



# Daily practice in the Brazilian Unified Health System in its third decade

*Atuação cotidiana no Sistema Único de Saúde em sua terceira década*

*Práctica diaria en el Sistema Unico de Salud en su tercera década*

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## ABSTRACT

**Objective:** to understand the daily practice in the Brazilian Unified Health System, in its third decade, from the perspective of primary health care professionals (PHC). **Method:** this qualitative research was anchored in the Grounded Theory and Symbolic Interactionism, with 82 health professionals working at PHC. It had as a source of evidence individual open interview and memoranda. Data collection occurred between April 2017 and March 2018 in 14 PHC units of three cities from different sanitary regions of Minas Gerais. **Results:** the daily practice in the SUS is presented by PHC professionals and permeates their understanding of SUS, the work in PHC and its implication in professional practice; the impact of management; the current context of SUS and its influence on (un)safe care. **Conclusions and implications for practice:** factors that cause insecurity to professionals may compromise the quality of care and good practice, contribute to reflections of professionals, managers and users on the relevance of proactivity in popular participation so that changes occur in the context of PHC, enabling professionals to be safer in their actions and improvements in the quality of health care.

**Keywords:** Primary Health Care; Unified Health System; Access to Health Services; Working Conditions.

## RESUMO

**Objetivo:** compreender a atuação cotidiana no Sistema Único de Saúde (SUS), em sua terceira década, sob a ótica dos profissionais da Atenção Primária à Saúde (APS). **Método:** pesquisa qualitativa, ancorada na Teoria Fundamentada nos Dados e no Interacionismo Simbólico, com 82 profissionais de saúde que atuam na APS. Teve como fonte de evidências a entrevista aberta individual e memorandos. A coleta de dados ocorreu entre abril de 2017 e março de 2018, em 14 unidades de APS de três municípios pertencentes às regiões sanitárias distintas de Minas Gerais. **Resultados:** a atuação cotidiana no SUS é apresentada pelos profissionais da APS e perpassa pela compreensão que tem do SUS, do trabalho na APS e sua implicação na atuação profissional; pelo impacto da gestão; o contexto atual do SUS e sua influência na assistência (in)segura. **Conclusões e implicações para a prática:** fatores que ocasionam insegurança ao profissional podem comprometer a qualidade da assistência e as boas práticas, contribuindo para reflexões de profissionais, gestores e usuários sobre a relevância da proatividade na participação popular para que mudanças ocorram frente ao contexto da APS possibilitando ao profissional mais segurança em suas ações e melhorias na qualidade da atenção à saúde.

**Palavras-chave:** Atenção Primária à Saúde; Sistema Único de Saúde; Acesso aos Serviços de Saúde; Condições de Trabalho.

## RESUMEN

**Objetivo:** comprender el desempeño diario en el Sistema Único de Salud (SUS), en su tercera década, desde la perspectiva de los profesionales de Atención Primaria de Salud (APS). **Método:** investigación cualitativa, anclada en la teoría fundamentada y el marco teórico del interaccionismo simbólico con 82 profesionales de la salud que trabajan en APS. La fuente de evidencia fue la entrevista individual abierta y los memorandos. La recopilación de datos tuvo lugar entre abril de 2017 y marzo de 2018, en 14 unidades de APS en tres municipios pertenecientes a diferentes regiones de salud de Minas Gerais. **Resultados:** el desempeño diario en el SUS es presentado por los profesionales de la APS e impregna su comprensión del SUS, el trabajo en la APS y su implicación en el desempeño profesional; el impacto de la gestión; El contexto actual del SUS y su influencia en la atención (des) segura. **Conclusiones e implicaciones para la práctica:** los factores que causan inseguridad al profesional pueden comprometer la calidad de la atención y las buenas prácticas. Contribuir a reflexiones de profesionales, gerentes y usuarios sobre la relevancia de la proactividad en la participación popular para que los cambios ocurran en el contexto de la APS permitiendo al profesional más seguridad en sus acciones y mejoras en la calidad de la atención médica.

**Palabras clave:** Atención Primaria de Salud; Sistema Único de Salud; Acceso a Servicios de Salud; Condiciones de Trabajo.

