

## UNIVERSALIDADE DO ACESSO E ACESSIBILIDADE NO QUOTIDIANO DA ATENÇÃO PRIMÁRIA: VIVÊNCIAS DE USUÁRIOS DO SUS

### UNIVERSALITY OF ACCESS AND ACCESSIBILITY IN THE DAILY CARE OF PRIMARY CARE: SUS USER EXPERIENCES

### UNIVERSALIDAD DEL ACCESO Y ACCESIBILIDAD EN EL COTIDIANO DE LA ATENCIÓN PRIMARIA: VIVENCIAS DE USUARIOS DEL SUS

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#### RESUMO

**Objetivo:** Compreender o acesso e a acessibilidade à saúde na perspectiva de usuários, em atendimento à demanda espontânea em unidades de Atenção Primária à Saúde (APS). **Métodos:** Estudo de Casos Múltiplos Holístico-qualitativo, fundamentado na Sociologia Compreensiva do Quotidiano com 60 participantes, em município de grande porte de Minas Gerais. **Resultados:** Revelam a Saúde como uma questão de luta no cotidiano da APS, destacando as dificuldades enfrentadas pelos usuários do Sistema Único de Saúde (SUS), no que concerne o acesso aos serviços, ações, exames e medicamentos. Denotam a desorganização administrativa e morosidade do Sistema, a questão política, a judicialização. A situação contemporânea do SUS foi questionada: o que precisa no SUS? **Conclusão:** A realidade vivenciada pelos usuários indica que ainda não foi alcançada a idealização de um Sistema universal, equânime e integral. Ademais, a pesquisa possibilitou reflexões de todos os atores envolvidos, usuários, profissionais de saúde e gestores, sobre o exercício da participação social no SUS e a formação de sujeitos proativos na tomada de decisões políticas para o cumprimento e vigor das legislações que implementam o SUS.

**Descritores:** Acesso aos serviços de saúde; Universalização da saúde; Atenção Primária à Saúde; Necessidades e demandas de serviços de saúde; Sistema Único de Saúde.

#### ABSTRACT

**Objective:** To understand the accessibility to health from the perspective of users in response to spontaneous demand in Primary Health Care (PHC) units. **Methods:** Holistic-qualitative Multiple Case Study based on Quotidian Comprehensive Sociology with 60 participants, in a large municipality of Minas Gerais. **Results:** They reveal Health as a matter of struggle in the daily life of PHC, highlighting the difficulties faced by users of the Brazilian Unified Health System (SUS) regarding access to services, actions, exams and medications. They denote the administrative disorganization and slowness of the System; political issues; and judicialization. The contemporary SUS situation was questioned: what do you need from SUS? **Conclusion:** The reality experienced by users indicates that the idealization of a universal, equitable and integral system has not yet been achieved. Furthermore, the research allowed reflections of all users, health professionals and managers on the exercise of social participation in SUS and the formation of proactive subjects in making political decisions for the compliance and vigor of the laws that implement SUS.

**Descriptors:** Health services accessibility; Universalization of health; Primary Health Care; Health needs and demands; Unified Health System.

#### RESUMEN

**Objetivo:** Comprender el acceso y la accesibilidad a la salud en la perspectiva de los usuarios, en respuesta a la demanda espontánea en unidades de Atención Primaria a la Salud (APS). **Métodos:** Estudio de Casos Múltiples Holístico-cualitativo, fundamentado en la Sociología Comprensiva del Quotidiano con 60 participantes, en municipio de gran porte de Minas Gerais. **Resultados:** Revelan la Salud como una cuestión de lucha en el cotidiano de la APS, destacando las dificultades enfrentadas por los usuarios del Sistema Único de Salud (SUS) en lo que concierne al acceso a los servicios, acciones, exámenes y medicamentos. Denota la desorganización administrativa y la morosidad del sistema; la cuestión política; la judicialización. La situación contemporánea del SUS fue cuestionada: ¿qué necesita en el SUS? **Conclusión:** La realidad experimentada por los usuarios indica que la idealización de un sistema universal, equitativo e integral aún no se ha logrado. Además, la investigación permitió reflexionar sobre todos los actores involucrados, usuarios, profesionales de la salud y gerentes, sobre el ejercicio de la participación social en el SUS y la formación de sujetos proactivos en la toma de decisiones políticas para el cumplimiento y el vigor de las leyes que implementan el SUS.

