



# Access, accessibility, and demand at the family health strategy

*Acesso, acessibilidade e demanda na estratégia saúde da família*  
*Acceso, accesibilidad y demanda en la estrategia de salud familiar*

Giannina Marcela Chávez<sup>1</sup>

Selma Maria da Fonseca Viegas<sup>1</sup>

Gabriel Rios Roquini<sup>1</sup>

Thiago Rocha Santos<sup>1</sup>

<sup>1</sup>Universidade Federal de São João del-Rei,  
Center-West Campus. Divinópolis, MG, Brasil.

## ABSTRACT

**Objective:** to understand demand, access, and accessibility in the face of health needs, from the perspective of Family Health Strategy (FHS) professionals and users. **Method:** this Grounded Theory was anchored in Symbolic Interactionism, with 34 FHS participants, users, and professionals from a large city. **Results:** the daily demands at FHS and access limitations make the teams struggle due to low population coverage, high number of registered people, low resolution, lack of professionals, ineffective management and scarcity of scheduled actions. The conceptions of access, accessibility, and resolution are contextualized in embracing and humanizing, in the precision of expanding population coverage and access, in addition to users and professionals expressing their feelings of frustration, anguish and dissatisfaction due to low resolution and insufficient resources. **Conclusions and implications for practice:** FHS still works on the logic of curative care, whose activities are carried out within the office, with insufficient resources, high repressed demand and many challenges. It presents subsidies for health professionals, users, and managers, to collaboratively seek strategies to face high spontaneous demand and difficulties in access.

**Keywords:** Health Services Accessibility; Family Health Strategy; Primary Health Care; Grounded Theory; Nursing.

## RESUMO

**Objetivo:** compreender demanda, acesso e acessibilidade perante as necessidades de saúde, sob a ótica de profissionais e usuários da Estratégia Saúde da Família (ESF). **Método:** utilizou-se a Teoria Fundamentada nos Dados, ancorada no Interacionismo Simbólico, com 34 participantes, usuários e profissionais da ESF de município de grande porte. **Resultados:** as demandas cotidianas na ESF e as limitações do acesso evidenciam as dificuldades enfrentadas pelas equipes pela baixa cobertura populacional, elevado número de pessoas cadastradas, baixa resolutividade, falta de profissionais, ineficácia da gestão e escassez de ações programadas. As concepções de acesso, acessibilidade e resolutividade são contextualizadas no acolhimento e humanização, na precisão de ampliar a cobertura populacional e o acesso, além de os usuários e profissionais expressarem seus sentimentos de frustração, angústia e insatisfação perante a baixa resolutividade e insuficiência de recursos. **Conclusões e implicações para prática:** a ESF ainda trabalha a lógica da atenção curativa, cujas atividades são realizadas dentro do consultório, com recursos insuficientes, elevada demanda reprimida e muitos desafios. Apresenta subsídios para que os profissionais de saúde, usuários e gestores busquem, de forma colaborativa, estratégias de enfrentamento da elevada demanda espontânea e dificuldades de acesso.

**Palavras-chave:** Acesso aos Serviços de Saúde; Estratégia Saúde da Família; Atenção Primária à Saúde; Teoria Fundamentada; Enfermagem.

## RESUMEN

**Objetivo:** comprender la demanda, el acceso y la accesibilidad frente a las necesidades de salud, desde la perspectiva de los profesionales y usuarios de la Estrategia de Salud Familiar (ESF). **Método:** se utilizó la Teoría Fundamentada, anclada en el Interaccionismo Simbólico, con 34 participantes, usuarios y profesionales de ESF de una gran ciudad. **Resultados:** las demandas diarias en la ESF y las limitaciones de acceso muestran las dificultades que enfrentan los equipos debido a la baja cobertura de la población, el alto número de personas registradas, la baja resolución, la falta de profesionales, la gestión ineficaz y la escasez de acciones programadas. Las concepciones de acceso, accesibilidad y resolubilidad se contextualizan en acoger y humanizar, en la precisión de ampliar la cobertura y el acceso de la población, además de que los usuarios y profesionales expresen sus sentimientos de frustración, angustia e insatisfacción ante la baja resolución y los recursos insuficientes. **Conclusiones e implicaciones para la práctica:** la ESF todavía trabaja con la lógica de la atención curativa, cuyas actividades se llevan a cabo dentro de la oficina, con recursos insuficientes, alta demanda reprimida y muchos desafíos. Presenta subsidios para que los profesionales de la salud, los usuarios y los gerentes busquen en colaboración estrategias para hacer frente a la alta demanda espontánea y las dificultades de acceso.

**Palabras clave:** Accesibilidad a los Servicios de Salud; Estrategia de Salud Familiar; Atención Primaria de Salud; Teoría Fundamentada; Enfermería.

### Corresponding author:

Selma Maria da Fonseca Viegas.  
E-mail: selmaviegas@ufsj.edu.br

Submitted on 11/21/2019.

Accepted on 04/27/2020.

