ORIGINAL ARTICLE

WORK PROCESS OF MANAGERS OF PRIMARY HEALTH CARE MANAGERS DURING THE COVID-19 PANDEMIC

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Highlights: (1) New flows for communication, avoiding agglomeration and the spread of Coronavirus. (2) Democratization of management, tensioned by hierarchies and advances in local participatory management. (3) Precarious working conditions and illness of frontline workers. (4) Weaknesses in care include the mischaracterization of comprehensive and longitudinal care.

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WORK PROCESS OF MANAGERS OF
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ABSTRACT

Objective: To understand the work process of Primary Health Care (PHC) managers during the COVID-19 pandemic. **Method:** A qualitative, descriptive-exploratory study with data collected through semi-structured interviews with 11 managers. Thematic content analysis was carried out based on the theoretical framework of the health work process and the psychodynamics of work. **Results:** Five thematic categories were constructed: 1. Production in action: reformulations of the service to maintain PHC as the gateway to the SUS, in which the managers pointed out the reformulation of the service to keep care in PHC; 2. New flows to serve users in the context of the pandemic in the healthcare network; 3. Democratization of management: participatory versus autocratic in planning and decision-making; 4. Precarious working conditions and the sickening of frontline workers; 5. Weaknesses imposed by the pandemic: mischaracterization of comprehensive and longitudinal care in PHC. **Conclusion:** The research made it possible to produce memories and learnings to understand the crossings in the work process of managers, between prescribed and actual work, and the objective and subjective aspects of this complex web of initiatives.

Keywords: Primary Health Care; COVID-19; Health Management; Unified Health System; Work.

INTRODUCTION

COVID-19 has tested the resilience of health systems worldwide, implying immediate adaptation in the work process to unexpected demands. This pandemic has had an impact, above all, on people management due to excessive workloads, lack of supplies, and shortage of personal protective equipment (PPE). It has also created the need for in-service education to update practices constantly through scientific evidence, proper use of PPE, and clinical management of users infected with SARS-CoV-2[1-2].

Primary Health Care (PHC) is considered a privileged place for actions to control and respond to endemics and pandemics due to its commitment to playing a significant role in the health response by identifying and screening potential cases, making early diagnoses, strengthening prevention and protection measures, and reducing the demand for hospital services.[3]

WORK PROCESS OF MANAGERS OF
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Health work processes have been significantly modified since the World Health Organization's (WHO) declaration of a global pandemic, from the first Brazilian case to its end. In the context of PHC, in the Brazilian Unified Health System (SUS), new guidelines and protocols were drawn up and disseminated as the pandemic progressed in all three spheres: municipal, state, and federal[4]. These actions directly impacted on all the Health Care Network (RAS) services. They required efforts to maintain existing services and lines of care and adaptation to meet the new ones related to COVID-19, control of the spread of the virus, and health education, among others.

Health management is the space workers' practice in the daily production and consumption of health services. In the light of the concept of the health work process, as an activity carried out for a specific purpose, it is possible to understand both the structural and operational aspects of work, and to adopt other conceptual contributions that allow us to analyze the changes in the world of work, above all to understand the subjective relationships that permeate its practices. In other words, the daily interactions in the field of micropolitics, in the meetings between managers, workers, and users, show relationships permeated by disputes and power[5]. It is understood that these approaches include the micropolitical and intersubjective dimensions, which are central to producing care.[5-6]

From this perspective, in addition to the constituent elements, it is necessary to consider that in health work, interaction between agents is a *sine qua non* condition of care, which translates into a space for exchanges to achieve the purpose of care, the satisfaction of health needs[7].

