

# Social appropriation of the Brazilian National Health System: listening to the voices of users

Apropriação social do Sistema Único de Saúde: ouvindo a voz dos usuários (resumo: p. 16)

Apropiación social del Sistema Brasileño de Salud: oír la voz de los usuarios (resumen: p. 16)

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This investigation aimed to analyze the perceptions of users of the Brazilian National Health System (SUS) regarding social appropriation of this public health policy. In particular, it was sought to ascertain whether this met their needs and whether they were participating in processes for organizing and evaluating the healthcare system and services that they were using. This was a qualitative study among users of this system who had experienced an episode of hospitalization for conditions that were sensitive to primary care. The results were systematized via content analysis and were discussed in the light of critical hermeneutics and the reference framework of "Paidéia". The findings demonstrated that the beneficiaries recognized SUS as a public policy, could describe its operational logic and benefits when they needed healthcare; and could state its effects, especially regarding creation of new care practices at primary care units after a hospitalization episode. However, there was no mention of participation in social control spaces.

**Keywords:** Public policy. Brazilian National Health System. Social control. Qualitative research.



## Introduction

The historical process through which public policies have been constituted around the world shows the dispute between the social needs of the population and neoliberal economic interests, and the result of these clashes reveals contradictions<sup>1-6</sup>.

Social policies are seen variously as mechanisms for maintaining the workforce, as achievements by the workers, as arrangements made by the bloc in power or a ruling bloc, as a donation from the ruling elites, or as an instrument to ensure increased wealth or rights for citizens<sup>2</sup>. (p. 8)

In Brazil, implementation of social policies has not differed from this, but has been made more difficult by its position as a peripheral country in the capitalist world. It has been accompanied by political and economic clashes that have been highly influenced by determinations and decisions made by capital and world powers<sup>7,8</sup>.

The Brazilian federal constitution of 1988 oscillates between movements to expand and reduce the participation of the State in the financing and organization of social actions and programs, but is always permeated by inclusion of the market to respond to social demands. While the constitution is notably framed in terms of equity and universal social rights, it maintained conservative propositions in the economic, tax, administrative and political system. The conceptions of a minimalist neoliberal state and universalist social protection have contested political conduct over recent decades<sup>6</sup>.

The Brazilian National Health System (SUS) is considered to be one of the most important consolidations of social policy in this constitution. It places health as part of universal social rights, through affirming that it is the duty of the State to maintain healthcare and subordinating private practices to State regulation. Moreover, the constitution makes provision for participation by society in bodies that control healthcare<sup>9</sup>.

Brazil faced difficulties due to instability brought about by the economic crisis of the 1990s. This led to pressure for rediscussion of the size and role of the State and for adoption of the neoliberal model. This context has undermined full implementation of SUS, even though efforts have continued to be made by public health doctors and users, towards changing the direction that has been taken<sup>6,10-12</sup>.

The historical scenario was formed by publication of the healthcare organizational law in 1990. This regulated the mechanisms for popular participation and social control. It defined the creation of joint councils between managers, service providers, workers and users, to perform the function of deliberating on and controlling public policy actions, such that society would come to have a formal function in making decisions about and controlling healthcare actions<sup>13,14</sup>.

The present study is situated within this context. Its aim was to analyze the perceptions of SUS users regarding their social appropriation of this public policy. In particular, it was sought to ascertain whether this met their needs and whether they were participating in the processes of organizing and evaluating the healthcare system and services that they were using.

The day-to-day routine within which public healthcare policy is implemented consists of production and provision of healthcare. It involves people's lives and, thus, is a space for conflicts and contradictions at all levels: social, political, economic



and cultural<sup>8</sup>. Within this, it was sought to obtain users' opinions about how they perceived this reality, how they felt its effects in everyday life and how they participated in it, i.e. how they socially appropriated all this babble.

Social appropriation is taken here to start from the proposition that society has a need to access and incorporate scientific and technological knowledge<sup>15-17</sup>. This is associated with the argument that, beyond access, society needs to have effective involvement in processes of production and evaluation, in social spaces that take into consideration the pluralities of society's actors, so that they achieve legitimacy and recognition of its benefits<sup>15,18,19</sup>.