DOI:

<https://doi.org/10.1590/2177-9465-EAN-2019-0331>

## INTRODUCTION

Access to health services is a broad topic that covers several dimensions such as availability, accessibility, functional adequacy, financial capacity, and acceptability. It is determined by political, economic, social, organizational, technical, and symbolic factors.<sup>1</sup> The guarantee of the right to health and the principles of universality, integrality, and equity, which indoctrinate the Brazilian Health System (SUS – *Sistema Único de Saúde*), will depend on access of users to health services and resources. Thus, to understand the expression “universal and equal access”, this must be ensured both in preventive and curative care for all, so that there are no privileges or discrimination. Public policies based on hypo-sufficiency are not allowed, because the State has the duty to assure health for all.<sup>2</sup>

Currently, SUS aims to achieve a balance between supply and demand in health, in order to adapt Primary Health Care (PHC) care practices and outline strategies to deal with the different situations presented in the daily life of health services. Therefore, there are limitations in the dimension of access in terms of accessibility, fragmentation of the System, decentralization and regionalization of Health Care Networks (RAS – *Rede de Atenção à Saúde*), and inadequate process of embracing and assisting certain groups.<sup>1</sup>

Accessibility is described as a series of determinants related to the provision of health services aiming to facilitate or hinder the use of services, so that users are able to obtain care according to their desire, in an easy and convenient manner, and may take to situations of imbalance between supply and demand.<sup>3,4</sup>

A study carried out “with people with a high frequency of use of health services revealed the protagonist role of users in the construction of care maps, arising from practical knowledge resulting from their own experience and observation of how to achieve access to care characterized as necessary”<sup>5:2013</sup>, using the medical-hospital-outpatient service, regardless of whether it is public or private.<sup>5</sup>

An international research program, including informants from PHC organizations, associations and university departments in Australia, Canada, the United Kingdom and the USA, showed disparity between the dimensions of supply and demand. They listed the areas that could benefit from a greater attention in order to close the equity gap for populations vulnerable to access to PHC services that correspond to their needs.<sup>6</sup>

In China, researchers have suggested that the Dongguan model, which is based on assured law and use by family medicine physicians, appeared to work best in terms of improving access and quality for patients with chronic conditions. It was emphasized that the PHC system, with well-structured financing and organization, can play a positive role in the provision of services and has potential to improve patient care.<sup>7</sup>

In the city of São Paulo, Brazil, a study showed that access to health services was high, when analyzed in two periods, with a difference of five years, and that the proportion of access and

use of health services in SUS has not changed since 2003. Differences were found regarding socioeconomic factors and their relationship with the demand for health care and resolution of these problems, which was more pronounced in people with better socioeconomic status or who used the private sector.<sup>8</sup>

The lack of access to health services and waiting time to use the desired service are increasing, especially among individuals with lower economic status. Such indicators express the quality of care<sup>9</sup> and are essential, since they are related to the possibility of continuity of care, health maintenance, prevention of injuries and complications in chronic conditions.

After the implementation of the Family Health Strategy (FHS) in 1994, in Brazil, there was an expansion of significant coverage since the 2000s. However, it was identified that this expansion had different rhythms when evaluating the different regions and cities. Currently, there is a concern regarding the expansion of coverage and strategies for improving quality and PHC strengthening in terms of its attributions, especially in terms of access.<sup>10,11</sup> Despite the advances achieved, difficulty accessing health services is still considered as one of the main challenges to be faced in the country.<sup>12</sup>

Considering this context, it is clear that SUS faces several difficulties related to structuring and consolidation of a health care model centered on users, full access to actions and services, which compromises its performance.<sup>2</sup> In view of this, it is questioned: how do FHS professionals and users understand the demand for health, access and accessibility in view of the health needs of each individual? Health needs, in this study, means taking the concept of social determination of the health-disease process so that, on a daily basis, the health team can answer “for them in the context of the roots of the problems, of the determinant, and also of the results, the disease, and forward the policy public health towards universal law”.<sup>13:1261</sup>

This study aimed to understand health demand, access, and accessibility in the face of health needs, from the perspective of PHC professionals and users.

## METHOD

We used Grounded Theory (GT)<sup>14</sup> and Symbolic Interactionism (SI).<sup>15,16</sup>

GT is used in the development of a theory based on data, systematically collected and analyzed, which aims to understand reality from people’s perception or meaning about a given context or object. The theory is built during real research and in continuous interaction between analysis and data collection.<sup>14</sup>

SI represents meaning as one of the most important elements in understanding human behavior, its interactions and processes used to achieve a full understanding of the social process. The understanding of human conduct is based on its internal aspects, considering how each person deals with events or reality around him/her, and how this will influence his/her experience.<sup>15,16</sup>

SI is based on analysis of three premises: the first is that human beings guide their actions towards things according to what they mean to them; the second deals with the consequences of this meaning in the social interaction that they have with their neighbor; and the third states that meanings are manipulated and modified through an interpretation process developed by persons when faced with things encountered along their way.<sup>15,16</sup>

The data collection for this research was carried out from October 2016 to May 2017 in a large city in the State of Minas Gerais, with an estimated population of 234,937 inhabitants. Open-ended and individual interviews were used as evidence sources, with a semi-structured script, records in operational memos, directed to functional procedures of the research, and initial memos, performed after each data collection.<sup>14</sup> The city has 32 FHS teams that were selected by lot. As an inclusion criterion, we considered minimum complete teams (general practitioner, nurse, nursing technician, and community health agents),<sup>17</sup> and as an exclusion criterion, traditional PHC units in transition to FHS. Of the 32 teams, 12 (37.5%) met the adopted criteria. These 12 units were listed and drawn for data collection, which occurred until theoretical saturation for GT formulation. This study, therefore, included five FHS units (with a registered population ranging from 2,646 to 7,000 people) as the study setting (memorandum), considering theoretical saturation.<sup>14</sup>

The study involved 34 participants, including 16 health professionals. Among them are five nurses, four physicians, three nursing technicians, three community health agents (CHA) and one oral health assistant (OHA) from five FHS teams, who worked for at least six months. Eighteen users over 18 years old, able to answer for themselves, registered and followed by one of the five FHS teams and who attended the unit to attend to spontaneous demand (SpD) or scheduled demand (SD) on the day of the interview. During data collection, it was necessary to add four questions to the professionals' interview script and three to the users' script (memorandum) to deepen the codes that emerged from the results and to contemplate the analysis process according to the method of GT to achieve data saturation.<sup>13</sup> The interviews lasted an average of eight minutes, were recorded and transcribed in full for later analysis. There was no refusal or withdrawal by any guest-participant in this study. The interviews were identified with the letter "I" to represent all interviewees, the letter "H" to identify health professionals and the letter "U" to identify users. The numbering was represented according to the chronological order of data collection ( $I_{H1}$ ;  $I_{U1}$ ;  $I_{H2}$ ;  $I_{U2}$ ...).

