

The narrow entrance door of Brazil's National Health System (SUS): an evaluation of accessibility in the Family Health Strategy¹

La estrecha puerta de entrada del Sistema Único de Salud (SUS): una valoración del acceso en la Estrategia de Salud de la Familia (ESF)

A estreita porta de entrada do Sistema Único de Saúde (SUS): uma avaliação do acesso na Estratégia de Saúde da Família

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INTRODUCTION

Sistema Único de Saúde (SUS – Brazil's National Health System) has extended the accessibility to primary healthcare by means of *Estratégia de Saúde da Família* (ESF – Family Health Strategy), which was created in 1994² and has been growing significantly since then. In 2007, ESF reached more than 90% of the Brazilian municipalities and covered approximately 87 million inhabitants (46%), with 27 thousand installed teams (Giovannella, Mendonça, 2008). Such expansion has become fundamental to guarantee accessibility through primary healthcare (Brasil, 2006), which has assumed the function of entrance door to SUS.

However, this idea of “entrance door”, present in the Brazilian health system, is, according to Merhy and Queiroz (1993) and Cecílio (1997), inconsistent with a model that intends to fully fulfill the integrality of individual and collective actions. Friedrich and Pierantoni (2006) share this opinion, as they argue that the way in which the production process of the ESF teams is organized presents serious contradictions between the purpose of this strategy and users' demand. To these authors, ESF is predominantly developed in a “divided, fragmented and isolated” way, compromising the main meaning of “entrance door”, which is the integral access to the health system.

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² When it was created, in 1994, the Family Health Strategy was called *Programa Saúde da Família* (PSF – Family Health Program).

As the object of analysis in the present paper, the access³ assumed here is based on the understanding that the existence of a service in a certain place, although being an important aspect, does not guarantee its effective utilization (Viera da Silva, 2005). Therefore, when we examine the subjects' discourse, their way of viewing and experiencing the access to the health services that they need, we will probably find that the population builds its own concepts and access strategies, and that it reacts in the countless times it is induced to accept certain health system organization models in whose creation it did not participate. In this aspect, access should be analyzed in light of a power relation, according to Foucault's (1979) sense, which involves diverse interests and "hidden agendas which are not always immediately revealed"⁴ (Cecílio, 2002, p.295).

The analysis of access has been part of the agenda of many health policy researchers, even when this is not the central theme. In a study about the quality of healthcare developed in the primary healthcare network of Natal (Northeastern Brazil), Dimenstein et al. (2003) observed that access constituted a difficulty. More recently, Elias et al. (2006), comparing PSF and the UBS (*Unidades Básicas de Saúde* – Primary Healthcare Units) in the city of São Paulo based on the evaluation of users, managers and professionals, identified that accessibility was considered the worst dimension of primary care in the two models.

To Fekete (1996, p.116), accessibility can be an interesting axis of analysis in evaluation processes because it favors the "apprehension of the relation that exists between the population's needs and aspirations in terms of 'health actions' and the supply of resources to meet them". This perspective – access related fundamentally to individuals' needs – suggests that difficulties in the utilization of the health services have a substantial value (Viera da Silva, 2005).

Viewed in this way, the concept of access is deeply connected with the principle of integrality with which Mattos (2001) and Cecílio (1997) work in the field of health. Integrality consists of abolishing reductionisms in care, and is expressed in the concretization of the "universal right to receive assistance in case of health needs". That is, the individual's right to have access (without any type of impediment) to all the technologies that the system offers to meet his needs (Mattos, 2001, p.63).

In this sense, the individuals' experience of access in the direct or indirect contact with the health services tells a lot about the system's capacity to correspond to their expectations and needs, and to ensure a human and social right – the right to having health – which, in the scope of the public policies, should reflect respect for the multiple singularities that compose the complex demand of the user population. It is in this perspective that Bobbio (2004, p.65) understands social rights. According to him, as regards social rights, "individuals are equal only generically, but not specifically". This can be considered the reason why the approach to access does not take the whole for the sum of its parts; rather, it considers that the whole is multidimensional and inseparable, fed back and re-codified in the objective and subjective daily routine of the human experiences.

