Original Article

Accessibility and demand at an Emergency Care Unit: the user's perspective*

Acessibilidade e demanda em uma Unidade de Pronto Atendimento: perspectiva do usuário

La accesibilidad y demanda de atención de emergencia: perspectiva del usuario

Mariana Figueiredo Souza Gomide[1], Ione Carvalho Pinto[2], Luana Alves de Figueiredo[3]

ABSTRACT

Aim: To analyze the search for Emergency Care (EC) in the Western Health District of Ribeirão Preto (São Paulo), in order to identify the reasons why users turn to these services in situations that are not characterized as urgencies and emergencies. **Methods:** A qualitative and descriptive study was undertaken. A guiding script was applied to 23 EC users, addressing questions related to health service accessibility and welcoming, problem solving, reason to visit the EC and care comprehensiveness. **Results:** The subjects reported that, at the Primary Health Care services, receiving care and scheduling consultations took a long time and that the opening hours of these services coincide with their work hours. At the EC service, access to technologies and medicines was easier. **Conclusion:** Primary health care services have been unable to turn into the entry door to the health system, being replaced by emergency services, putting a significant strain on these services' capacity.
Keywords: Primary health care; Health services accessibility; Emergency medical services

RESUMO

Objetivo: Analisar a procura pelo Pronto Atendimento (PA) do Distrito Oeste de Saúde do município de Ribeirão Preto (São Paulo) para identificar os motivos pelos quais os usuários, em situações não caracterizadas como urgência e emergência, procuram esse serviço. **Métodos:** Estudo qualitativo descritivo. Foi aplicado roteiro norteador para 23 usuários do PA, abordando–se questões relativas à acessibilidade e acolhimento aos serviços de saúde, resolução das necessidades, motivo pela procura do PA e integralidade da atenção. **Resultados:** Os sujeitos relataram que, nas Unidades Básicas de Saúde, houve demora no atendimento e agendamento das consultas e que o horário de funcionamento desses serviços coincide com a jornada de trabalho dos usuários. No PA, o acesso foi facilitado às tecnologias e medicamentos. **Conclusão:** Os serviços de atenção básica não têm conseguido tornar-se a porta de entrada do sistema de saúde, mas, sim, os serviços de urgência/emergência, causando expressiva lotação desses serviços.
Descritores: Atenção primária à saúde; Acesso aos serviços de saúde; Serviços médicos de emergência

RESUMEN

Objetivo: Analizar la demanda del servicio de emergencia (SE) del Distrito Oeste de Salud del municipio de Ribeirão Preto (Sao Paulo) para identificar los motivos por los cuales los usuarios, en situaciones no caracterizadas como urgencia y emergencia, buscan ese servicio. **Métodos:** Se trata de un estudio cualitativo descriptivo. Fue aplicado una guia norteadora a 23 usuarios del SE, abordándose preguntas relativas a la accesibilidad y acogida de los servicios de salud, resolución de las necesidades, motivo por el cual buscan el SE e integralidad de la atención. **Resultados:** Los sujetos relataron que, en las Unidades Básicas de Salud, hubo demora en la atención y la programación de las consultas y que el horario de funcionamiento de esos servicios coincide con la jornada de trabajo de los usuarios. En el SE, el acceso fue facilitado a las tecnologías y medicamentos. **Conclusión:** Los servicios de atención básica no han conseguido convertirse en la puerta de entrada del sistema de salud, mas, sí, los servicios de urgencia/emergencia, causando un expresivo aumento en la capacidad de esos servicios.
Descriptores: Atención primaria de salud; Accesibilidad a los servicios de salud; Servicios médicos de urgencia

---

** Study taken from the Master's thesis entitled "Health care accessibility: an analysis of the search for emergency care from the users' perspective" – presented to the University of São Paulo at Ribeirão Preto College of Nursing – USP – Ribeirão Preto (SP), Brazil.*

[1] Ph.D. candidate, Graduate Program in Public Health NursingUniversity of São Paulo at Ribeirão Preto College of Nursing – USP – Ribeirão Preto (SP), Brazil.
[2] Associate Professor, Department of Maternal-Infant Nursing and Public Health, University of São Paulo at Ribeirão Preto College of Nursing – USP – Ribeirão Preto (SP), Brazil.
[3] Ph.D. candidate, Graduate Program in Public Health NursingUniversity of São Paulo at Ribeirão Preto College of Nursing – USP – Ribeirão Preto (SP), Brazil.