Based on these concepts, Malvezzi<sup>20</sup> proposed that social appropriation of public healthcare policy would involve three fundamental and complementary elements: recognition of and access to information on the main guidelines, principles and rights of SUS and how this system is organized; the value attributed to the effects of its actions and services in the light of its users' healthcare needs; and effective insertion of the first two elements in the process of formulation, deliberation and evaluation of the results from public healthcare policies<sup>20</sup>.

## Methodology

This was a qualitative study guided by a critical hermeneutic stance. It was sought to understand how humans felt, thought and acted within their reality, which they experienced and constructed with each other, through their relationships, representations, interpretations and intentions<sup>21,22</sup>.

Through this perspective, it was sought to avoid making the researcher deaf to other diverse "*truths*", by letting them be questioned by the material under study and by the "*thing in question*", thereby recognizing the otherness of the other thing, more through its strangeness than through familiarity with it, as a condition for gaining understanding<sup>23,24</sup>. This was a type of empathic identification, in which it was sought to understand the situation in which human actions have (or acquire) meaning, by virtue of the system of meanings to which the subject belongs<sup>25</sup>.

The researcher's interaction was a dialogical and shared experience that influenced and was influenced by the encounters in this relationship, which in turn reproduced social relationships within which inequalities, asymmetries and even conflicts between the researcher and the research subjects could be represented.

The present study was approved by the ethics committee of the researcher's institution under CAAE no. 52891715.6.0000.5504. It was conducted between 2015 and 2019. The empirical field chosen was 17 primary healthcare units (PHUs) in a single healthcare district in a city in the state of São Paulo, Brazil. This empirical field was chosen based on the existence of a proposal for integration between public healthcare services in this district<sup>26</sup>.

The sample of subjects comprised SUS users aged over twenty years who had experienced hospitalization due to conditions that are sensitive to primary care. This sample was non-probabilistic, for convenience<sup>21</sup>, and was identified at the PHUs involved.

Data were gathered through individual interviews, using a semi-structured script. A procedure of successive movement was used, such that elements that emerged in one interview could be included in the next interview<sup>27</sup>. This was done until the saturation criterion was reached<sup>28</sup>. Ten users were interviewed between November 2017 and August 2018, and the interviews were audio-recorded and transcribed in full by the researcher.

The data thus collected were systematized in accordance with the framework of content analysis, with emphasis on the thematic modality<sup>21,29</sup>.

The Paidea theory<sup>30-32</sup> was adopted as a reference framework for discussion of the results. The central element of this theory relates to seeking to expand the capacity for analysis and intervention regarding people and groups, assuming the place of subjects in the construction of institutional democracy. Campos<sup>31</sup> highlighted the following:

In practice, no one, no single agent, produces democracy. Democracy is a social reform, a product of the praxis of subject groups and producer of subjects. There is no democracy without the deliberate intervention of concrete subjects. Democracy is therefore a social product. It depends on the correlation of forces, the confrontation between social movements and established powers. It depends on the social capacity to build spaces of shared power: wheels. The existence of these spaces is a sign of democracy. Democracy is, therefore, the possibility of exercising power: having access to information, taking part in discussions and decision-making. Democracy is, at the same time, a construction and an institution<sup>31</sup>. (p. 41)

## Presentation and discussion of results

Regarding the research subjects, there were five of each gender, aged between 49 and 90 years, living in areas of great social vulnerability. Five of them were doing paid activities and all of them were dependent on SUS. These were patients with chronic diseases that worsened and resulted in hospitalization.

From the systematization of the data collected, three “thematic centers of meaning” were reached. These represented the following sets of perceptions: (1) Care for health needs; (2) Reflections on hospitalization regarding supply and production of care; (3) Social appropriation of the processes of organizing and evaluating the public healthcare system.

### Thematic center 1 – Healthcare needs

The interviewees recognized their healthcare needs at times when their suffering worsened, or on occasions when follow-up of their chronic diseases was required. They indicated that a variety of public healthcare services formed resources for these circumstances: PHUs, hospitals, mobile emergency care services (SAMU), emergency rooms (ERs), emergency care units (ECUs), specialty outpatient clinics and reference centers.