**Descriptorios:** Accesibilidad a los servicios de salud; Universalización de la Salud; Atención Primaria de Salud; Necesidades y demandas de servicios de salud; Sistema Único de Salud.

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## INTRODUCTION

The 1988 Constitution of the Federative Republic of Brazil instituted the Unified Health System (UHS), to ensure the guarantee of universal access to health as a duty of the State, arguably the greatest social achievement of the Brazilian population. However, more than 30 years after the implementation of UHS, important challenges remain to guarantee the right to health in the country<sup>(1)</sup>.

Considering the materialization of health as a right that belongs to all<sup>(2)</sup>, and the construction of the Universal Access System, the reorganization of Primary Health Care in Brazil, occurred with the creation of the Family Health Program (FHP), in 1994, incorporating the previous experience of the Community Agents Program, initiated in 1991, transformed into a national strategy by the National Primary Care Policy (NPCP), in 2006<sup>(3)</sup>, the Family Health Strategy (FHS).

In 2017, the NPCP is revised by Ordinance No. 2436, of September 21, 2017, which considers the terms Primary Care and Primary Health Care as equivalent terms, in order to associate both the same principles and guidelines of this level of health care. Thus, PHC is defined as “the set of individual, family and collective health actions that involve promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance, developed through integrated care practices and qualified management, carried out with multidisciplinary team aimed at the population in a defined territory, over which teams assume health responsibility”<sup>(4)</sup>.

PHC/ FHS as the preferred port for the user and family, is present in 5,477 municipalities of the 5,570 existing in Brazil<sup>(5)</sup>, offering all citizens their own and essential actions and services, without any exclusion, with universal, comprehensive, equitable access, adapted to the health needs of their individuals-families-community in its multiple realities, considering the determinants and conditions of health. It is the communication center of the Health Care Network (HCN), care coordinator and organizer of the actions and services available in the HCN<sup>(4)</sup>.

However, “it is not enough to apprehend the living conditions and needs of users and families. It is necessary that the population has access to a System with integral actions as a right”<sup>(2)</sup>.

Access to health involves the availability of resources and services, acceptability, which is a

motivating factor for the preference for the service because it provides the achievement of its objectives, that is, the resolute response to the need, contemplating accessibility<sup>(6)</sup>.

Although PHC constitutes a gateway to the System, the priority, attendance, in its majority, arises from spontaneous demand, based on the individual needs of users, since the interests are generally for medical consultations, referrals to specialties and distribution of medicines. In spontaneous demand, the individual seeks health services unexpectedly, aiming at access and resolution of what they seek. “It is believed that by allowing free access of spontaneous demand to PHC, especially in the case of chronic diseases that require continuous treatment, the effectiveness of care and the bond may be compromised, as users turn to PHC units aiming at punctual care, confronting the control of acute illness situations with health promotion strategies in chronic diseases, proposed by this level of care”<sup>(7)</sup>.

With the expansion of the PHC / FHS, over the past 30 years of UHS, access to medical consultations and reduction of hospitalizations for conditions sensitive to this scope of care has expanded. However, “despite advances in population coverage, significant challenges still remain for the continuity of UHS and the improvement of the quality of care: supply and quality of services, underfunding and public-private relations”<sup>(8)</sup>.

We have a public UHS, with insufficient and inadequate funding for its tasks. “Although UHS is exclusively responsible for serving 75% of the population, it does so with about 46% of the sector's resources”<sup>(9)</sup>. In addition, the entire population is assisted by UHS, even users who, in care, prefer to resort to health plans, as UHS does not only develop actions related to health care, but also health surveillance, epidemiological surveillance, vaccination, among others<sup>(10)</sup>.