This understanding of working relationships can be based on the Dejourian approach, in which work is perceived as a specific form of personality involvement, a response to a task circumscribed by material and social pressures. Therefore, work is not just an activity of producing the objective world; it is a form of social relationship, made up of multiple subjective and objective determinations, in which what is prescribed is not always experienced.[8-9]

In this context, management makes it possible to achieve the purpose of the work in [7-10] spaces marked by tensions that highlight the logic of privatization and the precariousness of health work in public-private arrangements for financing and providing services. In this sense, research carried out during the COVID-19 pandemic identified differences in work processes. In the first year, PHC strategies were disorganized and focused on caring for COVID-19 positive cases; in the second year, routine activities were resumed, but with the expansion of

vaccination and the worsening socio-sanitary situation, there was an overload of work and increased tensions in interactions, with weaknesses in collective spaces and co-management.[10] Thus, managers work to provide the necessary resources for health care, achieve targets, and monitor indicators[11] to ensure direct care for users, mediating day-to-day relationships and interactions in the services, which go beyond these objectives and more challenging conditions. In this way, Dejours' theoretical constructions are relevant and contemporary for understanding work relationships in this neoliberal context, in which subjectivity is often suppressed in the name of productivity and competitiveness.[8-9,12]

Dejours's thesis is that the relevance of work lies in complex reasons that require scientific and philosophical reflection. After all, when doing work, workers relate to the world, others, and themselves in a way that affects their lives, fears, and hopes[12].

Thus, by exploring the work process of PHC managers during the Covid-19 pandemic, it is possible to analyze the actions carried out to organize the service to implement public policies in an emergency, considering both the perspective of objective relations, inherent to management, but also the interaction of people, the subjectivities present, pressures and unequal relations, which conflict in the dynamics and strain the manager's work process. Furthermore, by analyzing health work from the perspective of local managers, the aim is to create evidence that will allow us to be better prepared for future health crises.

Given the limited evidence on this subject, the study sought to answer the following questions: How has the COVID-19 pandemic influenced the actions taken by local PHC management in the SUS? How have the emergency measures adopted to combat the Coronavirus affected the work process of these managers? The objective was to understand the work process, actions, and perceptions of health management in PHC in the context of the COVID-19 pandemic.

METHODOLOGY

This qualitative, descriptive-exploratory study is suitable for investigating social phenomena that include relationships between subjects, singularities, meanings, and intersubjectivity[13]. The Consolidated Criteria for Reporting Qualitative Research (COREQ) were adopted to disseminate the results[14].

The research was carried out in 25 PHC services in a regional health center in a city in São Paulo. The location was chosen due to the increasing notifications of confirmed cases and

deaths from COVID-19 in epidemiological bulletins made available by the Municipal Health Department (SMS) since April 2020[15].

The participants were 11 managers from the regional health territory, responsible for health services with 535,402 inhabitants, who met the inclusion criteria: having been a manager for at least one year and having participated in the organization of the service since the declaration of the COVID-19 pandemic in the municipality in March 2020. Managers away from work during data collection were excluded.

The first invitation to the service was made by telephone. Subsequently, an invitation was sent to the email address provided by the manager and, if they accepted, a virtual interview was scheduled, guided by a semi-structured script, with questions identifying the interviewees and the work of PHC managers in the context of the COVID-19 pandemic. Each manager was contacted, and after 11 interviews with those managers who had voluntarily consented to participate in the data collection, data saturation was reached, i.e., the interviews were concluded when no new information about the researched object was presented[16].

The interviews took place between August and September 2021 using Google Meet and were conducted by one of the researchers after consent had been given in the Free and Informed Consent Form (FICF). They were audio-recorded, lasting an average of 30 minutes, totaling five hours and 43 minutes of recording, and stored on protected access *hardware*. The audios were transcribed in full by an outsourced professional, and the interviews were randomly coded by the word 'Manager', followed by a sequential number to guarantee the confidentiality and anonymity of the participants.

Thematic content analysis was carried out so that the meanings linked to the objective and systematic description of the content were extracted and interpreted, firstly, with a floating reading of the interviews, for individual analysis of the nuclei of meaning, followed by pre-analysis, exploration of the material, vertical, horizontal and transversal analysis to identify similarities and contradictions, in the light of the theoretical framework[13].

In the interpretative analysis, we looked for approximations with the psychodynamics of work and reflections to highlight the more complex reasons that permeated the actions carried out by PHC managers during the COVID-19 pandemic, between the prescribed and the effective.

The research was approved by the Research Ethics Committee (CEP, in Portuguese), under protocol number 4.743.539, and authorized by the technical health supervision. The

recommendations of Circular Letter No. 1 of 2021 of the National Research Ethics Committee[17] and Resolution 510 of 2016 were followed.

