

# Realities of the practices of the Family Health Strategy as driving forces for access to SUS health services: a perspective of the Institutional Analysis

*Realidades das práticas da Estratégia Saúde da Família como forças instituintes do acesso aos serviços de saúde do SUS: uma perspectiva da Análise Institucional*

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**ABSTRACT** The access to health services in the Unified Health System(SUS) significantly affects the living and health conditions of individuals and communities, and health professionals are the protagonists, through their practices, to implement and qualify it. This study aims to analyze the promotion of access to Primary Care from the perspective of SUS health professionals. It is a qualitative research with a theoretical-methodological approach to the assumptions of Institutional Analysis. It was developed by means of individual interviews and a feedback group. The results point to the reception, the work that is developed by the Community Health Agents, as well as the teamwork as powerful and effective realities to qualify the access. Issues related to communication among professionals, the presence of a reference team for care, home visits in the territory, and the search for the user's first contact with the network compromise the effectiveness and availability of access to Primary Care.

**KEYWORDS** Access to health services. Health personnel. Welcomeness. Institutional Analysis. Qualitative research.

**RESUMO** O acesso aos serviços de saúde no Sistema Único de Saúde (SUS) incide significativamente nas condições de vida e saúde dos indivíduos e comunidades, sendo que os profissionais de saúde são os protagonistas, por meio das suas práticas, para implementá-lo e qualificá-lo. Este estudo teve como objetivo, analisar a promoção do acesso à Atenção Básica, na perspectiva dos profissionais da saúde do SUS. Trata-se de uma pesquisa qualitativa com aproximação teórico-metodológica aos pressupostos da Análise Institucional. O desenvolvimento ocorreu na forma de entrevistas individuais e um grupo de restituição. Os resultados apontam o acolhimento, o trabalho que é desenvolvido pelos Agentes Comunitários de Saúde, bem como o trabalho em equipe como realidades potentes e efetivas para qualificar o acesso. Questões relativas à comunicação entre os profissionais, à presença de equipe de referência para o cuidado, à realização de visita domiciliar no território e à busca pelo primeiro contato do usuário com a rede comprometem a efetividade e a disponibilidade de acesso à Atenção Básica.

**PALAVRAS-CHAVE** Acesso aos serviços de saúde. Pessoal de saúde. Acolhimento. Análise Institucional. Pesquisa qualitativa.

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## Introduction

One of the main goals of health services is the production of equitable access to minimize disparities in the population's health conditions<sup>1</sup>. In this sense, equity is essential for improving the health of the population, encouraging policies to reduce inequalities and expand access to essential health services for their realization<sup>2</sup>.

Access to health services can be influenced and conditioned by different factors and reflect the diversity of healthcare<sup>3</sup>. The offer of a set of health services does not guarantee access to them, as the existence of geographic, financial, organizational, and cultural barriers may influence the use of these services<sup>4</sup>. Perceiving access as something that transcends the concreteness of the speeches and permeates the diversity of concepts, offers, and practices, we approach the perspective of the institutionalist movement to analyze access to health services in the Unified Health System (SUS).

The institutionalist movement is formed by a set of currents that, despite carrying some differences among themselves, aim at placing institutions under analysis and cause change processes in the search for restoring the protagonism of subjects<sup>5</sup>. In the Brazilian context, currents such as Institutional Analysis (AI) and Socioanalysis created by René Lourau and Georges Lapassade, and Schizoanalysis by Gilles Deleuze and Félix Guattari<sup>6</sup> stood out. This research was developed based on some concepts of Institutional Analysis and socioanalysis, in an approach used to promote analysis and intervention with collective. Institutional Analysis aims at "understanding a certain social and organizational reality, based on the subjects' discourses and practices"<sup>7</sup>. For René Lourau, Institutional Analysis is intended to highlight existing contradictions in institutions, understand the relationships between their constituent elements and clarify problems that were previously unspoken, or that were hidden in the subjects' practices<sup>8</sup>.

In the path of understanding based on these authors and concepts, we believe that Primary Health Care (APS) units should focus their actions on the needs of individuals and the territory, organizing their work process to promote access, reducing inequalities. There is no way to determine access rules to standardize the work process of health teams, due to the uniqueness of the context of each community and health teams, but it is necessary to put into action tools that promote more equitable care. Thus, we aim to collectively analyze and reflect on practices to promote access to APS services, considering the importance of the role of healthcare professionals and the institutionalization of these practices.

