STRENGTHS AND WEAKNESSES OF THE CARE DELIVERED IN THE TRADITIONAL PRIMARY HEALTHCARE UNITS AND FAMILY HEALTHCARE STRATEGY UNITS IN THE PERSPECTIVE OF USERS [1]

Maria José Sanches Marin[2], Milton Marchioli[3], Maria Yvette Aguiar Dutra Moracvick[4]

[1] Part of the study - Comparison between the care provided by Traditional Primary Healthcare Units and the Family Healthcare Units in the city of Marilia from the perspective of users and professionals.

[2] Ph.D. in Nursing. Professor, Nursing Program, Faculdade de Medicina de Marilia (FAMEMA). Marília, Sao Paulo, Brazil. Email: marnadia@terra.com.br

[3] Dermatologist. Professor, Medicine Program, FAMEMA. Marília, Sao Paulo, Brazil. Email: somebody@terra.com.br

[4] Ph.D. in Medicine. Professor, Education in Health Sciences, FAMEMA. Marília, Sao Paulo, Brazil. E-mail: marchioli@unimedmarilia.com.br

ABSTRACT: This study was aimed at analyzing the strengths and weaknesses of the Family Healthcare Strategy and the Traditional Primary Healthcare Unit from the perspective of users, based on the assessment dimensions proposed by Starfield in relation to primary healthcare. A qualitative approach was used in this research, carried out through interviews with users of these distinct healthcare models. The weaknesses and strengths of these models of healthcare are similar regarding the access, gateway, healthcare services offered at different levels of technological density and their articulation. For the users of the Family Healthcare Strategy, the bond, longitudinality and focus on the family occur in a more effective way. As for the professional team, the users of the traditional Primary Healthcare unit are more satisfied than the users of the Family Healthcare Strategy, since these do not have all their needs met due to the fact that this service only offers access to a general practitioner. It can, therefore, be concluded that there is a need to make changes to the two models of healthcare services.

DESCRIPTORS: Primary health care. Unified Health System. Quality of health care.

FORTALEZAS E FRAGILIDADES DO ATENDIMENTO NAS UNIDADES BÁSICAS DE SAÚDE TRADICIONAIS E DA ESTRATÉGIA DE SAÚDE DA FAMÍLIA PELA ÓTICA DOS USUÁRIOS

RESUMO: A pesquisa teve como objetivo analisar as fortalezas e as limitações da Estratégia Saúde da Família e da Unidade Básica de Saúde tradicional na ótica dos usuários, pautando-se nas dimensões de avaliação da atenção primária à saúde proposta por Starfield. Investigação de abordagem qualitativa, a partir de entrevistas com usuários que utilizam as distintas modalidades de atenção à saúde. As fragilidades e as fortalezas das duas modalidades assemelham-se quanto ao acesso, porta de entrada, oferta de serviços de saúde de diferentes níveis de densidade tecnológica e sua articulação. Para os usuários da Estratégia Saúde da Família, o vínculo, a longitudinalidade e o enfoque familiar ocorrem de forma mais efetiva. Quanto à equipe profissional, os usuários da Unidade Básica tradicional demonstram maior satisfação. Para os usuários da Estratégia Saúde da Família, ao se disponibilizar apenas médico generalista, não se atende a todas as necessidades. Depreende-se a necessidade de ajustes nas duas modalidades de atenção.

DESCRITORES: Atenção primária à saúde. Sistema Único de Saúde. Qualidade da assistência à saúde.