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## INTRODUCTION

The Brazilian Unified Health System (SUS – *Sistema Único de Saúde*) embodies the social right to public health in Brazil and intensifies the expansion and strengthening of Primary Health Care (PHC) as the generating center of the Health Care Network (RAS – *Rede de Atenção à Saúde*). Thus, it creates the Family Health Strategy (FHS), with a view to implementing universal, comprehensive and equitable care to the population, without restrictions, reaffirming the accessibility of Brazilian citizens to health actions.<sup>1-3</sup>

However, after three decades of creation of SUS, PHC still cannot meet health demands of users in a timely and necessary manner, with major obstacles to consolidating SUS principles. “Guarantee and expansion of access and effectiveness of care in the SUS depend on the availability of resources, and it is crucial to seek the improvement of funding”.<sup>4:1760</sup>

The daily work of health professionals is characterized by several factors that compromise care, including work overload, lack of infrastructure, (de)valuation and (de)motivation of professionals and difficulties concerning relationships with users.<sup>5,6</sup>

Studies conducted in Brazil (São Paulo) and Chile showed that health professionals feel overwhelmed and frustrated because they are unable to perform all the functions proposed for their work.<sup>7,8</sup>

It is known that health work, as a field of knowledge and practices, is essential for assistance and care. In this sense, knowing the daily work of professionals is paramount to achieve safe and quality care.<sup>9,10</sup>

Studies conducted in the United States have shown that continuity of care improves equity, and it favors the quality of health, enabling the interaction of professionals with users, in addition to improvement in care.<sup>11,12</sup>

Difficulties encountered by professionals to work at SUS are an impacting factor in the daily life of health services, since they compromise the implementation of SUS principles and guidelines, making it impossible to provide comprehensive care to the population.<sup>6,13</sup>

Therefore, the proposal of this study is justified by the relevance of understanding the daily life of SUS, in its third decade, from the perspective of PHC health professionals in three cities of Minas Gerais and questioned: how is the daily practice in the SUS, in three cities of the state of Minas Gerais, Brazil, from the perspective of PHC health professionals?

This study aimed to understand the daily practice in the SUS, in its third decade, from the perspective of PHC professionals.

## METHOD

This is a qualitative study anchored in the Grounded Theory (GT)<sup>14</sup> and Symbolic Interactionism (SI)<sup>15</sup>, designed to identify data on the daily practice in the SUS, in its third decade of creation, from the perspective of PHC professionals. Considering the relevance of SUS as a public system in the performance of the right to health of the Brazilian population, the complexity of

health care, and the variability of social phenomena and human actions for professional action in public health, people act based on meanings, which is defined and redefined by the interaction among them.<sup>14,15</sup>

GT is a process that requires methodological rigor to base the data collected through the organization of concepts and formulation of a theoretical model, which directly depends on the level of complexity of the analysis attributed to the phenomenon under study. GT aims to generate a unified theory or theoretical explanation for a process, in an action or interaction configured by the vision and understanding of experiences of many research participants, which is evidenced in the collected data.<sup>14</sup>

The study setting included three cities belonging to the West Minas Gerais Extended Health Region, Brazil, defined after classification regarding population size and sanitary microregion. The selection of health units in the three cities was performed by random draw, and data collection occurred in 14 of the PHC/FHS units from April 2017 to March 2018. Sources of evidence were open and individual interviews and memo records. The interview was conducted in a reserved room of the health unit, recorded by digital means, transcribed in full and analyzed concomitantly with data collection.

Eighty-two health professionals from the traditional PHC and FHS teams participated in the study, 37 from city 1, 25 from city 2 and 20 from city 3. They were invited to the workplace through acceptance and availability. The inclusion criterion was professionals having at least six months of experience working at PHC and, as an exclusion criterion, professionals being on vacation or away. Data theoretical saturation was reached when new or relevant data no longer emerged in relation to a category.<sup>14</sup>

Data analysis was performed in interdependent stages: open, axial, selective coding, for the process.