When addressing user access and accessibility in PHC daily life, one can understand everyday life as the “way of living on a daily basis, expressed by their interactions, beliefs, values, symbols, meanings, images and imagery that outline their process of living punctuating their life cycle”<sup>(11)</sup>. However, this “journey through the life cycle has a certain cadence that characterizes their way of living influenced, both by their duty to be and by their daily needs and desires, which is called the rhythm of life and living. Thus, the daily life is not only shown as a scenario, but, above all, it reveals both the scenes of living and living

together"<sup>(12)</sup>. Thus, "everyday life is the object of study in the different scenarios of research in Nursing and Health, not only as a synonym for day to day, but also, as an expression of a way of living in a certain context"<sup>(12)</sup>. Thus, this study is justified, considering the universality of access and accessibility in the daily experiences of users in PHC.

Considering the daily life of PHC in the face of spontaneous demand from users, the question is: How is access and accessibility to health established, from the perspective of users in care in spontaneous demand in the daily life of PHC?

This article aimed to understand access and accessibility to health from the perspective of users, in response to spontaneous demand in PHC units.

## METHODS

This is a Holistic-qualitative Multiple Case Study<sup>(13)</sup>, based on Michel Maffesoli's Quotidian Comprehensive Sociology<sup>(14)</sup>.

The Holistic Multiple Case Study enables the social investigation of the empirical reality of a real life context, preserving the totality and the unitary character of the studied phenomenon<sup>(13)</sup>. The scenario of this study included five units of traditional PHC, without FHS teams, and five units with FHS teams, complying with the data collection criterion until data saturation, defined by random drawing of the 43 PHC units from the urban region of a large municipality in Minas Gerais, Brazil (32 from FHS and 11 from traditional PHC). Data saturation occurred in the 60th interviewed participant, by literal replication<sup>(13)</sup>. Thus, these are two cases that contemplate different realities due to the form of team composition and organization of daily work in the context of PHC. Each case involved an empirical and "complete" investigation<sup>(13)</sup> contemporary phenomenon within the context of real life, in which convergent or divergent evidence was sought, with respect to the facts and conclusions for the cases<sup>(13)</sup>. This study, for being holistic, had as a single unit of analysis, for both cases: "access, accessibility and spontaneous demand in the daily life of PHC".

In the municipality where the study was carried out, 64 public health establishments are accounted for providing services in 11 traditional PHC Units, 32 ESF teams, one Polyclinic, one Regional Emergency Care Unit (ECU), one Psychosocial Care Center (PCC), which has the services of Urgent and Psychiatric Emergency,

Psychiatric Outpatient and one PCC AD III, seven pharmacies for dispensing basic medicines, one Health Surveillance unit, one Immunization Center, one Regional Rehabilitation Center, one Specialized Dentistry Service, three auxiliary diagnostic and therapy services, and Mobile Emergency Care Service (SAMU). Other private / philanthropic establishments participate in a complementary way to UHS, including three hospitals and 16 specialized services (Field Notes - FN).

Understanding Quotidian Sociology<sup>(14)</sup> abaliza, in this study, the understanding and interpretation of the contemporary phenomenon access and accessibility, from the user's perspective, in view of the daily practices exercised in the context of PHC, in meeting spontaneous demand, considering the services and actions offered in UHS versus the needs of each one looking for care. Thus, it is concerned with seeking knowledge "through an internal vision"<sup>(14)</sup>, because "there is no single reality, but different ways of conceiving / knowing them"<sup>(14)</sup>. "This reference is convenient to describe the context of this or that social situation where we are an integral (and interested) part of what we want to talk about"<sup>(14)</sup>.

The participants in this research were the users who were in the ten PHC / FHS units to accommodate spontaneous demand, whose participation was voluntary, in a total of 60 participants. Saturation occurred in each case, until the sample was closed, and significant data were obtained for the analysis and interpretation of holistic multiple cases, which occurred through literal replication that provides similar results, and not sampling. That is, after revealing a significant discovery in the first case, the immediate objective of this research was to replicate that discovery by conducting the second case. The replication logic is analogous to that used in multiple experiments that, after discovering a significant result through a single experiment, we try to replicate this finding by conducting other experiments<sup>(13)</sup>.