FORTALEZAS Y FRAGILIDADES DE ATENCIÓN EN UNIDADES BÁSICAS DE SALUD TRADICIONALES Y ESTRATEGIA DE SALUD FAMILIAR DESDE LA PERSPECTIVA DE USUARIOS

RESUMEN: Este estudio propone analizar fortalezas y limitaciones de Estrategia de Salud Familiar y Unidad Básica de Salud Tradicional desde la perspectiva de usuarios, basándose en dimensiones de evaluación de atención primaria de salud propuesta por Starfield. La investigación es cualitativa, basada en entrevistas con usuarios que utilizan las diferentes modalidades de atención a la salud. Las debilidades y fortalezas de las dos formas son similares en términos de acceso, puerta de entrada, prestación de servicios de salud con diferentes niveles de complejidad y su articulación. Para los usuarios de Estrategia de Salud Familiar , el vínculo, longitudinalidad y el enfoque familiar ocurren de manera más eficaz. Sin embargo, considerando el equipo profesional, los usuarios de Unidad Básica de Salud Tradicional están más satisfechos que los usuarios de la Estrategia de Salud Familiar, porque sólo refieren que un médico general es suficiente. Al parecer, existe necesidad de ajustes en ambas modalidades de atención.

DESCRIPTORES: Atención primaria de salud. Sistema Único de Salud. Calidad de la atención de salud.

INTRODUCTION

The Unified Health System (*Sistema Único de Saúde* - SUS) caused a major breakthrough by proposing a healthcare concept that considers the various determinants and constraints involved in the health/disease process. Thus, health has been considered as a social product and as good quality of life. It also proposes that healthcare follows the principles of universal access, holistic care, equity, decentralization and social participation,[1] which focus on primary healthcare.

Primary healthcare is defined by the Ministry of Health (MS) as "individual or collective actions, developed in the first level of the healthcare services system, focused on the promotion of health, prevention of diseases, treatment and rehabilitation".[2:44] Primary healthcare is a gateway to the system for all new needs and problems, is focused on people, and also serves to coordinate or integrate the care provided in another level of healthcare.[3] It is in primary healthcare that resources are organized and optimized, both basic and specialized, and that the connection and accountability for the healthcare needs of people, families and community are maintained.

The current healthcare proposal of the SUS strongly differs from the model that, for many decades, prevailed in our reality and has not been able to meet the real needs of the population, which involves individual care focused on the complaint, the biological aspects, the division of care and has the hospital as the main healthcare scenario.

The necessary change has posed a great challenge and, in order to face it, the Ministry of Health has been using some strategies, with emphasis on the Community Health Agents Program (PACS), since 1991, and the Family Healthcare Program (PSF), since 1994.[2] The Family Healthcare Strategy (ESF), in particular, has been considered as the most comprehensive and instigating proposal and, therefore, is subject to further investments, expectations and questions in relation to its effectiveness.

Throughout the two decades of efforts put into changing the healthcare model, some advancement concerning the guiding principles of SUS and the strategies proposed could be witnessed. However, there are still some difficulties, such as the division in the work process and in the relationship among professionals, the lack of complementarity between primary healthcare and the referral system, poor interaction within teams and lack of skills to deal with the subjective dimension of healthcare practices, low investment in the training of workers and in the promotion of co-management and also the disregard to users' rights.[4]

A study that analyzes the ESF, taking into consideration its possibilities and limits based on publications related to its performance, points to a slight superiority of this strategy over the traditional primary healthcare units, leaving theoretical and operational challenges that still need to be faced in relation to its implementation.[5]

In establishing a framework that is comprehensive and effective for the study of primary healthcare, some authors have used[2] the dimensions of primary healthcare assessment,[3] which include access, gateway, bond or longitudinality, list of services, coordination or integration of services, family focus, orientation to the community and professional training.[6] These dimensions represent important indicators of primary healthcare quality, being used to analyze the potentiality of the different models found in healthcare services.