## Material and methods

Study of qualitative approach of the research-intervention type carried out with a group of workers of a Family Health Unit in Porto Alegre/RS. We use the following devices: interviews, restitution group and research diary. The methodological approach was based on Institutional Analysis assumptions and concepts from the perspective of René Lourau. The main concepts that supported the design of the object of study and the production and analysis of research data were: the notion of implication, the institution and its dynamics (instituted, instituting and institutionalization) and the analyzers.

We understand access as an institution, as it is a set of abstract and material logics, which, through the existing standardization and even unconsciously, is present in the practices of SUS workers, and shapes the work of these agents by determining professional attitudes and behaviors<sup>8</sup>.

The study setting was a Family Health Unit and all unit teams (2 teams, totaling 18 professionals) participated in the study. The collective of participants consisted of six Community Health Agents (ACs), four nursing technicians, three doctors, two nurses, a dentist, an

oral health assistant and an oral health technician<sup>9</sup>. As for employment relationships, only one professional was statutory, all the others were employees of the Municipal Family Health Institute (IMESF), Public Private Law Foundation of the indirect administration of the municipality of Porto Alegre. This unit was selected for convenience, based on the indication of the Municipal Health Department (SMS) of the municipality. The territory assigned to the health unit covers very different micro-areas, with locations with adequate housing and sanitation conditions and others with irregular occupations with precarious sanitary conditions. The resident population is mostly dependent on the actions and health services offered by the SUS. It is emphasized that access to health services in the selected health unit occurs through intake of spontaneous demand, programmatic care (older people, childcare, prenatal care, women's health, tuberculosis, and chronic diseases), Home Visiting (VD), vaccines and health education groups aimed at pregnant women and users with chronic diseases.

The production of research data required articulation and contacts with different agencies and different instances so that the interface with research participants, as well as living spaces for data production, were built. The intervention, following the assumption of socioanalysis within a short-term intervention, as a data production and analysis process, was carried out in the period between December 2018 and March 2019, through semi-directed interviews and conducting a restitution group. The restitution constitutes the socialization with the group of participants in the analysis/intervention process of the initial analyses with the purpose of resuming the analysis produced from the reading of the socioanalyst/researcher and promoting the collective analysis of the data.

The interviews were audio recorded and using an interview guide for their conduct. The observations of the responsible researcher about the interviews were recorded in the

form of a research diary for memory triggers for the analysis of the interviews, the restitution group and its own implications. In the living space of a team meeting, the restitution of what was produced in the individual interviews was made to the group, aiming to collectively discuss and confirm or refute the analyses carried out by the researcher. To conduct the restitution meeting, a roadmap was used with the analysis of individual interviews in the form of topics/themes, which served as triggers for analysis, discussion, and collective reflection.

This research was approved by the Ethics Committee of the Federal University of Rio Grande do Sul (UFRGS) and CEP-SMS-POA with a single approval number 2.024.818.

## Results and discussion

The proposal of this research came from an order requested by the Municipal Health Department (SMS) of Porto Alegre and is also characterized as an offer by researchers due to its implications for access to SUS. Initially, it is important to highlight that the results come from an offer by the researcher to a group of workers, as scientific research for discussing practices in the field of collective health. We also emphasize that the results were built from the production of data resulting from the self-analysis collectively produced in the restitution group during the intervention. This meeting is intended to enable the co-management of the intervention process and a fusion between the research and intervention process<sup>7,10,11</sup>.

Despite not starting from the demand of the participating group, but from the SMS, the intervention developed involved collective discussion about overcoming access barriers and enhancing actions that optimize the use of services. The analysis of this demand is related to the process of understanding the real and implicit reasons of an institution for requesting an analysis or intervention, it is the identification of its problem<sup>7</sup>.

Based on the concept of analyzers constructed by Lourau<sup>12</sup>, as support devices for the analysis of institutional dynamics and for inducing change, we identified a Guide to Support Decision Making for Patient Intake with Identification of Needs in APS Units in Porto Alegre<sup>13</sup>. We consider this document as a central analyzer, as it proposes the analysis and reorientation of access promotion practices, revealing something about access that made workers speak the unsaid<sup>13</sup>. Thus, the 'Access Institution' finds an organization in the municipality's Municipal Health Department that is intended to materialize it. Institutional Support also represented another important analyzer of this institution, as the supporters were the triggers of the analysis process and the movement to remodel access to health services in APS teams through permanent health education actions.