As an inclusion criterion, the following were adopted: users registered by FHS teams or by traditional PHC units in the municipality, after being attended by the team in spontaneous demand, and over 18 years of age. As an exclusion criterion, the person unable to answer for his or her actions was established.

Data collection took place in 2016, with evidence of the open and intensive individual interview with semi-structured script; records in

field notes (FN) directed to the operational procedures of the research, describing characteristics of the municipality, the teams of the traditional PHC and the FHS teams; performed after each data collection.

A priori, a pre-test of the interview script was carried out, under the coordination of the researcher responsible. The interview was conducted, individually, after attending the user in spontaneous demand, in a private and secure room provided by the Health Institution. The consent form was presented, clarifying the objective, the theme of the study and voluntary participation. Of the users approached, ten refused to participate in the research. The interviews lasted an average of 20 minutes, were digitally recorded and transcribed in full.

For the analysis of the data, thematic content analysis was used, according to the phases: pre-analysis, material exploration, treatment of results, inference and interpretation<sup>(15)</sup>, integrating with the assumptions of Quotidian Comprehensive Sociology<sup>(14)</sup>, when considering the notion of access and accessibility to health from the perspective of users, in response to spontaneous demand in PHC units. According to Maffesoli<sup>(14)</sup>, notion is more generous than the word concept, and “the comprehensive method allows for an inductive approach”<sup>(14)</sup>, being that our common knowledge is what prepares us for life [...] With that, the sociology that works with sociality, imaginary or everyday should no longer produce content, but rather operate as a point of view<sup>(14)</sup>.

The research was developed, according to the Resolution of the National Health Council No. 466, of December 12, 2012. Data collection started after the project was approved under the opinion of No. 1,251,730 and CAAE 48043315.2.0000.5545. It is worth mentioning that the anonymity of the research participants was maintained, by means of the alphanumeric identification, in which the letter “E” identifies the word interviewed, with consecutive numbering, according to the sequence of the interviews.

## RESULTS

The presentation of the results, considering the thematic category “Universality of access and accessibility in daily primary care: experiences of UHS users” is presented in two subcategories: “Health, a matter of struggle?” and “At UHS, accessibility is difficult, but what does the Health Plan guarantee?”

The subcategory “Health, a matter of struggle?” leads to consider that the Sanitary Reform Movement was the largest and most important political and social achievement of the Brazilian people. Such an achievement, however, was not free from disputes that, even at the time and until today, at the age of 30 years of UHS, impose significant efforts on the full realization of the universal right to health. Thus, we experience the difficulty of accessing comprehensive care, because even the basics are lacking, according to the report:

“Usually, I think they trick people, you know? Because they say they have to take it to the health department (referral). [...] Another time there is no doctor, you have to wait to hire a doctor. Saying that there will be no way to answer they don't speak! Only, if you wait, the person may even lose his life, right? Because a lot has happened. [...] And what you need in UHS, which is the essential, the basic, there is not!” (E<sub>1</sub>)

Among the spontaneous demands, the participants inferred about the transcription of prescriptions coming from the PHC, due to the renewal due date and those prescribed in the private/supplementary sector (E<sub>1</sub>, E<sub>2</sub>, E<sub>3</sub>, E<sub>31</sub>, E<sub>33</sub>, E<sub>44</sub>, E<sub>48</sub>).

According to information recorded in field notes, even with health insurance or consultations in the private sector, most medications are purchased in the public sector. Thus, without the transcription or renewal of prescriptions, access to medicines is prevented:

“I have the prescriptions to transcribe and see if I can get the drugs through UHS, he made an appointment just two months from now, I will have to buy the expensive drugs [...] But there is also nothing in the drug, no, just Prednisone and Metiformin” (E<sub>3</sub>).

“Today I came to see you, because I have a hemorrhoid problem [...] Only they told me that I couldn't see it here. Yesterday I went to the private (doctor), to try to get a prescription, then he told me he was not going to see me, that I should see a specialist” (E<sub>33</sub>).

