

Access to healthcare in the Family Health Strategy: balance between same day access and prevention/health promotion

Acesso ao cuidado na Estratégia Saúde da Família: equilíbrio entre demanda espontânea e prevenção/promoção da saúde

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Abstract

This article presents some guidelines for organizing the working process in Primary Health Care (PHC) and Family Health Strategy (FHS) concerning the challenges of providing access and balancing the everyday healthcare services activities which includes health promotion and prevention of diseases, as well as access for those suffering ill-health. Firstly, it addresses some specific ideas about the importance of access to the quality of the health care services, followed by a brief critique - based on Geoffrey Rose's concepts - to the high-risk preventive strategy that has had high impact on health care organizational routines. Secondly, it contextualizes health promotion and its relations to individual health care in PHC/FHS, discussing the synergic potential of care and health promotion in their individual and collective dimensions to transcend the biomedical-mechanistic model. Finally, based on the above topics and concerning their operational consequences, as well as using a concrete example, it outlines general guidelines for organizing the working process and the agenda of doctors and nurses in the FHS, in order to facilitate both balance and synergy between access to health care and prevention/promotion, aiming to strengthen the FHS as local coordinator of care and main entrance of the Brazilian National Health System.

Keywords: Primary Health Care; Family Health Strategy; Health Services; Access; Disease Prevention; Health Public Policy.

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Resumo

Este artigo propõe algumas diretrizes para a organização do trabalho na Atenção Primária à Saúde (APS) e na Estratégia Saúde da Família (ESF), relacionadas aos desafios de prover acesso e equilibrar no cotidiano dos serviços, ações de prevenção de agravos e promoção da saúde com o cuidado ao adoecimento. Primeiramente, apresenta algumas ideias específicas sobre a importância do acesso para a qualidade dos serviços de saúde, seguidas de uma crítica sintética - fundamentada nos conceitos de Geoffrey Rose - à estratégia preventiva de alto risco, que tem tido alto impacto na organização das rotinas assistenciais. A seguir, contextualiza a promoção da saúde relacionada ao cuidado individual na APS/ESF, discutindo o potencial sinérgico do cuidado e da promoção da saúde, em suas dimensões individuais e coletivas, para transcender o modelo biomédico/mecanicista. Finalmente, apoiado nos tópicos anteriores, no que tange aos seus desdobramentos operacionais e utilizando um exemplo concreto, propõe algumas diretrizes para a organização do trabalho e das agendas de médicos e enfermeiros da ESF, de modo a viabilizar equilíbrio e sinergia entre acesso ao cuidado e prevenção/promoção, com vistas ao fortalecimento da ESF como coordenadora local do cuidado e principal porta de entrada do Sistema Único de Saúde.

Palavras-chave: Atenção Primária à Saúde; Estratégia Saúde da Família; Acesso aos Serviços de Saúde; Prevenção de doenças; Políticas; Planejamento e Administração em Saúde.

Introduction

In developed societies the State is responsible for the protection of life, health promotion, prevention and the organization of provisional care to the sick. In terms of health outcomes, health care systems have a very valuable, specific, but limited role, since most health achievements are produced by other sectors of society such as: formal education, redistribution of wealth, effective deployment of democracy and transparency in public power, the development of a profession/work in acceptable working conditions, access to proper housing, clean drinking water, and basic sanitation (Gérvas, 2008; WHO, 2009). Therefore, prevention and treatment of diseases/illnesses are more directly dependent on the health system, while the other responsibilities belong mainly to other sectors of the State and society.

In Brazil, the Brazilian National Health System (SUS) has been growing as one of the main government instruments for the protection of citizens' lives, having at least two types of function: public health and the treatment of the sick. The proposed organizational model for Primary Health Care (PHC) services has been the Family Health Strategy (FHS). Taking into account PHC 'filter function' (Gérvas; Pérez-Fernández, 2005), which is essential to the effectiveness, fairness and rationality of care, FHS carries this dual nature: the clinical care and health promotion/disease prevention.

This relationship between clinical care and health promotion/disease prevention in the context of the organization of PHC services was first debated in Brazil by Campos (1991) and Schraiber (1990). Campos values individual care and public health measures as citizens' rights and being the purpose of PHC, based on clinical tradition, interdependence of clinical knowledge/technologies, and epidemiological studies. Schraiber values programmatic actions (whose object is the "health-disease in its collective dimension"), making a distinction between clinical practice and epidemiology. The latter being the main criteria for organizing PHC services based on the public health tradition and health planning in a time when PHC coverage was very limited and far from the desired universality. Other variants, such as the health surveillance (Paim, 2003) and local health systems based on health districts (Mendes,

1993) were also proposed, but were similar to the programmatic logic.