Corresponding Author: **Mariana Figueiredo Souza Gomide**
Rua Triunfo, 425, apto 41
E-mail: mari_figueiredo@ig.com.br

Received article **01/07/2011** and accepted **29/07/2012**

INTRODUCTION

The Unified Health System (SUS), created in 1988, is one of the largest public health systems in the world, which ranges from outpatient care to organ transplantation, guaranteeing comprehensive, universal and free access to the Brazilian population[1]. For this purpose, health care in the SUS was ranked according to care levels. The division into basic, medium and high-complexity care is aimed at better programming and planning actions and services in the system[2].

Primary Health Care Units (UBS) are the basic physical care structure for SUS users. When these work appropriately, the population is able to solve most of its health problems, consequently reducing queues at the medium and high-complexity levels. Hence, the most common health problems start to be solved in the UBS, so that specialty outpatient clinics and hospitals can play their true role, resulting in greater user satisfaction and more rational use of existing resources[2].

The need to take into account the users' perspective on health service quality is increasingly acknowledged as, based on this premise, health practices and the organization of health work and services can be reconsidered.

The demand for health service care is observed through consultations, examinations, medication administration, procedures, or the search for answers to socioeconomic issues, bad living conditions, violence, solitude, the need for bonding with a service or professional or, also, access to some specific technology that can improve the quality of life, thus expressing the user's needs[3].

To respond to these needs, health services need to be organized, so that primary care services reorder the system into an articulated and integrated network. In that perspective, the mission of Emergency Care (EC) is to deliver qualified care to urgencies and emergencies, prioritizing welcoming with risk classification, based on the identification of users who need immediate treatment, according to the potential risk and health problems[4].

The EC is the unit where care is delivered to users who are at risk of death or not, whose health problems need immediate care[5]. In Ribeirão Preto – (SP), EC units are intermediary units between UBS, Family Health Units (USF) and the hospital network. Emergency Care units function 24 hours per day and should be apt to deliver problem-solving and qualified care to users affected by acute clinical or trauma conditions and chronic patients going through acute episodes. During care and diagnostic investigation, the need is defined for forwarding to more technological hospital services or not.

The EC represents an entry door into the health system and receives, besides actual urgencies, patients who were not attended in primary care and specialized units. Hence, some users will probably turn to the EC repeatedly. If the reason for the search is always the same, some considerations will be due: the user did not have access to the UBS; did not bond with the team or care was not comprehensive, or was unable to solve the problem, among other possibilities.

Accessibility needs to be guaranteed from a geographical viewpoint, through appropriate planning of health services' organization; from an economic viewpoint, through the removal of barriers deriving from the user payment or contribution system; from a cultural viewpoint, through the adaptation of service standards and techniques to the habits and customs of the population they are inserted in and from a functional viewpoint, through the supply of timely services that are appropriate to the population's needs[6]. Having a health unit in one's coverage area is not enough to guarantee that people will not only have access, but will also be able to reach the health services[7].

As a result of the increasing demand and search for urgency and emergency services, an increase was observed in the user circulation flow at emergency services, demanding the reorganization of the work process at these units, so as to attend to different degrees of particularity and needs, in accordance with different priorities, and no longer in order of arrival[4]. Hence, instead of prioritizing care delivery to the first patients to reach the service, the users' clinical situation should be prioritized, first attending to people who are at most risk in function of their health problem[4].