“What is missing, sometimes, are some medicines, but it is missing everywhere, isn't it?” (E<sub>44</sub>).

Judicialization was contemplated:

“Every month I come, because my husband has to take control, he had to take medicine and I had to go to court, the defense to get the medicine, you know? Because it was very expensive [...] in the range of about 70 thousand

reais for the medicine. Then I went to the Public Ministry, got the medicine, I went in April 2015, running after, and in June 2015 he took" (E<sub>3</sub>).

The lack of access to exams or the long wait, and why the wait was pointed out by the participants (E<sub>4</sub>, E<sub>9</sub>, E<sub>17</sub>, E<sub>25</sub>, E<sub>51</sub>). The long waiting period is delegated to the precarious administration, since high taxes are attributed to citizens:

"But, it is a fight, take my exam that has been here for five years! [...] I need an emergency ultrasound and the request is for a private consultation, I had to pay for the consultation. I already did the survey and I am not able to do it, because my husband is not working, so I will have to wait, she says it is a year, more or less" (E<sub>51</sub>).

"They asked my mother for an ultrasound and it's already nine months old, but she couldn't do it. So, you get that worry, the person gets frustrated and even stops taking care of himself, because he can't get an exam! Now there are even blood and urine tests, the problem is these more complicated tests, and in particular it is really expensive!" (E<sub>17</sub>)

"What bothers me is the delay not only for me, but for many people. My son takes exams and they take too long [...] he may even end up dying because of the delay. His father died of cancer because the delay was so long, unfortunately the cancer took over his body. And this delay is the fault of the governors who are terrible administrators, because this country has money, the people pay a lot of taxes" (E<sub>25</sub>).

Ease of access was pointed out in another reality:

"I am not from here, there in my hometown I have never had so much difficulty, it is a much smaller city, of course for some more specific consultation or an exam, we have to go to another location, but there they can get the referral fast. Here, I know it's not just here, the whole metropolitan region is like that, with a lot of difficulty in this health issue" (E<sub>17</sub>).

During the period of permanence of the researchers, at the reception of the Health Unit to wait for the user to be attended on demand and, later, approach him for possible interview, the demanded needs turned to: referral to specialist, request or claim non-scheduling; the transcription of prescriptions and exams requested in private or supplementary services; the complaint about the lack of medication; and access to medical appointments; corroborating with the interview data (FN).

The subcategory, At UHS, accessibility is difficult, but what does the Health Plan guarantee? Corresponds to the PHC users' reference to health plans (E<sub>11</sub>, E<sub>22</sub>, E<sub>48</sub>, E<sub>52</sub>, E<sub>60</sub>). Users maintain a health plan to expedite some actions and consultations, but they always resort to the public service due to the limitations of access, and the co-participation to burden the family budget, in the amount to be paid for consultations, exams or other procedures (FN).

"Why is health insurance for what? To ensure what? It does not guarantee health. What ensures health is life posture, good food, not being angry, it is having awareness to take care" (E<sub>22</sub>).

"I have health insurance, but I hardly use it, I only pay for emergencies. I don't use it much, just in case I do an exam to walk faster, then I come and show it here" (E<sub>48</sub>).

"Look, I had a more cut plan, it was very expensive, very bad, we were going to move and when I needed it, it didn't work. I was in the hospital for 20 days, I had a plan and I was in the corridor, I mean, I threw seven thousand reais away, it didn't do any good" (E<sub>52</sub>).

It was noticeable a closer relationship with the health team, when users have the FHS team as a reference, demonstrating that even though they are looking for assistance in welcoming spontaneous demand, they are followed up against chronic conditions or in preventive actions of risks and aggravations (FN).

Health, a matter of struggle, highlighted the difficulties faced by the UHS, concerning access to services, actions and medicines, especially for the experienced setback by users to the transcript of revenue, scheduling appointments and lack of availability of tests and medicines provided by the System, configuring the assistance to illness. In everyday life, this search and struggle of the user, for access to health, took place every day of data collection (FN).