Through recognizing public healthcare services, they signaled both that they knew of the existence of these services and that they had incorporated the notion that these services provided benefits for their daily lives within society. This showed the constituent elements of SUS and expression of dimensions of its social appropriation.

This perception comes very close to what Campos<sup>32</sup> called the value of use of the service, especially through its potential capacity to meet the needs pointed out by society. However, it can also reveal an understanding that takes the value of use and the usefulness of the service as if they were equivalent to the needs of society. This portrays the daily tension between what the population demands and what healthcare services offer<sup>31</sup>.

The subjects pointed out the consequences of this equation. They highlighted a series of positive features relating to the healthcare system that they were using, while also pointing out challenges to be overcome for their needs to be met.

In relation to PHUs, although they recognized them as a reference point in seeking healthcare, they reported that their perception was that the service had worsened over time. They cited the organizational arrangement for receiving patients as a barrier, especially with regard to situations that were outside of the established routine, i.e. spontaneous demand or emergencies.

Campos<sup>31,32</sup> considered that access was one of the points that most materially interested the population. Through a strategy of “welcoming”, it would become possible to favor qualified listening and provide answers, in addition to scheduling medical consultations or other routine actions. This would imply assessment of risks and vulnerabilities, on a case-by-case basis, and, if necessary, regulation for referral to other services.

However, what we found in the present study was a perception differing from the above. This was not in relation to offering future scheduling or referral to other services: rather, it came from the subjects' reports that healthcare professionals were not getting involved in assessing the risks and vulnerabilities shown by the subjects through their demands for healthcare. The subjects were dealt with in a bureaucratic manner, in which they were simply offered future appointments or guidance towards seeking other services, under the justification of limitations on local provision, without the local teams doing any evaluation or taking any responsibility.

It was also possible to identify from the subjects' reports that links had been established with the reference PHU and with the care team. Thus, the subjects demonstrated that they recognized quality and accountability for continuity of care, with regard to connecting with and enabling provision of therapeutic resources and complementary tests, along with supply of medications. They highlighted the work of community health agents as a significant link relating to this sense of recognition and belonging. The subjects had close ties to these agents and felt that they provided a channel for closer relationships and communication.

Regarding the other healthcare services that the subjects used when they needed examinations or follow-ups in situations of greater complexity or emergency, their perceptions allowed exploration of the existence and conformation of the network that makes up the public healthcare system and recognition of PHUs as the level that makes connections and enables referrals. Regarding use of SAMU, the subjects stated that



they sought it on their own initiative, without mediation from the PHU, and that it was the means of access to a hospital ER or ECU.

In relation to hospitals, a service where the subjects sought to meet their most complex needs, they expressed different perceptions. They recognized through their experiences in the wards and in outpatient clinics that they had found provision of care in response to their needs, and they extend this evaluation to situations in which they had needed to be transferred to other hospitals. However, in referring to ERs, complaints emerged regarding difficulty of access and degradation of care.

In addition to public healthcare services, the subjects of this study also commented on their desire to access private services to meet their needs. They thought about this option when they felt that the public services did not respond as they would wish, especially because of waiting in long lines or the length of time it would take for an appointment to become available. Cordeiro *et al.*<sup>33</sup> analyzed this phenomenon and highlighted the influence exerted by the social imaginary, in which there is predominance of the idea that the private system is more efficient than the public system, which is reinforced by the liberal position that is strongly predominant among healthcare professionals.

## **Thematic center 2 - Reflections on hospitalization regarding provision and production of care**

This thematic center addressed the subjects' experiences relating to episodes of hospitalization and their ramifications relating to production of, linkage with and continuity of care within the public healthcare network. It should be emphasized that the participants in this study were identified at PHUs, and that they had maintained ties with these units after their hospital stays. Moreover, their hospitalizations had occurred due to potentially preventable causes.

The subjects' reports showed that their experiences of hospitalization were relevant and remarkable within their lives and that these episodes left a perception of adequate and satisfactory care. However, they noted that their arrival in the hospital ER was a moment of distress and discomfort.

