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UNIVERSAL ACCESS TO HEALTH SERVICES AS PSYCHOSOCIAL CONSTRUCTION OF USERS

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ABSTRACT

Objective: To analyze universal access to health from the social representations of users about the Unified Health System, in the city of Rio de Janeiro, Brazil. **Method:** A quantitative-qualitative study, based on the Theory of Social Representations, in its procedural approach. Data collection was performed in 2010, through a semi-structured interview. The data were analyzed using Alceste 4.7 software. **Results:** 104 users of the health system participated, most of them women, income up to a minimum wage and residents from Rio de Janeiro. Two textual sets were evidenced in the lexical analysis: "The process of evaluation of the health system: the experience of users" and "The health system: structure and purpose". **Conclusion:**Health service users have built the experience of a system in permanent construction that lacks, in some situations, financial resources, basic and essential routinely actions, but that actualize the universality of social classes and different levels of complexities of care.

Keywords: Universal access to health care services. Universal Health Insurance. Unified health system. Community health nursing.

INTRODUCTION

The consolidation of the Unified Health System (SUS) in the Brazilian Constitution of 1988 is considered as a milestone in the idea of health, since it incorporates access to health as a universal right and its guarantee as a duty of the State through economic and social policies through social policies aimed at reducing risks of diseases and other grieving and providing conditions for universal and equal access to services and actions for promotion, protection and recovery[1]. Universal health coverage is based on the principles of integrality, equity, universality and social participation and aims to ensure universal and comprehensive, curative and preventive care, through the decentralized provision and management of health services, favoring the participation of the community at all levels of government[2].

Considering the regional differences in Brazil, historically the construction of the system has made the differences that particularize the nation and the construction of new relations based on more flexible citizenship and human dignity. The vanguard position of Brazil has repercussions in the international context, with the adoption of a resolution by the World Health Organization (WHO), defining strategies for universal access to health[3], proposing an improvement in the training of human resources at the primary level; consolidation of multiprofessional and collaborative health teams; granting the access of these teams to health information and introducing new professional and technical profiles according to the model of comprehensive care, respecting the guiding principles of the Brazilian system[4].

In the national context, with a scenario of economic crisis and demographic, social and political transformations, new health demands were placed on the system. These new demands are characterized by the universalization of care at all levels of health care, including universal access to antiretrovirals, cancer treatment, organ transplants, among others. However, at the same time to this advance in the coverage of health needs, there is a space of contradictions,

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evidenced by the difficulties of access to different services, frequent insufficiency of medicines, long waiting for care and conflicts between professionals and users[5]. Social transformations that strongly interfere with its genesis, such as the exploitation of natural and human resources, the lack of confidence in national politics, the growing impoverishment of the population, unemployment and the weakening of labor relations that present themselves as an obstacle to sustainable growth[6].

The contradictions of SUS are not exclusive and not sectoral, are experienced by professionals and users in their work process, to born, to live, to become ill and to die. In this context, these social groups attribute to the system senses in according to what they know, the experiences they had and the social position they occupy. Thus, understanding these meanings is an act of exploring the psychological constructs in a social context in order to understand how SUS was introduced in the daily life of health users and workers[7-8].

The study of social representations is an alternative of knowledge production in the field of health due to the importance of health-disease phenomena for social life and the potential elucidation of cognitive processes and social interactions in the definition of practices through theory[9]. In the field of analysis of the social representations of health systems, we highlight works on to the analysis of the judicialization of health care[9], the elucidation of the principles of SUS retranslated in professional representations[5], the analysis of the humanization of practices of care, among others, showing the importance of using Social Representation Theory (SRT) in this field of study.

In this study, the hypothesis of the existence of a precedence of representations determining the formation of the practices of access and attention to health is developed. Practices based on universal access to health services and equity of attention were shaping the pre-existing representations of the SUS, according to historical construction, based on the organizational and philosophical principles defined for the system[10].