RESULTS AND DISCUSSION

Eleven managers, two male and nine female, aged between 31 and 52, with an average age of 35, took part in the study. Seven were nurses, and the others were speech therapists, psychologists, hospital administrators, and dentists. All had at least one specialization. They worked in PHC for between one and 12 years, with an average of six years. The employment relationship was exclusive to a Social Health Organization (SHO) that managed the UBS.

Five thematic categories were constructed, presented in Chart 1, and discussed sequentially in analyzing the empirical material.

1. Production in action: service reformulations to maintain PHC as the gateway to the SUS.
2. New flows to assist users in the context of the pandemic in the RAS.
3. Democratization of participatory versus autocratic management in planning and decision-making.
4. Precarious working conditions and the illness of frontline workers.
5. Weaknesses imposed by the pandemic: mischaracterization of comprehensive and longitudinal care in PHC.

Chart 1. Thematic categories of the actions and perceptions of PHC service managers in the context of the Covid-19 pandemic. São Carlos, 2024. Source: elaborated by the authors.

Production in action: service reformulations to maintain PHC as the gateway to the SUS

The unpredictability aggravated by the pandemic and the need to guarantee safe access to health care required reorganizing the work process, creating and redesigning flows, routines and new communication strategies between workers to avoid crowds and contain the spread of the SARS-CoV-2 virus. The managers spoke about the measures to control COVID-19 so as not to jeopardize care for the population, considering BHU as the gateway to the network, comprehensive and longitudinal care, as shown in the excerpt:

> (...) the actions involved restructuring and structuring the work processes, coordinating these processes with the team, coordinating and organizing patient care, and the regulatory processes so patients who need specialized treatment don't lose out. They don't have access to these services (Manager) 10).

The first thing that stands out about this finding is the recognition of managers' efforts to solve tasks that affect the community and the technical value of the work carried out in reorganizing the work process[12].

This result is similar to that described in another study since PHC teams continued to address users' health problems during the pandemic, adapting to the social distancing measures imposed. The number of people in the environments and guiding the self-isolation of confirmed cases and contacts[2]. The managers highlighted the maintenance of some strategies already carried out in PHC in the face-to-face format, home care, meetings between managers, the Management Council, and matrix support for the Family Health Strategy (FHS) teams, according to excerpts:

> For bedridden patients restricted to their home, the care actions were discussed at a team meeting, and then the CHA [Community Health Agent] would go and report what they needed to the family (Manager 1).

> We even maintained matrix support and the network meetings with mental health, And then we maintained this articulation with the network, even with the Management Council, which I consider a fundamental network. So, communication was maintained here at [name of UBS] and at [name of other UBS]. I kept these face-to-face meetings because we had spaces to maintain distance (Manager 7).

A recent study on UBS's responsiveness showed that the company needed to readjust its physical structure, provide PPE, conduct COVID-19 tests, actively search for users with suspected COVID-19 through phone or home visits, monitor transfer flows in the RAS, and provide telehealth[18].

Therefore, PHC flows were reformulated. This reformulation guaranteed that the health needs of the managers interviewed would continue to be met based on priority lines of care and spontaneous demands.

Above all, there was a commitment to access to health for the territory's population, guaranteeing care. As a critical reflective study highlights, in the health work process, workers, including managers, must transform methods, roles, responsibilities, and relationships with staff and users from an innovative and adaptive perspective related to the complex daily routine of health care[19].

It is noteworthy that in the face of the pandemic, the actions of managers have been directed towards PHC as a gateway, community and home care, matrix support for FHS teams,

network management, and maintenance of the Management Council. However, new strategies have been adopted, such as telehealth and remote meetings between professionals, reinforcing that caring for the territory's population involves bodily and mental efforts for a good purpose, apart from the pleasure directly derived from this activity. From the perspective of the conception of work as an activity, fundamentally, organizations comply with partially determined rules. In this sense, the reorganization of work to maintain the service corresponds to the search to carry out the prescribed work in the face of the adversities imposed by the pandemic[12].