Two aspects of their care in the ER stood out: firstly, speediness in attending to patients was taken as a criterion for evaluating the service; and secondly, the ER was characterized as a barrier to access to other hospital services. While speed can be considered to be an attribute of efficiency, delay relates to non-use of risk criteria for prioritizing cases, degradation of the relationship between professionals and users and lack of service structure.

According to Campos and Amaral<sup>34</sup>, there are in fact structural, cultural and political obstacles to transformation of traditional hospital practices. They recognized that there is high demand for care, but pointed out that the way in which these services organize the distribution of their teams, often through vertical shifts, results in difficulties in establishing bonds, accountability and longitudinal therapeutic follow-up among these patients, thus reinforcing the fragmented care model and favoring degradation of care<sup>34</sup>.



Regarding hospitalization itself, the subjects' statements about the presence of many physicians and occurrence of transfers to other hospitals to perform complex procedures, which were both mentioned as points that placed value on the service and its problem-solving capacity, can be highlighted. In this regard, there was a reaffirmation of the hegemonic image of hospitals and physicians within society that portrays them as occupying a central role in the healthcare system<sup>34</sup>.

The subjects' reports about the time of discharge from hospital revealed different types of guidance that they received regarding follow-ups for their treatments. Two types of guidance stood out: in one, the hospital remained the reference point, through its outpatient clinics; while in the other, PHUs were indicated as the place for continuity of care.

Regarding hospital-based follow-ups, the subjects said that this guidance was given because of the complexity of their cases and the lack of resources in the PHU for the treatment to be continued, including the specialist physician. However, in these cases, even if continuity of treatment with the specialist was necessary, the subjects did not mention the possibility of joint follow-up with the PHU. They reported that they only received guidance to seek care from the PHU if this related to changing dressings, withdrawal of medications and/or materials and emotional support.

It can be seen that in these reports there was devaluation of the integration between services within the network, especially consisting of denial of the role of PHUs within the healthcare system. Moreover, appropriate therapeutic alternatives with availability were not shared with users, thus restricting their participation in the co-production of their care plan.

Regarding the other type of orientation, i.e. indication for continuity of care at PHUs, either exclusively or and in a shared manner, the interviewees recognized in this a certain integration between the hospital and the PHUs, which gave them greater security. However, in these cases, the subjects did not perceive that any criterion of lower risk or complexity in comparison with the cases of the first situation was being used.

In giving these orientations, there seemed to be a recognition by the hospital team of the capacities and resources installed in the PHU that enabled continuity of care. This therefore indicated that an understanding of co-responsibility between services for care within the network existed. Moreover, along these lines, articulation of the possibility of integration between services was perceived, thereby expanding the possibility of implementation of a networked system.

Pinheiro and Mattos<sup>35</sup> explored the concept of integrality and translated it as the capacity of healthcare services to provide responses, not only to cope with diseases, but also to take a more complex approach in which the needs of the population served would be perceived. Furthermore, they pointed out the need to include the knowledge of the people involved, in a process of negotiation and agreement aimed at broadening the understanding of these needs and the consequent structuring of service provision.

In this regard, statements about care in the post-discharge PHU emerged. These reflected the perception that changes would occur in relation to qualification of the actions provided, i.e. that something different and new would happen, once the subject became identified as having been discharged from hospital, regardless of whether the subjects themselves gave this information or whether it was found out by the PHU through an active search.



From this observation, there was a sense of belonging, in that the subjects began to be identified in their singularity, with recognition of their needs, such that they felt that they were part of the PHU. These changes were portrayed through changes in the dynamics of the service, and especially through expansion of the participation of other team professionals in the subjects' care plans. This contrasted with the previous (almost) exclusively medical routine consultations. The reference team started to increase its frequency of home visits and monitoring of compliance with the guidelines and attendance at scheduled appointments at the PHU or at other back-up services was implemented.

In correlating these reports with the concept of integrality, we identified movement by the PHUs in this regard. We can therefore highlight what Campos<sup>32</sup> stated: "in order to achieve comprehensive care it is necessary to reformulate and expand the clinic and collective health at the same time, one interacting with the other" (p. 104).