Currently the expansion/construction of PHC/FHS and the simultaneous intensification of knowledge/technologies indicate the need for two approaches. Paim (2008) and Coelho (2008), in synthesizing care models for the SUS and PHC, agree that these proposals are complementary rather than antagonistic and that health care practices should be included in them. Therefore, to find a balance between prevention, health promotion and treatment of illness becomes a daily challenge for professionals and PHC/FHS services (Gérvás; Heath, 2008).

On the one hand, the discussion about disease prevention/health promotion and organization of health care services is not new, containing abundant literature, the same cannot be said about its operationalization, specifically regarding the balance mentioned previously, and the configuration in the routine care of PHC/FHS services. Under this latter perspective, the operational aspect, a non-systematic search that was conducted in bibliographic databases was frustrating, which suggests a lack of consensual background that represents a “state of the art” concerning this issue, with a shortage of clear operational guidelines to organize the practice of FHS teams (Tesser; Norman, 2014).

The objective of this article is to present and explain some guidelines for the organizational practice of professionals of the FHS, more specifically doctors and nurses, focusing on the issues of access and the need for balance between the practice of disease prevention/health promotion and the care for the sick. First, we show some ideas about the importance of access to the quality of PHC services. Second is a short analysis - based on Geoffrey Rose (1985, 2010) - of the high-risk preventive strategy, which has had strong impact on care routines (Gusso, 2009). Third, it addresses health promotion related to the care in PHC/FHS³. Finally, reinforcing the previous discussion, this article discusses operational guidelines for PHC/FHS services that still remain almost absent in the discussion and practice of FHS teams, managers/policy-makers and public health.

Access: the pillar of health services quality

Avedis Donabedian was a pioneer in structuring a system for evaluating quality of health services in three dimensions: structure, processes and outcomes (Raffle; Gray, 2007). As stated by Donabedian (2005, p. 692), “[...] criteria of quality are nothing more than value judgments, which implies that the definition of ‘quality’ is a [...] reflection of values and goals current in the medical care system and in the larger society of which it is a part.” Thus, health services, due to the richness and the complexity of their environment, may receive a more comprehensive definition of quality ranging from a purely social construction to a more objective definition, which basically encompass two aspects: access and effectiveness (Kordowicz; Ashworth, 2013).

Regardless of the perspective adopted, the definition of quality of health services should cover both the individual level of care as well as the population. In this sense, Campbell and Roland (2000), adopt an “objective” view of quality of formal health systems, including its individual and population dimensions, and place access as a *sine qua non* condition for the quality of health services (Table 1).

As seen in Table 1, the quality of the health care system and the dimension of individual care, is oriented by the access and the effectiveness of the care provided; while the population dimension, depending on the optimization of resources, is anchored to the relationships between equity, efficiency, and cost. The commonality of the two levels is access because equity is only a subcomponent of access, relevant to both the structures and practices in health services. Equity refers to the social justice of access, to the extent that resources are mobilized to reflect the need of a given population (Chapman et al., 2004). In other words, equity on the horizontal plane implies effective care accessible to all patients, but on the vertical plane access is for those who need care the most (Starfield, 2011; Gulliford et al., 2002).

The theme of access is so fundamental to the quality of health care systems that the British government has determined that, from April 2004

3 A broader discussion relating to access and health promotion in the routines of PHC services, complement what is presented here, in Tesser and Norman (2014).

Table 1 - Individual and population dimensions of health services quality

	Basic Components	Definition of quality
Individual dimension	Access and effectiveness	Is dependent on two conditions: "individuals can access the health structures and processes of care which they need, and whether the care received is effective." (p. 1614).
Population dimension	Equity, efficiency and costs	"the ability to access effective care on an efficient and equitable basis for the optimization of health benefit/well-being for the whole population." (p. 1617).