Open coding originated 31 codes *in vivo* through the concepts identified, which were grouped and classified according to similarities and divergences, resulting in five subcategories, which were: *Understanding SUS from the perspective of PHC professionals*; *Daily life in PHC and its implication in the practice of professionals*; *Impact of management on the context of SUS*; *Determinants and constraints of Professional Safety in PHC: professional training, infrastructure, support, and technical responsibility*; *Professional safety: physical protection, psychological support, suffering and feelings reveal the (unsafe) conditions*.

Axial coding comprised the relationship of categories and subcategories, following the lines of their properties and dimensions, and led to the conceptual definition of two categories: *Daily practice in the SUS in its third decade: perspective of primary health care professionals*; and *Safety of professionals in the Daily Life of Primary Health Care: a Grounded Theory*. These two categories were integrated and refined in selective coding, until identifying the central category. Data were transformed into the theory “Safety of Professionals in the Daily Life of Primary Health Care”. This theory presents “the essence of research, meaning the central idea that relates other concepts to it”.<sup>14:149</sup>

In coding for the process, data analysis considered the question: how were the structure and conditions related to the

process of strategies, actions/interactions of professionals in response to the problems and questions experienced, and which present the (in)security to the professional in their actions and activities in the daily life in PHC?

The paradigm of analysis, from the theory formulated, weighed the structure of services and working conditions for health care in PHC, reported by the 82 participants of this study. Structure and conditions were related to the process of strategies, actions/interactions of professionals in response to the problems and issues experienced, and which present the (in)security to professionals in their actions and activities.

This research met the ethical precepts of Resolution 466, of December 12, 2012, of the Brazilian National Health Board (*Conselho Nacional de Saúde*). The Research Ethics Committee of the *Universidade Federal de São João del-Rei/Center-West Campus* approved the study, under Opinion 1.994.924. The Informed Consent Form was elaborated in two copies, being signed by the research participants and the responsible researcher. To ensure confidentiality and anonymity of participants, an alphanumeric code symbolized by the letter "I" (interviewee) was used, followed by the number corresponding to the order of conducting the interviews to designate them (I1, I2... I82).

This paper comes from the Master's thesis entitled "*Segurança do Profissional no Cotidiano da Atenção Primária à Saúde: Uma Teoria sobre a Atuação aos 30 anos do SUS*", presented to the Academic Master Graduate Program in Nursing of the *Universidade Federal de São João del-Rei, Center-West Campus, Divinópolis, Minas Gerais, Brazil, 2019*.

**RESULTS**

Theoretical sampling<sup>14</sup> composes meanings experienced by 82 participants in daily work in PHC as: 22 Community Health Agents, 14 nurses, 13 nursing technicians, 08 physicians, 08 dentists, 07 Oral Health Assistants, 04 nursing assistants,

02 Oral Health Technicians, 01 speech therapist, 01 physiotherapist, 01 psychologist, 01 nursing resident. Of the 82 participants, 91.46% were female, the age ranged from 20 to 67 years, with the predominance between 30 and 50 years, representing 79.3% (65). The time of professional practice at PHC ranged from 6 months to 32 years, and 39.02% (32 participants) have 10 years or more of work in PHC.

From the process of systematic data analysis and integration, the phenomenon of the study emerged, supported by two interrelated categories. In this article, the category "Daily practice in the SUS in its third decade: perspective of primary health care professionals" will be addressed, as illustrated in Figure 1.