In non-urgent situation, the search for EC is justified by the fact that, although overcrowded, impersonal and acting on the primary complaint, these units also join resources like consultations, medicines, nursing procedures, laboratory and radiology tests that attend to the population's needs, thus guaranteeing greater possibilities of serving as an entry door to health services[8].

Situations in which users repeatedly visit the EC, but without characterizing emergencies, can disclose the weakness of the health system in bonding and in adopting a posture that is capable of listening, welcoming and more appropriately responding to users[9]. Welcoming is considered as a humanized and receptive relationship workers and services as a whole establish with different types of users[10].

In that sense, with a view to a more welcoming work process, the nursing team plays a fundamental role in users' bonding with health services, represented by the professional who is present throughout their trajectory, from the reception desk to the exit, whether through procedures or forwarding.

Thus, in this study, the aim was to analyze the demand for the EC service in the Western Health District of Ribeirão Preto – SP from the user's perspective, with a view to contributing to a health service reorganization policy, considering the access to and welcoming of health services, attendance to needs, reason to visit the EC and care comprehensiveness.

METHODS

This qualitative and descriptive study was undertaken at the EC of a Basic District Health Unit (UBDS), located in the Western District of Ribeirão Preto – (SP).

At this unit, care is delivered exclusively to SUS users, 24 hours per day, seven days per week, attending to urgencies and emergencies and cases that demand non-urgent care, but are considered priorities by users.

The EC has a well-distributed physical structure and is separated in three large wings: adult, pediatrics and emergency. This structure includes reception, welcoming rooms, medication/inhalation room, observation room – adult and pediatric, besides consultation rooms.

When they arrive at the EC, the users complete a form at the reception desk and are forwarded to the welcoming room. In that room, an auxiliary nurse or nursing technician receives the user and asks for the main complaints, according to the referred symptoms and vital signs measured. Then, the patient is forwarded to the medical consultation, observation room, emergency room or emergency room. In case of any doubt in the identification of the patient's signs and symptoms, according to the unit protocol, the professional contacts the nurse on duty.

The criteria to select the interviewed professionals were: age 18 years or older, no previous attendance due to emergency situations, living in the district's coverage area for more than two years, no signs and/or symptoms of mental confusion or drunkenness, accepting to be interviewed, and signing the Informed Consent Form.

Before starting data collection, standards established for research involving human beings were complied with by submitting the research project to the Internal Review Board at the Health Teaching Center of the University of São Paulo at Ribeirão Preto Medical School. Authorization was obtained under number 049/2009. The researchers took part in the research field through the simple observation technique[11], using the physical area were EC users are welcomed, so as to identify the main complaints that made them seek care. The users observed and who complied with the selection criteria were interviewed during welcoming.A guiding script was used about the aspects related to the reason to visit the EC, addressing questions related to accessibility, welcoming at the health services, care delivery, solution of health needs and care comprehensiveness.

The observation and interviews took place in December 2009, from Monday to Saturday, during alternating shifts, so as to cover all shifts on different weekdays. In total, 23 users were interviewed.

In order to guarantee that users could answer the questions privately, the interviews were held at one of the welcoming rooms soon after the welcoming and before the medical care. The researcher recorded, transcribed, interpreted and analyzed the interviews and users were identify by the letter "U", followed by the interview number.

The development of the thematic analysis[12]involved three phases: the first was the organization of the interview data based on the consideration of the proposed research aims, as well as validity, exhaustiveness, representativeness, homogeneity and pertinence criteria.

The second phase involved the exploration of the material, including floating reading of the transcribed interviews, one by one, in full, and then as a whole; followed by exhaustive reading of the records and data coding by separating the excerpts, according to the convergences, divergences and the unaccustomed, resulting in the organization of the material[12].

In the third phase, the data were classified and organized in themes for analysis. The thematic analysis process of the interviews resulted in the theme accessibility in the network and the demand for the EC, and four subthemes: geographic accessibility, organizational accessibility, sociocultural accessibility and economic accessibility, permeated by the health services' technological organization.