This study is based on the search for an empirical finding of the existence of a social representation of the SUS, which has consequences for the practices of access to health care, in addition, the social and political importance of the SUS defense in the discussion of existence of a universal system as the basis for access to health in Brazil[8]. Considering the symbolic dimensions associated to the health system, especially considering that thought and action establish important relationships, the objective was to analyze the universal access to health from the social representations of users about the Unified Health System, in the city of Rio de Janeiro, Brazil.

METHODOLOGY

This study is part of an integrated research project entitled “Municipal Health Policies in the Context of SUS: Memories and Representations of Institutions, Professionals and Users in the City of Rio de Janeiro”. It is a study guided by the Theory of Social Representations, in its procedural approach[11], which directs the description of the representational contents of the analyzed phenomena and their dimensions, considering the supports by which the representations are disclosed in everyday life. Such supports are based on the individual and group discourses that hold the representations and define the social behaviors and practices. The theory considers social representations as *sui generis* collective sciences, assigned to the interpretation and elaboration of the real, built in the scope of social psychology and widely used in the nursing science. It is emphasized that a representation is made of a set of beliefs, information, opinions and attitudes about a certain social object, organized and structured in a socio cognitive system[10].

This is a quantitative-qualitative study involving five health institutions in the city of Rio de Janeiro, Brazil, obeying the inclusion criteria: easy access to the population; service to the users of diverse localities of the municipality and the state; various social insertions; large number of visits; and offer services at many levels of assistance and complexity of the system. A federal hospital, a state hospital, a municipal hospital, a philanthropic institution associated to SUS and a basic health unit were

studied, aiming at contemplating all the levels of care involved in SUS.

The convenience sample consisted of 104 users, distributed proportionally among the five services, hospitalized in wards in hospital units or who went to consultations in the basic health unit. The inclusion criteria were: to be at the chosen research field receiving attendance, being therefore, user of the study institution and age group over 40 years, considered as critical period for the constitution of memory[12] and in a way of having experiences as users of health services before 1990. The exclusion criteria were:to be at the emergency, maternity, pediatric and surgical clinic units, as well as users with intellectual impairment.

The information was collected in 2010, through semi-structured interviews, recorded and later transcribed, and an identification questionnaire. Topics included in the interview guide were topics about perceptions, concepts and images of the SUS, roles of the SUS, judgments about the practices of the system, existing and used services in the SUS, structure and working of SUS, guiding principles of SUS.

The analysis of the discursive *corpus* was performed using the descending hierarchical lexical analysis technique, using Alceste 4.7 software. The software identifies the major thematic axes discussed by the interviewees and allows a description of theexpressed discursive contents, evidencing the dimensions and contents participating in the SUS social representation. This analysis highlights the key words(category), the relationship between classes and the discursive context of words. The software uses textual statistics, considering the co-occurrence of functional words (nouns, adjectives, verbs) in the same statement[13].

The development of the study met national and international standards of research ethics involving human subjects.

RESULTS

Participating users were: 76% women and 24% men; 53% aged between 40 and 50 years, 32% between 50 and 60 years, and 15% over 60 years; 58% with personal income below a minimum wage, 30% between two and three minimum wages and 12% above three minimum wages; 72% lived in the municipality of Rio de Janeiro and 28% in other municipalities. The representational content constructed by the users is presented in two themes: "The process of evaluation of the health system: the experience of users" and "The health system: structure and purpose". These blocks comprise 3,208 elemental context units (ECU) cut by the software.

According to Figure 1, these clippings are distributed in seven classes (categories), which present proximity or opposition of content, according to their position in the hierarchical division of the text and the established relations.

