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Reflection Article

Hope and despair: reflections on access in Primary Health Care

Esperança e desespero: reflexões sobre o acesso na Atenção Primaria à Saúde

Esperanza y desesperación: reflexiones sobre el acceso en la Atención Primaria de Salud

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Abstract

Objective: to reflect on access in Primary Health Care (PHC) through analogies of two Brazilian television shows. **Method:** this is a theoretical reflection based on elements of Brazilian popular television culture, based on the shows: the door of hope and the door of the desperate. **Results:** the access to health within the scope of PHC can be analyzed from the perspective of three doors: hope, in the solution of their needs; despair, aimed at those who cannot find solutions to their demands; and the priority, based on the attributions that constitute it and the right to health. **Conclusion:** PHC needs to overcome the typology of the door of hope and of the desperate for the achievement of its ordering attribution of the health care network.
Descriptors: Primary Health Care; Universal Access to Health Care Services; Universal Health Coverage; Unified Health System; Public Health

Resumo

Objetivo: refletir sobre o acesso na Atenção Primária à Saúde (APS) através de analogias entre dois programas televisivos brasileiros. **Método:** trata-se de uma reflexão teórica sustentada em elementos da cultura televisiva popular brasileira, a partir dos programas: a porta da esperança e a porta dos desesperados. **Resultados:** o acesso à saúde no âmbito da APS pode ser analisado na perspectiva de três portas: esperança, na solução de suas necessidades; desespero, voltada aqueles que não conseguem encontrar soluções as suas demandas; e a prioritária, pautada nas atribuições que lhe constitui e no direito à saúde. **Conclusão:** a APS precisa superar a tipologia de porta da esperança e dos desesperados para efetivação da sua atribuição ordenadora da rede de atenção à saúde.
Descritores: Atenção Primária à Saúde; Acesso Universal aos Serviços de Saúde; Cobertura Universal de Saúde; Sistema Único de Saúde; Saúde Pública

Resumen

Objetivo: reflexionar sobre el acceso en la Atención Primaria de Salud (APS) a través de analogías entre dos programas de televisión brasileños. **Método:** se trata de una reflexión teórica a partir de elementos de la cultura popular televisiva brasileña, a partir de los programas: la puerta de la esperanza y la puerta de los desesperados. **Resultados:** el acceso a la salud en el ámbito de la APS puede analizarse desde la perspectiva de tres puertas: la esperanza, en la solución de sus necesidades; la desesperación, dirigida a quienes no encuentran solución a sus demandas; y la prelación, con base en las atribuciones que la constituyen y el derecho a la salud. **Conclusión:** la APS necesita superar la tipología de la puerta de la esperanza y del desesperado para cumplir su tarea de organización de la red de atención a la salud.
Descriptores: Atención Primaria de Salud; Acceso Universal a los Servicios de Salud; Cobertura Universal de Salud; Sistema Único de Salud; Salud Pública

Introduction

The declaration of Alma-Ata[1] was a milestone for health promotion and protection, which highlighted the need for government mobilization, the importance of Primary Health Care (PHC), considering aspects of social participation, the inseparability of health regarding socioeconomic development and the universal access or initial contact with the health system.[1-2] More than 40 years have passed since this historic health milestone, and it is still possible to see the difficulty of guaranteeing equity, progressive mitigation of inequities, reduction of socioeconomic disparities and, mainly, expansion and guarantee of access to health.[3]

With regard to the structuring of PHC in the world, some more vulnerable populations end up lacking governmental support, presenting difficulty in accessing health services, resorting to family members, community or even alternative means to meet their health needs.[4] The PHC in Brazil has a coverage of over 73%, but it shows funding problems, excessive bureaucratization, and also an overload of users due to the low number of professionals.[5] Besides that, it presents heterogeneity in its access, in especially rural populations, forests and water.[6] In addition, austerity policies have contributed to the difficulty of universal access, with little or almost no emphasis on the potential for PHC coverage and assistance.[7]

The difficulties in achieving spontaneous demand are the main factors involved in

the low satisfaction of users.[8] The PHC must practice actions that equally cover and involve both acute and chronic situations, from the perspective of continuous care, centered on the person, family and community, with the help of specialized care when necessary.[5] In this, PHC presents itself in an ambiguous way in the provision of care and access to the health network of the Unified Health System (*Sistema Único de Saúde* - SUS). This duality is anchored on the one hand in the sense of despair, when seeking help, which sometimes frustrates the user, making him/her skeptical and resentful with a system that should provide him with resoluteness; or in the possibility of hope, as the only source of help for their health needs. In view of this dual relationship, the present manuscript aims to reflect on access in PHC from analogies between two Brazilian television shows.

Method

This is a theoretical-reflective study that aims to make analogical comparisons about the role and access to PHC with elements of Brazilian popular television culture, specifically, two tv shows that were broadcast on national television: the door of hope, and the parodied version of the tv show also known as the door of the desperate.