RESULTS

Among the 23 users interviewed, 13 were female and the mean age was 40 years.

The analysis of the collected material revealed the reality involved in users' search for EC, as well as a range of different situation related to access to public primary health care services. Next, some reports are presented that indicate the reasons why users visit the EC. One factor found was the difficulty to get immediate care, which users experience in health services at different levels in the service network.

There's never any place, they never attend. You arrive at the PHCU and they say: "– We cannot see you now". If I go to the unit they tell me to arrive around seven, and they'll see if they can fit me in. You have to make an appointment. [...] I ask them to schedule one and they do for two, three months from now (U23).

According to the users, the opening hours of the primary health care units was considered another factor that justifies the search for EC.

[...] The other day, at the unit, a child arrived who was burning with fever and the doctor said: "– No, I won't see her. Send her to the EC. I'm leaving. My office is closed and it's time for me to go".That's how it works, you see? And that doesn't happen at the EC. They saw me each time I came to bring my children [...] (U23).

I prefer to come to the EC because, generally, I work, and it's difficult to keep on being absent like that, so I come to the EC at night, it's easier, isn't it? At the unit, they attend until 5 in the afternoon and I leave work late (U5).

The organization of primary health care services follows the opening hours, which are the same as business hours, when most of the population works. On the other hand, the organization of care through previous appointments, with little room for spontaneous demand, makes it difficult to get access to this part of the population, which explains the demand for EC, which attends 24h per day and does not send away users, so that all clients are attended.

The way user welcoming functions at the health service defines the demand as another predisposing factor. In this regard, users report on the importance of bonding with the health service, where welcoming is defined as an important instrument in the process of attending to users' needs. This importance is revealed by the fact that even proximity between a health unit and the user's home does not overlap the relevance of the relations established between user and worker.

Let us say that the EC is not the closest. There are others near my home. They're just fuller, you see? (...) At the EC, although it is further, they pay more attention to us than at the unit that is practically in front of my home (U18).

[...] I can't tell you about the other health services because I hardly go there. I went there only once and the care time was much faster than at the EC. But, at the EC, the doctors give you more attention, the nurses ask more about your problem. So I didn't return to the other health units (U12).

Another factor that explains the demand for EC is the valuation of more technologically dense instruments[10], which facilitate the solution of the population's health needs. The following statements demonstrate that both users and professionals organize attendance to spontaneous demands, according to the availability of these instruments, and the user's destination is clarified in view of this demand. This indicates the fragmented organization of health services. The excerpt "The need to go to an EC to administer an injection" reveals the notion that primary health care is not a space for hard technology to put the solution of health needs in practice.

One thing that does not exist at the PHCU is that, if you have to get an X-ray, a more thorough exam, that's only available at the EC. So you go straight to the PHCU because you go to the PHCU and they send you straight to the EC. [...] the necessary equipment is not available at the PHCU (U10).

There is no medication at the FHU. [...] Because sometimes, if you have to take dipyrone in the vein or some injection, you have to come to the EC (U3).

Because, at the EC, at least the doctor asks, he's interested in our problem. At the unit, on the other hand, you get there [...] sometimes the doctor does not even touch us. [...] you used to go for a consult and the doctor evaluated you, he touched you and watched. Not today, I don't know if that is because there are exams, he reads the exam and won't need to touch you (U2).

If, on the one hand, clinical care is the instrument that facilitates the diagnostic process and care at health services, it is a technology that can sustain the relation between professional and user. Through clinical care, the user feels welcomed, listened to, his needs attended to, as a factor that indicates accessibility to health services.

The social construction of the relation between public and private is illustrated in the following statement. The cultural issue of public care, as a free service, without materializing the logic of capitalist consumption, shifts the concept away from universality as a right to empathy with the professional who is delivering care.