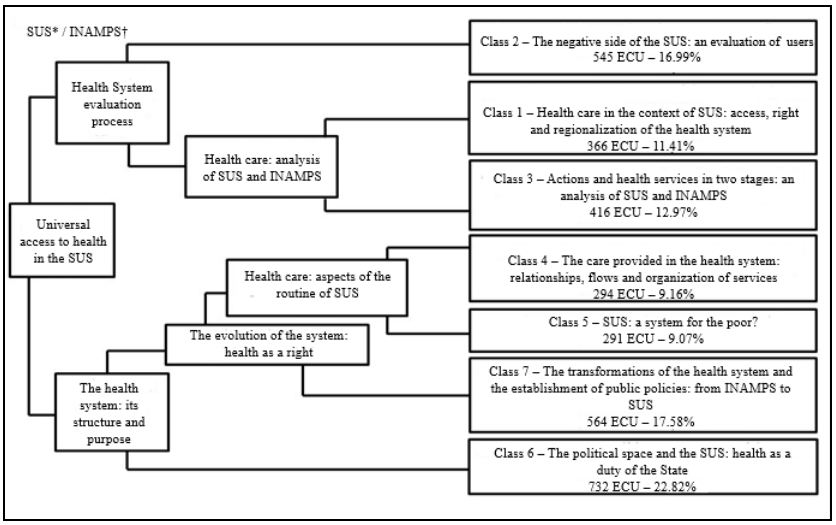

Figure 1. Classification of the discursive contents of SUS users. Rio de Janeiro, 2015.

Thematic I - The process of health system evaluation: the experience of users

This block corresponds to 41.37% (1,327 ECU) of the *corpus* analyzed and includes three lexical classes: Class 1 – Health care in the context of SUS: access, right and regionalization of the health system (11.41%, 366 ECU); Class 2 – The negative side of SUS: an evaluation of users (16.99%, 545 ECU); Class 3 – Actionsand health services in two phases: an analysis of SUS and INAMPS (12.97%, 416 ECU), according to Figure 2.

Discursive contents are evidenced with negative connotations of the public health services, pointing to a scenario of negligence and lack of resources, which makes it impossible to access and resoluteness of the demands brought about by the population, which can have repercussions on the aggravation of morbidity of users.

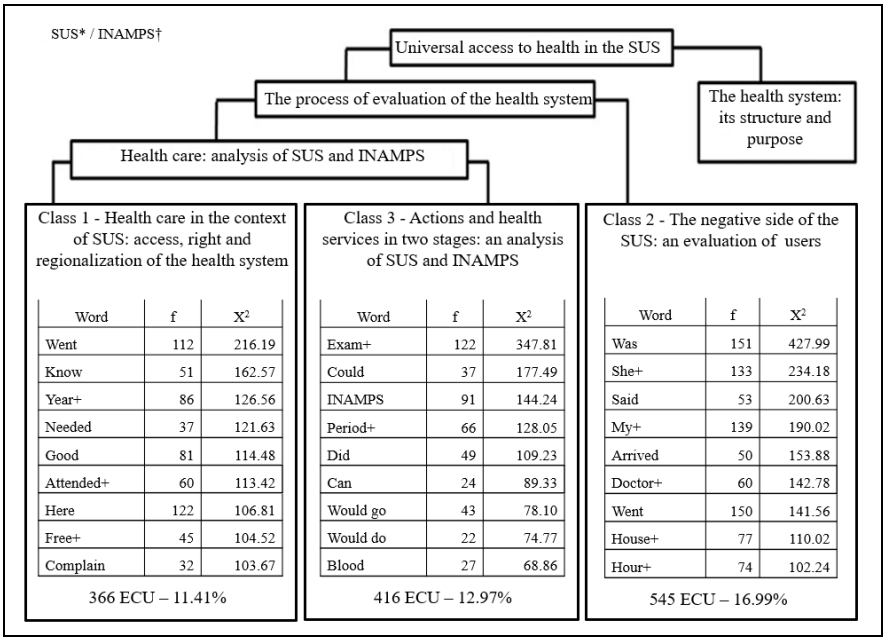

Figure 2. Classification of discursive contents, Thematic Block I. Rio de Janeiro, 2015.

Still, among the negatively evaluated elements is the need to resort to health units away from home, as well as implications and difficulties for users and their families, pointing to the fortuitous success of the principle of regionalization of care.

> My father, when he was run over, spent two days on a stretcher in the emergency room, first on the floor, then he got a stretcher, went on the twenty-first of April, Hospital [refers to a municipal emergency hospital in the center of the city] after, he died, but I know it is everywhere, legs amputated arrive. (E25)

> We would leave the house at four, three-thirty in the morning, there was no bus, I would wait for buses to arrive to Tijuca to operate my son in the hospital. (E78)

The evaluative content results from the current or past experiences of the users, at the public health units, which are also evaluated positively, from the recognition that access to care is generally achieved, even with difficulties.