In this line of thought, operationalizing the concept of access to the health services implies considering the relationship that is established between the individuals and the health system, in a context of complex needs and of answers which, in the majority of times, are limited.

It is from this perspective that Donabedian (1984) defines access as the degree of adjustment between the characteristics of the health resources and those of the population, in the process of searching for and obtaining health assistance. This view is shared by Starfield (2002), to whom access is the first requirement so that primary healthcare truly becomes the entrance door to the health system; it is necessary to eliminate financial, geographical, organizational and cultural barriers.

Also based on this conception, Fekete (1996) identifies four dimensions of accessibility: i) the *geographical dimension* refers to physical aspects that impede the access (rivers, large avenues); distance between the population and the resources. ii) The *organizational dimension* refers to obstacles originated in the mode of service organization: a) in the entrance: - delay to schedule the

³ The concept of access is not a consensus in the literature, and the employed terminology is also variable. In the present study, access and accessibility are considered synonymous, and the term access is predominantly adopted.

⁴ All the quotations have been translated into English for the purposes of this paper.

medical consultation, type of scheduling, scheduled time of the medical consultation; b) after the entrance – waiting long to receive medical assistance; continuity of care, which is related to mechanisms of referral and counter-referral. iii) The *sociocultural dimension* refers to the population's perspectives: individual's perception of the severity of his illness, fear of the diagnosis and interventions, beliefs and habits, shame; and to the health system's perspectives: professionals' education; the teams' lack of preparation to assist patients with distinct sociocultural characteristics; incipience of the participation processes. iv) The *economic dimension* refers to the consumption of time, energy and financial resources to search for and receive assistance; losses caused by being absent from work during days; cost of treatment.

The expansion of the primary healthcare's coverage enabled by the ESF has been amazing and its enrolled population is likely to coincide soon with the entire needy population of Brazil. In Recife (Northeastern Brazil), from 2000 to 2007, the number of teams increased by 730%, which enabled a leap in the population's coverage, from 6.5% in 2000 to 51% in 2007 (Recife, 2008).

However, the supply of these services seems not to meet users' needs, as the access is not integral, limiting, in practice, the objectives of the ESF, as was explained above. This was the hypothesis that was raised to answer the question that guided this study: does the ESF enable (integral) access to the enrolled population? Thus, the general objective of this study was to evaluate the access to ESF based on users' perception.

Methodology

This research consists of a qualitative evaluation of the access to the ESF in a locality of Recife, state of Pernambuco, focusing on the process, understood as "a series of activities performed by and between professionals and patients (Donabedian, 1984, p.95).

The qualitative approach, according to Chizzoti (2005), understands that knowledge is not merely a set of isolated data that are sewn by some theory that explains them. As an integral part of the knowledge process, the subject-observer assumes an interpretative posture towards phenomena, to which this same subject attributes meanings.

Regarding the area of study, it was carried out in the municipality of Recife, in the territory corresponding to Sanitary District IV, where there are 39 Family Health Teams that cover 37,916 families (136,500 people, totaling 49% of the District's population).

Data collection instruments were: interview (with semi-structured script and open questions), direct observation and documental analysis. The script used for observation and documental analysis consisted of the sub-items of each category of analysis, which served as a guide to the notes, among them: form of receptiveness, time, user-professional bond, supply and demand of services and inputs, unit's functioning and organization, availability of medicines, and mechanisms of referral and counter-referral.

As for the sample, in a qualitative research, the definition criterion is not numerical. Rather, what matters is to look at the phenomena from many points-of-view and observation perspectives, always taking into account the principle of saturation of the theme (Minayo, 1999). Thus, we used a random sample of 24 subjects older than 15 years, users of two Family Health teams, selected among the population enrolled in the catchment area of the two teams by means of File-A (user enrolment file). With the support of the *agentes comunitários de saúde* (ACS – community health agents), the individuals were identified and contacted at their own residences (where the interviews also took place), but only those who voluntarily adhered to the research participated, after having read and signed a consent document. All of the subjects were informed of the objectives of the research and of the content of the consent document before they signed it. The interviews were recorded with the participants' permission.