I have nothing to comment, but I am always well attended and medicated. You have to consider it like this: it's the SUS, not private, you go there to suffer really. So what do you expect: just being attended and medicated. You have to count on their good will (U8).

In this perspective, access and welcoming are considered as the professional's favors to the population, making suffering and waiting normal and part of routine when the SUS is used.

DISCUSSION

The analytic axis for the proposal to study users' demand for EC in situations that are not characterized as urgencies and emergencies was accessibility, in a combination of factors in different dimensions, including: geographic, organizational, sociocultural and economic accessibility[6], all of which were permeated by the health services' care model.

In the context of the proposal to put in practice the SUS and the ideals of the Health Reform, over the years, the structuring of the health system has been observed, based on principles like universalization, access, regionalization and hierarchization, among others, guiding the organization of health care models. Today, the hegemonic service organization model is the technical care model, represented by a pyramid, whose broad base of primary health care units, which equally serve as the entry door in their coverage area, is responsible for referring the population to more technologically dense health services – represented by the specialty outpatient clinics and EC units at he center of

the pyramid, while regional, state and national hospitals figure at the narrow tip.

This hierarchization guarantees patient access and entry through the entry door to all technological possibilities the health system has at its disposal to cope with pain, disease and risk of death. To that extent, the pyramid almost symbols the struggle in defense of life[5].

In this study, the users' demand for care was not based on the principle of the health units' geographic location, but on the response these units offer to satisfy their needs. Although geographically more distant from the EC, the population chose that service, considering that they are attended there – independently of the waiting time, presence of technological inputs, welcoming and listening.

Hence, people seek the care that according to them will respond to their health needs. Geographic accessibility is measured according to the transportation time and means used to obtain health care[7], does not characterize a health unit as the entry door to the service for the clients covered, nor does it guarantee that users will be able to use the health resources available closer to their place of residence.

Users do not limit themselves to the imposed standard, which is their entry door to the health system. They consider the freedom to choose a health service based on their experience and interest. This choice implies autonomy and participation when one chooses to seek care at a given health service instead of others[13]. The quality of the welcoming also influences the choice of where to seek care, even if this demands further transportation. Hence, the presence of relative distances is not a limiting factor for users to seek a given health service[14].

The delay to receive care and schedule consultations in primary health care was cited by users as a factor that equally justifies the demand for EC as the starting point to enter the health services[14-17].

The contents of some statements point towards the need for more agile attendance, so that users can be forwarded to another referral service when they are received in primary health care. In addition, when users face barriers to obtain this care, they act as protagonists in their health care process. Through their experiences, the people identify the organization of health services in the city. They know what technologies are available at each health service level, as well as the organization of referrals and counter-referrals, justifying the demand for EC, due to the easier access to other levels in the system.

Organizational accessibility, represented by obstacles in the way health care resources are organized, appears before the user enters the health service. Examples are the delay to get a consultation, work shifts, waiting times to receive medical care and undergo laboratory exams, like at the health unit[6].

Issues like the rationalization of care at the EC, which attends to the population's spontaneous demand, and the presence of equipment and medicines are factors that facilitate the population's demand for EC. On the opposite, this circumstance is enhanced when related to the lack of this equipment, besides apparatus and medicines at the primary health care and family health unit, where users considered it as an important reason to visit the EC.

As regards sociocultural accessibility, this is considered as individuals' perception about their health and disease condition, the treatment type and the supply of available health services[6]. In that sense, it corresponds to the relation established between the user and the health team. The first contact is the link that needs to be established appropriately, with a view to enhancing subsequent contacts.

In general, users' attitude is responsible for the initial contact with health services, while health professionals are responsible for subsequent contacts[18]. Hence, when they are welcomed at a health service and bond with the professionals, based on this initial contact, this favors the institution and these users' involvement with that health service. And, generally, nursing team professionals participate in the responsibility to create and maintain users' bonding with the health service.

