The dimension of health care in Health Promotion: notes on the approach to care

A dimensão da atenção à saúde na Promoção da Saúde: apontamentos sobre a aproximação com o cuidado[1,2]

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Abstract

The aim of this text is to explore the interfaces between Health Promotion (HP), health care and the care process. It starts from the assumption that the dimension of health care is essential for the theoretical-practical construction of HP, so that it can contribute to better health conditions. This is a qualitative research, a consultation was carried out with managers and municipal workers of Health Primary Care, using an electronic form, which had 215 respondents; and 13 interviews with experts, so called members of the Working Group of the Brazilian Association of Collective Health; also a categorical-thematic analysis was performed. As a result, stands out that: there is not necessarily a dichotomy between HP, , clinical care; the way in which care is produced becomes relevant since considering HP principles and guidelines is necessary, thus care would be related to HP even though the perspective is the recovery of health in cases of illness. Thus, defending the importance of the health care dimension is not to ratify the hegemony of health care over other components of care process, and considering individual needs alongside the social dynamics and the context in which people live is essential.

Keywords: Delivery of Health Care; Primary Health Care; Health Services; Integrality in Health.

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Resumo

O objetivo do presente texto é explorar as interfaces entre a Promoção da Saúde (PS), atenção à saúde e processo de cuidado. Parte-se da premissa de que a dimensão da atenção à saúde é essencial para a construção teórico-prática da PS, de forma que possa contribuir para melhores condições de saúde. Trata-se de pesquisa com caráter qualitativo; foi realizada consulta a gestores(as) e trabalhadores(as) municipais da Atenção Básica, utilizando formulário eletrônico, que teve 215 respondentes; e 13 entrevistas com especialistas, membros do Grupo de Trabalho da Associação Brasileira de Saúde Coletiva; também foi realizada análise categorial-temática. Como resultado, pode-se destacar: não necessariamente há dicotomia entre PS, Clínica e cuidado; a forma como o cuidado é produzido torna-se relevante, já que é necessário considerar princípios e diretrizes da PS; e que o cuidado estaria relacionado à PS ainda que a perspectiva seja a recuperação da saúde em casos de adoecimento. Assim, defender a importância da dimensão da atenção à saúde não é ratificar a hegemonia da assistência à saúde sobre outros componentes do processo de cuidado, sendo essencial considerar necessidades individuais em conjunto com a dinâmica social e o contexto no qual vivem as pessoas.

Palavras-chave: Assistência à Saúde; Atenção Primária à Saúde; Serviços de Saúde; Integralidade em Saúde.

Introduction

Health Promotion (HP), as a set of strategies and ways of improving health, refers to the search for encompassing the complexities related to health and life. In this sense, HP dialogues with the individual aspect, through the development of healtier ways of life, and with the collective and societal aspects. So, this leads people to have effective possibilities (or not) of adopting these modes, if they want to. In other words, what conditions allow people to have healthier options if they want to, or prevents them from it if not.

Thus, as a field, that generates differentiated policies and practices regarding the existence of a dimension of health care, HP has brought the challenge of raising possibilities that enable and incorporate care strategies guided by the principles of integrality and equity (Bagrichevsky, 2021). Besides the importance of access to quality health services, it is necessary to face the full range of health determinants, which requires healthy public policies, intersectoral coordination, and population mobilization (Buss et al., 2020).

HP thus recognizes the need for intra and intersectoral articulation and cooperation for the formation of the Health Care Network (HCN), in integration with other social protection networks (Brasil, 2014). However, it is possible to say that such care strategies end up being marginalized in discussions about HP, even though intrasectoriality is one of its principles. The HCN, as an important space for the operationalization of HP (Brasil, 2014), and Reorientation of Health Services, as one of the HP fields of action (World Health Organization, 1986), allow us to infer the existence of a dimension of health care. However, this dimension, if not denied in the literature, is not properly explored.

Health Care is understood as the actions that involve caring for the human being's health, including actions directed at protection, prevention, recovery, and treatment of diseases and at HP, encompassing performance at all levels of care of the Brazilian National Health System (SUS). As at all levels of government, actions are aimed at individuals or the community and provided in outpatient or hospital settings, as well as in other

spaces, including at home (Brasil, 2013). Besides, it would be the object of action of the health services and the field of competence of the health professional within the health-disease process, understood in its complexity and multidetermination, recognizing the limitations of the Health sector in this process (Demarzo, 2013).