Data analysis started with open coding, a phase that performs categorization and naming of the phenomena. An investigation of the data was carried out to, comparatively, highlight the similarities and differences between them, and raise questions about the phenomena to which the data refer to.<sup>14</sup>

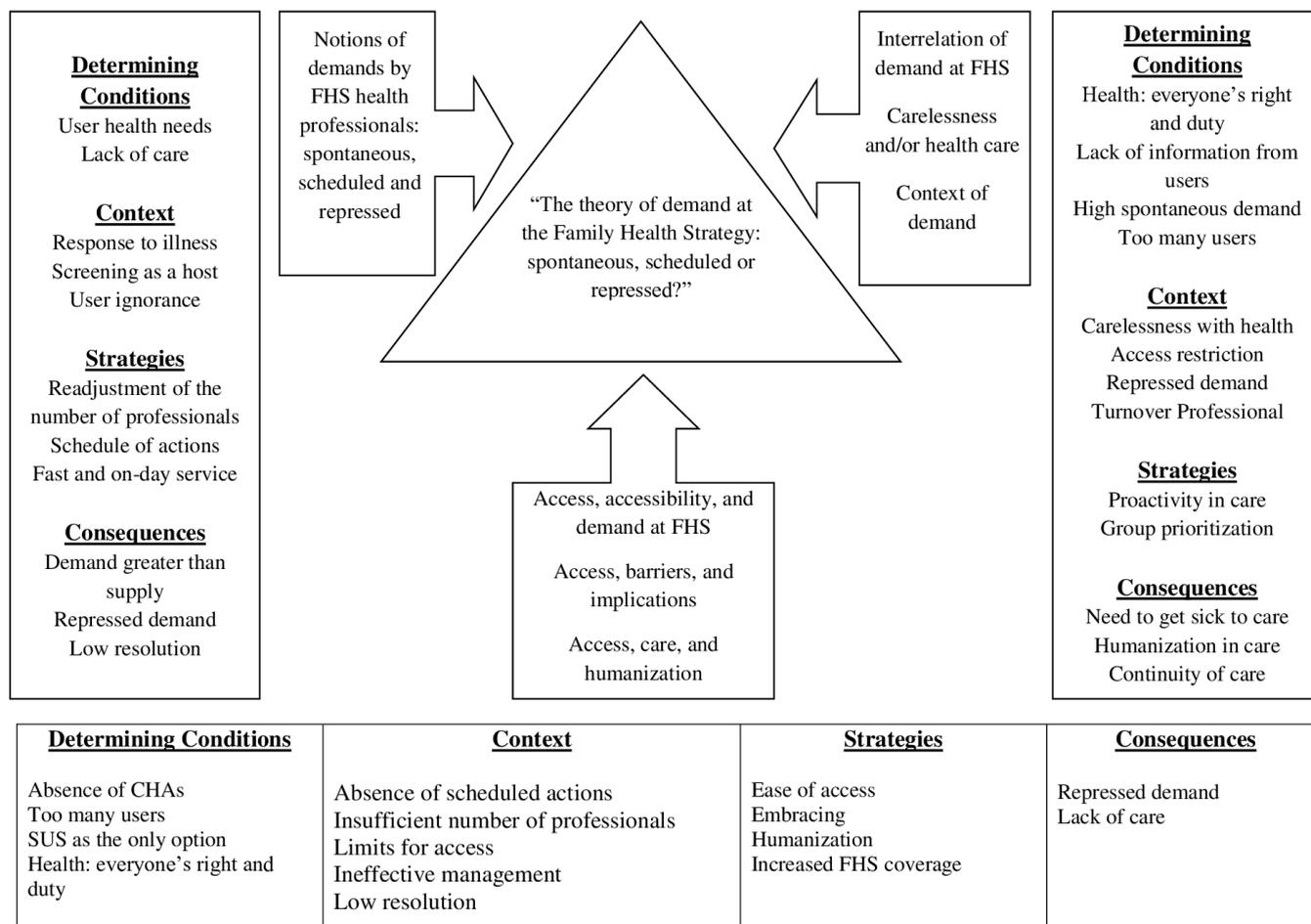
Subsequently, focal coding was performed, which uses the most significant and/or frequent codes in order to thoroughly analyze the data and allow analytical understanding to categorize the data in an incisive and complete manner. At the end of this phase, axial coding started, in which the categories were related to the subcategories, regrouping the fragmented data in the open coding, to guarantee analysis consistency and define the determining conditions, the context, the strategies and the consequences.<sup>14</sup>

Finally, theoretical coding was carried out, which specified the possible relationships between the categories found in the focal coding. Theoretical codes led to formulation of the central category: *The theory of demand at the Family Health Strategy: spontaneous, scheduled or repressed?*, which made the experience and understanding of the research participants on access, accessibility, and demand at FHS explicit.<sup>14</sup> The survey was approved under Opinion 1,686,000 and CAAE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 58465316.1.0000.5545. All voluntary participants signed the Informed Consent Term.