New flows to assist users in the context of the pandemic in the HCN

The managers emphasized the need to build new flows of care for SARS-CoV-2-positive users and symptomatic workers in the units and their respective referrals in the network:

> (...) Together with the other managers, I set up all the flows (...) for this respiratory symptomatic population, how we were going to provide this care, and the flow of care for employees (...) with respiratory symptoms. I also set up how this user was going to move through this network (Manager 5).

> (...) This issue involves ensuring that professionals are safe, doing everything within the protocol and what is required, and guaranteeing care for those (patients) who most need monitoring (Manager 11).

It is understood that recommendations, regulations, processes, and codes - the prescribed organization - are essential in health work, but there is more to the job. The individual work of these managers can be recognized in the effort to make their contributions viable, and their know-how, knowledge, and skills can be translated into new workflows[8]. As Dejours points out: "for the work process to work, it is necessary to readjust the prescriptions and fine-tune the actual organization of work, which is different from the prescribed organization"[8:p.32].

When these effective work initiatives are efficient, they result in rules and collective agreements[8]. However, they can also express task overload, pressures imposed by new flows, the overvaluation of technical skills in work management, and therefore of people and their resources[20].

The population and the health team do not always know the flows accumulated in the RAS. Another difficulty reported by managers in implementing these flows was infodemics, divergent sources of information, and gaps in technical details, as shown in the excerpt:

> (...) Several communications within the unit (...) made it very difficult and caused many problems with the patient. And then we listed some actions that we considered to be strategic actions to reorganize the unit, which is to redo the flows, reorganize the flows and routines, build, would be to train all the professionals to have something standardized and thus make everyone understand the organization of the service, the network, how it works, so that we could also, at the same time, raise awareness and, in a way, educate the patients (Manager 10).

Fake news has invaded social media during the COVID-19 pandemic, a distressing situation because it has damaged users' trust in SUS services and health programs[21]. In managers' perception, this infodemic has even interfered with the organization of services and the work carried out by workers. To overcome it, educational actions and media campaigns were needed.

When people work in an organization, they follow the rules established by that organization, but there is an interpretative dimension to the rules. After all, even technical rules require mediation for someone to apply them to a specific case[12]. For this reason, some rules and their interpretations had to be revised during the pandemic to make them familiar to all.

Even intellectual work requires techniques to deliver a "product". In other words, given a demand, workers use their physical, cognitive, emotional, and spiritual resources to respond to it. However, the technical nature of the work does mobilize the subjective life of the worker[12]. The results suggest that managers recognize the need for technical and scientific training.

In comparison, the lack of technical updating can lead to job security. A national survey indicated that almost half of health professionals lacked training during the pandemic, with 17.7% seeking information independently.[22] This reinforces the need for managers to establish prescribed rules regarding technical and scientific updating in Continuing Education and Permanent Health Education spaces to fulfill their organizational role.

The managers emphasized that the development of strategies to deal with COVID-19 required coordinated actions between health services in the HCN, with support from Health Surveillance, as well as intersectoral actions to support the BHU and the territory:

> (...) The supervision helped us design and direct this type of work at various times. We received support from the surveillance staff because we were more committed to ILPIs [Long Term Care Institutions for the Elderly]. We are also the unit with the most ILPIs in the territory (Manager 8).

A COVID-19 crisis of this magnitude can stimulate some people's willingness to cooperate[23], so the manager's presence can favor collaboration between different RAS services, as the results show. However, the intention to collaborate may not be enough to maintain teamwork and coordination of care due to the stress generated by the pandemic, and it is necessary to establish commitments and partnerships. For Dejours, "cooperation presupposes a commitment that is at the same time always technical and social. This has to do with the fact that working is not only about producing it is also, and always, about living together."[8:p.32].

Other new flows adopted in the work process to ensure that the population's demands are met, highlighted by managers, were telehealth, telephone monitoring, and remote team meetings, considered a novelty generated by the COVID-19 pandemic, according to excerpts:

> It's a key strategy and the network's involvement in the sense that we can take the cases to them via teleservice since it's no longer possible to hold those meetings (Manager 4).