Care is understood as the set of interconnected actions that permeate all levels of health care, considering the integrality of the subject and involving the sectors that intervene in the social determinants of health. Technical and ethical quality is sought through the recognition of the user's rights, subjectivity and cultural references, ensuring respect for issues of gender, ethnicity, race, economic situation, and sexual orientation, among others. In other words, the definition refers to comprehensive health care (Brasil, 2013).

Thus, there are some indications about the relationship between HP and care through what we call the dimension of health care, emphasizing reciprocity, since HP is included in the concept of health care and this is included in HP. In addition, there is recognition of the complexity and multidetermination of the health-disease process; the need for interconnected actions that consider the integrality of people; the involvement of sectors that intervene in the social determinants of health, and the production of health in the articulation and intrasectoral cooperation in the HCN.

There are inaccuracies and confusions related to the actions developed in/by the health services. There are limits for the political and paradigmatic incorporation of HP in the professional performance. Moreoverprovision of HP actions aimed at specific groups is hegemonic: chronic diseases, women's health, etc., so that the care process in Primary Health Care (PHC) is strongly influenced by the biomedical model of health care, and it is necessary to rethink it (Netto; Silva, 2018; Kessler et al., 2018).

As a result, refusing to deepen the discussions and reflections on the dimension of health care in HP, or what was originally known as the reorientation of health services, can lead to the some topics "crystallization" in health practices. And those are vital for HP, allowing us to infer that its partial operation may occur, with a view to creating "niches" that do not connect to each other. For example, a health action is either HP or care, with no possibility of connections and interpenetrations.

The objective of this text is to explore the interfaces between HP, health care and the care process, seeking to know the understanding of different people with distinct SUS dimensions. Based on the assumption that the dimension of health care is essential for the theoretical-practical constuction of HP, so that it is able to provide better individual and collective health conditions, and from the understanding of the care process as the main action from this dimension. Problematizing HP through the critical analysis of some topics, especially the dimension of health care, which has no consensus and even recognition about its relationship with HP, becomes important to advance in the theoretical-conceptual construction and to provide elements for practice in the SUS.

The HP principles that have a greater relationship with what we believe to be a differential element in the search for contributing to better health conditions through the dimension of health care are: integrality; expanded health concept; equity; intrasectoriality, and social participation, in addition to the following values: ethics; respect for diversities; humanization; co-responsibility; justice, and social inclusion (Brazil, 2014). Thus, care practices would be linked to the appreciation and defense of life, recognizing and respecting the complexity and uniqueness of people and collectivities, with shared responsibilities among those involved in the process and with equitable access, which refers to the right to health as a benefit of life in society (Brasil, 2014).

Methodology

This text is based on qualitative research with an exploratory character with the objective of critically analyzing HP in the SUS, and it presents a discussion about how it is connected to care. Two groups were consulted: PHC managers and workers, by means of an electronic form (FormSUS), and interviews with HP specialists, who are members of the Brazilian Association of Collective Health (GTPSDS/Abrasco).

Managers and workers played an important role in the process of institutionalizing HP (Malta et al.,

2016); they were invited to participate by e-mail and virtual social networks, such as Facebook and WhatsApp, and were asked to divulge the research, and also to support its dissemination in institutions such as the National Council of Municipal Health Secretariats (Conasems), among others.

In the FormSUS – which can be made available through contact with the authors –, nine municipal experiences (ExpMun) were described, previously selected for being related to HP. They were extractedfrom the Experience Catalog of the 2015 *Mostra Brasil Aqui Tem SUS*, an initiative of Conasems that seeks to give visibility to initiatives developed at the municipal level, encouraging the exchange of experiences and valuing the work of managers and health teams (Conasems, 2016). This option was based on the fact that they were developed in realities similar to those of the respondents.

In the FormSUS, after reading the open questions represented by the ExpMun, the respondents were instructed to classify them as HP actions or not, indicating the elements that led to this. There were 215 respondents from 24 Brazilian states (there was no respondent from AM, TO, and RS), between August 2017 and June 2018. The content of the responses was analyzed using Microsoft Office.The objective was not to privilege the quantitative aspect, that is, the number of respondents agreeing or disagreeing that a particular ExpMun, was HP, but to consider the richness and diversity of the multiple and even contradictory responses (not simply a matter of "yes" or "no" and "because,"). Therefore, it was assumed that the interpretative multiplicity is constitutive of the HP field. Thus, the classification of the action as HP, in the FormSUS, was not the most relevant nor was it accounted for; there was special interest in the arguments, justifications, affirmatives and negatives about the reason for this option, as they contained elements that allowed the analysis and enriched the interpretive possibilities of HP.