Source: Compiled from Campbell and Roland (2000).

onwards, the population would have access to a PHC medical professional in a maximum of 48 hours and any other PHC professional, usually a nurse, within 24 hours (Meade; Brown, 2006). This concern to facilitate access aimed to help people to have greater control over health resources, in order to preserve or improve their health (Gulliford et al., 2002). Although delineating access is a difficult task, especially what is considered to be a high level of accessibility to services, from the point of view of individuals, good access is one in which the patient is able to obtain "... the right service at the right time in the right place." (Rogers; Entwistle; Pencheon, 1999, p. 866); in essence: the patients get the care they need.

In this sense, Starfield et al. (2008) propose two questions. Firstly, is it justifiable that check-up appointments constitute almost half of all visits to health services in the United States, where many people are in need of medical care? And secondly, is the concept of prevention still useful with increasing focus on one or several diseases or particular risk factors? This concern reflects the importance of establishing priorities in care organization aimed at reducing inequities in population health, because the emphasis on preventative care can divert access for the asymptomatic, resulting in the inverse care law, "... that the availability of good medical care tends to vary inversely with the need of the population served." (Hart, 1971, p.412). This emphasis on preventative health care can result in an escalation of medicalizing preventive care with little effect, and strengthening the marketing of medical procedures and the consumerism attached to it (Montori; Isley; Guyatt, 2007).

Geoffrey Rose: criticism of the high-risk preventive strategy

The idea of prevention departs from a linear time concept - which aims to prevent an undesirable episode in the future - within which a distinction is made between preventive actions, those which aim to prevent the occurrence of diseases (primary prevention) and those that hold or delay its progression or sequelae (secondary prevention) (Leavell; Clark, 1976). There are simple preventive actions that are safely implemented and evaluated, while others, more complex, may be valued differently by people, can cause damage, and its benefits are not directly transferable to individuals (Gérvas, 2008).

Geoffrey Rose (2010) discussed the foundations of preventive medicine in relation to the reduction of risk factors for cardiovascular diseases, classifying the preventive actions in individual high-risk strategy and population strategy. The present article focuses on measures of high-risk strategy because they are activities which are increasingly valued in PHC/FHS.

This approach refers to the strategy of classifying people by selecting high-risk groups for the application of a preventive measure: separate a "problematic" minority from the rest of society considered as "normal" (Rose, 2010). Although intuitive for patients and professionals, this approach has little impact on public health, because a large number of people subjected to a small risk will produce more cases of disease than a small group with high-risk (Rose, 1985). For example, pregnant women below 30 years old, although they are low risk, as they are numerous generate 50% of the children born with

Down syndrome, while high-risk pregnant women (≥ 40 years) generate only 13% of them (Rose, 1985). This happens in the various situations in which the risk is universally distributed in the population, as

in the case of hypertension (Chor; Faerstein, 2000) (Table 2). The more illustrative image is the iceberg: the tip (high-risk group) only indicates the existence of a much larger mass that sustains and produces it.

Table 2 - Advantages and disadvantages of High-risk Approach

Advantages	Disadvantages
The intervention is appropriate for individuals	The prevention becomes medicalized
Avoids needing to work on people who do not have high risk	The success is palliative and temporary
Offers cost-effective resources	Is behaviorally inadequate
Rapidly accommodates within service organizations	It has limited ability to predict the outcomes of individuals
Selectivity improves the risk-benefit ratio	Presents problems and costs for its realization
	Contribution to control global disease is frustrating

Source: compiled from Rose (2010).

In spite of its small impact on public health, the high-risk strategy is expanding by lowering cut-off points and ranking large portions of the population progressively as “high-risk” or sick, multiplying its problems and generating more demands for PHC/FHS (Starfield et al., 2008).

The high-risk approach is associated with secondary prevention which screens and treats risks, conditions and diseases, such as: hypertension, obesity, dyslipidemia, cancers, etc. Screening of diseases mimic the “function” of high-risk strategy with individual interventions being repeated, maintained by several generations, using “hard” and expensive technologies, and producing pre-diseases, pseudo diseases, overdiagnosis and overtreatment, as well as causing significant damage and social medicalization (Welch; Schwartz; Wolosin, 2011). Screen and treat does not reduce susceptibility, does not address causes and has little impact on population’s disease morbidity and mortality rates. For example, the reduction in the mortality rate from breast cancer through screening was questioned (Jørgensen; Zahl; Gøtzsche, 2010) and estimated at only 15% in other studies (Silva, 2012). Gøtzsche and Jørgensen (2013) highlight the significant damages attributed to overdiagnosis and overtreatment (Bleyer; Welch, 2012; Welch, 2011). The relationship

