarantee of a health care module and expanding it through guaranteed access, based on universality; comprehensiveness; equity; decentralization and social control (BRASIL, 2015).

Primary Care (PHC) is based on the principle of decentralization, seeking to have maximum contact with people, ensuring the appreciation of equity and comprehensiveness of care, thus contributing to being the gateway with an emphasis on social participation, where the focus on the patient and also on their family context collaborates for the insertion of the bond, humanization and community orientation (Arantes; Shimizu; Amann, 2016).

The National Primary Care Policy (PNAB), through the Care Networks, developed a line of



care related to the needs of the population, such as the Family Health Strategy (ESF), Street Office Team (ECR), increased municipalities that could join the Family Health Support Center (NASF), facilitated the creation of Basic River Health Units (UBSF) and Family Health Strategy for Riverine Populations (ESFR) (BRAZIL, 2012).

Primary Care (PHC) proposed that, among the concepts to be changed, the treatment model with the objective of cure should be replaced by the prevention of diseases, looking at the user as a whole and understanding their needs with regard to the sanitation of the environment in which they are inserted, the nutritional aspect, immunization interventions and health education. Understanding that the positive indicator of the user's health presence is understood as a factor of the health of the whole society (Perrealt et al., 2016).

In 2003, the PNH, National Humanization Policy, was launched with the aim of transforming the management and care of the daily service of the SUS, based on the principle of innovative transformations, in which it leads to thinking about public health, which ensures, through constitutional principles, the right of every citizen to access health services in an equal way (Martins; Luzio, 2017).

Humanization is a support related to the professional and users, in which it contemplates an intimate relationship based on welcoming to develop qualitative care. Even with studies aimed at making humanization feasible, it is still difficult to develop such practices (Mongivi et al., 2014).

The PNH, National Humanization Policy together with the Ministry of Health work as incentives for power relations structures among managers instigates dialogue so that there are no attitudes that negatively assimilate health professionals and do not harm users in their care, aiming at favorable working conditions and a functional reference network strengthening the potential of the PNH (Lopes et al., 2014).

Through guidelines and strategies, Humaniza SUS is practiced by supporters and groups that work with the integration of users, managers, workers in the creation and management of care, the work process and the elaboration of health. Humanization is linked to the integration of management and care, through contact between the team and users to understand the real needs, systematizing



the work, seeking through questioning the production of health as a common good (Martins; Luzio, 2017).

It is important that the PNH is present in all SUS policies and programs, as it aims to bring the professional closer to the community, enabling balance in the ordering of tasks with the participation of all. The importance of this proximity triggers a junction of groups and people in terms of communication, thus abolishing the idea of hierarchization that often contributes to the isolation of the community and the unrestricted integration that helps for the harmony of those committed to the humanization process. This exchange of information favors broader knowledge, experience acquired through those who are assisted, together they form a health in a cooperative way (Silva; Pereira; Araújo, 2018).

With regard to management, the user must seek knowledge and be included to be aware of changes that may occur, expanding the opportunity for a solid base in PHC, as the SUS encourages the user as a health propagator, not only recognized as a patient. The team must ensure that care takes place in the unit as a basis for each event presented, observing in detail, helping to reduce damage and improving the user's living condition and establishing the creation of bonds (BRASIL, 2017).

Welcoming is a practice ensured by the professional's contact with the user, based on the service provided in Primary Care, which is a structure of the Unified Health System (SUS) and a reference for care and comprehensiveness in various care areas. Welcoming is a policy that strengthens health services and stabilizes the principles of the SUS and Primary Care. The nursing team is responsible for the unit in organizational principles of management and care, so it must be clarified about welcoming practices to ensure comprehensive and problem-solving care, in view of a relationship between the care provider and the being who receives the aforementioned practices, with their individual and collective needs met by the multiprofessional health team in search of a common goal (Oliveira et al., 2015).

In this context, welcoming is an opportunity to get to know the population to act on their real needs that are often not perceived in the first contact, through an established dialogue where trust



will be created based on the practice of care that will be evidently expressed. The execution should take place in all sectors of the unit through concrete daily situations, which will be revealed in the perspectives and intentions in the user's perception, as it is not only the professional who defines the health needs. The user has the power to define how important it is, and how relevant it is to him, taking into account that when opinions do not coincide, it is necessary that through knowledge in relation to the user, actions that translate into dissatisfaction, repeated returns, complaints and search for other services are identified. Practicing welcoming has the function of generating knowledge of each user, facilitating the daily service of the unit through the organization of teams, so that there is daily synchrony, increasing the satisfaction and confidence of users (BRASIL, 2013).