Upon observing the implantation process of the ESF in a medium-sized city, which also experiences the model of Traditional Primary Healthcare Unit (UBST) with the incorporation of PACS, some advancements could be noted, as well as some remaining difficulties. Thus, it is important to examine in which aspects this strategy is contributing in relation to attending to the real needs of the population and in relation to the implementation of a healthcare model that proposes access, bonding and integrality as its main guiding axes. It is therefore proposed in this study to analyze the strengths and weaknesses of the ESF and the UBST, from the perspective of users, based on the dimensions of primary healthcare quality.[3]

METHOD

A qualitative approach was used in the present research. The field of study is limited to the primary healthcare units of a city located in the Center-West of the state of Sao Paulo, which currently has 220,000 inhabitants. According to the management documents of the Municipal Health Council, the healthcare model has been gradually reoriented to a progressive transforma-

tion, in order to implement the ESF, guided by the principles of SUS.

Currently, the city has 12 UBSTs and 30 Family Healthcare Units (USFs).[7] Despite having incorporated the PACS, there was little change in the work process of the professionals in the UBSTs of the city. The team meetings are sporadic and it is not always possible to get everyone to participate.

Generally, the USFs of the city meet the minimum requirements for implementation, according to the recommendations of the Ministry of Health, in relation to physical structure, minimum team formation and development of the primary national programs. These units are installed in areas where the population has higher socioeconomic needs, assisting approximately 110,000 people, which represent around 50% of the city's population. In order to carry out this study, four UBSs and 12 USFs were randomly selected, being one UBS and three USFs from each region of the city (North, South, East and West).

Data were collected through interviews with semi structured questions, based on the dimensions access, gateway, bond or longitudinality, list of services, coordination or integration of services, family focus, guidance to the community and professional training.[3] Concerning the selection of participants, this sought to include adult people of various age groups, with or without illnesses. Thirty-two interviews were performed, being 16 with users of the UBSTs and 16 of the ESF, which were fully recorded and transcribed. The participants were contacted at the healthcare units by an experienced interviewer, before or after treatment, through convenience sampling. Data collection took place in November and December 2010.

Data analysis was based on dialectical hermeneutics and, after obtaining the statements of the participants, they were organized into a table that displayed the data per participant and question, so as to show the empirical facts and order the data. Secondly, the data were classified into central ideas and this involves understanding that the data do not exist by themselves, but they are developed based on theoretically grounded questions. Therefore, the relevant structures of the participants' statements were identified and grouped into themes, in which broader meanings are addressed, moving towards a summary through the development of possible meanings.[8-9] Then, the final analysis was undertaken, when the data collected were articulated with the theoretical framework of the research, through a dialectical movement which considers the divergence, the contradiction, the concrete and the abstract, the particular and the general, in order to reach the concrete thought.[9]

This research had the approval of the City Health Department and of the Research Ethics Committee in relation to research involving human beings at the Faculdade de Medicina de Marilia, registration number 682/08, and all participants who agreed to participate in the study signed an Informed Consent Form.

RESULTS AND DISCUSSION

In analyzing the interviews, based on the dimensions of quality in primary healthcare proposed by Starfield,[3] six themes were developed and indicated the weaknesses and strengths of the two healthcare models, which are similar in some aspects and different in others, and are as follows:

The easy access resulting from the location of the unit in contrast to the waiting time to schedule medical appointments

Concerning the access to the unit, its location does not represent a problem to any of the models. As for availability of appointments for medical assistance, the users of the UBST reported the frequent lack of professionals and the need to arrive very early in the unit in order to be able to schedule an appointment, and nevertheless faced some difficulties. For the users of the ESF, the main difficulty is the waiting time to schedule an appointment, which sometimes takes months.

The location is also good because I live very close, but I do not like to come here very early because I am afraid of robberies, I fear that, but anyway if I need to (E2, UBS East, 74 years old, F).

Well, you have to make an appointment right? Then, it takes some months, but when we are not very well, they do something and we get well, at least in my case they assist (E3, USF1, South, 53 years old, F).

Then you have to come here, wake up at 5am to get an appointment. Then they change you to the afternoon, then you are not attended, you see? It is always later, they never have time available […] *We go to the doctor because we are not well and we need a doctor, but always receive an answer like this, 'ah, come later?' 'They are*

not here! They are on holidays!' It is not possible for all the doctors to take holidays at the same time, there is no way (E1, UBS East, 27 years old, F).