The reflections presented here are essentially based on the articulation of the discussions present in the scientific literature that cover the diverse conceptual and organizational frameworks of PHC, and the cultural elements of Brazilian television culture, with the aim of expanding the debates around the real role of this point in the healthcare network. Regarding aspects involving television shows, the online platforms of their respective broadcasters were used as a source of research.

Results

In the search to play an allegorical role to carry out the proposed theoretical-conceptual reflections, the results will be presented in two distinct stages, explaining in detail how the television shows of the door of hope and of the desperate worked. In this way, it will be possible to relate how the cultural elements embedded in the social imaginary extrapolate the television reality and enter the population's way of thinking and acting in the face of the PHC organizational structure.

Prize, achievement, and the hope of the door

The "Door of Hope" (*Porta da Esperança*) was a tv show broadcast by the Brazilian Television System (*Sistema Brasileiro de Televisão* - SBT), with the first exhibition in the year 1984. It was presented by Silvio Santos, who materialized in the sending of letters by the viewers to the show reporting their dreams, needs, and requests, in the expectation of being called and having their wishes fulfilled.[9]

Figure 1: Introduction of the "Door of Hope" TV show.
Source: Youtube – Video *Porta da Esperança SBT Eletrônica Santana* 1986.[10]

The dynamics proposed by the tv show was anchored in granting the participants' wishes, whose provision took place through the engagement of supporters and/or sponsors who donated the good or service to publicize their product or brand. It should be noted, however, that often the wish was not fulfilled, and the participant received in parts what he/she wanted, or just something similar, generating frustration. There are several videos on the YouTube platform that comically present people who received exactly what they wanted and ended up being disappointed when faced with the prize, seeing that perhaps, the opportunity to receive something was wasted.

When making an analogy of PHC, it stands out the stance of philanthropy and clientelism, which diverges from the constitutional right to health. Assuming PHC as a

door of hope is to diminish the legal achievement materialized by the creation of the SUS. The user needs to understand the service, not as a concession of benefits, just as the health professional and health management cannot assume a clientelist posture of stimulus to dependence. Access in PHC does not represent a hope, whose demands are sometimes denied, but rather incorporated as a right that must be strengthened, stimulated, and guaranteed.

Monsters and the despair of the door

The “door of the desperate” consisted of a “parody” tv show that alluded to the “door of hope” presented by the comedian Sérgio Mallandro.[11] The game proposed for the “desperate” was different: instead of the individual directly winning what he/she would like as in the “door of hope”, he was given the option to choose between three doors, where only one would have the prize, while the others had monsters inside them, which when they were “freed” chased the participants.[12]

Figure 2: Choice options at the “door of the desperate”.
Source: Youtube - *Relembre o clássico "Porta dos Desesperados" do Oradukapeta*.[13]

To participate in the choice of the doors, the presenter always asked the children if

they were good students and if they got good grades at school, otherwise they could not exercise their right to choose. In addition, the program was also based on the paradox of the three doors of the American program “Let's Make a Deal”, since it worked with questions of statistical probabilities in the choices, whose prize was only found in one door.[11] Even if the participant chose a door, at the final moment, before opening, it was allowed to change doors, generating an intuitive deadlock, leading to the uncertainty of remaining in the initial choice, or the fear of changing doors and losing the prize. When this door is opened, the “monster” personifies itself in unhappiness and runs after the one who opened it, hunting their hope, and frustrating their expectations. This logic reported on access in PHC is established in the perspective that there are “bad” and “good” users, who would or would not be worthy of greater care investment. In addition, the probabilistic deadlock of the doors, leads to the fear of not knowing what will be found: the resolution (the prize) or the monstrosity? Assistance or negligence? These obstacles make the user think twice before resorting to the SUS, more specifically the PHC, where access may not occur, or if it "occurs", it is done irregularly.

But what would these monsters be? Perhaps the professionals who look with disregard on the user who enters a Health Unit; the absence of continuity of care to the user of the ascribed territory; the monster of scheduling due to the attendance plastered at a specific time of the week, among so many other monsters that materialize in the practice of services causing the PHC, at times, to create the imaginary of despair and monstrosity. The access to PHC should not represent a door that promotes despair, on the contrary, it should be a device to welcome and provide dignified care to all, especially to the desperate and socially “helpless”.