When analyzing the expansion of access by the host organization, the professionals mentioned realities that reveal the Institution's limits and potentialities of Access Institution in the routine of the units, which allowed us to analyze its dynamics. Instituting forces are related to economic, geographic and functional aspects and analyzers related to the optimization of access include: the Family Health Strategy (ESF), the presence and action of Community Health Agents (ACSs) and teamwork. The instituting forces that are associated with contradictions include situations related to health units, municipal management, and the individual issues of users. Thus, we present and discuss the results following a set of instituting forces that made up the real ESF practices of access optimization.

We assume that the fundamental purposes of institutionalist currents include self-analysis and self-management of social groups<sup>5</sup>. Institutions represent something existing in groups, of the order of the unconscious, that precedes their creation and that shapes and molds them<sup>14</sup>. In the relationships developed with institutions, individuals' structure and sustain their identity<sup>14</sup>. It should be noted that

the Support Guide proved to be an element resulting from the workers' self-analysis movement, and that during the process of interpreting the results, it allowed workers to identify problems that were not perceived prior to this intervention<sup>13</sup>. In this context, the guide also allowed joint and collaborative decisions between the team in defining access.

The results presented and discussed in this text are products of a primary implication in the interrelationships between the author and the group of workers. Thus, these interrelations show individual wills, ideals and experiences that guide the way of acting, interacting and analyzing and are manifested in the actions of the subjects<sup>8</sup>, which in turn are reflected in the realities and practices of the Family Health Strategy (ESF) as analyzers of the optimization of access to health services.

Access, as an institution subject to analysis, reveals patient intake as the most effective way of promoting access to health services, with impacts on the resoluteness of care for users assisted by the teams. In addition, the presence and action of ACSs and teamwork represent manifestations that induce change in this institution. In addition to these aspects, the ESF is identified as a factor that optimizes access to health services, as the units that carry out this strategy provide care close to the users' homes, developed by reference teams and professionals. Thus, the ESF provides the development of bond and trust between users and healthcare professionals and qualifies and makes care unique, as professionals know the users, the territory where they live and their life stories. Such perceptions were not discussed prior to this intervention research. Thus, ACSs, teamwork, territory, bond and longitudinality of care, in a way, indicate devices and realities that optimize access to health services in the APS of SUS.

*It's not just technical like that, I think everyone here is 100% important. They come here because they trust us somehow, somehow, they have that trust, or it's an escape valve, an escape, a call for*

*help, for something they come and I think it's very important, for sure. (18).*

*By the way, when the entire team has this type of family healthcare, family doctor, family nurse, then it's different. The difference is clear when the whole team goes to this line of knowledge. (RESTITUTION GRUP).*

Participating professionals mentioned the importance of the FHS to promote access due to the proximity of health units to the users' homes, the longitudinality of care, the bond developed between professionals and users, and the home visiting (VD) being conducted.

We understand the ESF as an instituting force, as it allows access and is a space for changes in workers' practices and a reflection of the production of care. As for territorial proximity, professionals reported that the location of the ESF units represents a facilitator of access, as users do not need to commute extensively, and use means of transportation to obtain health care. The proximity of the health unit to the users' homes and obtaining care for demands without the need for major displacements is a factor that determines the search for APS units and facilitates and expands access to health services<sup>15</sup>.

Thus, the existence of the ESF represents an instituting element that facilitates access to services and health, representing the expansion of the offer of services, reduction of queues at health units and geographical approximation between the provision of health services and the user.

Reference teams and professionals for care, agents of change, are perceived by the access institution as something that allows professionals to know the users, their life contexts and their health needs, as well as to develop bonds and trusting relationships and to carry out care centered on needs and based on the knowledge that professionals have about the life context and health history of each individual.

We realized that when considering family and social elements, and discussing cases

together, the ESF professionals favor the link with longitudinal care, the demedicalization of diagnosis and therapy, prevent excessive referral to other professionals and overlapping treatments. The collective of workers under study represents a health team responsible for the continuity of care for users<sup>16</sup>. In this perspective, this collective is responsible for a longitudinal access, as it favors the user's search, facilitates therapeutic relationships, makes the work of the health team more resolute and qualifies access to APS services. Qualified access through longitudinal care and bonds allows health professionals to broaden their gaze on the needs of individuals and communities, establish more participatory care relationships and base behavior on the uniqueness of each situation. Thus, they provide support for the construction of the expanded clinic in the routine of health services<sup>17</sup>.