To consider accessing and receiving healthcare easily and conveniently when needed, the ideal parameter of distance is a walk of twenty to thirty minutes, also taking into consideration the aspects related to public transport, such as costs and waiting periods. From the functional point of view, the need to offer continuous and convenient services that meet the real requirements and are able of ensuring access to the other levels of care can be emphasized.[10]

Four explanatory dimensions are related to access: political, economic, technical and symbolic.[11] From this perspective, and based on the statements of the users, an unbalance between supply and demand can be noted, which is reflected in the economic dimension. Although the geographic distribution of the healthcare units has been organized, facilitating the arrival of users, the provision of services does not seem to meet the needs of the population.

On the other hand, based on the statement of the USF users, it is necessary to consider the waiting period of a few months after booking an appointment, because seeking care is often translated into a need that is difficult to clarify when based on purely objective criteria, such as when using a risk classification system to define the urgency of the consultation. This aspect is based on the technical dimension of the access, which expresses the use and the difficulty of users to receive the desired care. It is possible that, while waiting for months after the need is felt, other alternatives are found to solve the problem. This aspect deserves more in depth study in order to investigate the missed appointments booked months earlier, as well as the measures the users adopt to solve the access problem.

In relation to the symbolic dimension of access, it is revealed that users only point out the needs and difficulties arising from medical consultations, giving the idea that the supply of the remaining services is satisfactory or that they are not considered able to attend to healthcare needs. Thus, a movement in the opposite direction can be observed when proposing changes to the healthcare model with focus on the promotion of health, although the medical consultation represents an important aspect of primary healthcare. The meaninglessness of the political dimension of access as the development of health awareness and community organization is therefore revealed.

Primary healthcare as a gateway to the system, often understood by the users of both the UBST and the ESF as a condition that bureaucratizes the access

In the current organization of the healthcare system, primary healthcare is the priority gateway, given the guidelines of integrality and regionalization that represent an important movement for the reorganization of the model, imputing rationality to its functioning. This direction comes from the need for more adequate resources for health, since many of the problems could be resolved with the use of light technology. This way, scenarios of higher technological density can be optimized to assist real demands and reduce costs.

Concerning the care network approach of the healthcare system, it is necessary to retrieve the business rationality assumption, according to which the correct structural arrangements reduce the problems and increase performance. Although this organizational guideline has benefited public health, many challenges are mentioned, such as the ineffectiveness of primary healthcare, the heterogeneity of the service and the flow difficulties faced at the healthcare levels.[12]

Such indicators are also addressed in the statements of the users of the UBST and the USF who were interviewed.

It is the healthcare center. Firstly, if there are resources to assist me there, with the need we have, it is there that I go and we do not have to pay. It is that, because we do not pay anything there, we go to the healthcare center. It is a poor people's resources, isn´t it? (E1, UBS South, 70 years old, F).

[…] *it is a little hard because sometimes there is no doctor there, we have to come back without it, because we need it and have to find an emergency service at night, because we need a referral and it is bureaucratic* […] (E2, UBS North, 46 years old, F).

Look, the big issue is that things sometimes happen at a time that the doctor is not there. Then, what happens? We have to travel to other units, and we do not know where to go. Or we go to the Santa Casa, or go to HC, where do we go in an emergency when there is no doctor? […] *we do not have this information* (E4, USF3 East, 66 years old, M).

Yes, we come here first to get a referral, we have to come here. If you do not come here, you do not get treatment. Now, if you go there in the afternoon, like around 5pm, then anyone who goes there gets a consultation (E5, USF4 North, 57 years old, F).

The statements clearly show the gap in primary healthcare as a gateway, since its users do not find the required support to have access to the technologies they are entitled to. On the other hand, by feeling lost, they change the organizational arrangements and find an escape to have their needs met. As a result, the flow is bypassed, resulting in the maintenance of the care overload in the healthcare levels of higher technological density.