> For me, the SUS is everything, because I do not know what it would if it were not for it. Ever since I got married, my children and I have always been treated in the SUS, we never had a health insurance. (E23)

> I have nothing to say about this clinic, for me it's great. This health clinic is for everything, I like it. I've been here for over ten years, I've even got a card, it's all here, I have just updated my records. (E84)

In addition to the health system itself, the services are also evaluated based on the users' experiences, in negative and positive aspects. Among the negatives that make access difficult

are the interference of professionals and third parties in favoring access to care for some, interfering with the principle of equity, and the service queues seen as inherent in public services:

> Sometimes the people who have better financial conditions are better served than the people who really need them. Because there is that [professional] that says: this patient is like this but is a person who does not need it. (E45)

> Sometimes, you can die even with care, but without care is worse. I hope to find good care. We have always left early, every time we go to the hospital for any health service we go early because it has a queue and we must wait. (E24)

Human resources in the SUS is also an object of concern for users, highlighting the need for better remuneration for professionals, based on the assumption that it would bring an improvement in the quality of care. Communication presents itself as central to the service, however, users are confronted with less empathetic professionals and build an explanatory system for such behavior:

> You are a professional ... you are from the nursing area, you are a nurse, you are a doctor and you do not get paid, how will you take good care of the other? You must have your money, if you do not have your money you will not take good care of anyone ... You also have a job. So, you will not treat me well if you are not getting paid, you will do like many: will go on a strike and whatever. (E93)

> So, talking with people, with the population, trying to feel what they really need, is what can be done, will improve more and more. (E44)

Within the institutions, the evaluation unfolds in the human relations between the patients, the families, the professionals and the institution. This relationship may be positive or conflictive, depending on the situations faced in the daily life, as well as the meanings attributed to them. The process of reference and counter-reference is at the heart of these relations.

> He had an acquaintance who sent me to the eighth ward, did an examination and told him to go to the Hospital [X]. And in this hospital, when I went up the stairs screaming with so much pain, they treated me well, it was great. I was only annoyed because I did not want to do the saphenous vein and she insisted, insisted and told my son to sign it. (E95)

As pointed out in the classes that compose this theme, there are contents related to access, right and regionalization of the health system, negative evaluation of SUS and previous health services, institutionalized in INAMPS. The last class, comparing SUS and INAMPS, revealed a process of idealization of the past, typical of the formation of social memory, in which the past overlaps with the present in the positive aspects.

Thematic II - The health system: structure and purpose

Covering 58.63% (1,881 ECU) of the *corpus*, this block includes: Class 4 – The care provided in the health system: relations, flows and organization of services (9.16%, 294 ECU); Class 5 – SUS: a system for the poor? (9.07%, 291 ECU); Class 6 – Thepolitical space and the SUS: health as an obligation of the State (22.82%, 732 ECU); Class 7 – The transformations of the health system and the establishment of public policies: from INAMPS to SUS (17.58%, 564 ECU), according to Figure 3.

The different roles played by the federal, state and municipal spheres in the health sector and the abandonment of a posture of submission of the users concerning the public health decisions are highlighted by the users. Knowledge of the process of municipalization as the basis of the system, as well as the responsibility attributed to the regulatorsto make good use of the financial resources to "benefit the people" are highlighted in the recognition of health as a duty of the State.