The subjects' reports also showed that there was a feeling that integration between the hospital and PHU teams existed and that exchanges of information between them were occurring, even if they were unaware of how this was happening. Specifically in this regard, they pointed to the episodes of hospitalization and occasions on which they had used specialized back-up clinics. The presence of aspects of the constitution of healthcare networks can be emphasized here.

This perception indicated that there was recognition that a process of innovation of public healthcare policy in its care dimension was occurring. This process was increasing the quality and effectiveness of care through introducing new ways of providing care actions<sup>36</sup>.

### **Thematic center 3 - Social appropriation of the processes of organizing and evaluating the public healthcare system**

When users mention SUS as an expression of public policy, the reports are generic. Users make stronger allusion to politicians than to the policy itself, emphasizing how their speeches are of electioneering nature, made on dates close to elections, with promises that are not fulfilled. Thus, politicians' words seem to these users not to be aligned either with the real healthcare needs of the population, nor with the conditions under which public services are functioning.

Campos<sup>30</sup> highlighted the central role that the State has in putting public policies into operation, especially with regard to actions to effect social inclusion and wellbeing of the population. The right to healthcare is included in this. However, historically, the capitalist model has been hegemonic, and its pro-market forces and neoliberal tensions have imprinted a logic of reduction of the State. This has stimulated demobilization of society and, consequently, the State's commitment to guaranteeing social protection policies<sup>36</sup>.

This situation may explain, at least in part, SUS users' perception of critical weakening of public policies. A visible and concrete part of this context is transferred to politicians, but they are no less exempt from responsibility for the effects of capitalism and its tendency towards a minimal state. Public policies are understood more as a concession of government than as a right of citizenship.

In dealing with this concept, Campos<sup>30</sup> pointed out that:





[...] support for social reforms and democracy depends both on reformulation of the traditional ways in which social movements have been organized, and on changes to the ways of organizing and managing public policies. (p. 16-7)

Campos<sup>31</sup> also stated that:

[...] one line for this change relates to construction of collective spaces that stimulate and facilitate participation by agents other than those with management functions, along with agents who are external to the collective. (p. 143)

Subjects are constituted and strengthened through expanding their capacity for analysis and intervention, for participation in and construction of institutional democracy. This results from praxis of these subjects, as a social reform, i.e. a social product produced democratically in spaces of shared power, which drives new social changes<sup>31</sup>.

Fleury<sup>36</sup>, corroborated this through referring to processes of social innovation as a means for expanding and strengthening active citizenship. This gives rise to the capacity to influence public policies, thereby leading to changes in the power structures of the State. This necessarily occurs through constituting and incorporating autonomous and emancipated subjects. "Do things with people and not on them"<sup>32</sup> (p. 26). We can affirm that this is a principle of SUS, as shown through its framework.

In addition, regarding users' perceptions about the way in which SUS works and its installed capacity, the interviews portrayed a situation of coexistence of a system that meets the needs with another that is insufficient to meet the demands for healthcare from the population. When the subjects of this study indicated that SUS was meeting their needs, they mentioned the provision of various healthcare actions of different complexities and in different services. However, significantly, their statements were correlated with the fact that SUS was the only resource, as if there was a tone of attenuation or conformism.

Regarding statements about the precariousness of the system, the subjects highlighted the poor application of available resources, the need for improvements in the structure and organization of services, the insufficiency of the provision of actions and the worsening of this provision due to limitations and or lack of criteria for access.

It is important to return the observation that the alternative of participation in the management spaces of this system was not mentioned. Without such participation, the possibility for these users to influence the conduct of this process would be restricted. This would limit the subjects' own powers and it suggests that power would be delegated to unnamed other people. It is very likely that these others would be the same politicians who they were complaining about because of failure to solve their problems. Alternatively, these others could be the PHU manager or healthcare service workers. The subjects did not manifest any desire to become protagonists in this process.

Regarding healthcare service workers, the subjects manifested solidarity with and a protective attitude towards these professionals, who they considered to be just as much victims as themselves, because of their unfavorable working conditions. On the other



hand, the subjects felt that this could not justify disrespect or poor care from these workers, an attitude that the subjects considered incompatible with these worker's public service, emphasizing that their salaries are funded through payment of taxes by the population.