## RESULTS

Of the 34 participants, 16 are health professionals and 18 users. Concerning characterization of professionals, 13 (81.3%) were women; the average age was 48 years old; and the average working time at FHS was 9.8 years. Five nurses, four physicians, three nursing technicians, three CHA and one OHA participated. Of the nine higher education professionals, seven had a specialization in FHS. In relation to users, 13 women (72.2%) and five men participated, and the average age was 42 years old. As for the level of education, nine had incomplete elementary school, three had complete elementary school, three had complete high school, two had higher education, and one declared himself illiterate. Of these, only five were from SD and eight had some type of health insurance.

Three theoretical codes emerged from the analysis of the study: *Notions of demands by FHS professionals and users: spontaneous, scheduled, and repressed; Interrelation of demand at FHS; Access, accessibility, and demand at FHS*. These theoretical codes led to the formulation of the central category: *"The theory of demand at FHS: spontaneous, scheduled or repressed?"*. The results indicated 32 codes *in vivo* that mark the speech and meanings of the research participants before the demand at FHS. The focal codes emerged from data comparison, identifying context, determining conditions, strategies, consequences, behaviors of professionals and users in the face of the demand in the daily services, settings of the study, giving the analyzed data the formulation of the categories and theoretical integration (Figure 1). This article deals with the category, *Access, accessibility and demand at FHS*.



**Figure 1.** Diagram of the representation of the central phenomenon of the theory of demand at FHS

Source: research data. In this manuscript, the theoretical code, *Access, accessibility, and demand at FHS*, and the respective codes *in vivo* were discussed, which identify determining conditions, context, strategies, and consequences.

SI subsidizes, from the perspective of the research participants, the experience of demand at FHS. This experience implies provision of health services, reception, humanization of care, increased repressed demand and user dissatisfaction with the System.

The focal code, *Access: barriers and implications*, refers to the daily impact of demands on FHS and access limitations within the scope of SUS, emphasizing context, strategies established, some of its determinants and conditions.

### Determining conditions

*We have difficulties because it has a large uncovered area of 60%. There are two micro-areas that have been discovered for more than five years, and we have a great ignorance of the reality of this discovered population [...] so, this information needs to reach them as to how they will search. Often, understanding is reduced when it comes to understanding, that it is better to schedule than to come for a screening, at the reception, for example. Care is differentiated, different from one to another (I<sub>H</sub>1).*

*Look, there is a very spontaneous demand due to the lack of an agenda that can serve the population, because our population here is above capacity (I<sub>H</sub>8).*

*I have to look for SUS, because I have no conditions, it is the means for us. We don't have the money to pay for a private hospital, so we go to SUS and FHS to provide the assistance we need (I<sub>U</sub>14).*

### Context

*I should do home visits; I don't have a home visit scheduled due to lack of time and because there is not enough staff. Therefore, I do a visit when they call in case of emergency, because if I leave, there is no one who stays. [...] we should work on prevention before people get sick. [...] I think health needs are people working to not get sick, but we also don't have the infrastructure to do that (I<sub>H</sub>9).*

*Resolution is what is expected when we look for it, isn't it? I think this is also a hope, it is everyone's right too, isn't it? Sometimes, there is treatment that takes longer, you will have to come back, but what everyone expects is that it will be resolved (I<sub>U</sub>14).*

*Like everything in life, everything has rules, and we have to follow, there is a limit. So, each health service has its routine, I usually say, "this is not an ER". We try to work on prevention, of course the curative part is even more striking, but it is not just because patients will arrive here at five and ten, five and fifteen, to get a vaccine, that I will apply it. So, it is their right, but our schedule is over and this vaccine can wait until tomorrow, they had all day to come. They have access, but they also have to respect us who are professionals, and that places have their rules, otherwise we just put-out-a-fire. If you open for urgency all day, you don't do anything else (I<sub>H</sub>11).*

## Strategies

*Access? You should be able to solve everything for users, right? Often, we are able to make the first call, but then we are unable to solve the problem of users, which they really need, referral to the secondary level (I<sub>H</sub>5).*

*Greater coverage is lacking, so that prevention is actually done and that knowledge reaches the patients, so that they understand the dynamics of SUS, how the flow works, and not only to minimize this issue of spontaneous demand. I think that this will always exist, but for users to consciously and adequately seek and be served in their demand (I<sub>H</sub>1).*

*I think it is to facilitate access by all professionals, not to be limited. Just like we deal with the reception, the evaluations go up to half past eight, but we are embracing throughout the day. So, this access is even easier. When the patients arrive, we are willing to help (I<sub>H</sub>2).*

*Health access means we arrive, are served and have the service available. Unfortunately, it is poor, we see, the media always shows. From one to ten, in my opinion, I would rate it two in relation to access, because it is very poor (I<sub>U</sub>2).*

## Consequences

*At SUS, today, users arrive at the FHS unit. Now, from now on, things get harder because of specialists. There is no orthopedist and cardiologist at the polyclinic, only at the federal university and there is only one neurologist. Surgery? Very complicated! It is difficult for you to get physical therapy; I think we can at FHS. So, access is*

*restricted, I think it's going well so far, isn't it? At the entrance door, but then it gets harder (I<sub>H</sub>12).*

*Resolution would be solution, an attitude that would solve the problems, but, for me, it is another thing that is poor. The government is very fragile. We see that the media shows cities that care and effectively care, they work, but in general, they also work very badly (I<sub>U</sub>2).*

*Resolution would be us being able to serve users in a timely manner, right? That would be it, they would come to make the appointment, be able to schedule the exam quickly for them to come back, show and be referred. Quick within they need. In fact, if they are feeling sick, we can serve them, if they need to be referred to a cardiologist, then the physician gives "priority", then we should be able to schedule them for at least this month. Sometimes, I can't even schedule them in a year! There is a huge waiting list (I<sub>H</sub>5).*

The second focal code, *Access, care, and humanization*, describes the conceptions of access, accessibility, and resolution, contextualizing care practices developed at FHS, expressing the feelings experienced by users and professionals.