The subjects were selected according to the life cycle: eight youths, eight adults and eight elderly individuals, with the following characteristics: 18 were ESF attenders – 12 women and 6 men – and six were non-attenders, whose sex varied according to the draw. The option for this numerical difference was based on the proportionality in the demand and utilization of the health services, in which the proportion of women and users is known to be higher than that of men and non-attenders.

We decided to listen to some professionals (a total of eight) and the manager (director of the Sanitary District), which allowed to draw some contrasts and comparisons, as well as expanded the universe of reflections. The interviewed professionals were four from each of the two drawn teams: the doctor, the nurse, the dentist and one ACS. All of them accepted to participate in the research (they signed the consent document) and were interviewed at their respective healthcare units.

The interviews were performed from August to December 2006. The direct observation was carried out at the two *unidades de saúde da família* (USF – family health units), during the months of November and December 2006, and the documental analysis was performed during the year of 2006. Seven systematic visits were made to the units, distributed in the two periods of functioning (morning and afternoon).

The categories of analysis that constitute the access dimensions are: geographical, organizational (obstacles in the entrance and after it), sociocultural and economic, and have already been detailed above. Such categories were based on the systematization proposed by Fekete (1996) and on the conceptual contributions of Donabedian (1984) and Starfield (2002).

For data analysis, Content Analysis (Bardin, 2004) was used. All the discursive material and the field records were treated and analyzed according to the adopted categories and to the values attributed to the meaning nuclei.

Results and discussion

The geographical dimension of access

It is widely known that barriers related to distance are associated with the services' level of complexity: the less specialized they are, the nearer to the population they are located, and the inverse is also true. Access in this dimension was not criticized by users, which was already expected, as the healthcare units under focus are located in the territory where the enrolled families live. Probable barriers in the route (such as open grooves and unfinished or unleveled sidewalks) were not mentioned as limiting factors, even when the interviewee was an elderly person with visible locomotion difficulties. Thus, regarding the distance to arrive at the health unit, the following fragment summarizes how users classified it:

“It is near here, I go there on foot”. (**user 8, male adult, attender, team A**)

Organizational dimension

Obstacles in the entrance

One of the reasons why some users did not attend the unit and, consequently, did not use the team's services, was the

“difficulty in scheduling the medical consultation [...]”. (**user 10, female adult, non-attender, team B**)

This difficulty remains an important access problem in primary healthcare, as Araújo et al. (2008) have demonstrated, constituting, still today, a challenge to SUS. In spite of recognized achievements in this sense – in view of studies that show the significant increase in primary healthcare coverage (Sá, 2002), and the advance towards equity (Facchini, 2006; Piccini et al., 2006; Travassos et al., 2000) -, there still are, as we can see, situations in which users do not find space to meet their needs in moments of pain and acute suffering.

The difficulty in scheduling a consultation has also been attested by the professionals' discourse, as we can see below.

“We are very numerous, there are many families, so they complain [...]” (**professional 1**)

In this study we observed, unlike the result found by Araújo et al. (2008), that this issue is intimately related (but not only) to the insufficiency of professionals to meet users' demand, as the population enrolled in one of the studied units was highly above the limits accepted by the Ministry of Health (Brasil, 2006). Piccini et al. (2006) and Cohn et al. (2002) identified a similar problem, corroborating the idea that "the quantitative insufficiency of supply implies, to a certain extent, qualitative insufficiency" (Cohn et al., 2002, p.8).

In the case of access to the dentist, this situation was even more evident, due to the fact that there is only one oral health team to two family health teams. The fragment below reflects this issue.

"Scheduling the dental consultation is even more difficult. As I perform more concluded treatments, I restrict the access even more". (**professional 7**)

This finding is corroborated by Oliveira (2002), in a study developed about access to and utilization of dental services of SUS in 2001, as the author verified that not even the basic procedures are guaranteed in all municipalities.

Another aspect that was negatively highlighted by users was the emergency care which, in view of their most acute needs, they expect to find in the nearest health unit:

"I caught the infection [...]. I went there and no one assisted me, the woman told them to take me to emergency care. This unit was supposed to have it". (**user 12, female youth, attender, team A**).