With HP specialists, in general university professors and researchers who act as protagonists in HP teaching (Minowa et al., 2017), there were 13 semi-structured interviews, between November 2017 and February 2018, with members of GTPSDS, a group which argues that HP requires action in social determination and is not restricted to risk factors and protection of NCDs (Abrasco, 2017). They were asked specifically about the object presented in the text: "For you, is there a dimension of Health Care in HP? Tell us about your position"; "How can HP (assumptions, principles and guidelines) be articulated with the care process? Or are they different things for you?" From these initial questions, complementary questions and topics were introduced according to the answers, reflections, questions, etc.

Still related to the research object, they were asked about the critical analysis of HP in the SUS, the role of the Health sector, the behavioral changes, and the daily actions of the PHC services. The recordings were transcribed and analyzed in the aforementioned manner. Respondents consented to their participation and the research was approved by the Research Ethics Committee of Ensp/Fiocruz under protocol n. 2.182.130.

In both ways of obtaining data – electronic questionnaire and interviews –, the categorical-thematic analysis was carried out with a view to revealing the nuclei of meaning that make up the communication and whose presence has meaning for the object under analysis (Minayo, 2008; Bardin, 2011). The dimension of health care, one of the founding topics of the initial hypotheses that we wanted to problematize and discuss, was naturally included in the triggering questions of the interview and were part of the ExpMun, allowing it to be understood as a foreseen topic (Oliveira; Jaime, 2016). Even though both the ways of collecting data and the profile of respondents were different, HP and related topics were "guiding threads" that allowed categorization.

Results and discussion

The results are presented considering the premise that the dimension of health care is essential for the theoretical-practical construction of HP, thus, topics considered relevant are discussed and it is indicated whether they emerged from the ExpMun or from the interviews.

Self-care was remembered in the responses from the reading of five ExpMun, being seen as HP. Such an occurrence indicates that there is an understanding

that people's participation in the care process is essential. Also in the responses, considering five ExpMun, treatment, care and referral were addressed in a perspective of improvements from the valuation of professionals, revealing that this stage of the care process is part of HP. The increase in the resolution of cases with the reduction in the number of medical and nursing consultations was recalled in the response of an ExpMun.

A way of understanding HP close to care can be seen in the statement related to an ExpMun: that in addition to treating, it was sought to reduce the number of consultations, that is, curing or mitigating the repercussions of health conditions is essential for HP, which is not intended to be just discursive, only with a macro objective of changing health and living conditions, not giving due importance to illness and its mitigation. Thus, the conceptual boundaries between HP and care can be blurred and interpenetrate, refuting the idea that HP is one thing and care and Clinic are another, as if they could not be permeable and dialogue.

In order to think of HP as a component of the care process, it is necessary to recognize that, in general, health professionals are trained to follow protocols, and there is a greater difficulty when things come out of that "little box." HP actions are procedural, fluid, even transitory, and may not be palpable; with the concreteness that a protocol brings, when people do not follow what was recommended or prescribed - a "slip" that "threatens" the power of the health professional from their technical training -, this professional usually blames the subject for their health condition.

Care also contributes to providing quality of life for those who are sick, as well as to the quest to live well by those who already have a disease, as mentioned in the response from an ExpMun. The authors of this text do not agree with the idea that turning attention to people who have a certain health condition would break one of the first HP principles, that is, to think of the population as a whole and not in terms of groups of risk. When defending the existence of the Health Care dimension in HP, it is argued that care is a necessary condition for people to reach increasing degrees of health, including acting on determinants and conditioning factors.

In the Health Care dimension, diagnosing and treating signs, symptoms, pain and suffering can also be HP, but it is clear that this is not all. It is necessary to look and act on the context beyond the biological body, identifying and seeking to act on the causes. Heidemann et al. (2015) argue that there are new challenges to reformulate, reposition and renew efforts to strengthen HP in its role of reorienting health services.

The consideration of personal needs, the analysis of the population's epidemiological profile and, therefore, the prioritization of the main lines of care, was highlighted in the response of an ExpMun, in addition to the performance of a multidisciplinary team, considering the responses of four ExpMun, defended for expanding the possibilities of success of the therapeutic process, especially when matrix support takes place, for encouraging users to achieve collectively established goals. Silva and Tavares (2016) emphasize that teamwork and interdisciplinarity are characteristics of the PHC work process, which contributed to the renewal of the Health Care model. An expanded approach to the Clinic with a comprehensive dialogue of users' values, beliefs and preferences (Chiesa et al., 2011), together with the health professional's technical-scientific knowledge, would compose a care process with a greater possibility of success.