In relation to collectives that are organized for production, here focusing on workers, Campos<sup>31</sup> pointed out that a double objective is fulfilled:

Producing goods or services of social interest, i.e. with the potential to meet social needs; and, at the same time, ensuring the survival of the organization itself and of the set of agents who form part of it or depend on it. (p. 121)

Furthermore, it was pointed out that these aims do not necessarily act in concert. There may be contradictions and conflicts due to this double objective, because they are not interests that can easily be reconciled.

We repeatedly saw that there was also no mention among the subjects of this study of initiatives towards problematization when situations of conflicts or standoffs with workers occurred. Nor did they mention any movements in the opposite direction, in which the workers themselves or the local manager had addressed these possibilities.

Some of the study subjects brought up an idealized situation that could solve some of these problems, consisting of a desire to subscribe to private health insurance. However, no arguments comparing SUS and private services appeared explicitly, possibly because of the subjects' high dependence on SUS.

Following construction of alternatives for improving, or at least softening the perceptions of lack of care provision, we found that the subjects expressed views about how the possibility of society's participation at different levels of the healthcare services could expand the analysis on this conjuncture and enable formulation of indications for possible improvements in this context.

When we deepen the conversations about the spaces for society's participation in SUS, there was recognition, albeit not unanimously, that the population could gain strength and importance. Expression of society's views would be closer to the different realities and, consequently, would aid in designing solutions and achieving results. This would be in line with the vision of Bazzo *et al.*<sup>37</sup>, who indicated that this would strengthen the process of social participation and meeting of demands. This position was not unanimous among our study subjects because statements also emerged that reflected the feeling that some users have more individualistic stances, with little regard for collective issues and little motivation to propose changes, i.e. more aligned to neoliberal conceptions.

However, following the logic of movement through protagonism, the subjects reported that they had not found any space for this democratic exercise. They had encountered a position of little availability for such meetings or for debating of opinions within healthcare services, both among managers and among professionals. Regarding managers, in particular, the subjects reported feeling even greater distancing, such that the managers were placed in a position of wielding authoritarian power to which they did not have access and in relation to which they did not feel that they were protagonists.



Conflicts and contradictions were expressed in this little-consolidated relationship. The movement towards exercising active citizenship was taking place in an environment in which, although the discourse was demonstrably in favor of engagement of society, in practice it was still dominated by the hierarchical and unidirectional culture of the State<sup>7</sup>.

Regarding motivation and willingness to participate in social control, the subjects of the present study had differing views. Among those who knew about social control or who had already participated in it, statements of disbelief were predominant.

In relation to local healthcare councils of PHUs, for example, there were different understandings about why they existed and, therefore, about the results that they could bring. While recognizing these as a possible space for user participation, the subjects of the present study did so with many caveats, placing them as a forum level of low credibility. They referred to these bodies as a dimension with little organization that were bereft of deliberative clout and were used only for exercising micropowers or for leveraging other aspirations in a political career.

The subjects who were unaware of these bodies showed interest in them and saw them as an opportunity for participation, but their statements were permeated by caveats. One of these, of a more institutional nature, was that the subjects should be given the opportunity to have effective contact with the existence of these spaces. Another caveat related to personal characteristics and interests, desires and needs, such as limitations to their availability, depending on the time and places where these meetings were held. Thus, this brought to light the ever-challenging nature of collectively negotiated arrangements.

This fragility of social participation pointed out here is consistent with what was described in some recent studies. Kruger and Oliveira<sup>38</sup> highlighted the democratic basis of political articulation that exists within the institutional conformation of the Brazilian National Health System, but pointed out that, in commemorating the 30<sup>th</sup> anniversary of SUS, one indicator that should be used was the little space for social control that existed in SUS.

Ricardi *et al.*<sup>39</sup> sought evidence to qualify social control within SUS. They reported that users faced obstacles to their participation consisting of poor dissemination, mobilization and empowerment. Ventura *et al.*<sup>40</sup> also reported that there were obstacles relating to communication between the various actors and social institutions, thus emphasizing that popular participation is precarious. Oliveira and Lima<sup>41</sup> add that there was a lack of support from healthcare managers for making social control effective.