This finding coincides with what was found in the study conducted by Dalmaso (2000), who showed that emergencies are a (repressed) demand that is very frequent at the primary healthcare units. Other authors (Merhy, Franco, 2005; Merhy et al., 2002; Trad et al., 2002) recall that, mainly in the ESF, the lack of this service is one of the main reasons for users' dissatisfaction. This result is, to say the least, curious, in view of the fact that emergency is a service that is already regulated in the ESF, and it is present in the management plan as an additional resource to guarantee the principle of integrality in SUS (Brasil, 2006).

It is in this direction that some authors criticize the structure of the ESF and the insufficiency of primary healthcare (Merhy, Franco, 2005; Cohn et al., 2002; Cecílio, 1997). To these authors, users search for the health service in situations of acute suffering and, when the primary healthcare unit does not respond to their needs, they end up in the emergency services, crowding them with demands that are considered "simple", which might have been solved at the level of primary healthcare. This aspect could be verified by Kovacs et al. (2005), in a study carried out at a pediatric emergency clinic at Recife, in which they observed that the access difficulty in primary healthcare was an important reason for users to search for the analyzed emergency service.

Obstacles after entrance

To some attenders, the obstacle would be in waiting for assistance at the unit, as the fragment below shows:

"The doctor stays in the room and takes too long to assist us. [...]" (**user 4, female adult, attender, team A**).

Other users situated the problem in the stool tests, urinalysis, blood tests and cytology. The difficulties would not be exactly in performing these tests (collection is facilitated because it takes place in the healthcare unit), but in the return of their results. This problem was mentioned concerning only collections performed at the unit, and not at the contracted out laboratory services – which, in general, are located in areas that are more distant from the peripheries where the primary healthcare units function. This issue is relevant because it results in an additional effort of users (who have to go to the laboratory and pay for transportation) in the search for a service that they believe is better, or, as far as this study is concerned, more accessible.

“I did it there [at the unit], then it took very long [...] This week he asked me to do some blood tests, [...] in the city, at a [contracted out] laboratory, I did them, and five days later I went there to get the result”. (**user 24, elderly woman, attender, team B**)

The explanation lies in the fact that the ESF units have only the collection service; the laboratory analysis is performed at the Municipal Laboratory, which is also responsible for sending the results to the collecting healthcare units. The poor functioning in this other dimension of care (diagnostic support) contributes to disqualify the actions carried out in the assistance dimension.

As for the continuity of care in reference services, it was not regarded a problem by users. The difficulty in scheduling consultations in the local unit (USF) – the entrance door – seems to have been more felt by the population than the difficulty in scheduling consultations with specialists or exams outside the unit’s catchment area.

“[...] It took a while but it arrived, so that I could go to Ermírio de Moraes, because they assist me there as heart physician”. (**user 9, elderly woman, attender, team A**)

We identified, in this aspect, a certain difference between the discourses of users, professionals and the manager concerning the perception of access. To the professionals and the manager, the access to consultations with specialists constitutes a great obstacle in the ESF, and to some specialties the difficulty is even greater.

“Sometimes it takes two months to schedule a consultation [...] neurologist, cardiologist, psychiatrist, not everybody is able to schedule it”. (**professional 2**)

From the manager’s point-of-view, the difficulties are related to the excessive number of referrals performed by primary healthcare, as she believes there are cases that can be solved in the scope of the unit which, however, are referred:

“With the organization of the scheduling of consultations at Policlínica by the family health units, I think this has facilitated the access [...] Many patients are referred to specialists without need [...]”. (**manager**)

Without tackling the polemic discussion that involves the question of problem-solving capacity or of the results of healthcare as a reference element for access (Travassos, Martins, 2004, p.197), it is important to explain that this perception should be seen with caution. First because, as the authors explain, “the population’s health does not result directly from the action of the health systems”; second because, in the SIAB Indicators Evaluation Document, produced by *Gerência Operacional de Atenção à Saúde* (GOAS – Health Care Operational Management) of Sanitary District IV, the contrary was identified: the average of referrals performed by the ESF in 2006 is within what is expected of the studied teams – around 13% in one team and 6% in the other -, in view of the fact that the Ministry of Health recommends to the ESF the referral, to the reference services, of 20% of the assistances at the most. The difficulty perceived by the professionals and the manager seems to be associated with the insufficient number of specialty quotas to each family health unit – a frailty that is closely related to limitations in the referral and counter-referral mechanisms.