As for the non-characterization as HP, in the responses from three ExpMuns, it was stated that health actions were exclusively a health care strategy. Here, the understanding that care and HP are necessarily different things is denoted. Silva et al. (2015) emphasize that the Health Care model, focused on disease, has a historically established force that will not give in just for good intentions. It will be an important step for HP to be able to dialogue and enter the "space" of care to make health practices more effective when considering more than signs and symptoms. Thus, the treatment will start from the search for understanding and also acting on the causes, which will expand the possibilities for people to follow the suggested therapy, from the understanding of what favors or prevents them from reaching increasing degrees of health.

As for the specialists, of the 13 interviewees, only two did not speak explicitly about the dimension of

Health Care. The opposition to the dichotomy between Clinic, care and HP was striking in the responses of the interviewees, as well as the recognition that there is no dedication to implementing Health Care as a field of HP; leaving the discussion about care aside, with an exclusive or exaggerated focus on improving living conditions, cause health conditions to be discussed in the abstract field, as if illness were not part of them.

> *I do not agree with the dichotomy between HP and clinic, there is a possible dispute for space between them, but I argue that HP actions and the interrelationship with the issue of care can be thought of from the dimensions of integrality. The development of skills for HP of professionals who work in health care, based on the HP values and principles, is essential.* (E1)

Akerman and Rocha (2018) state that there is no dichotomy between Clinic and HP, since, within the health services and in the Clinic, the closeness between them would imply the expansion of care strategies from the understanding of illness as an event in the patients' lives. For Prado, Falleiro and Mano (2011), care is an essential function of the health professional and a common objective between them and the user, and should not be associated with control. Penido and Romagnoli (2018) emphasize that it is necessary to take into account that the Clinic, in HP, starts from the founding challenge related to the centrality of the disease for its scientific and practical discourse, although efforts to expand the concept of health beyond the simple absence of disease have to be recognized. For the authors, such expansion contributed coniderably to questioning clinical practices in health, especially in PHC. Thus, the care process will benefit greatly by incorporating HP principles and values.

It is relevant that, in the emergence of one of the most widespread HP concepts in 1986, by means of the Ottawa Charter, it was recorded that the concept appeared because of the need for overcoming the exclusive or predominant focus of health care. As already mentioned, the Reorientation of Health Services, one of the HP fields of action, brings need to change the attitude and organization of health services so that they focus on the individual's global needs as an integral person (OMS, 1986).

Thus, the challenge is to overcome the aforementioned exclusive or predominant approach, but without disregarding its importance; that document, essential for HP, already stated that health services need to adopt a comprehensive posture, respecting cultural peculiarities and, with that, support the individual and community needs for a healthier life, besides affirming their responsibilities to provide clinical and emergency services (OMS, 1986).

The understanding of HP, in this text, approaches its critical aspect, thus recognizing its relationship with broader issues, such as working conditions, employment, income and access to social goods; however, the dimension of health care is usually relegated to less important plans due to the possibility of denying or relativizing one of its most important principles – intersectorality –, among other reasons.

The aforementioned need to overcome the exclusive or predominant focus of health care does not mean that there is no role for health services in terms of health care, since it is argued that HP, even with the breadth and complexity of its proposals, can also be learned and operationalized in the micropolitical spaces of health units (Sperandio et al., 2016) through care practices that, in part, shape health care. Westphal (2006) argued that the critical aspect of HP can be applied in health care in prevention, treatment, and rehabilitation activities.

According to Cecílio (2012), our actions and practices are informed in a more or less explicit way, by theories, concepts, worldviews, ethical-political projects that, according to the author, delimit how we think about the State, public policies and their effective operationalization. Thus, based on the premise that theories and concepts shape doings and practices, not debating the health care dimension of HP may mean the incomplete search – or even not expanded, as the critical aspect of PS defends – for improvements in the living conditions and individual and collective health, acting on the health-disease-care process.

In addition, two specialists highlight the way in which this care is produced, considering the

HP principles and guidelines, in particular the empowerment, autonomy, and protagonism of the subject. In this way, clinical action takes on other contours; the focus is no longer an exclusively medicalizing approach only on signs and symptoms, and starts from a broader perspective that will allow the subject to effectively participate in the care process.