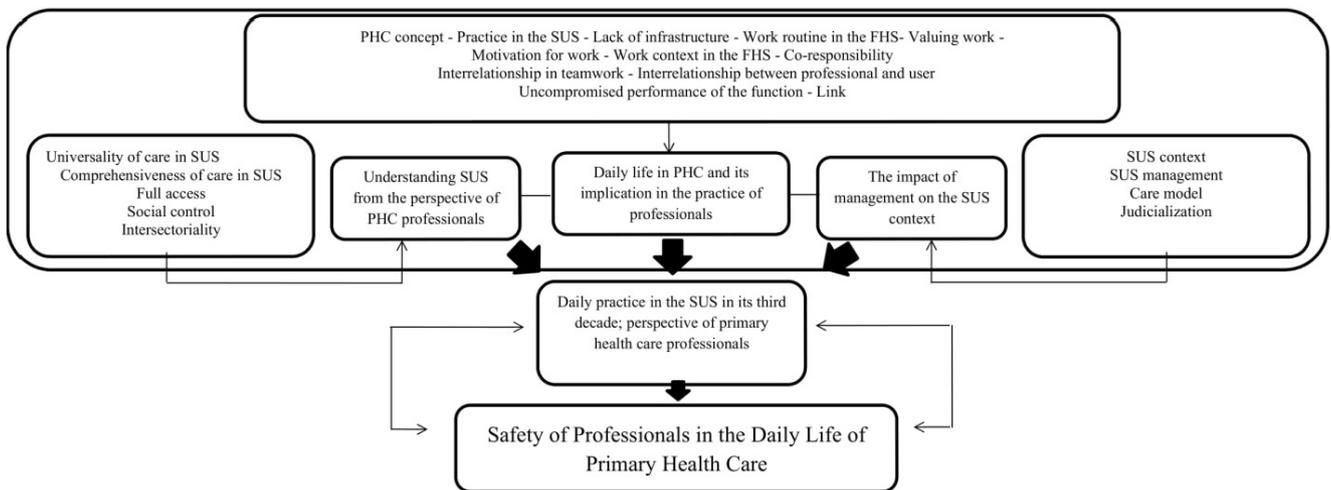
Participants talk about their understanding on SUS, expressing universality and comprehensiveness of care and access of users to the services offered. It highlights that social control is not seen by professionals as a tool for change, and intersectoriality favors the context of professionals' actions:

*The SUS is to serve all people of Brazil, regardless of whether it is poor or rich. When the person searches for the SUS entered the door inside it is their user. (I<sub>1</sub>).*

*The SUS... is comprehensiveness within care. To see users as a whole in a comprehensive assistance, with equity, knowing how to give more to those who have less, is to be fair. Try to offer a comprehensive health even, you have to contemplate that human being... (I<sub>26</sub>).*

*It is a public health system that everyone has the right to use. [...] in practice the patient does not get everything he needs, until the basics that would be the consultation, the initial evaluation, he cannot. (I<sub>73</sub>).*

*It gives a certain disbelief in working at SUS. Firstly, you have nothing to do but you and you, don't you?! The professional does not require, the population does not require. Orthopedist is missing. You'll give it a little way,*



**Figure 1 - Theoretical Model: Safety of Professionals in the Daily Life of Primary Health Care.** Source: authors' preparation.

*get your appointment and the rest that explodes! There is no collective, there is the navel. I solve my problem. [...]. So, what I hope for the future is that we wake up [...] until we learn that the collective has strength, everything will be missing. (I<sub>13</sub>).*

*All work together, FHS teams, CRAS (Social Assistance Reference Center), all institutions together in one purpose: the good of the population. (I<sub>44</sub>).*

PHC as the gateway and the FHS team as a reference for the enrolled population:

*PHC is the gateway to the health system, the first step of the population is there. Is to work with the enrolled population, to increase the bond. Just that: FHS for the family... it is that we enter the house, know the problems of that family, share with them the situation. We end up experiencing the family problem with them, right?! This is the truth. And without a doubt, I think it was the best strategy that could have existed in health, in the SUS, which is the organizer of PHC and of the entire health service network. (I<sub>46</sub>).*

Inadequate infrastructure compromises access to actions and services:

*One of the great problems of SUS is actually the lack of professionals who want to work and really want to make it happen. (I<sub>30</sub>).*

*You have difficulty when you need secondary and tertiary level. Getting consultations with specialists and in rehabilitation, due to the lack of professionals or because this access is difficult even due to the difficulty of transporting the patient himself. [...] many medications SUS does not offer. [...] there are patients who wait years in line and, sometimes, when they succeed, it may be too late ... [...] we have a lack of human resources, a lack of materials, and the excess of activities, all this certainly affects the quality of work. (I<sub>64</sub>).*

The professional's performance in the daily life of PHC contextualizes work overload, (de)valuation of work and (de) motivation for work:

*Overload [...] we held a meeting with the health secretary, regarding the salary floor, which is much lower and everyone is dissatisfied with the salary and overburdened with the service. (I<sub>43</sub>).*

*Professional valuation, and this undoubtedly affects the assistance to the population. [...] I just don't feel 100% realized by the wage devaluation, which, unfortunately, is a very devalued class. (I<sub>46</sub>).*

*I see a great strain on all professionals and a great disbelief on the part of all professionals with the network, with the system in general, you know?! (I<sub>34</sub>).*

*User come and demand, because it is the entrance door. We keep our hands and feet tied because we try to do it, solve it, but not everything depends only on us. If I could speak, "Your exam will be out next week", would be excellent! And then I get insecure, worried about the progress of this patient and really frustrated and the demand is very high. (I<sub>34</sub>).*

Co-responsibility in health promotion and care/self-care does not manifest itself as shared responsibility:

*It is drying ice, because the population needs to be aware that it is responsible for their health. Because, sometimes, they end up thinking that we even have a responsibility to take care of their lives, of adequate food, of a diet, understand?! What you see most is the use of medicine for diabetes and hypertension, you know?! So, the person says "I'm on a diet" and has glucose up there and doesn't do it. (I<sub>34</sub>).*

Professionals express some characteristics that compromise the work in the SUS: inter-relationship in the team work, inter-relationship of professionals with users, lack of commitment in the performance of the function, (non) bond:

*The union of the team because the Community Health Agent alone does not do it, there is no way ... it's the team together. So, security is in a united team. (I<sub>28</sub>).*

*There are many users who like, praise and welcome us very well at home. There are those who are aggressive, especially here inside the unit, because they want to consult, arrive late and have no vacancy, then they transfer that to whoever is there at the reception. So, we go through stress here and there on the street too (I<sub>1</sub>).*

*SUS for me is in chaos due to the people who work at SUS. [...] because people on the edge are the ones who have to search for users, they don't have to dispatch users. They have to do everything for users to feel comfortable in that place. So, if they put barriers and difficulties, users will not come to the Unit, they will look for other ways that, at times, is much more expensive, tortuous and difficult for them. (I<sub>29</sub>).*

*We create bonds with users, know their health and social problems. We care about them and want them to be well-attended to and their problem solved. It often has flaws. (I<sub>9</sub>).*

Biomedical culture and carelessness with health determine the demand for care in PHC in spontaneous demand. In addition,

the financial crisis of users who had private health plans and who migrated to SUS is declared:

*The real problem in PHC is the greater spontaneous demand, a cultural issue of the population to seek more the Unit when they are sick, not to seek to promote health. Take care before getting sick... so, in this sense, the staff arrives chronologically. Despite this, we have managed to be resolute. But I don't know if Brazil is prepared for this SUS in financial terms. And, as health plans are getting more expensive, there is a large population migrating to SUS, and I don't know if this SUS will be able to handle it. But I believe in the SUS. (I<sub>26</sub>).*

*Users' lack of knowledge about SUS and PHC assumptions. [...] they don't understand what a PHC is, they don't understand what an urgency and emergency is, what an emergency room is. This is really confusing and hinders the organization of SUS. [...] people have access, only because they do not understand much they think it has to be everything today [...] SUS is very beautiful to see, it should work according to its principles and guidelines, but I see a great difficulty to put it into practice, it is a challenge! (I<sub>51</sub>).*

Implications of management in the daily practice in the PHC, influence of the current model of care and judicialization are factors that interfere in the care provided:

*I think that maybe some professionals lack commitment, and there is a management limitation [...] the secretary always changes and the director always changes. I think there is a person missing to get it from beginning to end, so that it can happen. [...] it is a very high turnover and each one comes with an interest, comes with a value, comes with a culture. (I<sub>26</sub>).*

*It is a poorer population, so communication is difficult. Trying to transform the health vision they have for the less medicated view. [...] however, health is a result of several factors: education, food, physical activity ... and get it out of people's heads: "Ah, won't you give me some medicine?" It's hard. Also, there is the issue of lack of resources. (I<sub>49</sub>).*