A study on the health practices developed in the city of Rio de Janeiro has also identified that this principle is not respected, as users seek emergency services for the assistance of any of their needs, therefore not complying with the planned system hierarchy.[13]

The immanent relationship with the ESF team, less intensely engaged in the UBST

In relation to the changes to the healthcare model, the MS proposes the ESF and defines as its purposes: "the establishment of bonds and the creation of commitment ties and accountabilities between the population and the healthcare professionals".[14:7] Support and bond can be identified in the meeting of workers and users during the performance of live work. Live work is the work in progress, which is in process of development. During live work, workers can be creative and autonomous with regard to the instruments available, within an objective intended to be achieved.[15]

In the proposed attributes,[3] the bond and the longitudinality are identified as a central feature of primary healthcare. For the author, in the follow up of users over time, an implied relationship of accountability and trust can be noted, which permits more accurate diagnosis and more effective treatments.

Look, the staff here is very caring. They always stop by your house, concerned, to know how the people who live there are going. When I had a baby, they stopped by several times with the dentist, as they were concerned with the baby's reaction. I look after myself well. I think they are very concerned in this sense (E2, USF2 West, 28 years old, F).

I think they are very caring, they come to our house. To see things like that, like I was sick and on those days they came to see me. The nurses, the girls from there, you know? They always follow up on me at home when I cannot go there (E1, USF2 North, 63 years old, F).

Ah, yes, they show to be worried, yes! But there are some, like, sometimes they do not get very concerned with the conditions: if you can or cannot afford a medication, you know? (E2, UBS South, 49 years old, F).

They know, they know, they also stop by there. We see them a lot walking in the street during the campaigns, with a lot of things. We always see them in the street, they are always present (E1, USB West, 38 years old, M).

Although many difficulties and challenges exist for to the ESF, it should be acknowledged that the team has the potential to know people in the social, emotional, family and financial context. This privilege is unique, compared to other healthcare scenarios which, in order to obtain information about the life and health status of their users, need to perform extensive anamneses, with all the implications this represents in relation to the time spent and the conditions and availability of people to provide the information required to develop a plan that addresses their health needs.

Low supply of medical specialties, specific exams and low visibility of the integration among healthcare services of different levels of technological density, common to both models

In the statements of users, it can be noted that the list of services falls far short of their needs, especially with regard to specialized care. In the city where this study was undertaken, the supply of primary healthcare services has been increasing for more than a decade, due to the implementation of the ESF. Although this aspect undoubtedly increases the possibility of access, such access is often limited to the gateway, since the services of higher technological density have not been increased to the same extent. It is possible that, without the flow of this demand, this will frequently return to the gateway and form a cycle of high demand and low resolution, besides wearing out the professionals who deal with the needs of the population daily. In addition, the professionals and the population believe in the model centered in the disease and in

the hard technology, which limits the possibilities of moving forward with the perspective of health promotion and the use of light technology, based on increased listening, bond and accountability as essential conditions for advancements in the assistance of health needs. The following statements point to the difficulties users face in relation to the healthcare services which they are legally entitled to, although they are not aware of them.

[…] *it is private, the medication and the test, because it takes too long you know? Like me, I have a small problem in the intestine. If I were relying on the medications from here, I would never get treated. So, I buy the medications and I do the tests privately* (E1, UBS East, 27 years old, F).

[…] *referral, I waited for two years to get a neurologist for my daughter, two years* (E2, UBS North, 46 years old, F).

You can get it [consultation with specialist], *but it is a matter of one to two years, because there was a time when I requested the referral* […] *I waited for one year and three months* […] (E3, USF2 North, 36 years old, F).

They have a consultation to find out what I have [referring to the specialized service]. […] *the result I went to get after 15 days; everything was fine* (E2, UBS West, 63 years old, F).