> The SUS is a unified health system and depends a lot on the structure that each municipality has, and what is the commitment of the mayor to receive this money and know how to manage so that it will benefit the people of that municipality. (E53)

> The Ministry of Health, nowadays, or the Municipal Health Department, or the State Department of Health, all municipal, state, and federal health-related bodies, in fact [the SUS] is the real seat of government. (E74)

The provision of health actions and services is recognized as a duty of the State in relation to the collection of taxes. And, since the resources invested do not result in quality of services, the SUS is again evaluated:

I agree that health is a duty of the State, because we pay taxes and we have this right, it is their duty to comply.(E12)

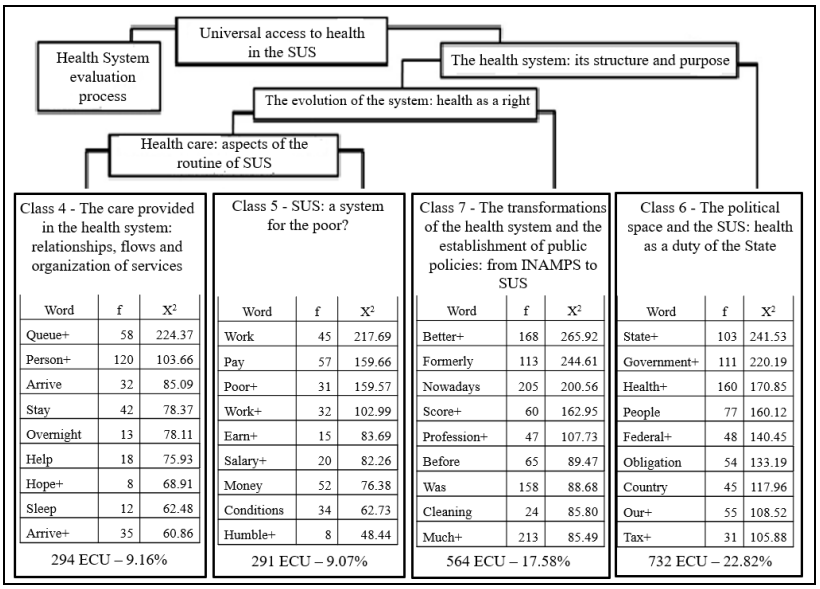

Figure 3. Classification of discursive contents, Thematic Block II. Rio de Janeiro, 2015.

The regionalization of the system and the counter-referral are associated with the service process. It is considered that the objective counter-referral is that the system is adjusted to the needs of users, however, the referred service does not always offer the necessary care, leading private units to assume a complementary role in the implementation of public assistance:

> Where you live? The person lives in such a place, so I'll give you a referral to that health unit near you. Then, you do not come from so far to be attended here, because you may not have the money for the transportation and it stays like this, having the referral is better, now it will depend on whether it will get to that person, and if the person will be attended. (E74)

> There is referral, as for example, from here you go to a certain place, you go, and sometimes, there is not what you ask for. For example, if you want to consult a doctor they do not have, then they will send you to another hospital and stay in that pushing game. (E19)

When comparing the assistance provided in the SUS and INAMPS, the users mention the environmental cleaning, the care of the professionals, the material, financial and human resources, the examinations and the access to services as evaluation items. The quantitative existence of financial, material and human resources is perceived as important for the implementation and quality of care. The need for greater integration between services is highlighted by users.

> The cleaning is better now, because in the old days cleaning was more precarious, the rooms have improved compared to before, it has improved. Today, people tend to be better and more caring, people used to be rude with patients. (E18)

> There is lack of many things, such as funds, human resources and materials that are important to better serve the population, because the population is very poor. I think, as far as possible, services should be more integrated, this integration is still very scarce. (E17)

> Regarding access for exams, medications and hospitalization, today and in the past, the users surveyed attribute to the SUS less access difficulty when compared to the previous system. However, the complexity of takingexamins and the time required for access to services are also elements of comparison between the current context of health and the period of INAMPS:

> Then one could do an exam and could not do the other because the apparatus was broken, to find an X-ray in a hospital back then, in the INAMPS was more difficult. (E83)

> Laboratory exam and X-rays is simple, and it is easier to get now, but for an upgraded exam the difficulty remains the same. (E47)

As for the public to which the SUS is intended, the users point to the low income social group and cannot afford health care, it seems to be represented as a "system for the poor", which, to a certain extent, rescues the non-universality of access, characteristic of the previous health system, and the mixture with the current one, establishing a separation between poor and rich:

> Nowadays, for example, there is some difficulty in attending, because I imagine the SUS as an organ for the poor, who works, earns a minimum wage, and who cannot afford a health insurance.(E04)

> They use the SUS, because there will be more money left, you will not have to pay the health insurance there is more left. Mine is little, I have togo through SUS, but there are people who look for the SUS and do not need so much, they mess up those who need it. (E32)

As pointed out in the naming of the classes that compose this theme, the relations, flows and organization of services stand out; the social purpose of SUS; the recognition of health as a duty of the State; and the establishment of public policies over time.