## DISCUSSION

Accessibility to health services in PHC is considered as one of the main problems related to care<sup>(16)</sup>. These problems are linked to the quality of services, to the efficiency of management, to the difficulty of access to consultation in the face of spontaneous demand, which can be an urgent matter, to the queues for scheduling and long waiting times, for care at the PHC and for referrals to referral services<sup>(16-17)</sup>. Such findings are similar to the speeches reported in this study, indicating that such difficulties are being faced in several

Brazilian municipalities. This leads to an increase in the lack of assistance, to the discontent of UHS users, who find themselves, most of the time, left to their own devices with few or no resources to cover expenses for treatment or health recovery.

A study carried out in Pernambuco, Brazil, shows weaknesses regarding the coordination of care, the physical structure, the reception with risk stratification, which have negative repercussions on the resolvability of the PHC network<sup>(16)</sup>.

As instituted, health is a right of all and a duty of the state and it is up to the public authorities to formulate and implement public policies that solve and address the main health problems of the population in an equitable and comprehensive manner as ensured by UHS. However, for users of this study, health has become a matter of struggle, after all, there are several access difficulties encountered in the daily routine of PHC.

In view of underfunding for public health<sup>(8)</sup>, it is necessary that the individual has persistence and struggles to be served at the threshold of scarcity of resources in the treatment, especially in chronic conditions that can bring important limitations to their quality of life, in case the treatment is interrupted or postponed.

The scarcity of resources was attributed, by the research participants, to the political mismanagement of public supplies, since high taxes are attributed to citizens. In this perspective, in its 30 years, "the biggest obstacle and threat to UHS has been the underfunding and privatization within the scope of the financing of the public budget, and the biggest challenge remains a political one"<sup>(18)</sup>.

For Maffesoli<sup>(19)</sup>, society is the representation of its political leader, it holds, in its hands, control and decision-making power in different social spheres. The politician must govern, through the management of passions, which consists of balancing, securing and protecting all the fundamental elements of a society. If such a balance is not achieved, the politician will bear the consequences of the social effervescence of the uprising of the masses.

Universal access to all health services, with equity and completeness, and the implementation of comprehensive therapeutic assistance actions, including pharmaceuticals, are regulated by UHS. However, a study identifies insufficient access to medicines and the need for an effective guarantee of accessibility to treatment with quality and resolution<sup>(20)</sup>.

A study carried out in the Tigray region of Ethiopia found that the general availability of priority drugs to save the lives of children <5 years was low, 34.1%. There were also all medicines available in the public and private sectors, with availability of 41.9 and 31.5%, respectively. The low availability and accessibility to lower-priced priority generic drugs in the public and private sectors reflect a failure to implement health policy on priority drugs to save the lives of children in this region<sup>(21)</sup>.

The results of this study point to judicialization as an alternative for obtaining the medication. Judicialization reflects the precariousness in public health administration, especially pharmaceutical assistance, either by providing a prescribed medication or by not contemplating any public policy for a specific disease. However, "the dilemma faced in the provision of health services and judicialization is to reconcile the equitable distribution of scarce financial and non-financial resources and to meet the demands of society, which are endless, which implies seeking a balance between the right collective and the individual right to health"<sup>(22)</sup>.

In Brazil, 54% of health spending is in the private sector, which serves only 25% of the population. "But UHS problems also persist, because international actors, like the World Bank, never accepted the universal and integral character of the Brazilian health system. From time to time, they release documents about UHS, disqualifying it and reaffirming the efficiency and effectiveness of the private sector. In fact, they are agents of capital that seek to expand consumer markets, transforming health into merchandise"<sup>(9)</sup>. "As the UHS is intended, in practice, the most exploited population, the consideration of health problems and the quality of health services, to a large extent, is similar to the neglect with which these people are treated"<sup>(23)</sup>.

In, At UHS, accessibility is difficult, but what does the Health Plan guarantee? The perception of users about private health plans was declared, emphasizing that having a health plan in Brazil does not always mean having the right to health, assured, but it facilitates access to some services and for the performance of exams.