Performing VD was also identified in this research as something that expands access to health services for users. It is considered that the home is part of the territory, that there are users who have difficulties in getting to the health units, and that the professionals of the APS teams must be responsible for the health needs of the residents in their coverage area. Such facts guarantee access. In the individual and collective reports, it was possible to observe that the VD represents a health action that has been developed by different health professionals in the studied health unit and consists of the care or monitoring of users and families in their place of residence.

The VD, also understood as an instituting force/element, represent an advance for change in the work process in APS towards more comprehensive therapeutic actions, as they allow for the strengthening of bonds as the professional moves from their place of power and start to build care along with users, calling them to take the lead and co-responsibility for their process of living and falling ill<sup>18</sup>.

However, we observe that VD is an activity that has been systematically carried out only

by the ACSs. Technical and higher education professionals have diversified routines for performing VD, some with a reserved time in the weekly schedule, others only perform it when there is a specific need, demonstrating that the emphasis remains on clinical procedures and care during the performance of VD. This demonstrates the need to strengthen the VD space as a possibility of getting closer to the territory, promoting bonds and guaranteeing access.

In triggering these perceptions, the ACSs were also appointed by the participating professionals as facilitators of access to health services, as they develop daily actions to guide the functioning of the health unit and ways of accessing services. The ACSs share with the health team relevant information about the living conditions and health of the population they care for, identify situations of vulnerability and monitor and search for more complex situations for adherence to care. The work of the ACSs is one of the main differentiators of the ESF as a care model in APS.

Professionals identify the power of ACSs to promote access to health services, as can be seen in the following statements:

*And the search for the health unit was much smaller, when we arrived here there were a thousand and a few people served, today it exceeds 6,000, so we ended up bringing all these people into the health center. (110).*

*The community health agent (ACS), being well instructed on how patient intake works, I think this makes it much easier, because as they are on the street, a person who stops to ask for information, they give the correct information, things will arrive here at the right time, so I think the community health agent makes all the difference in the health unit, it wouldn't be the same without them. (113).*

Access to information allows the user to know the services that are made available, how they function and how to access the health units and use the services that are developed

by the APS teams in a timely manner. Guidance to families on the use of health services is part of the routine of activities carried out during the VD carried out daily by the ACSs. The exchange of information takes place in the context of the lives of families based on the diagnosis made by the ACSs, which helps in the proper targeting of health services, qualifies, and expands access and health coverage, and facilitates the proper use of health resources<sup>19</sup>.

It is interesting to note that professionals recognize that the good relationships established between ACSs and the population enable better access to the health unit. This worker favors the establishment of a complex 'web' of relationships and interactions between the community and healthcare professionals and allows the user to benefit from professional care in the best way possible, improving access to health services and the assistance provided<sup>20</sup>.

It is known that the ACSs are the members who establish the link between the community and the team, as they have access to the family environment and, as they are community residents, they generally know and experience the demands that are brought by users<sup>21</sup>. From the approach to the user initiated with registration, the ACSs develops a unique relationship of bond and trust, being the only member of the team who has access to certain information that is relevant to maintaining the health of individuals<sup>20</sup>. Regardless of the location, whether at home, on the street or at the door of the house, the work developed by the ACSs allows the creation of a relationship of trust and affection with users<sup>22</sup>.

The presence of ACSs in the territory facilitates the identification of needs and vulnerabilities and the direction for the patient intake of the multidisciplinary team, as can be seen in the following speech:

*And the ACSs, they are the ones who bring them, we can't walk around the village all the time, we are in here, because if I leave, there is no one [from the same professional category] here, so they are the*

ones who do this initial outflowing of the patients to the clinic [...]. Nowadays, with the agents 'fishing' and talking, we have caught them [users with chronic diseases who did not go to the clinic more often] [...]. (13).

The results of this research reinforce the importance of the ACSs for the quality of care for the population and for the expansion of access to APS services, demonstrating that the current proposals are in line with what is reported by professionals who are involved in the practice of health services.