DISCUSSION

The users' speech is based on a framework of exhaustion of the health care system, given the deepening of social and regional inequalities. It should be noted that this framework cannot be disregarded, since it expresses the social base on which the representations are built; in addition, it jeopardizes the right to health and the strengthening of the system. On the other hand, such problems presented are common problems in countries that face a deep social inequality and not only Brazil[14-16].

The two thematic axes of the analyzed speeches express different representations about SUS and reveal organizational problems of the system, which are reflected in the daily use of health services. In the representations of the users, the reference to the SUS is observed as a system of health for all[7,16], but aimed at the poor, revealing a contradiction not only of the system, but also of the users' own symbolic constructions. It should be noted that a universal health system can be conceived by users as a system for the poor, which is used as the only alternative for those who do not have the financial resources for other forms of access to health. However, universal coverage must be aimed at reducing social inequalities, guaranteeing the use of health services by all social strata, according to the constitutional norm[8,14,17-19].

The weaknesses of the SUS decentralization and regionalization process compromise access and continuity of care, leading the user to seek multiple services for the resolution of their demands[20]. This way, the decentralization strategy came through the legitimation of the autonomy of the three levels of government in the management of health actions and services, the transfer of decision-making power, responsibilities and financial resources in a vertical way, from the Union to the States and from these to the municipalities, which assumed a broad role in the healthfield. However, the fragility of the regional planning of SUS decentralization strategies has compromised its adequacy to the multiple Brazilian realities, so that, still today, problems are perpetuated with regard to inequity in the supply and access of actions and services, fragmentation and to the disorganization of services, observed by users in their daily experience[21-22]. It is pointed out, therefore, that regionalization must be assumed as a project of government, which is not limited to a territorial division[17-19].

The health system and the treatment offered by the services are evaluated both positively and negatively by users, depending on their different experiences with the system and the recognition of success or failure in access to hospitalizations, surgeries and medications. However, such access presents fragilities expressed in the need to search for services away from the home, which implies the user's financial availability, sometimes preventing the full exercise of the right of access to services according to their needs[6,8]. The attitudes toward SUS in representational content are established based on the comparison between the period of validity of the SUS and that of INAMPS, related to access to medicines, examinations and the time for their

implementation, which give a positive point of view to SUS, signaled by greater accessibility.

The users point out that the difficulties found also relate to the state of conservation of health services and the lack of material and human resources. Many faults, failures and difficulties constitute barriers to the provision of a service that may or may not be performed due to the inability to achieve the desired care[8], thus corroborating that access to health is not a guarantee. This is reflected in the psychosocial construction of access among users, seen as a possibility, but not a guarantee, and commonly defined as a "lucky matter".

The professional-user relationship, essential for the implementation of the SUS and for access to services, is perhaps the greatest challenge, considering the apathy of professionals, hostile at times and welcoming at other times[6]. The Brazilian experience shows that it is not enough to create competent and fair legislation in the field of health, but it is necessary to invest in formal mechanisms for the implementation of this new social and political order and, above all, in the representational and psychosocial construction, in order to transform professionals and users in allies and builders of another reality. It is within this framework of difficulties and faults, but also of potentialities and encounters, that the health professional is pointed out as someone capable of favoring users' access, sometimes only by indicating to the user the best way, in other occasions to use mechanisms, sometimes questionable, impairing the right of equal access to health services and actions.

About nurses, these have a role of importance for the consolidation of SUS as a universal system, since it should focus the person to be cared for[4]. In addition, they are professionals prepared to respond and manage health in the vital process, contributing to the reduction of morbidity and mortality in the most deprived areas, and the development of policies that support and value the profession is essential[14].