## Determining conditions

*I understand that people have to have access to health, because health is everyone's right, but people have their duties as well. [...] we have our duties to take care of you, but you also have your duties, which is to come, to tell us that your medicine is running out, to make an appointment in advance. It's not getting here needing things for yesterday! Of course, unless a person is sick at dawn, but it is not the case of ER (I<sub>H</sub>9).*

*I think the government had to give more priority to us as we are unable to get a health insurance and do a proper check-up. It is very difficult to see a physician, get treatment and if you are very seriously ill and wait, you die (I<sub>U</sub>1).*

## Context

*The State, unfortunately, is very weak, it is very poor, it leaves much to be desired. In my knowledge as a citizen, the State is in a position to provide a better care to the citizen, but it does not due to corruption, lack of commitment, investments, in every way, is it? Equipment, human material, this requires a lot of funding. The demand becomes difficult, doesn't it? It's problematic, it's problematic (I<sub>U</sub>2).*

*I have little hope in medicine, I think people look for assistance, consultation, exam. Health is expensive, isn't it? Because there is no professional in SUS, because they pay little, the salary is low, colleagues do not accept, they will do other jobs. Then they do private care, you better*

*attend a private consultation than ten in public health [...] after 45 years of age, people start to have chronic diseases, so there will be needs for exams, consultations and surgeries. So, there an inclination to increase even more the number of people who need treatment and secondary prevention (I<sub>H</sub>12).*

*A problem is that politicians understand the importance of PHC, right? Because I One problem is that politicians understand the importance of PHC, right? I came to this city eight years ago, and what I see is that the city is very organized around Secondary and Tertiary Care. So, the indicators of diseases and complications are bad, things that a good and organized PHC could be preventing these. There is a need for managers to understand this importance and move towards that direction. As long as this city has this precarious PHC, there will be all kinds of complications getting there in ER, such as heart attacks, diabetics to amputate, maternal and child mortality, sexually transmitted diseases like syphilis. We are unable to assist the population, but there are hospitals and diagnostic exam clinics, and this is valued (I<sub>H</sub>14)*

## Strategies

*Creation of other FHS teams, because the population is above capacity (I<sub>H</sub>8).*

*Well, the proper composition of the team, with the appropriate number of professionals would be the first step. Another thing would be to increase the quotas for appointment with specialists, as it is the need that we see here most, of people waiting one, two years to get an appointment with a specialist. Another thing is to provide faster release of exams in order to arrive at the proper diagnosis (I<sub>H</sub>16).*

*The proposal is perhaps the obvious one, to embrace this patient at the time of the consultation, to have the patience to look at this patient as a whole to see if this demand decreases, if the patient does not come so much for little, for something that can wait, if the patient can understand that he/she can come here in a while (I<sub>H</sub>11).*

*Sometimes, the solution is to have good employees, to be willing to attend. [...] do not ignore people because there are people who come here with a lack of education level and all, but you have to keep a professional attitude. I think that this professional attitude is missing, in addition to health care center and people embracement (I<sub>U</sub>11).*

## Consequences

*Poor accessibility! Because you need hospitalization, but there isn't. Like in ER, people are sleeping on the floor, chair, there is no stretcher, nothing. It is not the professionals'*

*fault, because they treat us well there, but the SUS service is very insufficient. [...] there has to be a service by SUS that gives more confidence, more comfort, because it is bad, see?! [...] SUS does not offer conditions for the professional to work, because if he were able, then the employee would work with more satisfaction, right? What is really missing is SUS learning to manage, because I pay too much (I<sub>U</sub>13).*

*So, I open the agenda for the whole month, the person arrives, and with me having the vacancies, I schedule, if it is urgent, do not wait for the appointment day (I<sub>H</sub>3).*

*Unfortunately, today, SUS is sometimes omitted, it does not serve everyone. He does not offer decent service, which is my case, I have a problem with my sight and the problem just keeps going, then time goes by! [...] ah, we are hoping to have a physician, have this and have that. You are served, but they don't solve your problem (I<sub>U</sub>14).*

## DISCUSSION

The daily demands at FHS and access limitations make the teams struggle due to low population coverage, high number of registered people, low resolution, lack of professionals, ineffective management and scarcity of scheduled actions.

A study conducted in the city of Recife, PE, Brazil supports the findings of this study by identifying that, in the opinion of most professional categories, there is a limited offer of actions at FHS and low population coverage due to lack of CHA.<sup>18</sup>

In the city of Belo Horizonte, Minas Gerais, Brazil, a study indicated that "exclusive SUS users are 60% more likely to have difficulties in obtaining consultations compared to their peers affiliated with a private health plan"<sup>19:08</sup>, regardless age, sex, and education level.<sup>19</sup>

A study carried out in Quebec, Canada, after reforms in PHC, found that accessibility increased, almost triple, when it was possible to access medical or nursing consultation on the same day, in addition to increasing the physician's daily workload.<sup>20</sup> Thus, organization of PHC services, with resource management, can influence access to actions more quickly, with good performance and resolution.