between cost and benefits of this screening begins to be inconclusive or negative, questioning the generalized indication of mammography screenings, since radiotherapy in low-risk groups (women with pathological findings resulting from the screening) can bring important consequences, such as excess mortality attributed to heart failure (27%) and lung cancer (78%) (Gøtzsche; Jørgensen, 2013). Therefore, proposals for organized screening programs (Brazil, 2010) need to be reviewed in the light of new evidence, so that information within the organized programs is decoded in a language that is easy to understand, which also portrays the potential harms (Spiegelhalter, 2011); empowering patients (in the case above, the women) to make decisions about their health and their bodies and help professionals to exercise quaternary prevention, essential to the quality of PHC (Norman; Tesser, 2009).

The ethical requirements for establishing preventive interventions are much more stringent than in clinical care situations, because health professionals conveying the notion of risk to their patients may be “ [...] like putting a drop of ink into the clear water of the patient’s identity; it can never be completely clear again “ (Sweeney, 2005, p. 222). Thus, some potential consequences of preventive measures include “[...] disruption of cultural and individual

capacities to cope with sickness, pain, and death” (Gérvás; Starfield; Heath, 2008, p. 1997). The accurate evaluation of preventive interventions must be crucial for determining the type of preventive care services offered to the population, which should be made only when it is certain that it will bring more good than harm. This certainty is obtained by good quality scientific evidence that is backed by robust and reputable institutions (Raffle; Gray, 2007).

This is important because the medicalization of pre-disease and risk factors is becoming the rule, with increasingly strict and hard to reach targets - usually requiring the use of medication - for hypertension, cholesterol, osteopenia and obesity. The prospect of marketing drugs for healthy people greatly contributes to the expansion of the drug market, increasing the costs to society and health services, which may reduce the quality of life by converting healthy people into patients (Montori; Isley; Guyatt, 2007). These preventative ideas may be hindering access to health services, which, from the point of view of equity, is ethically questionable (Heath, 2007), by favoring healthy people with some biomedical marker risk (raised to the status of patient by the medicalization of risks) to the detriment of significantly ill people.

Therefore, the biggest challenges when proposing preventive health policies are establishing priorities for improving health in general, such as: reduction of overall mortality rates for specific age groups, improving life expectancy and reducing disability, and the perception of poor health rather than disease (Starfield et al., 2008). According to Rose (2010), institutions (i.e. ministries, Health departments, professional associations, political leaders, civil officials, and media) have an important role in debating mass population preventive and promotional policies as well as social, economic, cultural and infrastructure issues (food quality, work conditions, wealth distribution, leisure, safe and sustainable mobility, etc.), which are the fundamental pillars of health promotion (WHO, 2009). This has been the key of convergence between the social determinants of health, considered as of great impact on the quality of life and collective mortality, among which stands out the distribution of wealth, since poverty and socioeconomic inequality are harmful to health care as a whole (Wilkinson; Pickett, 2010).

Health promotion and relief of suffering

The change in mortality profile in developed countries, in recent decades, has not achieved the same effect with respect to suffering. Barsky (1988) referred to this phenomenon as the “health paradox” although objectively health has improved, subjectively people feel more “sick.” The author points out four reasons for this discrepancy: 1) the reduction in mortality from infectious diseases has resulted comparatively in the increased prevalence of chronic diseases, 2) there was an awakening of consciousness with regard to health, leading to greater self-scrutinization of the body and awareness of symptoms and feelings of sickness, 3) the widespread commercialization of health and an increasing focus on health issues in the media created an atmosphere of apprehension, alarm and insecurity about diseases and risk factors, and 4) progressive medicalization of everyday life has brought unrealistic cure/prevention expectations causing intractable diseases, risks and discomforts to look even worse. These reasons, also present in Brazil, intensified by poor social conditions, generate a clear increase in demand for PHC.

The question of suffering and its relation to physical illnesses have been addressed little in the literature and in medical care practice (Sweeney, 2005). Based on clinical observation, a distinction is made between physical suffering and distress; the suffering is experienced by people, not merely by their bodies, threatens its integrity as a complex social and psychological entity, and may include physical pain but is not limited to it (Cassel, 1982; Helman, 2007).

The relief of suffering and the cure/treatment of diseases should be seen as an indivisible obligation of health professionals (Heath, 2007); however, if they do not understand the nature of the suffering of people, these professionals can produce interventions that do not relieve or even can be the sources of suffering. Thus, relieving suffering should be one of the fundamental purposes of health care (Cassel, 1982).