> *...programs and actions in health services, in which there were issues related to the care of a certain health condition, but in them the actions were guided by some of the HP principles, for example, empowering the citizen, the search for more autonomy in decision-making, participation in the construction of their health care protocol. These are actions that approach the HP principles, even with a focus on a particular health condition.* (E2)

It is evident that the way in which health care has been hegemonically operationalized is also an important obstacle to its consideration in HP. Aquino et al. (2014) state that there is recognition of the determinants and conditions of health and need to act on them by health professionals who work in HP. The authors emphasize that their discourse has already overcome the focus exclusively on the disease; however, the actions developed, despite some advances, are still strongly focused exclusively on changing the individual's behavior, with attribution of responsibility for their condition based mainly on the traditional model of health education, establishing a vertical professional-user relationship (Aquino et al., 2014).

For Pettres and Da Ros (2018), overcoming the perspective of fragmented action, with therapies on the body as a machine or health simply as the absence of disease, brings the understanding of health as produced by society and influenced by the ways of organizing life, sociability, affection, culture, and leisure, among others. Haeser, Büchele and Brzozowski (2012) claim that leisure, education, social relationships and work, in short, living conditions, are determinant elements for the constitution of health. Prado, Falleiro and Mano (2011) approach the idea of care production, expressed in the sense of process, construction, path to be followed by individuals who bet on dialogue and listening. According to the authors, attentive listening to versions, truths, beliefs and stories of the other is necessary at a time when the health professional gives up speaking and pays attention to the speaker. Beato, van Stralen and Passos (2011) state that, regarding the existing meanings of the HP ideology, there is frequent fragmentation and polarization between Clinic and programmatic collective actions. Both are guided by logics that rarely dialogue with each other, becoming, by overlapping, a single strategy by virtue of institutional norms.

The interrelationship between the determinants and conditions of health, Clinic and care is highlighted, considering that these are not separated from the context in which people live. Although there are questions related to the proposal to reorient the health care model; to HP presenting itself at all levels of complexity in the management and care of the health system, and to the challenges for building a resolute Health Care model focused on comprehensive care, in general, the literature related to HP does not specifically address Health Care.

An important point, addressed by eight specialists, is to think about care not only in the form of specific therapies for health in a stricter sense, such as the use of cinema and meditation. One should also consider activities that do not focus specifically on the problem or on a particular health condition, but that allow people to enjoy, have fun, relax, increase self-esteem, without wanting to target a specific part of the body or health condition.

> *...it is necessary to overcome the restricted view of health and illness. The human being is much bigger than that, much broader, everyone has their potential, so in addition to biomedical care, other forms of treatment besides strictly assistance, considered unconventional treatments, are important.* (E3)

> *we are working with cinema, physical activity, conversation circles, with professionals from different areas, not just health, so we are putting into practice what I understand to be the dimension of health care in HP.* (E4)

It is relevant to understand, evidenced by three specialists, that care would be related to HP even if health is considered the absence of diseases, that is, from the perspective of health recovery in cases of illness, as this is necessary for the people's potential to be developed and lived. Therefore, in the care process, when pharmacological therapies or other interventions close to the more procedural idea of health are needed, it can still be HP from its dimension of health care.

> *...even if the understanding of the term health is limited to an older, more classic view of the absence of diseases, I still believe that there is a part of the care that concerns HP. The care of health issues or illness provides conditions for people, with or without illness, to reach their full potential.* (E5)

> *...therapeutic complementation was necessary... through pharmacological therapy, with articulation with the outpatient clinic...even when the situation required pharmacological therapy, it is still an HP action since it is necessary to provide answers to those who have needs, offering care for that individual in an extended way.* (E4)

Also for three specialists who addressed the issue of the biomedical model, it is neither less nor more important; in some moments it will be essential, it cannot be missed; in others, it will only be helpful.

> *to relativize the criticism of the biomedical model because competent professionals are needed, who, for example, know how to make accurate diagnoses, etc., but understanding the possibilities of complementarities beyond curative medicine... The problem is when the biomedical approach is solely directed and centralized. HP plays a key role in this by discussing this model, this paradigm, and pushing for change.* (E5)

The general understanding of the biomedical model is based on hard, curative, hospital-centric, medicalized and commodified natural sciences, it is hegemonic in health systems, and have legitimacy and institutionality in its practices (Sá; Nogueira; Guerra, 2018; Pettres; Da Ros , 2018). Thus, the biomedical perspective harms the translation of the HP theory into action, even generating ambiguity, regulations and contradictory documents, which affect not only the theory, but also the SUS materiality, preventing or delaying the transition of health care practices towards a more integral and participatory approach (Sá; Nogueira; Guerra, 2018). Thus, the main criticism focuses on the hegemony of this model, as it is believed to be necessary, but not sufficient.