Despite the fact that FHS needs to offer actions in full to the enrolled population, according to the needs of each one and the community, considering the determinants and health conditions,<sup>17</sup> the focus is still biomedical and with intramural actions. "Users, mainly, considered the number of home visits carried out by both higher education professionals and CHAs to be reduced. One of the justifications is high demand for consultations within the unit, with no time left for households, restricting access to users who cannot travel"<sup>18:644</sup> Moreover, "there is an overload of work for other team professionals and search by users for highly complex services"<sup>18:642</sup>

A study carried out in the city of Rio Branco, Acre, Brazil, in turn, found that, in the routine of the PHC units, the service

offer is “authoritarian, since users are obliged to submit to the available offers, without taking into account their health needs, contrary to the principle of integrality. Units must organize their work based on the vulnerability of their users, providing responsible and resolute referral to demands, including those that the PHC team is unable to solve”.<sup>21:385</sup>

According to participants in this study, barriers to access PHC actions are the lack of information from users about services, who do not know which flow or unit they should look for according to their health needs. Misinformation of users was pointed out in a study as “paths taken by people through their lay behavior, seeking to face their health problems”.<sup>18:2014</sup>

A survey of 840 families in selected urban, peri-urban and rural communities in northern Nigeria showed that there was no barrier to health information and service delivery, suggesting good awareness of health problems. This was also confirmed by community involvement and participation in health issues, regardless of districts.<sup>22</sup>

A study carried out by the World Health Organization between 2007 and 2010, comparing the performance of the health system in six countries (China, Ghana, India, Mexico, Russia, and Africa), showed that overmore than 90% of respondents reported having received care when needed. However, there were variations in this indicator in China, with the most disadvantaged populations and least likely to report receiving health care whenever necessary, compared to riverine populations.<sup>23</sup>

In the city of Belo Horizonte, Minas Gerais, it was possible to identify that “scheduling appointments and exams of medium complexity is associated with poor resolution of PHC physicians. Delay in making appointments was associated with lack of specialists and difficulty regulating the municipal health system”.<sup>24:107</sup>

In the province of Quebec, Canada, it was identified that access to specialized care (physiotherapy, psychotherapy and nutrition) is problematic for people living in poverty, since the access of these people in socioeconomic deprivation is through the public health system, where the waiting time is more than one year. Survey participants recognized that the System’s limited resources made access to care difficult. For frontline health professionals, the most significant problem was the lack of family physicians in the Province, which negatively affects patients’ health. They pointed out, for instance, that patients often go to the Emergency Room after they have not received consultations at primary care clinics because their untreated conditions have worsened.<sup>25</sup>

The conceptions of access, accessibility, and resolution are contextualized by the participants of this research in embracing and humanizing, in the precision of expanding the population coverage and access, in addition to expressing the feelings experienced by users and professionals.

A study carried out in the city of Santa Maria, Rio Grande do Sul, Brazil, identified that embracing at FHS emerged as an important aspect to bring the health team closer to users. “Listening on the part of the team allows the knowledge of the users’ health needs from their reality, and makes the actions

meet the demand and be consistent with their possibilities. [...] In summary, the performance of the FHS team is not limited to medicating, consulting or examining, and passes to the significance of embracing the person itself, whether through a dialogue, a gesture or any donation attitude with the awareness of the therapeutic effect it provides”.<sup>26:4032</sup>

Another factor that directly influences the demand for health actions is the aging of the population, which brings about a change in the epidemiological profile configured by chronic diseases and by the increase in demand for health services. To this end, it is essential to strengthen strategies for the use of resources to meet the needs of aging.<sup>27</sup>

In southern Brazil, a study carried out in an Emergency Care Unit showed that “the population is used to the traditional model of care, so that care centered on the disease is incisively present in the daily lives of many users, evidenced, mainly, for the constant search for medicines and immediate resolution of the problem, that is, there is no perspective on preventing injuries and promoting health”.<sup>28:58</sup> Therefore, “without reorganization of health services, with a preventive and comprehensive approach that combines epidemiological reflection and planning of health actions, there is no way out”.<sup>29:1839</sup>

Although evidence from the study conducted in Guangdong province, China, suggests that having a regular source of care can improve the quality of primary care, this is still not a requirement in China and the government does not impose restrictions on the selection of the health care provider. For this reason, health resources may not be effectively used, as patients crowd in the tertiary hospital, although their illnesses are not so severe. This can not only reduce the quality of primary care received, but also a waste of health resources. The study suggested that if there was a health policy that would guide patients to use a regular care unit, the overall quality of primary care could improve and the use of health care resources might be more appropriate, especially for the growing number of patients with chronic disease, since the proportion of patients surveyed without a usual source of care in Guangdong was 56%.<sup>30</sup>

In Nigeria, a study showed that research participants have poor perceptions of general health services in communities. More than half of the users (50.4%) rated health services as poor, with a negative rating by rural residents. The periurban and urban respondents had a rating of 47.3%, considering the precariousness of the services.<sup>22</sup>

In addition to the user’s perception of the conditions of the services, professional satisfaction “with work is fundamental for users to feel in the team the security they need to take responsibility for their therapeutic and self-care plan”<sup>26:4031</sup>, creating bond.

Furthermore, the participants of this study address influence of politics and corruption, which is a barrier that alters the priority of financing financial resources for health and thus demand becomes problematic and interferes in the assistance for a better service for citizens.

The symbolic interaction of access, accessibility, and demand presented by the participants, users and professionals translate

the lived experiences and consider the meanings attributed to their experiences and their relationships in their environment. From this understanding, it is possible to expand the paths of knowledge and professional practice. Such perceptions refer to senses and feelings in relation to lack of access and accessibility in health and perspectives regarding health demands. SI promotes interpretation, definition of the process of interaction between people and how it can be modified, depending on the adaptation that occurs in the actions of the actors involved.