On the one hand, health does not necessarily imply the absence of disease, on the other, health

promotion involves relief of suffering, since these concepts, health and suffering, go beyond the boundaries of biomedicine. Therefore, to relieve suffering, the promotion of health needs a better understanding of the person; he/she cannot be reduced to parts, systems or risks. The analytical/reductionist scientific method, relatively successful in human biology, is of little help in understanding the whole person, and any proposed mechanical or biochemical-statistical simplification should be removed from the definition of suffering (Cassel, 1982), implying a demedicalizing vision of PHC (Tesser, 2010), especially in mental health (Tesser; Teixeira, 2011).

Thus, health promotion (in its micro dimension) and the assistance of the individual can be synergistic for the relief of suffering, encompassing all aspects of the person - their past and family life, culture and society, roles, associations and relationships, body, the unconscious, the political being, their secret life, the perception of their future and transcendent dimensions - all these aspects are subjected to loss and damages (Cassel, 1982). Therefore it emphasizes the inseparable character of health promotion and care, which converge in a clinical practice centered on the person, family and community (McWhinney, 2010, 1996).

The integration of health promotion/disease prevention and access to care is the primordial value of PHC/FHS and may be strengthened by population-based approach measures, for example, advising individuals/communities about quitting smoking or encouraging physical activity. This population approach (for instance, public policies and legislation that create leisure spaces and sustainable mobility, etc.) produces contexts that can be exploited, with synergistic results when combined, the second being the most impactful. One must consider, however, the limitations of the effectiveness of individual and community guidance in face of social, cultural and existential adverse conditions, commonly seen in Brazil. Thus, professionals should not blame patients (Castiel; Guilam; Ferreira, 2010) when they see that their recommendations are ineffective in promoting “healthy lifestyles.”

If health promotion (in its macro dimension) and the population preventive approach mainly depend

on measures that are beyond the sphere of health services in PHC/FHS (although it might include it), the individual care through collective activities (micro preventive dimension) of health promotion is possible and desirable, only if there is a commitment to respond to the suffering of individuals. The local collective practice upon social determinants should be pursued, but should not affect the longitudinal care of patients, the intrinsic “*raison d’être*” of PHC/FHS health professionals (Heath, 2007; Sweeney, 2005). Thus, health promotion gets legitimacy by the daily commitment to the exercise of patient care (Tesser; Norman, 2014), which taken to the depth, returns to expanded and empowered approaches. Promotional and preventive actions detached from the needs felt by the population, can and should occur, but without taking up considerable amount of time of doctors and nurses, and this is essential to carefully integrate practices of health promotion/disease prevention with quick access to continuing care in the PHC/FHS.

From the previous topics it becomes crucial for the operation of PHC/FHS services to provide easy access to demanding patients, reconciled and synergized, with insightful preventive and promotional activities. In doing so they eliminate the possibility of preventive practices of high-risk or even health promotion (for healthy individuals) to compete with the care of those patients already experiencing illness, in the daily demands for health services, therefore minimizing the medicalization of prevention. Accordingly, some strategies for organizing the schedules of doctors and nurses are hereinafter made by means of a concrete example.

Balanced Agenda: the example of the Tapera Health Center

In March 2007 the Integrated Program for Family Health Residency (IPFHR) began at the Tapera Health Center, linked to the Federal University of Santa Catarina (UFSC), in partnership with the Florianópolis Municipal Health. The introduction of IPFHR at Tapera HC produced major changes in services, as there was a substitution of previous health staff (such as physicians, nurses and dentists) by equivalent tutors and residents linked to the program.

Tapera is a suburb with difficult access and a population of approximately 12,000 inhabitants, one of the socioeconomically disadvantaged communities of Florianópolis. In the process of occupation of this neighborhood landfills were placed over mangroves, and sewage ditches were opened without proper treatment. There are few social facilities (schools, child care nurseries, police stations, no formal recreation area and precarious paving of the streets), and its residents are mostly employed in manual labor work and services. Currently Tapera HC has four teams of FHS (in 2007 there were only three), each with about three thousand assigned patients, and two offices for staff, in addition to other basic resources (auditorium for collective activities, dressing room, vaccines, etc.). Therefore, it is a relatively similar neighborhood to many realities of the FHS teams working in the country.