When moving through the instituting forces that point to situations that optimize access to APS services, teamwork is another factor identified in the professionals' reports as something collaborative, as can be seen in the excerpts of the statements that follow:

*[...] in every way it's the work that starts with us at the end, who go there to the reception, staff who welcome, who refer them, screening staff forwards the patient intake, or schedules the appointment, the vaccine staff who arrive, go there and prepare the vaccine [...]. (15).*

*[...] because if we can't solve it with the technician, we somehow cause them to be treated, the ACS can't do it, but then at the end, the doctor will manage to do it [...] but I think that the purpose of the healthcare center we are able to fulfill [...] we try to do what we can to help that patient and I think we are very united for this, if one cannot do it, they ask the other for help: 'I can't solve it, help me. What do you think?' Do you know it? There is no such thing here as: 'No, I won't help you', I've never heard this from any colleague [...] we always manage to do something [...]. (18).*

In general, teamwork, when performed collaboratively, with good communication, thinking about the common goal that is the care of the user, streamlines and qualifies the care that is provided and expands the possibilities of resolution of the team, thus allowing the expansion of access to services

and optimization of care provided by professionals in health units. It also increases the possibilities of sharing knowledge, situations identified in the care and the service itself among professionals, expanding the team's resolving capacity, enhancing the uptake and flow of the user between the professionals in the unit and the quality of care provided to users.

The work process of multidisciplinary teams comprises a set of actions that, even when carried out individually, occur in an integrated manner with the objective of meeting individual or collective demands, therefore, it involves the knowledge and practices of all professionals that make up the team<sup>23</sup>.

Working as a team in the health area means promoting a connection between different work processes, where mutual knowledge about the work of the other allows the valuing of the participation of each part in the constitution of the whole. Cooperation, interaction, division of tasks and sharing of planning to build consensus on the objectives and results of care to be collectively achieved are always aimed at meeting the needs of users with quality. The results of this research corroborate these findings, as teamwork is appointed by the participating professionals as a collective activity, where there is a relationship of help and cooperation between those involved for the development of a work process that allows for the resolution of the needs of users, qualifying access to services<sup>24</sup>. Teamwork represents a strategy for coping with verticalized work with an emphasis on specialties that, in the health area, tend to direct knowledge and intervention to some aspects of health needs, without covering or articulating other knowledge and actions<sup>24,25</sup>.

It is known that the articulation of actions resulting from teamwork increases the effectiveness of care to the population and expands access to health services, as the collective construction with cooperation, collaboration and sharing of responsibilities expands the possibilities of invention and intervention

of healthcare teams. In this process, there is also an interdependence of professionals to ensure continuity of care, connections between work with complementary professional performance and flows of internal care within the team in the form of consultations, as well as joint assessment and information sharing actions<sup>26</sup>.

Peduzzi and Agreli<sup>27</sup> advance this discussion and propose the development of collaborative interprofessional practices, as they consider that teamwork must be centered on the needs and characteristics of teams, users, communities and territories. Thus, in addition to team integration, there is a need for collaboration, where there is learning about, for and with others, with the intention of building more meaningful practices. Therefore, professionals need to develop work practices that enable effective communication between professionals, users and other sectors in order to improve access and quality of work and care developed and the satisfaction of professionals with work.

We know that the existence of multidisciplinary teams is not enough to institutionalize teamwork practices, as this way of working represents more than the sum of professional nuclei. Thus, teamwork emerges as a way to reorganize the work process and qualify the actions taken by professionals. Teamwork guarantees autonomy, freedom, and joy in the organization of the work process<sup>28</sup>. All interviewees referred to work situations in which they highlight the articulation of the work developed by the professionals, in the difficulties encountered in the daily work of the APS teams, supportive relationships and partnerships emerge for the development of care strategies. Thus, the results point to shared care experiences with transversality of actions, indicating a significant degree of communication.

Among the components of teamwork, communication was identified by professionals as essential for the development of beneficial relationships for the performance of the team

in ensuring access and resolving care, as can be seen in the following reports:

*More important is to maintain an open relationship, both in the doctor-patient relationship, which is me and the patient here in this room, and between me and the team, which a patient asks someone from the team, someone from the team asks me, this hotline has to be open. If I close the door and 'no one comes in here, unless I call them by name', it turns out that the person will have more difficulty in accessing it and then it interferes with everyone's work. (114).*

*[...] it works well because we don't have this kind of formality, you know? People pass by, talk, we solve it like a big family, which is what I think the team should be, right? (13).*

The existence of communication channels between team members is important for the establishment of more flexible relationships between professionals and expansion of the team's possibilities of action and resoluteness. Communication is one of the criteria that stand out in the construction of the integration-type teamwork process, it is a common denominator of teamwork. The symbolic mediation of language allows for articulating the actions of professionals and integrating knowledge from different areas involved in care with the purpose of interaction and cooperation between those involved to build consensus and outcomes relevant to each situation<sup>24</sup>. In the perception of the participating subjects, communication is essential for the development of effective care strategies, as it allows for the articulation of knowledge and capabilities of the different professionals that make up the health team.