## FINAL CONSIDERATIONS

The theory of demand at FHS allows to explain the perspective of FHS professionals and users regarding their conceptions and dynamics of access, accessibility, demand, and health care in the daily life of FHS and services through which they are referred. The conceptions are translated by singular meanings of difficulties of access, high spontaneous demand, and low resolution, configuring deficiency in accessibility.

As contributions to health and nursing, this study provides subsidies for health professionals, users, and managers to collaboratively seek strategies to cope with high spontaneous demand and access difficulties. Absence of participation by managers in the city's health sectors is considered a limitation of the research, due to turnover and because they do not include the inclusion criteria of this study. It is proposed to replicate the theory of demand at FHS in other realities.

## AUTHORS' CONTRIBUTIONS

Study conception and design, acquisition, data analysis and interpretation of results, writing and critical review of the manuscript, approval of the final version of the article, responsibility for all aspects of the content and integrity of the published article: Gianina Marcela Chávez.

Study conception and design, acquisition, data analysis and interpretation of results, writing and critical review of the manuscript, approval of the final version of the article, responsibility for all aspects of the content and integrity of the published article: Selma Maria da Fonseca Viegas.

Interpretation of results, writing and critical review of the manuscript, approval of the final version of the article, responsibility for all aspects of the content and integrity of the published article: Gabriel Rios Roquini. Thiago Rocha Santos.

## ASSOCIATE EDITOR

Aline Aparecida Monroe

## REFERENCES

1. Assis MMA, Jesus WLA. Acesso aos serviços de saúde: abordagens, conceitos, políticas e modelo de análise. *Cien Saude Colet*. 2012 nov;17(11):2865-75. <http://dx.doi.org/10.1590/S1413-81232012001100002>. PMID:23175292.
2. Dresch RL. O acesso à saúde pública e a eficácia das normas de regulação do SUS [Internet]. 1. ed. Brasília: CONASS; 2015 [citado 2017 Jul 4]. Disponível em: [http://www.conass.org.br/biblioteca/pdf/colecao2015/CONASSDIREITO\\_A\\_SAUDE-ART\\_18.pdf](http://www.conass.org.br/biblioteca/pdf/colecao2015/CONASSDIREITO_A_SAUDE-ART_18.pdf)
3. Tristão FI, Lima RCD, Lima EFA, Andrade MAC. Acessibilidade e utilização na atenção básica : reflexões sobre o absenteísmo dos usuários. *Rev Bras Pesq Saúde* [Internet]. 2016 jan/mar; [citado 2017 Jul 4];18(1):54-61. Disponível em: <http://periodicos.ufes.br/RBPS/article/view/15134/10715>
4. Donabedian A. Aspects of medical care administration. Cambridge: Harvard University Press; 1973.
5. Meneses CS, Cecilio LCO, Andreazza R, Carapineiro G, Andrade MGG, Santiago SM et al. O agir leigo e a produção de mapas de cuidado mistos público-privados. *Cien Saude Colet*. 2017 jun;22(6):2013-24. <http://dx.doi.org/10.1590/1413-81232017226.14822016>. PMID:28614520.
6. Richard L, Furler J, Densley K, Haggerty J, Russell G, Levesque JF et al. Equity of access to primary healthcare for vulnerable populations: the impact international online survey of innovations. *Int J Equity Health*. 2016 abr;15(64):1-20. <http://dx.doi.org/10.1186/s12939-016-0351-7>. PMID:27068028.
7. Shi L, Lee DC, Liang H, Zhang L, Makinen M, Blanchet N et al. Community health centers and primary care access and quality for chronically-ill patients – a case-comparison study of urban Guangdong Province, China. *Int J Equity Health*. 2015 nov;14(90):1-17. <http://dx.doi.org/10.1186/s12939-015-0222-7>. PMID:26616048.
8. Monteiro CN, Beenackers MA, Goldbaum M, Barros MBA, Gianini RJ, Cesar CLG et al. Use, access, and equity in health care services in São Paulo, Brazil. *Cad Saude Publica*. 2017 maio;33(4):1-13. <http://dx.doi.org/10.1590/0102-311x00078015>. PMID:28538789.
9. Nunes BP, Thumé E, Tomasi E, Duro SMS, Facchini LA. Desigualdades socioeconômicas no acesso e qualidade da atenção nos serviços de saúde. *Rev Saude Publica*. 2014 dez;48(6):968-76. <http://dx.doi.org/10.1590/S0034-8910.2014048005388>. PMID:26039400.
10. Ministério da Saúde (BR). Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB) - Estratos para Certificação [Internet]. Brasília: Ministério da Saúde; 2020. [citado 2017 Jul 4]. Disponível em: [http://dabgerenciador.homologacao.saude.gov.br/sistemas/pmaq/estratos\\_para\\_certificacao.php](http://dabgerenciador.homologacao.saude.gov.br/sistemas/pmaq/estratos_para_certificacao.php)
11. Alves MGM, Casotti E, Oliveira LGD, Machado MTC, Almeida PF, Corvino MPF, et al. Fatores condicionantes para o acesso às equipes da Estratégia Saúde da Família no Brasil. *Saúde Debate*; 2014 out;38(esp):34-51. <http://dx.doi.org/10.5935/0103-1104.2014S004>
12. Miranda GMD, Mendes ACG, Silva ALA, Santos Neto PM. A ampliação das equipes de saúde da família e o programa mais médicos nos municípios brasileiros. *Trab Educ Saúde*. 2017 jan/abr;15(1):131-45. <http://dx.doi.org/10.1590/1981-7746-sol00051>.
13. Campos CMS, Mishima SM. Necessidades de saúde pela voz da sociedade civil e do Estado. *Cad Saude Publica*. 2005 ago;21(4):1260-8. <http://dx.doi.org/10.1590/S0102-311X2005000400029>. PMID:16021264.
14. Strauss A, Corbin J. Pesquisa Qualitativa: técnicas e procedimentos para o desenvolvimento de teoria fundamentada (Tradução Luciane de Oliveira da Rocha) 2. ed. Porto Alegre: Artmed, Bockman; 2008.
15. Blumer H. A natureza do interacionismo simbólico. In: Mortensen C, organizador. Teoria da Comunicação: textos básicos. São Paulo: Mosaico; 1980. p. 87-104.
16. Blumer H. Symbolic Interactionism: Perspective and Method. Englewood Cliffs: Prentice-Hall; 1969.
17. Portaria nº 2.436, de 21 de setembro de 2017 (BR). Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União [periódico na internet], Brasília (DF), 21 set 2017 [citado 2017 Jul 4]. Available from: <http://www.conass.org.br/conass-informa-b-192-publicada-portaria-gm-n-2436-que-politica-nacional-de-atencao-basica-estabelecendo-revisao-de-diretrizes-para-organizacao-da-atencao-basica-no-ambito-do-sist/>
18. Lima SAV, Silva MRF, Carvalho EMF, Cesse EAP, Brito ESV, Braga JPR. Elementos que influenciam o acesso à atenção primária na perspectiva dos profissionais e dos usuários de uma rede de serviços de saúde do Recife. *Physis*. 2015 jun;25(2):635-56. <http://dx.doi.org/10.1590/S0103-73312015000200016>.