Thus, "it would be up to the law or rule to prohibit the use of budgetary resources, to finance private plans or companies. This prohibition would be a way to induce sectors of the economic and political elites to come closer to UHS, in addition

to increasing the financial contribution to UHS without increasing public spending<sup>(23)</sup>.

The signs of access limits can be metaphorized by the lack, because “the economy, social movements, the imaginary and, even, politics are suffering the hangover of a gigantic wave whose real amplitude is not yet evaluated. Social change that calls for a transmutation of language: that's what postmodernity is<sup>(24)</sup>. In short, what Durkheim called “logical conformism” prefers to continue to manage a normal institute over a potentially dangerous one. This is the difficulty that exists to apprehend nascent postmodernity, a difficulty that consists in reducing a dense and complex reality to a measurable reality. By compartmentalizing his study into separate and excluded subjects, one comes to a social life from which life itself is absent<sup>(24)</sup>. Because it is frequent in the experiences lived by users of this study, in search of access and accessibility in PHC, in its “human history that the surface of things gains primary importance<sup>(24)</sup>”.

Health can be inferred as a vital impulse, which generates collective sensitivity and needs political action. Bearing in mind that, to meet the needs of users, it is necessary to understand and empathize with them, as well as to organize and prioritize access and assistance for accessibility to them.

As a priority gateway and main point of contact, PHC needs to be resolute and be based on bonding and longitudinal care. The results of this study demonstrate that there is still no flow compatible with the demands for medium and high complexity health care.

The “insufficiency of public infrastructure, the lack of bottom-up planning, the difficulties with setting up networks in regionalization and the impasses for changing health care models and practices also compromise universal and equal access to health actions and services. There is a reproduction of the hegemonic medical model, centered more on the disease than on health, treatment rather than prevention or promotion, in the hospital and specialized services, and less in the community, in the territory and in primary care<sup>(25)</sup>”.

## FINAL CONSIDERATIONS

As provided for in the Constitution of the Brazilian Federative Republic, health is a right of every citizen. The State's duty is to ensure easy

access to quality health services in all Brazilian social strata.

The quality of the administrative and political management in UHS, for access to actions and services, considering user-centered attention focused on health needs in a singular and equitable way, leads to reflection on the still biomedical validity in free demand in PHC, specifically for specific groups, which can favor gaps in several assistance areas, considering the number of users who depend exclusively on the Brazilian Public System.

There are several problems experienced by users with regard to access and accessibility to health services and actions. Among them, access to medicines, consultations and exams. Such problems may be associated with UHS underfunding, but they may be associated with deficits in the management of this system, as well as with the medical culture.

Users are looking for welcoming and accessibility, but the scarcity of resources and actions, poor administration and slowness of the System make access and itinerary difficult to achieve resolvability in the face of their demands, configuring the growing repressed demand in the two cases under study, in the traditional PHC and FHS units.

In seeking universal access to health services, the need to resort to judicialization was pointed out. Some users look for alternatives, hiring private health plans, but end up declaring the difficulties faced to maintain this plan in the face of the financial crisis experienced and the dissatisfaction due to the lack of coverage of some actions and procedures. However, health plan users declared that they use the Public Health System, as not always having a health plan guarantees full access.

Historically, UHS has granted the right to health and voice to the Brazilian people, but in practice, this distances it, people have little participation, are submissive to political decisions, setbacks for the compliance and vigor of the laws that implement this System.

The contemporary situation of UHS, in its 30 years, in the voice of users, presents the restriction of access and accessibility materialized, in this article, by the question: what you need in UHS? The reality experienced indicates that the idealization of a universal, equitable and integral system has not yet been achieved.

As contributions to the area of Health, Nursing and the general public, the knowledge

generated by the notions of users, attended in spontaneous demand in PHC, about access and accessibility in health is presented. That these notions may allow reflections on this theme, enabling responses to the population's health needs and the difficulties still experienced in UHS, in view of accessibility, even in concrete conditions of expansion of the FHS in Brazilian municipalities.

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