When a better contact with the professional team improves the condition of bond with the user, and that access to structured information makes this affection dispensed to the community be controlled in such a way that it does not harm the established bond, so that the user does not want to take it for his own benefit with obtaining advantages, which is indeed worrying because when the bonding situation is misunderstood, the user has a tendency to want a quick resolution in the way that suits him, not taking into account the professional conduct of the team in the unit. It is important that professionals and users are informed and prepared about user embracement, so that it is not a barrier preventing a healthy progress of the health service (Lopes et al., 2015).

Such practices in the unit aim to facilitate and improve the accessibility of the population, so not only bureaucratic rules will have to be discussed, these functions are not restricted to those who are at the reception, because the reception does not have a place destined to take place or an appointment with a specific professional. Points that hinder proximity and the creation of bonds should not be created, this will should come from the entire working team and managers, involving the population, as it demands the construction of synchronized actions aimed at transforming care by producing solidarity actions, adding individual and team values among professionals (BRASIL, 2013).

When identifying the needs of users, it is important to improve the techniques instituted, as priorities change and the community is also important, thus the importance of being with the team



reconciling what is urgent and necessary. In view of such needs, it is necessary to adopt the practice of welcoming, because what happens in the unit is very different from what is proposed. The service is focused on directing the user to a professional, organizing them in queues and delivering limited tickets, without knowing what brought the patient to the unit, not all people need to be referred for medical care, it is not necessary that the reception is limited to a medical screening (Oliveira et al., 2015).

One of the advances of the SUS and strengthening of the reception was the institution of the Community Agents Program (PACS), ensuring a more unrestricted access to health and favoring the creation of bonds, since the Community Health Agent (CHA) makes home visits to the family enrolled in the reference unit. The ACS is a member of the community, being a bridge between users and health professionals, establishing security and trust with the population and also as a member of the multiprofessional team. The activities developed by the ACS are based on the evolution of health promotion and prevention activities, working with a broad concept, engaging their professional commitment (Carli et al., 2024).

Listening is an important method to elaborate the construction of an organization that is satisfactory, affecting the refusals available in the unit to meet the needs of the community that seeks support in the health service, as it is a reference close to the daily reality. Welcoming also contributes so that, when the user's needs are exposed and the situation is understood, the appropriate service is offered, carrying out appropriate interventions, contributing to the reduction of harm. The team needs to expand and be concerned with these measures in order to do quality work, ensuring the continuity of care, thus contributing to the team as a whole having contact with the population in the area covered (BRASIL, 2013).

Medical consultations, nursing consultations and home visits are developed in the practice of care. There is a dialogue, user awareness about the prevention of the current disease and there is a large margin of programmatic activities based on the services offered in the unit and consultations scheduled daily by the team, and in these consultations an intervention based on the main complaint



and not on the individual as a whole is observed. It is worth mentioning that a qualified medical or nursing consultation is very different from what happens, it goes far beyond drug prescription and test requests, strengthening an archaic care model that does not meet the current needs of the population, contributing to the patient having an idea that a qualified consultation is summarized in the cure of the main complaint through drug prescription, and that if the professional does not meet the expectations of care and cure (Santos et al., 2018).

On the other hand, it is perceived that, as it is a process of daily construction, there is still much to improve in Primary Care with regard to humanized care for users and the practice of welcoming, which, in the team's judgment, is seen more as a task to be performed by a specific professional than as a structural practice related to the humanization performed by all professionals in the unit. It is important that the biopsychosocial needs of the user are perceived and that the practice centered on the main complaint is reformulated, offering a broad and active listening, strengthening the conceptions in which the humanization of care is established, ensuring a complete resolution of the case presented and greater responsibility with the users (Oliveira et al., 2015).

CONCLUSION

It is concluded that most professionals who work in primary health care have little understanding or are unaware of the guidelines of the National Humanization Policy and the adequate conception of user embracement. In many cases, the actions conceived as welcoming are carried out at a time determined in the morning shift by the community health agent initially and not by a multiprofessional team.

Most professionals consider user embracement as the screening of an acute complaint that will produce a privileged medical approach. This practice makes welcoming a punctual activity, directed to a spontaneous demand, not being developed through qualified listening. Thus, they should believe in the organization of user embracement as an indispensable practice to improve work management



in primary care, enabling more humanized and problem-solving care.

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