19. Silva SS, Mambrini JVM, Turci MA, Macinko J, Lima-Costa MF. Uso de serviços de saúde por diabéticos cobertos por plano privado em comparação aos usuários do Sistema Único de Saúde no Município de Belo Horizonte, Minas Gerais, Brasil. *Cad Saúde Pública*. 2016 out;32(10):1-11. <http://dx.doi.org/10.1590/0102-311X00014615>
20. Pará-Plante A, Boivin A, Berbiche D, Breton M, Guay M. Primary health care organizational characteristics associated with better accessibility: data from the QUALICO-PC survey in Quebec. *BMC Fam Pract*. 2018 dec;19(188):1-8. <http://dx.doi.org/10.1186/s12875-018-0871-x>. PMID:30509205.
21. Chagas HMA, Vasconcellos MPC. Quando a porta de entrada não resolve: análise das unidades de saúde da família no município de Rio Branco, Acre. *Saude Soc*. 2013 jun;22(2):377-88. <http://dx.doi.org/10.1590/S0104-12902013000200010>.
22. Onyeneho NG, Amazigo UV, Njepuome NA, Nwaorgu OC, Okeibunor JC. Perception and utilization of public health services in Southeast Nigeria: Implication for health care in communities with different degrees of urbanization. *Int J Equity Health*. 2016 jan;15(12):12. <http://dx.doi.org/10.1186/s12939-016-0294-z>. PMID:26791575.
23. Alshamsan R, Lee JT, Rana S, Areabi H, Millett C. Comparative health system performance in six middle- income countries: cross- sectional analysis using World Health Organization study of global ageing and health. *J R Soc Med*. 2017 set;110(9):365-75. <http://dx.doi.org/10.1177/0141076817724599>. PMID:28895493.
24. Viegas APB, Carmo RF, Luz ZMP. Fatores que influenciam o acesso aos serviços de saúde na visão de profissionais e usuários de uma unidade básica de referência. *Saude Soc*. 2015 mar;24(1):100-12. <http://dx.doi.org/10.1590/S0104-12902015000100008>.
25. Loignon C, Hudon C, Goulet É, Boyer S, De Laat M, Fournier N et al. Perceived barriers to healthcare for persons living in poverty in Quebec, Canada: the equihealthy project. *Int J Equity Health*. 2015 jan;14(4):4. <http://dx.doi.org/10.1186/s12939-015-0135-5>. PMID:25596816.
26. Machado LM, Colomé JS, Silva RM, Sangoi TP, Freitas NQ. The meaning of professional making at Family health strategy: primary care as scenario practice. *J Res Fundam Care*; 2016 jan;8(1):4026-35. <https://doi.org/10.9789/2175-5361.2016.v8i1.4026-4035>
27. Gomes FFC, Cherchiglia ML, Machado CD, Santos VC, Acurcio FA, Andrade ELG. Acesso aos procedimentos de média e alta complexidade no Sistema Único de Saúde: uma questão de judicialização. *Cad Saude Publica*. 2014 jan;30(1):31-43. <http://dx.doi.org/10.1590/0102-311X00176812>. PMID:24627011.
28. Baratieri T, Almeida KP, Lentsck MH, Natal S. Percepções de usuários atendidos em um Pronto Atendimento: olhar sobre a Atenção Primária à Saúde. *Rev Saú Públ Paraná*. 2017 jul;18(1):54-63. <http://dx.doi.org/10.22421/1517-7130.2017v18n1p54>.
29. Veras RP. Prevenção de doenças em idosos: os equívocos dos atuais modelos. *Cad Saude Publica*. 2012 out;28(10):1834-40. <http://dx.doi.org/10.1590/S0102-311X2012001000003>. PMID:23090164.
30. Du Z, Liao Y, Chen CC, Hao Y, Hu R. Usual source of care and the quality of primary care: a survey of patients in Guangdong province, China. *Int J Equity Health*. 2015 jul;14(60):60. <http://dx.doi.org/10.1186/s12939-015-0189-4>. PMID:26227113.