The renewal of professionals resulted in the need to change its practice to organize it in the FHS logic. The previous scenario to the adoption of IPFHR was a stiff and bureaucratic relationship with the population. There was a “menu” of services organized in the form of an agenda, doctor centered appointments (and, when available, nurse appointments) and other services such as vaccinations, dressings etc. The

number of vacancies on the agenda was limited, with a “day” of the week for booking appointments: when the available slots ended, so did access to care, which Tesser, Poli Neto and Campos (2010) defined as a mixture of private office logic in synergy with a public office.

The strategy for operational changes was to dialogue with the organized population (the existing Community Council and local health forums, the latter a space set up by residents to stimulate the creation of a Local Health Council - LHC) to match service needs with community claims, whose priority was access to medical care. In these meetings it was proposed that each FHS team would take responsibility by the patients’ demands in their area (since previously the daily work was not organized according to each FHS team catchment area) and that all team members would participate in some form of service. The medical and nursing schedules were reorganized into six appointment slots of 20 minutes each, in the first half of the clinical session, on any day of the week (each clinical session lasting four hours). In other words, the first two hours of the morning and afternoon were intended for drop-in appointments; the remaining clinical session time was reserved for pre-booked appointments, home visits (HV), team meetings and group activities (Table 3).

Table 3 - Standard week of family health team 260 at the Tapera Health Center

Monday	Tuesday	Wednesday	Thursday	Friday
Drop-in appointments	Drop-in appointments	Drop-in appointments	Drop-in appointments	Drop-in appointments
Pre-booked	Pre-booked	Pre-booked	Meeting of FH team	Pre-booked
Lunchtime	Lunchtime	Lunchtime	Lunchtime	Lunchtime
Drop-in appointments	Drop-in appointments	Drop-in appointments	Drop-in appointments	Drop-in appointments
Home Visits	Collective activity	Pre-booked	Pre-booked	Pre-booked

In Brazil, the health centers seeking to implement same-day access guidelines basically use two modes of practice organization: one that values the territory, continuity of care and spontaneous demand and the other that does not follow this approach. In the first, patients’ demands are met specifically by each catchment area FHS team and in the second, these relationships are independent of

each other. The latter is organized with an “on duty” team, where professionals are responsible for the spontaneous demand of the day during the health center working hours. For them this type of practice works as “the quota of suffering for the week.” In this case, the demand is burdensome, not something the team considers as their duty and responsibility. At times an extra health care team is put in place

only for attending the emergency care at the health center. This hybrid context is not appropriate in the PHC/FHS logic as it tends to reproduce a walk-in surgery (24 hour clinics), with little accountability of the health teams for their patients, breaking continuity of care and facilitating the medicalization of care (Tesser, Poli Neto; Campos, 2010).

The Tapera HC appointment system is based on the first-mentioned mode: fulfilling spontaneous demand, valuing continuity of care, and professionals' accountability for the people ascribed to their catchment area. Gradually gaining strength and being adopted in other health centers of Florianópolis municipality, this system has already been proposed in a Brazilian reference treatise for family and community physicians as a model for managing clinical appointments in PHC (Gusso; Poli Neto, 2012). Although the IPFHR was removed from the community in late 2007, the tutors who remained there, together with the existing health staff team, kept the system running and, even with the departure of the last two former tutors in 2010, Tapera HC have not only continued further but also improved the initial idea, as can be seen in the material available on the health care center's blog⁴. In this appointment schedule system the community feels reassured, because they know that they will have a professional to meet and listen to their needs, with whom they have developed a bond and respect. This is particularly crucial in mental health care (Tesser; Teixeira, 2011). This example of appointment schedule system can serve as a guideline for the organization of practices that seek equity and expanding access to FHS without neglecting other activities (i.e. health promotion, disease prevention, surveillance) of the health team's responsibility.

From health professional's point of view, this system allows for changes in order to reduce stress on them. Thus, the demand for certain periods can be altered by an "X" number of appointments per clinical session, and people can be seen either by doctors or nurses. Having an excess of patients, they are welcomed by health care assistants, who provides adequate guidance and the provision of appointment for the next clinical session either afternoon or next

day. If necessary, they negotiate with their peers for immediate care. The volume of appointments is a constant balance between the health staff coping strategy and the community's needs, which might change over time (NHS, 2009). Commonly, there is a great demand for appointments at the beginning of its implementation, when there is a repressed demand for consultations, requiring sometimes to offer unlimited same-day care access. This process tends to attenuate the pressure for appointments, as a result of a permanent reassured quick access to health services and by a mutual trusting relationship between patients and health professionals.