*Judicialization is another. Anything, the prosecutor is here, is even interfering with revenue. You are going to prescribe a medication, of those that are there in the public service, for instance, there are many of them that are outdated. Will you use? I don't use it for my family. Now, if you prescribe another, the prosecutor says: doesn't it have to be just what you have in the public service? I mean: Medicine for the poor. From poor to poor, isn't it?! Then I ask: Does this give you any security? This patient will be coming back here with the same disease, right ?! (I<sub>15</sub>).*

*Sometimes, the city thinks that we are asking too much for the patient and ends up demanding us like this, "Look,*

*don't do this so much, because we can't afford it". And, sometimes, we know that the patient needs it and he is not able to have it any other way. I still ask, guide, help in whatever way possible, in terms of the roles he needs to enter this process. As long as he really needs it. More than insecurity in this sense of politics, it does. (I<sub>73</sub>).*

## DISCUSSION

SUS is a milestone in the history of public health in Brazil as a health system for all, based on the principle of universality and equal access to health actions and services.<sup>16</sup>

With regard to universality, comprehensiveness and equity, participants have an understanding of these principles. However, they report that there is a gap between the instituted and the practice, and recognize a reality that makes it difficult and even prevents users from having access to some services offered by SUS. Universality is understood as covering the entire population, but it must be added by equal access to health at all levels of assistance, if necessary, without prejudice or privileges of any kind. Principles of equity and universality are elements that challenge health policies and also everyday practices. The perception of these principles suggests PHC as a place of access and right to health as a priority port of the System.<sup>17</sup> However, a study carried out in Minas Gerais shows that it is still not possible to meet all users who seek assistance in PHC in a resolute way.<sup>18</sup>

Comprehensive health throughout the social construction of SUS "[...] has been incorporated into the critical awareness of health professionals. However, it is not enough that these professionals have an attentive eye and capable of understanding the needs of users if the population does not have access to a System with comprehensive actions".<sup>19:1096</sup> Comprehensiveness performance in the daily life of services "[...] depends on the organization of the network, services and health practices, the definition of health and social policies in an integrated manner".<sup>19:1097</sup>

Comprehensive health care and care is interdependent with planning, considering the needs of people, the organization of health services to accommodate the demands, the caregiver and the being cared for in their emotional, cultural and social dimensions.<sup>20</sup> Continuity of care is the result of a joint action, which is characterized as a reflexive, negotiated, shared, meaningful and coherent articulation of the different singular care actions by those involved, in the context of interactions in which it occurs and manifests itself, and the way users perceive this interdisciplinary action in care.<sup>21</sup>

The difficulty of the population and health professionals to recognize themselves as proactive in popular participation was manifested in this study. Social control democratically legitimized as a right and principle of SUS only takes on meaning when it is perceived as shared responsibility of health professionals, managers and users, in collaboration and involvement with the construction of health policies and in defense of SUS.<sup>22</sup> Participation and social control are fundamental elements in

health actions, since the social reality requires the construction of collective power from different knowledge, sectors and needs that permeate health and other protagonists involved.<sup>23</sup>

Intersectionality was pointed out by the participants as a facilitator in their daily professional activities, favoring the resolution of health problems in collective action. It facilitates the construction of RAS with the co-responsibility between health and other sectors, the exchange of knowledge, the planning of actions and the making of decisions in a shared way.<sup>23</sup>

PHC is recognized by professionals as a gateway to the System and the team as a reference for the registered population. FHS represents the main strategy to qualify the care provided in PHC, ensuring the principles of SUS, being a strategy capable of structuring and ordering the RAS for full and equitable access, according to people's needs.<sup>2,24</sup> Through RAS, seeks to provide services effectively and with horizontal relationships, and it is essential to ensure universal access to health actions and services, according to the need.<sup>25</sup>

However, even with the advances achieved in PHC after the implantation and expansion of the FHS, it is recognized that its principles and praxis still do not reflect the reality in the daily routine of services, especially in relation to comprehensive care; there are great challenges with regard to the profile of professionals and teamwork, with a view to resolving health demands.<sup>1,6,26</sup>