If this health professional is not open to dialogue, there will be no means to establish bonding, thus reducing users' possibility to share the responsibility for their health care. In addition, the bond between professionals and users stimulates the latter's autonomy and enhances their participation during care delivery[19-20]. This autonomy presupposes freedom and, for autonomous work to be effective, professionals need to be capable of assuming responsibility for other people's problems. Therefore, autonomy would only be established if the agents were interested and involved in a certain task[10].

In this study, the importance of qualifying health professionals is highlighted, with a view to receiving, attending, listening, dialoging, supporting and directing clients, seeking a welcoming and humanizing relation for health care delivery to the population[21].

Physical examination is one of the components of the expanded clinic that can approach professionals and users. A careful and detailed physical examination demonstrates the professional's interest and, thus, is one of the criteria users adopt to determine the choice of the health service[16]. If, on the other hand, users have negative background experiences with a given health service, it is reasonable to understand why they no longer visit a certain service, even if they need to.

Economic accessibility is closely linked with economic barriers to use health services, which includes the time, energy and financial resources spent to seek

and receive health care[6]. This form of accessibility is represented by the use of a health service, based on the population's purchasing power, in view of the prices of services and medicines[22].

The implementation period of the SUS in the 1980's departed from governmental actions, aimed at covering social sectors with lesser purchasing power, thus enhancing the market coverage in segments with purchase ability[23]. Some testimonies negatively indicated the SUS as the sole health care alternative. This reveals the discussion about the historical and institutional perspective on the public and private in the Brazilian health care policy, in which the population's preference for private services is highlighted, in combination with the representation of the public service as inferior, even if these negative images of care delivery were not constructed based on personal experience, but collectively constructed and transmitted[23].

The main contribution of this study was the identification of the fact that the primary health care services available to the population do not further welcoming by the team and service accessibility. This implies difficulties for primary health care services to serve as a the entry door into health care.

The development of the study in the universe of one of the health districts in Ribeirão Preto – (SP) represents a study limitation, as it cannot be generalized to other districts and contexts.

CONCLUSIONS

Considering that this study was aimed at analyzing the demand for Emergency Care (EC) in the Western Health District of Ribeirão Preto (SP) from the user's perspective, it was identified that accessibility could be discussed from the organizational perspective of the health service network, in which EC units are serving as an entry door. This organization may misfitSUS principles and public policies, which direct health service organization, according to which primary health care services, represented by primary health care units and family health units, shouldserve as the entry door.

The issue observed does not refer to the fact that the population receives no orientation to use the SUS, but to the population's need to learn how to use health services in accordance with its needs, and to the fact that its choices can emerge from preliminary individual experiences, as well as the collective construction of these experiences.

The population values technology use in solving their needs, but does not want to do without the clinical side, represented by welcoming, humanized listening and treatment in this study, which are mechanisms used to attend to their needs. Therefore, to maintain bonding, nursing work is fundamental to manage the user/worker relation.

Different justifications were evidenced in this study to turn to emergency services. Finally, however, the potential of EC to attend to the health needs of users should be emphasized.

Primary health care professionals need to get further qualification with a view to listening to the users' health needs, so as to guarantee that all clients are welcomed.

It should be highlighted that this study presents but one of the discussions about the accessibility of public health services. Future research is needed to investigate other forms to organize the care flow, orientation and forwarding in the primary health care network of the SUS.

Finally, this study has demonstrated that primary health care services have not actually served as the entry door to the health system, while emergency services have, as represented by the considerable use of these services capacity.