To access the list of services users are entitled to, as an alternative to the hierarchical and pyramidal structure of the current model of care, a model that works in circles is proposed, which associates the idea of movement, of multiples alternatives for the entry and exit of users into the healthcare system.[16]

In relation to the list of services, the low integration among them is associated to the difficulties the users face. Although, in order to be assisted in the specialized service, a referral is required, containing the users' status, the counter-referral is usually not issued by the specialized service, which makes users bring this information, and this may hinder the continuity of the care.

Aiming to advance this perspective, the Ministry of Health's Rule 4.279 issued on the 30th of December 2010, establishes guidelines for the organization of the Healthcare Network under the scope of the SUS, proposing to overcome the division of care and the management of healthcare services, with the purpose of providing users with the actions and services required to attend to their needs.[17]

The focus on the family context experienced primarily by the users of the ESF

The statements of the users of the ESF contain expressions denoting that the team captures their family context, more strongly than the users of the UBST, as per the following passages:

[…] *yes, because they do a whole family work, they ask questions. They are very loving, I think so* (E7, USF3 South, 23 years old, M).

[…] *look, the other doctor knew Dr XXX because I had my mother, who I told you about. She used to come to see my mother at home so she knew how our home situation was, right? She used to give a lot of instructions as to how to do things with her, with my mother right? So, she was like this, very helpful* (E6, USF3 South, 34 years old, F).

[…] *no, they do not know, I do not think so. They are not that concerned, no* (E1, UBS South, 59 years old, F).

The ESF, viewed as a proposal to restructure the healthcare model, is presented as an advance due to the possibility of recovering the multiple dimensions that involve healthcare, and to the approach of the team to the context of people's lives. It is highlighted, however, that the structural organization of the ESF, despite great potential for a special view of the process of health and disease, does not guarantee that the various professionals who are part of it perform their actions based on this orientation.[18]

It is understood, therefore, that by adopting multiple but not communicating and non complementary approaches to family-oriented care, there is the risk of various and partial practices that do not contribute to care integrality.[18]

Similarly, a study analyzing the integrality of care to children in primary healthcare has concluded that the limiting factors relate to the policy and management levels in the macro and micro space and to the personal and professionals aspects of the team members.[19]

The lack of specialist doctors experienced by users of the ESF

The proposed changes to the healthcare model have different features, based on the healthcare assumption existent in people's minds and, often, also in the minds of healthcare professionals and managers. In addition, although the SUS emphasizes the broad objective of "health for

everyone" in the different levels of healthcare, with right to use the different technologies available to the system, the emphasis is on primary healthcare, with the perspective of improving the living conditions of people.

The movement for the implementation of this new idea, even if it represents an achievement of the social fights for better conditions of life and health with the guarantee of access, equity and integrality of actions, by its dimension and in the conduction of a neoliberal policy that values and encourages private initiatives, sometimes to the detriment of public actions, it imposes difficulties to the society in understanding this proposal.

Therefore, the following statements express that the population has difficulty understanding the role of the ESF team:

[…] *look, I think that: to have a doctor for each specific area is right, because here there is only one doctor for everyone, but it is a rule of the unit, right? So, this is the only thing I have to complain about* […] (E4, USF3 East, 33 years old, F).

[…] *even when I came here, when the nurse took my blood pressure, she realized that it was not right and she even went to talk to the doctor, to ask what to do, and they gave me a pill to lower my blood pressure, and it was very good after I had this care* […] (E3, UBS West, 38 years old, M).

[…] *the family doctor is a little complicated because he is only a general practitioner, right? In the past, there were doctors that were not family doctors, there were more doctors, there were more options, right? Now, there are no doctors for family care, there is not even a pediatrician, there is nothing. So, there should be doctors* (E3, USF West, 65 years old, F).