Table 3 illustrates other activities other than individual care: weekly staff meetings and HV, which can also create other spaces for collective activities (therapeutic, health promotion, and educational), continuing education programs and matricial support, according to the needs of service. These activities should be dispersed throughout the week, without taking up an entire clinical session, especially during the first two hours of the clinical session, preserving access by avoiding simultaneous absence of all team members. Only during the weekly staff meeting will all of the team members get together to participate in health management decisions, reflecting, evaluating and organizing the service, as well as projects and activities of various kinds (clinical, programmatic, territorial, HV, surveillance, educational groups, etc). Thus, the community activities (facilitated and carried out mainly by the community health workers) are discussed, evaluated and organized during the meetings of the interdisciplinary team as well as during the HV - moments also privileged to continuing education, especially of the community health workers. The main potential moments for interdisciplinary practice, in this appointment schedule system and in PHC services in general are: the accommodation of same-day appointments (spontaneous demand), HV, collective educational activities, the weekly meetings and the informal daily encounters in the hallways, kitchens, doorways and offices, where professionals work together and build the organizational atmosphere of qualified care, as reported by

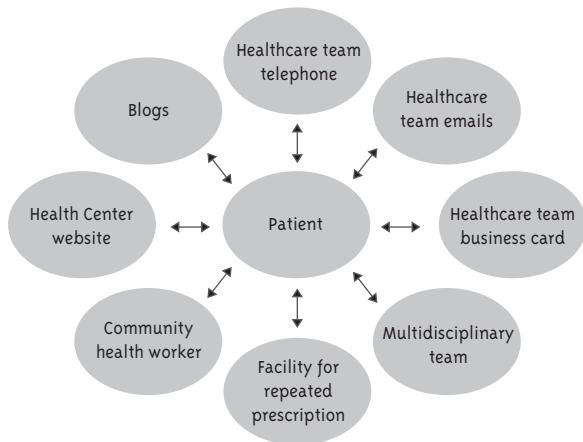
4 Available at: <http://cs-tapera.blogspot.co.uk/p/equipe-26o.html>.

Madeira (2009). As a result, this scheme facilitates the flow of same-day access (spontaneous demand), while maintaining and optimizing space and time for community activities (as well as intersectoral health actions), surveillance, health promotion and patients' education.

The above example is flexible, allowing a greater or lesser number of same-day access, according to the needs of the community (outbreaks/epidemics, local/regional needs and specificities - such as isolated communities that are deprived of resources) and the limitations of the service itself. It could also mean a reduction in the number of appointments in the event of employee vacations (without replacement), high rates of absenteeism, vacancy for conferences/training or when there is no policy for professional maintenance and training.

In addition, this system progressively reduces the queues, ending the need to a specific day for "making an appointment" - that many health centers still practice - since every day there is significant availability of same-day appointments. It also reduces the numbers of DNA patients (those who Did Not Attend), since they are booked by the health team staff for a few days or rescheduled as determined by the patients. It is therefore operationally important to avoid "blind appointments," performed at the request of the patients without mention of the reasons, respecting patients' privacy, to improve the easy qualified access to health professionals. It is necessary to minimize them in order to avoid unnecessary consultations for bureaucratic reasons (such as renewal of prescriptions/referrals, etc) or for acute conditions that needs to be immediately seen by the appropriate health staff. This contact can also be done by other forms of communication that do not affect the daily process of continuity of care by the FHS teams, as shown in Figure 1. For this reason, the agility of communication between patients and health team is paramount (via email, phone and community healthcare workers). Consequently, the pressure on the booking appointment decreases because many guidance, dialogues and decisions can be made by phone or (Hansen; Hunskaar, 2011) internet via e-mail (Atherton, 2013), however, these types of media are very rarely used in Brazilian PHC.

Figure 1 - Alternative channels of communication or access to the FHS teams



Other forms of first contact, keeping easier access on a daily basis, were drawn up in Brazil: experiences involving the entire FHS team in the first hour of their clinical session, streamlining listening and decreasing stress levels (Cavalcante Filho et al., 2009); appointment schedule system that intersperse same-day access for patients with pre-booked slots (1:1); collective discussion of patients' problems as a triage process (except when patients request a private space for being listened) and/or making appointments interspersed with problematization, health education and democratization of information. Ways to expedite access to PHC (called same-day access) are also discussed internationally. In other words, proposals and experiences that are found in the literature and in PHC practice, point in the same direction as discussed here (Murray; Berwick, 2003).