> So, I think the technology strategy was perfect. We had the challenge of the units not being prepared for this time of remote work and holding remote meetings. Today, we're here talking on video, me looking at you and vice versa, but it wasn't always like that. We sometimes had to stand there using our cell phones (Manager10).

Despite being a powerful tool for promoting access to health services, telehealth can become exclusionary[24] by disregarding existing digital inequalities for workers and users. This aspect deserves caution for services when adopting this tool, as it can detract from the purpose of this work, which is to meet users' health needs.

Democratization of management: participatory versus autocratic in planning and decision-making

Regarding decision-making, there were differences in the perception of planning. Some managers indicated that their actions were guided by hierarchical and autocratic decisions made by the upper levels of management, while others suggested that decisions were made collectively. In the latter case, they used strategic planning as an instrument of the work process. However, it is indicated for scenarios of constant change. However, they faced difficulties in implementing it, according to the excerpt:

> You also work only on an urgent basis, “it's for now”, “it's for two hours from now”, “it's for the end of the afternoon”, which makes our work very difficult (...) It's usually data or situations in which we know we could wait a little longer (Manager 6).

It's worth noting that the managers had a dual relationship, apparently under pressure from upper management, while at the same time trying not to reproduce the pressure suffered by the service teams. As participants in the collective action of the work process, they expect work to be organized not just based on technical rules and arbitrary management decisions but on reasonable rules. To be reasonable, it is essential that these rules can be corrected by the people whose actions are regulated by them[12]. Although the managers expected reasonableness from senior management, this was not always the case.

> I think a very positive strategy we had was that we formed a group; there was me, a nurse, a dentist, a doctor, a CHA [Community Health Agent], a [nursing] assistant, and we would sit down and talk every week like, “Last week was like this. We would look at the data on how the service was, how much we had, what demanded the most, if we had many removals, if we didn't, even if there was a trend towards an increase, an increase in the number of cases or hospitalizations. Why? We tried to plan at least ten, fifteen days ahead (Manager 6).

> So, as I said, we are coordinating the team and restructuring the work processes in the face of constant changes because many ordinances come and go all the time. Then we have the task of updating the team that is here (...) because you build a plan together with them [workers], but you must review that plan all the time (Manager 10).

The participatory management mentioned by the interviewees as a process of shared decision-making is close to the model of co-management[10] and shared leadership, evidence of which indicates improvements in teamwork relations and workers' well-being[25]. On the other hand, a study that analyzed the care offered by PHC in the city of Campinas-São Paulo, during the COVID-19 pandemic, from the perspective of the workers, identified that the spaces for co-management and meetings that were previously present were replaced by vertical conducts, with little communication and a praxis under construction in the municipality[10]. In this study, the managers noticed that planning was disrupted during COVID-19. It is worth remembering that a pandemic is characterized as a rapidly evolving crisis scenario, in which researchers, managers and health professionals are constantly discovering, learning and contributing to dynamic adjustments in government policies and this is reflected as a vortex of information in the practice of managers[21], especially when there is no alignment between the federative entities, which implies weaker relations, which affects care[10].

In the work process of PHC managers, there is management of physical resources, inputs, processes, personnel and results, as well as acting as mediators of public policies; after all, it is through management that the principles of the SUS and public health policies are consolidated, to a greater or lesser extent. During the pandemic, these managers have faced multiple crossings, as health is a space of "networks, plots, disputes and tensions that are being operated in the country in the face of the COVID-19 pandemic"[26:p.1]. Despite the crossings mentioned by the interviewees, the findings show that participatory management and the managers' experience with action planning were facilitating aspects.

A study carried out with SUS managers shows that, even in the face of the limiting factors faced, mobilizing aspects, such as the importance of solidarity, empathy, and sharing the actions experienced in health services during the pandemic, were possible to identify, fundamental elements for strengthening the commitment made in defense of life, the population, and the Brazilian health system itself[27].