In this regard, it is worth revisiting the reflections about the mystification of the general practitioners, because this area is considered to be a medical "specialty" that, by itself, is not able to implement new healthcare practices with the population, and it is suggested that the most appropriate would be to absorb more naturally other specialties and give them the opportunity to work with new forms of healthcare in overlapping areas of professional practice. In this proposal, it is added that, if general practitioners isolate themselves in their own field of knowledge, over time, they will become specialists in this generality area.[20]

Based on the above, it is possible to understand that the ESF team, with the purpose of working with light technologies in order to trigger the relationship networks infused with the attendance to people's healthcare needs, is not acting from the perspective of articulating the different knowledge among the team and between the team and the referral services, since the organization of services has often been governed by norms and rules that little contribute to the process of creation and invention, which is required by primary healthcare services. From this perspective, the challenges to be overcome are discussed, considering that the new healthcare idea proposed is still not incorporated into the daily healthcare practices in primary healthcare.[21]

FINAL CONSIDERATIONS

Primary healthcare presents clear assumptions aimed at implementing a new model of healthcare, based on health supervision and with emphasis on promotion, undertaken based on the principles and guidelines of the SUS. Even if this accountability is expanded to all types of primary healthcare, a more effective directionality is found in the EFS because, from the structural point of view, it has privileged elements to operate according to such idea.

In the analysis of the statements of the UBST and ESF users, in relation to the issue quality of primary healthcare, similarities can be seen concerning the access, since the two models have gaps in this aspect. The same seems to occur when questioned about primary healthcare as "the gateway to the system", since users depend on referrals when they need other healthcare services, and this is not always given to them according to their wishes and, in view of users, is a bureaucratic condition. In overcoming this difficulty, they often need to use other strategies, even if these are contradictory to the proposal of the current healthcare system.

On the other hand, concerning the bond and longitudinality, the proximity of the ESF team with the users is clear, but this is not effectively performed in the UBST. Concerning the proximity of the ESF team with the users, there was also mention that they know the family context. It can be highlighted that the USF, in some aspects, has been fulfilling its role of proximity and more in-

tegral approach, given that the knowledge about the social and family context is a unique condition in healthcare.

With regard to the provision of services of different levels of technological density and to the integration among them, a large gap between the needs presented and what is being offered is seen, both by users of the USF and the UBST. This aspect seems to suggest that only an increased access to the gateway is not sufficient to solve the health problems of the population, and this requires new forms of structuring the service flows. It might be as a result of this condition that especially the users of the USF mention the lack of specialist doctors in the unit as a difficulty they face.

Although the ESF has undoubtedly contributed to the access of the population, especially those with higher socio-economic needs, the axe related to equity of access to all available technology to improve the conditions of life and health has not yet been achieved, which in part occurs due the lack of articulation between different levels of healthcare.

Therefore, important hurdles and challenges in facing the change to the care model can be noted, since the implemented structural changes, despite being an important initiative to increase access, bond and longitudinality, are still requiring significant advancements and adjustments.