But what about programmatic actions?

Programmatic actions as activities planned, implemented and evaluated in PHC - epidemiologically and/or collectively significant (Schraiber, 1990), whether preventive, therapeutic or promotional - are distributed according to same-day access (spontaneous demand) and pre-booked appointments, coupled with personalized and longitudinal follow-up of the

enrolled cohort of patients, with the same level of importance as the patients' spontaneous demands for same-day appointments.

The delineated working unit for organizing the health service is defined by its cohort of patients of all ages, including clinical care and public health actions. Any permanent or prioritization of some intervention (i.e. pregnancy, well-baby care, and other specific actions) does not affect the organizational flexibility and access to care. This facilitates health integration taking the dual responsibility of individual care and public health. If programmatic actions (or "problems" detected by the service) are the main criterion for organizing health provision, there is a trend to occupy almost all the practice available appointment slots with specific actions, which can hinder access and induce attempts to limit the spontaneous demand, subliminally undermining it as a responsibility of the PHC.

The criteria and frequency with which programmatic activities are carried out also depend on participatory planning and dialogue with the community (Pinto; Coelho, 2008). For example, it is recommended that pregnant women attend a minimum of six visits to the health team during their prenatal care. There is flexibility in the organization because, generally, pregnant women have monthly monitoring and at the end of pregnancy, biweekly or weekly visits. Similarly, low-risk children may arrange their check-up visits up to six months, with appointments associated with their immunization schedule, in addition to other strategies, such as childcare collective educational activities. As for hypertensive patients and high-risk diabetics, they have priority over those of mild and moderate risk patients and represent small slice within that highest risk group, also subject to collective educational actions (Amaral; Tesser; Müller, 2013).

Age, diseases, and specific actions (i.e. pre-natal care, child health care) may be used as criteria for the evaluation of the FH teams' performance, but not used to organize the routine of services. During the weekly meeting the FHS team evaluates and decides which programmatic actions will be offered to the population and how, requiring the construction of a democratic-participatory culture of practice, co-management of the demands of the population, professionals and

institutional guidelines (Campos, 2000) and also negotiation with the Local Health Council.

A significant part of preventive practice can and should be done "in parallel" to medical care. This is the case with screening programs, a public health service provided to the asymptomatic population with protocols that do not need to involve clinical care in its initial phase (Brazil, 2010). For example: women may be invited to Papanicolaou by professionals (especially community health workers) by letter, telephone, or e-mail; where examinations are conducted and results received without the need for directly involving a physician or nurse consultation, which will take place if necessary, saving doctors and nurses time. Therefore, for a better balance between access to care and health promotion/disease prevention practices, FHS professionals should share tasks/responsibilities between individual and collective actions and preventive care practices, whether it requires clinical care or not, as in the case of spontaneous demand and pre-booked appointments.

Final Considerations

If the PHC/FHS aims to be the initial point of contact for the SUS and its structuring axis, it needs to promote and facilitate access, integrating care and disease prevention/health promotion and making a patient-centered practice (Merhy, 2002). The four principles that characterize PHC: 1) be an initial point of contact (with gatekeeping role for ascending the health system); 2) be the coordinator of care; 3) provide continuity of care and; 4) provide comprehensive care (that meet all the needs of common population) are also structural subcomponents of availability, i.e. the access (Campbell; Roland, 2000).

The operational guidelines presented emphasize access to care without neglecting disease prevention/health promotion, reversing certain preventative and promotional emphases in the organization of services of PHC (Tesser; Norman, 2014). The viability of access and patient centered care according to the FHS team catchment area (not fragmented by diseases and/or pathophysiological parameters) allows for a better understanding of population condition, especially for the most vulner-

able, and an appropriate response to peoples' health needs (Starfield, 2011). The organization of practice in PHC/FHS should be aimed primarily to care for the sick, through better access to longitudinal, comprehensive and qualified care, incorporating complementary measures of promotion and prevention (carefully selected). Therefore, the issue of access in the PHC/FHS services, as a civil right, needs better standardization and regulation in the SUS, as in other countries, and requires further discussion of the structures and practices necessary for the qualification of the PHC/FHS as main entry of the health system.

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