These mechanisms are items considered “necessary to the implementation of the Family Health Teams” (Brasil, 2006, p.24) and constitute the “guarantee of referral and counter-referral flows to the specialized services that provide diagnostic and therapeutic support, and also outpatient clinic and hospital support”. This problem is associated with the question of the unfinished decentralization of healthcare in the municipality, which still does not exercise the full management of the SUS assistance network, a complex situation in which the large public hospitals are still run by the state or federal governments.

As for the users, their perception of easy access may be associated with their low expectation in relation to the public services. The delay to receive specialized assistance is already expected by them, and the mere fact of obtaining assistance is already an important satisfaction factor. In this sense, the representations that the users have of the public health services are closely related to their experiences in searching for the assistance they need (Starfield, 2002; Halal et al., 1994). A similar perception was not observed in the study conducted by Escorel et al. (2007), in which the families had a clearer perception of this problem compared to the health professionals, who lacked mechanisms to measure the waiting time and the magnitude of the queues. The fragment below draws attention again to the question of continuity of care:

“[...] She referred me to Lessa de Andrade, I’m being treated there. No, I didn’t come back. I continue doing it there”. **(user 4, adult woman, attender, team A)**

This testimony reveals that the responsibility for treating the disease moved to another level of care, together with the responsibility for taking care of the subject, who, from then on, detaches himself from the professional-user relation established in primary healthcare. The focus on a professional’s discourse reflects this discussion.

“[...] This is important because if we have a primary healthcare unit with professionals who assist that user [...] and we want to give continuity [...] we need this feedback. [...] Then this user is lost”. **(professional 6)**

The continuity of assistance in another level of care, when the technologies available in the primary level do not meet users’ needs anymore, does not take the responsibility away from the health team to which these users are linked. The systematic follow-up of these users is a daily task in the ESF, and is conditioned to the commitment (to the other) both of the professional who refers and also of the one who receives the patient. According to Escorel et al. (2007), communication and information exchange among professionals is very important for the function of coordination attributed to the ESF and to guarantee continuity of care.

This characteristic of a network of interconnected services with links that give logic and meaning to the hierarchized health system constitutes a fundamental element in the issue that has been discussed in this study, as access without integrality of care limits the universalizing character of the system. In this perspective, it is important to remember the criticism made by Cecílio (1997) against the hierarchy of the healthcare model of SUS: besides the fact that this hierarchy, in practice, does not fully function (for reasons that cannot be explained here, due to the limit of space of this paper), this model is based on the notion of full functioning of a network whose constraints are felt already in the entrance door. Thus, a referral and counter-referral mechanism based on ESF tends to fail in its essential function, which is the guarantee of what Cecílio (2006) has called “amplified integrality”.

Sociocultural dimension

The reasons why users attend the healthcare units of this study expressed the priority demand for actions and services related to disease control or cure and/or reduction in some discomfort or indisposition, as the fragment below shows:

“it is something in the mouth, or in the teeth, in my vision too [...]” **(user 18, male youth, attender, team B).**

According to Cohn et al. (2002), the predominance of users’ references to individual and immediate consumption of the service shows that health is hardly seen and based on a collective perspective, situated in the sphere of citizenship. On the other hand, the offer of services presents a similar character, being constituted mainly of healthcare actions. Therefore, it is a pattern of supply and

demand in keeping with an understanding of the health-disease process centered on the biomedical model of healthcare, a conception that is fought by the reforming ideals of the Brazilian public health.

As regards the concern about health, this was related, by one of the users, to impossibility of working, or to the difficulty in getting a job due to an illness. This difficulty in having access to a reference service not only maintained but intensified his situation of shortage, both of a job and of treatment.