Precarious working conditions and the sickening of frontline workers

In the interviews, the managers emphasized that the pandemic exacerbated worker illness. When dealing with COVID-19, part of the manager's work process was to manage the sickness and absence of workers, as shown in the excerpts:

> So, the employees took time off because of back pain, headaches, the death of a close relative, and tiredness itself because we worked from Monday to Saturday, and some professionals worked up to twelve hours (...). I must maintain all the other organizations in the units, and often... I work in a large unit, and HR [human resources] is reduced due to sick leave and absences. Occasionally, some professionals are absent because they provide support elsewhere (Manager 7).

> I think this question of direction, of HR, is a big challenge, as is workers' health. Some professionals are sick, tired, and overworked (Manager 2).

Work impacts people, to a greater or lesser degree, both personally and collectively. It consists of what we do as a form of activity, which takes up most of most people's lives[12]. The workers' illness was perceived because of working on the front line, the increased workload

generated by the COVID-19 pandemic, and the suffering related to the loss of family members and colleagues during this period.

It is reinforced that in health work, "the 'caring' attitude needs to expand to the totality of reflections and interventions in the health field, to consider both the caring agent and the subject of care"[19:p.198]. An essential part of the manager's role is to care for the population, but also for those who care, according to excerpts:

> Honestly, dealing with spreadsheets, with the logistics of supplies, vaccines, and tests, is our routine. We know how to work; we know how to do it. If you take my team here and say: "We're going to do this now. Let's go", we're vaccinating over five hundred people a day, we'll do it. The hard part is doing this with sad people, with sick people, with sick people, that's the most significant challenge, doing everything we're doing and still having to deal with the whole context of bereavement (Manager 6).

> Reflecting also on the finitude of life itself, the issue of bereavement is also important because many employees have lost relatives, including me, losing a 47-year-old brother-in-law to COVID-19. So, this somehow impacts our behavior and how we do things. At the same time, we feel powerless. There were moments when I felt mentally tired. So, all of this has impacted some way (Manager 10).

Dejours and colleagues[12] point out that the effort required at work is not limited to the intellectual but includes the physical and emotional. Human beings cannot be separated into physical, intellectual, and emotional parts. Although it is possible to distinguish, to a certain extent, between mental, physical, and emotional fatigue, fatigue affects the whole person.

Research carried out with Belgian health workers in various settings, including PHC, identified that symptoms impacting mental health, such as stress, fatigue, fear, unhappiness, and discouragement, were significantly more pronounced during COVID-19 compared to the period before the pandemic[28]. Engaging and supporting workers should be one of the priorities for managers to strengthen PHC in pandemic situations, and it involves access to appropriate mental health care and support[29].

The findings of this research corroborate the interpretation of a recent study, which highlighted that the COVID-19 pandemic has affected public health due to the rapid spread of the virus. This has resulted in an abrupt change in care practices in health services, directly impacting the health of care teams due to the contamination and illness of professionals involved in care[30].

The interviewees reported concern about the overload and illness of workers, beyond controlling the number of staff, intending to strengthen the team, collaboration and care of these workers:

> The interviewees reported concern about workers' overload and illness. Beyond controlling the number of staff, we need to strengthen the team, collaboration, and care for these workers: We perceive a certain sickening of some professionals. Here at the unit, we lost an employee to COVID-19 right at the start of the pandemic, and the manager has this role of supporting the team, providing this support so that the processes don't stop either (Manager 2).

> (...) As a manager, I feel fear among all the professionals. You also had to find a way to make the team feel safe, to do everything within the protocol so that they felt that safety, that they were welcomed, that they could verbalize, and that at the end of the day, we could hug each other and say: "Come on, we're going the right way". We should encourage each other because it seemed that when I left home on the first day of lockdown, I had the feeling that I was going to war. (Manager 11).

It is noteworthy that in a survey carried out on the working conditions of Brazilian health professionals in the context of Covid-19, when asked about the work environment, just over half, 55.9%, felt protected from falling ill with Covid-19, and almost 60% reported not having received institutional support[22].

The underfunding of the SUS and the precarious working conditions that were already underway even before the COVID-19 pandemic may have contributed to worsening the health conditions of PHC workers and, consequently, the quality of care. A national study indicated that the weaknesses present in health work conditions caused tensions for SUS managers, as vulnerability to the system's underfunding, coupled with lawsuits blaming them for needs not being met due to systemic causes, was a determining factor in some managers asking to be relieved of their positions[27].