REFERENCES

1. Buss PM. Promoção da saúde e qualidade de vida. Cienc Saúde Coletiva. 2000 Jan-Jun; 5(1):163-77.
2. Almeida C, Macinko J. Validação de uma metodologia de avaliação rápida das características organizacionais e do desempenho dos serviços de atenção básica do Sistema de Saúde (SUS) em nível local. Brasília (DF): Organização Pan-Americana de Saúde; 2006.
3. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília (DF): Ministério da Saúde; 2002.
4. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. HumanizaSUS: documento base para gestores e trabalhadores do SUS. 3ª ed. Brasília (DF): Ministério da Saúde; 2006.
5. Conill EM. Ensaio histórico-conceitual sobre a atenção primária à saúde: desafios para a organização de serviços básicos e da Estratégia Saúde da Família em centros urbanos no Brasil. Cad Saúde Pública. 2008; 24(supl 1):S7-16.
6. Elias PE, Ferreira CW, Alves MCG, Cohn A, Kishima V, Escrivão Junior A, et al. Atenção básica em saúde: comparação entre PSF e UBS por estrato de exclusão social no município de São Paulo. Cienc Saúde Coletiva. 2006 Jun-Set; 11(3):633-41.
7. Secretaria Municipal de Higiene e Saúde de Marília. Relatório de gestão 2002. Marília (SP): Secretaria Municipal de Higiene e Saúde de Marília; 2002.
8. Gomes R, Souza ER, Minayo MCS, Malaquias JV, Silva CFR. Organização, processamento, análise e interpretação de dados: o desafio da triangulação. In: Minayo MCS, Assis SG, Souza ER, organizadoras. Avaliação por triangulação de métodos: abordagem de programas sociais. Rio de Janeiro (RJ): Fiocruz; 2005. p. 185-221.
9. Minayo MCS. O desafio do conhecimento. São Paulo (SP): Hucitec; 2003.
10. Ramos DD, Lima MADS. Acesso e acolhimento aos usuários em unidade de saúde de Porto Alegre, Rio Grande do Sul, Brasil. Cad Saúde Pública. 2003 Jan-Fev; 19(1):27-34.
11. Jesus WLA, Assis MMA. Revisão sistemática sobre o conceito de acesso nos serviços de saúde: contribuições do planejamento. Cienc Saúde Coletiva. 2010 Jan; 15(1):161-70.
12. Quinellato LV. A diretriz de hierarquização do SUS: mudando a antiga perspectiva do modelo médico-assistencial privatista [dissertação]. Rio de Janeiro (RJ): Fundação Getúlio Vargas; 2009.
13. Oliveira DC, Sá CP, Gomes AMT, Ramos RS, Pereira NA, Santos WCR. A política de saúde brasileira e memória social de profissionais. Cad Saúde Pública. 2008 Jan; 24(1):197-206.
14. Ministério da Saúde (BR). Secretaria de Assistência à Saúde. Coordenação de Saúde da Comunidade. Saúde da família: uma estratégia para a reorientação do modelo assistencial. Brasília (DF): Ministério da Saúde; 1997.
15. Campos CMS, Bataiero MO. Necessidades de saúde: uma análise da produção científica brasileira de 1990 a 2004. Interface Comum Saúde Educ. 2007 Set-Dez; 11(23):605-18.
16. Cecílio LCO. Modelos tecno-assistenciais em saúde: da pirâmide ao círculo, uma possibilidade a ser explorada. Cad Saúde Pública. 1997 Jul-Set; 13(3):469-78.
17. Ministério da Saúde (BR). Portaria nº 4.279, de 30 de dezembro de 2010. Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União, 31 dez 2010. Seção 1.
18. Ribeiro EM. As várias abordagens da família no cenário do Programa/Estratégia de Saúde da Família (PSF). Rev Latino-Am Enferm. 2004 Jul-Ago; 12(4):658-64.

19. Sousa FGM, Erdmann AL, Mochel EG, Condições limitadoras para a integralidade do cuidado à criança na atenção básica de saúde. Texto Contexto Enferm. 2011; 20(esp):263-71.

20. Franco T, Merhy E. PSF: contradições e novos desafios [Internet]. In: Anais da 11ª Conferência Nacional de Saúde on-line; 2000 Dez 15-19; Brasília (DF): Ministério da Saúde; 2000 [acesso 2008 Out 28]. Disponível em: http://www.datasus.gov.br/cns/temas/tribuna/PsfTito.htm

21. Campos RO, Gama CA, Ferrer AL, Santos DVD, Stefanello, S, Trapé TL, et al. Saúde mental na atenção primária à saúde. Ciênc Saúde Coletiva. 2011 Dez; 16(12):4643-52.

Correspondence: Maria José Sanches Marin
Avenida Brigadeiro Eduardo Gomes, 1882
17514000 – Jardim Itamaraty, Marília, SP, Brasil
Email: marnadia@terra.com.br

Received: December 02, 2011
Approved: August 15, 2012