“When I had a job, I had to stop because of my spine, because it hurts a lot [...] Then I stopped working due to the problem. No, not until now [has not looked for treatment yet]. It’s hard to obtain referral to the doctor”. **(user 8, male youth, attender, team A)**

The mode of insertion of the individuals in the job market – and the degree of freedom that this insertion provides – may constitute an important limit, related: to the material conditions of existence in this society, to the user’s attendance at the unit and to the search for the assistance he needs, as can be observed below:

“[...] I had to ask for two leaves [...]. Because I used to work as an office boy [...], then I didn’t have time. When she [the employer] needed me, I was going there in a hurry and I had no register on my working papers, then I couldn’t go, then I asked her for only one leave”. **(user 23, male youth, non-attender, team B)**

According to Minayo (1999), in the capitalist society, the body represents the “workforce”, the only form that the individuals who do not own the means of production have of reproducing themselves, or, in other words, of maintaining their material conditions of survival. Therefore, from this derives a painful existential experience, “representative” of a reality in which the body constitutes the only source that generates goods. This understanding finds echo in other studies. Barbosa and Coimbra Júnior (2000) identified, in a research into schistosomiasis in a rural community of the Brazilian Northeast region, that this disease only started to be considered by the adults as serious when it disabled them from working or made the children be absent from school. Following the same reflection, Bercini and Tomanik (2006), in a study developed with fishermen’s wives in the municipality of Porto Rico (Southern Brazil), observed that, among the interviewed women, there was the perception – constituted of meanings and values that belonged to that locality – that a healthy individual is the one with disposition and capacity to work.

The community’s participation is one of the fundamental principles of SUS, and implies sharing power and responsibilities when making decisions which, after all, affect all the involved individuals, and whose success, in case it occurs, will be earned by all. Due to this, participation should be stimulated and, above all, promoted by the ESF professionals, as the Ministry of Health (Brasil, 2006) recommends. But, in a context of daily interaction (which is not always pacific) between players in different power positions, with distinct interests and possibilities, the participation idealized by SUS becomes a project which has not been finished yet, as the experience reported below corroborates:

“[...] they [the professionals] don’t even want to see us talk. [...] we don’t have the right to meddle into anything. [...] The community was supposed to get together, [...] and everybody would settle “it’s this and that”. **(user 14, male adult, attender of unit B)**

The incipient experience in the field of social participation, both of professionals and users, added to the insufficient qualification of the two groups, draws a conflicting picture in the local sphere, in the very space in which the closest relationships (in all their dimensions) among these players take place.

Thus, seen in a broad way, that is, as individuals' social needs, the health needs may be transformed into *potentialities*, as Stotz (1991) warns us, provided that the lacks motivate, commit and mobilize people.

Economic dimension

Economic issues are almost always highlighted in studies related to access to health services (Elias et al., 2006; Ribeiro et al., 2006; Travassos et al., 2000.). Such studies constantly refer to an inversely proportional relation between the individuals' socioeconomic situation and the possibility of access.

A favorable aspect in this dimension was the availability of medicines at the healthcare unit. However, in spite of the fact that the USF pharmacy is stocked on a monthly basis, it does not receive the amount of medicines that corresponds to the need of all users. This makes the search for medicines become a process that requires agility, because the guarantee is for those who arrive first (before they end). Thus, at the same time it was a facility – because, although in small amounts, the medicines are provided at the unit, which is nearby and makes the medicines available for people to fetch them – expenditures on medicines was also a serious difficulty for some users. The deep condition of social injustice to which these individuals are submitted (which already excludes them from access to other goods and products which are indispensable to the maintenance of life and health) deprives them, on a daily basis, of the right to incur this expense:

“No [he did not spend money on medicines]. I don't have this money. [...] The unit ran out of it once, but I never bought it [...]” (**user 11, elderly man, attender, team A**).