In summary, there is unanimous recognition of the value and institutionality of social control in Brazil, but recent studies have shown evidence that confirms that there is low participation of users in the spaces for social control within SUS.

## Final remarks

This investigation allowed us to affirm that there is evidence of movement towards the elements of social appropriation within SUS. Users reported having had access to information, such that they had become aware of the logic of the system, knew where to find and how to use its services and could decode its form of organization. Moreover, these users were prepared to attribute value to using this system, to the extent that they saw that their healthcare needs were being met and thus could recognize its benefits.



They also recognized that some kind of innovation may be underway, especially when they saw that they were personally recognized, such that a feeling of belonging to the system emerged.

However, the users represented here did not place themselves as political actors in the arena of SUS disputes and did not express any movement to get out of this situation. They preferred to delegate this function especially to so-called “politicians”. On the other hand, these users did not regard these “politicians” as agents who would be proponents of alternatives that would change SUS practices. Hence, this would leave participation and popular control more in the technical-bureaucratic sphere, within the field of discourse and expression of the SUS guidelines. Expansion of society’s participation in public policies is still a social innovation that needs to be strengthened.

The strength of the hegemonic, neoliberal and conservative sociopolitical model is undeniable. The majority of the population is subjected to this model, and especially the users represented here, whose socioeconomic condition puts them in a position of greater vulnerability and dependence on the State.

Although the assumptions of SUS point to mechanisms for its consolidation as a social public policy, it was seen in this study that this objective is far from being reached. Appropriation of SUS by society remains a challenge. Although social participation is taken to be a paradigm of public policies, its use in the processes of formulation and deliberation did not emerge as part of the daily lives of our interviewees.

Hearing the voices of users clarifies many of the dimensions and elements that make up this relationship, while leaving the certainty that challenges remain and that there is much to do to advance in this field. Further work may provide support that can result in reflections with other actors and in other regions. It may result in wheels of conversation, elements towards stimulating and constituting subjects and collectives and innovations and social appropriation. The challenge continues!



### Authors' contributions

All authors actively participated in all stages of preparing the manuscript.

### Conflict of interest

The authors have no conflict of interest to declare.

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Trata-se de uma investigação com o objetivo de analisar a percepção de usuários do Sistema Único de Saúde quanto à sua apropriação social desta política pública, em especial, ao atendimento de suas necessidades e à participação nos processos de organização e avaliação do sistema e dos serviços de Saúde em que estão inseridos. Estudo qualitativo com usuários que vivenciaram episódio de internação hospitalar por condição sensível à atenção primária, seus resultados foram sistematizados segundo Análise de Conteúdo e discutidos à luz da hermenêutica crítica e do referencial Paideia. Os achados demonstram que os usuários reconhecem o Sistema Único de Saúde como política pública, referindo sua lógica de funcionamento e benefícios quando necessitam de cuidados à saúde; e descrevem seus efeitos pela criação de novas práticas de cuidado nas unidades básicas após episódio de internação hospitalar; não mencionando sua participação nos espaços de controle social.

**Palavras-chave:** Política pública. Sistema Único de Saúde. Controle social. Pesquisa qualitativa.

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Investigación con el objetivo de analizar la percepción de usuarios del Sistema Único de Salud en lo que se refiere a su apropiación social de esta política pública, en especial a la atención de sus necesidades y en la participación en los procesos de organización y evaluación del sistema y servicios de salud inseridos. Estudio cualitativo con usuarios que vivieron un episodio de ingreso en hospital por condición sensible a la atención primaria. Los resultados se sistematizaron según análisis de contenido y se discutieron a la luz de la hermenéutica crítica y del referencial "Paidéia". Los hallazgos demuestran que reconocen el Sistema Único de Salud como una política pública, refiriendo su lógica de funcionamiento y beneficios cuando necesitan cuidados de salud. Describen sus efectos por la creación de nuevas prácticas de cuidado en las unidades básicas después de un episodio de ingreso hospitalario, sin mencionarse su participación en los espacios de control social.

**Palabras clave:** Política pública. Sistema Brasileño de Salud. Control social. Investigación cualitativa.