Discussion

The PHC is the main gateway to the SUS, considered the preferred way to enter the system, acting as a communication and coordinator center of care with the other services in the network.[14] This entry is called comprehensive or extended, related to a new conception of care model and a reorientation and organization of health systems, in the search to guarantee comprehensive care.[15] However, in Brazil, despite the significant increase in the number of physical PHC units in some places, this door still

remains narrow, resulting from the stagnation of the system in organizational models that are counterproductive to the logic prioritized by the SUS.[16] In this sense, the user that adapts to the offers of the system itself, and not the system that adapts to the user's needs, fragmenting care and failing to exercise the comprehensiveness.[17]

The access does not presuppose the simple scheduling of consultations or assistance to spontaneous demand, but the humanization of care, which also has repercussions on the user's assessment levels for the care provided in PHC.[8] The PHC must enable access to complex needs, not only health, but social, and when disconnected from its principles, the user's passage to enter the system is narrowed.[16] Herein, we can think that the universality of access reflects on actions that expand the care coverage of the SUS, with strong support of PHC, structuring of BHU, guarantee of supplies, and also provision and training of workers for the public health system.[18] There is also a relationship between user satisfaction with the resolution of their health problems, influencing the way they assess the service.[8]

It is proposed, then, for us to imagine for a moment, the PHC as a door to house, whose front, structure and decoration can represent the levels of reception and effectiveness of access. Would that door be open? At least willing to open up? In this door, is there a "peephole" that restricts the reception and assistance of users who seek to visit there? How is this door welcomed? Is the user received as a stranger or family member?

The PHC as a preferential door must be open, without barriers to restrict the right to health, without prejudiced eyes to the complaint, without restriction of entry. It is known that each and every analogy has its limitations in the representation of reality, but the illustration of these problems suits for a practical and allegorical reflection of the daily problems found in the service-user-professional relationship. As a priority gateway to the SUS, PHC in its legislative and aspects of ontogeny is structurally the point of the network in contact with the primary dimension of human needs, as it is established in a community, social territory, for the individual and his/her family. This door, when effective, produces health and community integration.

Access is established in the legislative and theoretical aspects related to PHC, however this point of attention still lacks integrative actions in the production of health, involving the user and consequently impacting on their satisfaction. For this integration

to achieve good results, it is necessary to approach both managers, professionals and users to identify barriers to access and divergences between them.[19] In addition to this agreement, it must be considered the overload of health professionals, due to the need to reduce the number of users per team to improve work processes, maintaining a balance in longitudinal and spontaneous care.[20] In the same perspective, the opening of health units after working hours and weekends contributes to the inversion of the logic of access barriers constituted for workers, highlighting again the importance of a greater number of teams, even in certain units.[19]

The opening of new "doors", therefore, has the potential to transform the "desperate" access into the "hope" access, not of the logic of clientelism, but of the right in a universal way and strengthening of social control and citizenship. On the other hand, the progressive precariousness of the SUS creates barriers that do not allow access, or when they do, it is precarious care, disconnected from the principles previously established as essential.[21] With this, resolute and comprehensive access becomes a glimmer of hope.

Nevertheless, the Brazilian political-institutional reality increasingly takes measures to dismantle constitutional rights, through contingency and freezing of public spending on health.[21-22] This economic policy, in turn, is detached from epidemiological projections, that predict a greater number of people with disabilities using public health services, which imposes the need for investment to adapt care environments to provide equanimous access to these users.[22]

It is also noteworthy the structuring and current changes of the Prevent Brazil Program within the scope of PHC. In view of the historical-institutional barriers of PHC for the applicability of comprehensive care, the movement proposed by the program increased the flexibility and autonomy of municipalities to generate greater efficiency and performance. It is believed that the program's funding model can broaden access and improve the quality of services, since it seeks to balance the financial values *per capita* of users registered in the PHC and the care performance of the teams, in addition to incentives to expand hours and computerize services.[23]

Still incipient, the new model divides opinions, generating debates about the relationship "quality-quantity". Although the increase in the number of visits and the working hours of the units are positive points, linking aspects in the longitudinality and

territorialization of care are lost, since the relationship of the teams with the locus of action is lost, with the possible reduction of the number of CHA and division of workload among different UBS by other team professionals.[23-24]

Another important factor is the tendency of health systems to integrate mental health treatments with primary care. The problem is that this integration that generates positive results for users is generally carried out in countries with a good functional capacity in PHC, since low-income or developing countries (such as Brazil) present a lack of resources to have the necessary capacity to provide comprehensive care at this point.[25] The difficulty in providing comprehensive care generate gaps in health care, in which users highlight the need for qualified listening, reception, bonding, humanization and continuity in care. Although these are points raised not only by mental health users in PHC.[8-19]

Besides the aforementioned problem, it is worth highlighting the impact of the new coronavirus pandemic, further exposing the weaknesses of the SUS, and directly impacting the functioning of PHC, generating a "crisis within the crisis". Thus, there is an urgent need for PHC to assume its leading role as the organizer of care in the SUS, since the struggle to overcome a pandemic, strengthen the SUS and the right to health of all Brazilians, primarily involves strengthening the PHC itself.

Conclusion

The way PHC is structured is essential, since its organizational and coordinating role of the system is not limited to solving all problems or needs. When poorly structured, outside of its principles and guidelines, it is the cause of the despair of the user in the system, it is the narrowing of the path in solving their problems. Let us not make the PHC a currency of illusory political-institutional exchanges as the *door of hope*, nor the cause of the negligence and unhappiness of users, typifying the *door of the desperate*. The PHC must be structured around what is assigned to it, what it is duty to be, the priority door and ordering entrance to several other points of attention in the Health Care Network.

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