Weaknesses imposed by the pandemic: de-characterization of comprehensive and longitudinal care in PHC

From the perspective of the managers, the pandemic resulted in an increased workload within PHC, as it became necessary to maintain routine care while simultaneously responding to the demands of the COVID-19 pandemic. This combination, according to the managers, led to a perceived decline in the quality of care, compromising essential characteristics of the FHS

and PHC—such as comprehensive and longitudinal care—and transforming PHC into a form of urgent care service, as evidenced in the following excerpts:

> It directly affected the functioning of the entire health unit—it wasn't just my work. My job as a manager remained the same in essence: managing a health service. However, what changed was that we truly lost some of the key characteristics of the Family Health Strategy, of care itself, and of the established care pathways. (Manager 6)

> Professionals working within the FHS generally appreciate the distinctiveness of the approach and the closer relationships it fosters—something that is no longer present. Nowadays, we've essentially become a mini emergency service: complaint/action, complaint/action, while trying to find ways to prevent the population from being left without care. I believe these are two major challenges: the loss of the service's defining characteristics due to the pandemic. (Manager 7)

For the managers, the pandemic increased the demand for work in PHC since it was necessary to maintain care while coping with COVID-19. This equation caused, in the perception of these managers, a decrease in the quality of care, with damage to the characteristics of the FHS, PHC, and comprehensive and longitudinal care, transforming PHC into emergency care, according to the excerpts:

> Look, it directly affected the functioning of the unit. It wasn't just my job; my job of managing is still a job of managing a health service, but with a difference in that we lost some characteristics of the FHS, of care, of the lines of care (Manager 6).

> The professional who works in this area of the ESF likes this differentiation and closeness, which we don't have nowadays. We've become a mini ER [Emergency Room], complaint/conduct, and other things we can do to avoid leaving the population unattended. So, I think these two challenges are the mischaracterization of the service due to the pandemic (Manager 7).

Other weaknesses stemmed from the difficulty of planning for the high-demand and insufficient material and personnel resources, with dissatisfaction among users and workers, according to excerpts:

> So, the number of ombudsmen has increased, and we must always respond (Manager 1).

> One of the things that makes it very difficult for us is a lack of material, supplies, medication, or whatever it may be. A lack is always a problem because you see a staircase of issues from the lack. The lack generates differentiated control, and then it generates a complaint. It generates a lack of assistance, which creates

> dissatisfaction and irritability for both the user and the employee because both sides end up being stressed by this lack. This isn't very pleasant for the manager. Lack of input, medication, and essential materials is a big problem (Manager 6).

It is understood that the fatigue and tiredness perceived at work stems, to a certain extent, from doing something that is not directly related to the pleasure derived from [it12]. In this sense, the managers recognized that the dynamics of their work did not meet their subjective needs to feel fulfilled, with self-esteem for what they delivered, generating dissatisfaction for themselves and others. It is noteworthy that the impacts caused by the COVID-19 pandemic on the physical and mental health of health workers were due to the work environment and pandemic conditions. Although the health needs of frontline workers were a concern for managers, there was a lack of policies related to workers' health by macro-management[31].

Managers also reported difficulties in managing in the context of the pandemic, process overload, lack of experience in the face of the crisis due to the exceptionalities of COVID-19, little technical knowledge available in time to make decisions, and persistent demands for productivity. The lack of materials and the excessive workload contributed to the perception of suffering, but these go beyond the individual governability of these managers. Objectivity and management are evoked by objectivity, especially in quantitative work evaluations. Although productivity allows it to grow, it compromises the subjective space of life at work, which can lead to illness[8]. The excerpt reinforces this interpretation:

> (...) I spent a week with my daughter in the ICU [Intensive Care Unit], my four-year-old daughter, and I got a call like “Get organized because your filometer has to be on time”, and I didn't have a problem with the filometer (...) And there I was in the ICU getting this call: “Get organized. You're there, but the service doesn't stop.” I said: ”My God, I'm a number. I'm a little doll in the game”. So, I treat my neighbor as a human being, but I can't demand that someone treat me the same. (Manager 3).