The discourse of all the professionals revealed the deep knowledge they seem to have of the reality of shortages which is recurrently experienced by the users, whose problems are reflected on the demands to the unit. There is also the feeling of impotence and distress in view of such a cruel reality, degrading of the human condition. In this sense, we highlight the discourse below:

“[...] Many times they don't eat, or eat very badly because the medicine they need is not available here at the unit. So, in a certain way, they spend money, they spend what they don't have”. (**professional 6**)

Living in a situation of permanent contact with pain and so many material shortages makes the working environment become complex, as well as the personal and professional interrelations which are processed in the daily working routine. Thus, “institutional symptoms” are produced, such as communication failures or excessive ideologization in defense of the SUS, as mentioned by Campos (2005). It is important to reflect that the understanding of healthcare should always be viewed within the context of the labor relations, of the peculiarities of the work of the care producers (Deslandes, 2005).

In the records of the field diary, the result of direct observation in the services, it was possible to identify, besides lack of medicines – including the ones contained in the list of medicines standardized by the municipality -, the lack of male preservatives, which have been supplied in the public services since the 1980s, as Ramos and Lima (2003) explain. These authors also identified this problem in a study about access and receptiveness at a healthcare unit located in Porto Alegre (Southern Brazil).

Some professionals' discourse about the expenses users must incur when they are referred to other services, belonging or not to the municipal health network, reveals another reality, as shown by the example below:

“[...] Many times they don't do it because of the ticket [...]. Sometimes it's difficult to reach a specialist, and when it happens, the person doesn't go to him because of the distance”. (**professional 2**)

These discourses reflect the mode of organization of the health services network; they refer to the principle of decentralization with hierarchization and regionalization of the services network. The chronic situation of social exclusion in which the great majority of the SUS users lives hold this model in check when it reveals that it is not articulated to another network – that of social services, including services of income generation. This aspect is fundamental, because this network meets other needs (health needs) linked with people's way of earning their living, with people's precarious material conditions of existence, which result from a scenario of injustices and social inequalities. These aspects have been worrying the set of social players engaged in making public health effectively accessible to all the Brazilians.

Conclusions

This study aimed to evaluate the access to healthcare in the SUS based on the perception of users of the Family Health Strategy, triangulating and confronting it with the point of view of the manager and of health professionals. It was observed that the existence of services, associated with the expansion of the coverage of primary healthcare, although important, does not imply effective access. Due to this, the organizational change arising with ESF has an important implication in the organization of the health system, because primary healthcare was regulated as the privileged form of access, assuming the function of restructuring the entire care model and reorganizing the assistance practices.

In the present study, the analysis of access brought to light aspects of healthcare in Brazil that are already known. The relevant issue, however, is the fact that problems related to access in the ESF reveal the existence of obstacles in the system that may compromise its entire structure of organization and functioning. Moreover, it may imply the exclusion of millions of individuals whose precarious life conditions already deprive them of many citizenship rights.

Elements that facilitate and hinder the access were identified. The facilitating ones were: the working hours, receptiveness and the proximity of the USF services.

The most critical situations pointed by the users' discourses were:

1 organizational dimension:

(i) delay to schedule a consultation; (ii) poor functioning of the referral and counter-referral system, compromising the access to specialists; (iii) excessive number of people enrolled in the teams' areas; (iv) delay, at the waiting room, to receive assistance; (v) delay to receive test results; (vi) ESF's low capacity to solve problems, particularly due to the absence of assistance to simple emergencies, implying overloading the services of medium and high complexity.

2 sociocultural dimension:

(i) professionals' and users' lack of preparation concerning the organization and execution of joint actions; (ii) low capacity to visualize the collective perspective of health, situated in the field of citizenship.

3 economic dimension:

(i) expenses on medicines and other inputs.

The ESF, as a strategy to promote the access of people with complex social needs to the health actions and services, proved to be a narrow entrance door, deserving to be evaluated with a more critical look that takes into account the situations that particularize the individuals who request its actions, and services organization based on the subjects' needs.

COLLABORATORS

Ana Lúcia Martins de Azevedo reviewed the literature, elaborated the research instruments, collected and analyzed the data and wrote the paper. André Monteiro Costa supervised the investigation, the elaboration of the instruments and data collection, analyzed the data and helped to write the paper.

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