For Pereira, Rivera and Artmann<sup>26</sup> in everyday conversations, professionals seek consensus on the possibilities of performing teamwork. The search for understanding to solve a problematic situation through communication puts individuals in interaction and enables the construction of new possibilities of



care, expanding the scope of the team's action.

When professionals base their work on the expanded concept of health, they recognize that specific areas are not capable of solving the complexity of situations that are attended to daily in health units<sup>29</sup>. Thus, for the development of quality care, it is necessary to articulate different areas of knowledge, to do so, they adopt communicative practices in order to clear doubts or share problem-situations with other professionals for the joint construction of alternatives that promote effective care.

The team meeting was mentioned as an activity that contributes to the qualification of the care provided by the teams and access to health services, as it favors communication between professionals, strengthens teamwork and enables continuing health education.

The team meeting is a space for the development of collaborative practice. The importance of team meetings to strengthen the work process and qualify the service is reported below:

*What makes it much easier is our group meeting [team meeting] that we have, we discuss a lot, a lot of things have already been discussed in the ongoing trainings, about what patient intake is and we have always been discussing, debating the right way, how one has to do, the correct ways, so I think that what has made it easier was this: us sitting down, talking. (15).*

The space for the team meeting presents itself as a way to allow for approximation and communication between workers, discussion about the work process and carrying out permanent education activities to build practices that are more effective. Accordingly, it contributes for access to health services through the possibility of qualifying the work carried out by the healthcare teams. The approximation of team members, in periodic meetings, to exchange information and knowledge, qualifies the work process of everyone involved and the health care aimed at the community<sup>20</sup>.

The team meetings were essential to enable the institutionalization of patient intake in APS units in the city of Porto Alegre. For the reorientation of access promotion practices, moments of analyses, discussions, permanent health education, planning and evaluations of the reorientation of practices were carried out, and the meetings represented the only moment in the work routine that allowed collective participation.

Another relevant issue addressed was the importance of promoting universal access and first contact with health services. The APS units, as SUS component establishments, are intended to provide universal access to health services. Therefore, there should be doors and not barriers to users' access to care, responding to their demands and contributing to promoting greater knowledge about SUS health services. Thus, it is essential that the APS units allow access and the first contact with health services to all users who seek the service, regardless of their place of residence, as indicated in the following excerpts:

*[...] but there has never been an impediment like that and even if it's a user of another clinic who knows that they are here in the vicinity, we first see what the situation is, care for them and then refer them, guide them to seek care in his reference, because we work with ascribed territory, but there were never barriers like that. (14).*

*Patient intake and often care, depending on the demand [...] we end up finishing this service and advising them to go [search for their reference unit], there is no way we would let the person leave without us performing the service itself, depending on the severity. (RESTITUTION GRUP)*

The interviews and collective discussion show that, although the APS units have a delimited territory for care, as the main gateway to SUS services, it is important that the units promote the first contact of users to the services, even for those who do not belong to their territory, as a way of listening to their needs,

providing guidance, forwarding them to the referral unit, or even solving their demand.

## Final considerations

The development of a scientific research that analyzed access to SUS services and its contradictions, revealed that this is an institution rooted in different practices and realities. It is understood that APS is still the great promoter of access to SUS services. This access only happens in an optimal way when welcomed by professionals who understand, defend and identify themselves with the Brazilian public health system. It is concluded that effective communication and collaborative practice between these professionals within the living space of care production, in a reference team, are fundamental factors in understanding access. It is access as an institution that seeks the user's first contact with the network and transverses its optimization within a specific territory.

Despite advances in the expansion and qualification of access to health services, instituting forces still influence health teams in maintaining user embracement as the preferred form of access to services and, also, the valuation by the VD team as work carried out by professionals to promote access. These strengths are

related to local management in the availability of quantitative human resources consistent with the demand of the population and in the articulation of the municipal health network to guarantee the continuity of access started in the APS health units, to the portion of health professionals that still develop practices dissociated from universality and equity of access and to users who are unaware of the possibilities of access to the health care network.

Thus, it is considered at the end of this study that there are realities and situations that must be reviewed and improved so that SUS users can have guaranteed access to health services with a solution to their needs. Therefore, in the current counter-reformist moment that the SUS is facing, it is necessary to advance in the expansion and qualification of the health network, in the permanent education of professionals, in the process of co-management of health services and in the dissemination to users of the access to actions and services offered by SUS.

## Collaborators

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