About feelings of suffering, the challenges perceived by managers, as explained in the last excerpt, were a subjective manifestation related to health work during the COVID-19 pandemic. It is worth remembering that when a relentless pursuit emphasizes individualism, productivity, and competitiveness, work generates suffering, frustration, and a sense of injustice, which destroy subjectivity and, consequently, mental health. There is no distinction between the “work environment” and the “environment outside of work” or problems that can be restricted to these two spaces because psychological functioning is inseparable[8].

In the same vein as these findings, study[32] points out that during the pandemic, managers focused their attention on the physical health of the population and on combating the infectious agent, and the implications for mental health often did not receive due attention, an aspect common to both users and workers.

The findings corroborate those of study[33] that identified elements that increase the workload of managers in the FHS: insufficient structure, materials, finances, and personnel; difficulties in planning for unexpected demands; problems with other management bodies; and burdens that appear as organizational violence for the service manager in the interface with different bodies. As a result, it wasn't easy to operationalize PHC attributes such as first contact care, longitudinally, comprehensiveness, and coordination of care.

The results reinforce that PHC managers face numerous challenges in meeting users' health needs in a territory, especially regarding the attributes expected of PHC services. These are generally related to the severe restriction of health funding.

In the Brazilian case, PHC has been undergoing an accelerated process of deconstruction of its original proposal since 2016, with influences from outside the health field itself, such as economic neoliberalism[34]. The perception of loss of quality of care reported by the managers, the mischaracterization of the principles of PHC, the lack of material resources and professionals, and the demand for productivity can be understood not only because of the COVID-19 pandemic. However, this may have exacerbated it, but also because of a broader context of dismantling the health system.

Notably, these managers have not addressed the difficulties arising from the increase in inequities, poverty, vulnerabilities, and comorbidities of users with a predisposition to COVID-19, considering the social determinants of health[2]. After the pandemic, it is necessary to analyze the organization of health systems carefully, identifying organizational weaknesses to achieve more integrated and resilient healthcare and management models [35]. In the case of this research, the objective aspects of the organization of health work affected subjectivities, generating suffering and illness perceived by managers and experienced by all workers.

The findings identified the relevance of managers' actions in dealing with COVID-19 to ensure PHC as the gateway to the RAS, offering services during the pandemic and emphasizing their commitment to the population and the SUS. Through the reports analyzed, it was possible to understand the actions and concerns arising from the work to achieve health care for users and workers. However, the challenges were often related to a lack of resources,

staffing levels, overload, and demands for productivity from senior management, which prevented them from reverberating in terms of safety and quality of care for the population and the workers.

Although the challenges highlighted come from managers' perceptions, these aspects can be related to macro-structural issues, such as economic neoliberalism and the underfunding of the SUS. This research's findings point to the importance of proactive policies that anticipate crises of the COVID-19 pandemic, especially from the perspective of people management and the subjective aspects inherent in health care and workers' health.

The research's limitations may be related to the fact that it does not reflect the totality of managers, who in other PHC contexts may have experienced the COVID-19 pandemic differently, and the fact that the data was collected at a specific time during the COVID-19 pandemic.

FINAL CONSIDERATIONS

The research enabled us to understand the work process of PHC managers, their actions, and their perceptions in the context of the COVID-19 pandemic, through the lens of the psychodynamics of work.

In the managers' perception, coordinating services while meeting the various health needs is between the prescribed and the effective. The actions carried out and coordinated by the managers involved a web of initiatives, constantly needing to reformulate the services' actions and define new flows to meet the population's needs.

In this process, the democratization of management recognized as a facilitator was not always possible, oscillating between participatory and autocratic actions. The challenges perceived by managers highlighted the illness of frontline workers and the precariousness of working conditions. Concerning the weaknesses imposed by the pandemic, there was a mischaracterization of the care provided in PHC, damaging the integrality and longitudinally of care. In this sense, the reports produced by the managers in this research highlight the need to problematize their work during the pandemic, recognize their efforts, and make memories and learnings that could contribute to future health, social, and humanitarian emergencies.

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