The health professional is usually trained in the aforementioned model and, even knowing the best evidence, for example, that a certain material or drug would be better than another, this professional can make another therapeutic option based on a user's context, as it will be better for the therapeutic process of that person/individuality/context. Therefore, the construction of therapeutic projects will consider the reality in which people are inserted, having a greater possibility of success due to their greater feasibility. It is not a matter of denying the most effective care available, but of dialoguing with the real possibilities of it being, in fact, implemented.

Prado, Falleiro and Mano (2011) state that hard technologies and the hospital structure give a false sensation that it is in this space that care, relief and healing will take place, emphasizing that not only the users but many health professionals think this way, which refers to a symbolic power that, according to them, contradictorily means health. However, they reinforce that hospital practice and/or focal specialization are not necessarily obstacles for subjectivity, feeling and care to appear. The expanded look and approach can be typical of a specialist and strange to a generalist professional, depending on how it relates to the other's suffering (Prado; Falleiro; Mano, 2011).

Thus, the professionals' awareness of the fact that the context conditions the possibilities of people to adopt or not certain recommendations will make these professionals more qualified for care. As an example, should people be held responsible/"blamed" for not performing one or another healthy behavior, such as physical activity or healthy eating, in cases where the workday inside and outside the home is long and tiring? With that, from the speech of two specialists, it is argued that the static and immutable

understanding that separates HP and care is not possible in the daily reality of health services, and it is something that finds support only in the conceptual sphere.

> *... HP is a great field of action within the Health sector and care, in fact, is a constituent element of HP, in addition to being an element that is part of the health-disease process, but based on the assumptions of humanization.* (E6)

Final considerations

As limitations of this study, the option for the joint analysis of the responses of PHC managers and workers stands outs, since they have different roles in HP and care production. However, this research option is justified because it is an incipient topic.

The elements highlighted on the dimension of health care in HP, from this research, are the following: there is not necessarily a dichotomy between HP, Clinic and care; the way in which care is produced becomes relevant, as it is necessary to consider the HP principles and guidelines, especially the individual's empowerment, autonomy and protagonism; care thought of in a broader way and not only in specific and strict therapies; prioritization of care based on the consideration of personal needs and the population's epidemiological profile; care is related to HP, although the perspective is the recovery of health in cases of illness; the biomedical model, at some point, will be essential and, at others, it will only be auxiliary.

We do not share the idea that the "mission" of the Health sector in HP is "only" to push intersectoral agendas or to recognize that it alone cannot achieve greater degrees of health for individuals and groups. We agree with this, but there is something intrinsic to Health, health care through the production of care, which is also part of this search for the aforementioned gradations. Thus, HP is defended as a way of producing health that cannot do it without health care, as well as it cannot be restricted to it.

Defending the importance of the health care dimension is not the same as defending the hegemony of health care over other components of the care process, an exacerbated bet on self-care and on the control of behaviors by people, which would reduce the risk of illnesses and health issues.

Therefore, the main recommendation of this research is that the effectiveness of the health care dimension of HP should passe through the essentiality of considering individual needs together with the social dynamics and the context in which people live, which will allow a comprehensive look at them, their lives and their health, and will differentiate HP that is operationalized in the reality and in the daily life of health services, from negotiation and agreement with people in the search for a better quality of life and to reduce risks and morbidity and mortality.

It is also essential, in the dimension of health care in HP, to seek the resolution or mitigation of health needs/issues from possible solutions to be carried out by users. There is a complex conjunction, from the services available, the team's work process, the availability of supplies and medicines, the necessary articulation with other points of the HCN. As well as respect for the users' cultural habits and customs and their participation in the evaluation of care, which will allow reformulations to achieve the objective of guaranteeing access with quality and resolution to PHC actions and services.

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Authors' contribution

Carvalho and Cohen were responsible for the study conception. Carvalho collected the data. Carvalho, Akerman and Cohen elaborated, revised and approved the manuscript final version, and ensured the accuracy and integrity of all aspects of the research.

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