REFERENCES

1. Brasil. Ministério da Saúde. Sobre o SUS [Internet] [citado 2010 Jul 22]. Disponível em: http://portal.saude.gov.br/portal/saude/cidadao/default.cfm
2. Brasil. Ministério da Saúde. O SUS de A a Z: garantindo saúde nos municípios. 3a ed. Brasília: Ministério da Saúde; 2009.
3. Cecílio LC. [Technical health care models: from the pyramid to the circle, a possibility to be explored]. Cad Saúde Pública. 1997;13(3):469-78. Portuguese.
4. Brasil. Ministério da Saúde. Acolhimento com avaliação e classificação de risco. Brasília: Ministério da Saúde; 2004.
5. Brasil. Ministério da Saúde. Terminologia básica em saúde. 2a ed. Brasília: Centro de Documentação do Ministério da Saúde; 1985. .
6. Fekete MC. Estudo da acessibilidade na avaliação dos serviços de saúde. In: Santana JP, organizador. Desenvolvimento gerencial de unidades básicas do Sistema Único de Saúde (SUS). Brasília: Organização Pan-Americana Saúde; 1997. p.114-20.
7. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: Ministério da Saúde/UNESCO; 2002.
8. Marques GQ, Lima MA. User's demands to an emergency service and their welcoming in the health system. Rev Latinoam Enferm. 2007; 15(1):13-9.
9. Marques GQ, Leal SM, Lima MA, Bonilha AL, Lopes MJ. [Practices and daily routine of professionals in health public services under the light of academic studies. Online Braz J Nurs [Internet]. 2007 [cited 2012 Set 10]; 6 (2): [about 5p]. Portuguese. Available from: http://www.objnursing.uff.br//index.php/nursing/article/view/j.1676-4285.2007.660/194.

10. Merhy EE. Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde. In: Merhy EE, Onocko R, organizadores. Agir em saúde: um desafio para o público. São Paulo: Hucitec; 1997. p.71-112.
11. Gil AC. Métodos e técnicas de pesquisa social. São Paulo: Atlas, 2007.
12. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2004.
13. Oliveira LH, Mattos RA, Souza AI. [Travelling citizens: the 'users' of the Brazilian Unified Health System and the meanings of its demand to the health care emergency services in the context of a process of assistential model reorientation]. Ciênc Saúde Coletiva. 2009; 14(5): 1929-38. Portuguese.
14. Ramos DD, Lima MA. [Health care access and receptivity to users in a unit in Porto Alegre, Rio Grande do Sul, Brazil]. Cad Saúde Pública. 2003; 19(1):27-34. Portuguese.
15. Kovacs MH, Feliciano KV, Sarinho SW, Veras AA. Access to basic care for children seen at emergency departments. J Pediatr (Rio J). 2005; 81(3):251-8.
16. Gaioso VP, Mishima SM. User satisfaction from the perspective of acceptability in the family health scenario. Texto & Contexto Enferm. 2007;16(4):617-25.
17. Lima MA, Ramos DD, Rosa RB, Nauderer TM, Davis R. [Access and quality care in health care centers from the users' point of view]. Acta Paul Enferm. 2007; 20(1):12-7. Portuguese.
18. Travassos C, Martins M. [A review of concepts in health services access and utilization]. Cad Saúde Pública. 2004; 20 Suppl 2: 190-8. Portuguese.
19. Schimith MD, Lima MA. [Receptiveness and links to clients in a Family Health Program team]. Cad Saúde Pública. 2004; 20(6):1487-94. Portuguese.
20. Brunello ME, Ponce MA, Assis EG, Andrade RL, Scatena LM, Palha PF, Villa TC. [Bond in health care: a systematic review of literature in Brazil (1998-2007)]. Acta Paul Enferm. 2010; 23(1):131-5. Portuguese.
21. Souza EC, Vilar RL, Rocha NS, Uchoa AC, Rocha PM. [Primary health care access and receptivity to users: an analysis of perceptions by users and health professionals]. Cad Saúde Pública. 2008; 24 Suppl 1:100-10. Portuguese.
22. Brasil. Ministério da Saúde. Glossário temático economia da saúde. Brasília; 2005.
23. Menicucci TM. Público e privado na política de assistência à saúde no Brasil: atores, processos e trajetória. Rio de Janeiro: Fiocruz; 2007.