CONCLUSION

SUS users experience the ambivalence of the Brazilian health system, recognize its importance and its potentialities, however, point out the difficulties that are present in everyday life. Ambivalence refers to the management, human resources and financial difficulties, among others, which reflect in access to services, because, at the same time as the system proposes to be universal, it does not provide enough resources for this; even proposing to be decentralized, does not allocate health units that are quantitatively sufficient and in different degrees of resolution in all regions of the country. Therefore, it is considered that the challenge is not to rethink the SUS as a system, but the lack of sufficient financial resources and political will to implement it and correct its distortions, as well as overcoming management difficulties in the different regions of Brazil, the states and municipalities.

As contributions, it should be noted that a health system recognized as the right of everyone present in the users' representations, but that is subjected to criticism, signaling the need for adjustments of practices carried out by health services and professionals, as well as greater management efficiency. As limitations of the study, it is highlighted the municipal scope, the non-matching of the quantitative of basic and hospital services and the extensive discursive production, which prevented an in-depth discussion of all the representational contents in the speeches.

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O ACESSO UNIVERSAL AOS SERVIÇOS DE SAÚDE COMO CONSTRUÇÃO PSICOSSOCIAL DOS USUÁRIOS

RESUMO

Objetivo: Analisar o acesso universal à saúde a partir das representações sociais dos usuários acerca do Sistema Único de Saúde, no município do Rio de Janeiro, Brasil. **Método:** Estudo com abordagem quanti-qualitativa, pautado na Teoria das Representações Sociais, em sua abordagem processual. A coleta de dados foi realizada em 2010, por meio de entrevista semiestruturada. Os dados foram analisados com auxílio do *software* Alceste 4.7. **Resultados:** Participaram 104 usuários do sistema de saúde, sendo a maioria mulheres, renda de até um salário mínimo e residentes no município do Rio de Janeiro. Foram evidenciados na análise lexical, dois conjuntos textuais: "O processo de avaliação do sistema de saúde: a experiência dos usuários" e "O sistema de Saúde: estrutura e finalidade". **Conclusão:**Os usuários dos serviços de saúde vêm acumulando a experiência de um sistema em permanente construção que carece, em algumas situações, de insumos e ações essenciais, rotineiras e básicas, mas que efetiva a universalidade perpassando classes sociais e distintos níveis de complexidades de assistência.

Palavras-chave: Acesso universal aos serviços de saúde. Cobertura universal. Sistema único de saúde.Enfermagem em saúde comunitária.

EL ACCESO UNIVERSAL A LOS SERVICIOS DE SALUD COMO CONSTRUCCIÓN PSICOSOCIAL DE LOS USUARIOS

RESUMEN

Objetivo: analizar el acceso universal a la salud a partir de las representaciones sociales de los usuarios acerca del Sistema Único de Salud, en el municipio de Rio de Janeiro, Brasil. **Método:** estudio con abordaje cuanti-cualitativo, basado en la Teoría de las Representaciones Sociales, en su enfoque procesal. La recolección de datos fue realizada en 2010, por medio de entrevista semiestructurada. Los datos fueron analizados con el auxilio del software Alceste 4.7. **Resultados:** participaron 104 usuarios del sistema de salud, la mayoría mujeres, renta de hasta un salario mínimo y residentes en el municipio de Rio de Janeiro. Fueron evidenciados en el análisis lexical, dos conjuntos textuales: "El proceso de evaluación del sistema de salud: la experiencia de los usuarios" y "El sistema de Salud: estructura y finalidad". **Conclusión:** Los usuarios de los servicios de salud vienen acumulando la experiencia de un sistema en permanente construcción que carece, en algunas situaciones, de insumos y acciones esenciales, rutinarias y básicas, pero que efectiva la universalidad yendo más allá de clases sociales y distintos niveles de complexidades de atención.

Palabras clave: Acceso universal a los servicios de salud. Cobertura universal. Sistema único de salud. Enfermería en salud comunitaria.

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