Thus, the System is unable to ensure continuity of care, leading to increased work, expenses and difficulties for users, being essential for the realization of access to services, the creation of a care network prepared to meet the demands of the population.<sup>24</sup>

Professionals are faced with a reality where access to other levels of care does not occur adequately and human and material resources are lacking, causing work overload and damage to the safety and quality of care provided, revealing the lack of these resources and the multiple tasks as negative aspects that influence the services provided.<sup>27</sup>

The professional practice in daily PHC was characterized by work overload and low remuneration, factors that cause dissatisfaction in health professionals. Studies corroborate this finding by showing that work overload and inappropriate working conditions can have major consequences for the professional. These factors cause a high level of emotional and physical stress, can affect health and influence professional practice and collaborate to a greater probability of making mistakes, compromising the care provided, causing damage to the people assisted<sup>5,6,28,29</sup> and professional insecurity. Moreover, low remuneration associated with overwork due to all the responsibility that professionals have contributes to dissatisfaction.<sup>6</sup>

Participants report not feeling valued, providing demotivation and, consequently, worsening the quality of care and reinforcing the need for salary improvements. Thus, the performance of the professional deserves greater attention from management, in order to enhance the worker, the recognition, appreciation and encouragement of the professionals, not only as a workforce, but as people responsible for a meaningful task. These professionals

influence their commitment to work, which is reflected in the assistance and quality of service offered to the population.<sup>25</sup>

The absence of a job and salary plan implies a rise within the institution and, consequently, better salary and recognition are some of the reasons that contribute to the demotivation of the professional. It is necessary to invest in strategies for salary improvements, since they can influence the work of this professional, his quality of life and the permanence or abandonment of the profession.<sup>6</sup> Also, motivation for work and professional qualification must be strategies adopted in the daily routine of PHC.

Participants feel unmotivated in the performance of their role and do not believe in changes. There are several demotivating aspects, among them: deficient human and material resources; inadequate remuneration; high turnover of professionals; poor infrastructure for work; difficulty to work interdisciplinarily and in a team; low resolvability; excess demand.<sup>26</sup>

Thereby, the daily work is characterized by insecurity and frustration of the professionals who work in the SUS and by the demand from users in view of the professionals' difficulties in responding to their needs due to lack of resources.

Participants emphasize the importance of users taking responsibility for their health demands, since this fact makes it difficult for the therapeutic bond. Continuity of care begins with interaction between professionals and users and their experience, favoring co-responsibility. However, users must be responsible for their health, taking over their role as protagonist, with active and continuous participation, in order to carry out their health monitoring.<sup>21</sup> In a study conducted in the city of Porto Alegre, it was observed that trust and dialogue between users and professionals are factors that contribute to compliance with what was proposed.<sup>30</sup>

Professional safety is increased when the work is done in a team. Participants report that it is not possible to perform their roles alone, since teamwork provides quality care, considering users as protagonists and co-responsible for self-care, maintenance and protection of their health. Thus, professional safety is determined by the co-responsibility of everyone, including professionals, teams, management and role of users, and not a connotation of blaming the professional for his safety.

Interdisciplinarity enables the sharing of knowledge and integration of professionals provides planning and division of tasks, cooperation, collaboration in a democratic manner, encompassing the various interests, needs, knowledge and skills. In this sense, articulation of knowledge and practices enables the quality of health care and increases professional satisfaction, where everyone must know the role and responsibilities of each one.<sup>6,31</sup>

Furthermore, when making a decision regarding care, the action of a professional may have a different meaning for another professional, especially when referring to different professional categories. These actions, when negotiated and understood in an interdisciplinary manner by these professionals, when interacting, are completed and converge in comprehensive care to users.<sup>21</sup>

Professional/user relationship is due to the respectful treatment, but it can become stressful, sometimes, when the

needs of users are not met and they become aggressive towards the professionals. A study corroborates this finding by presenting that users/professionals relationship is not always congruent, but it is up to the professional to develop capacities for coexistence and conflict management, since the good relationship between them is related to the quality of care provided.<sup>6</sup> Action-interaction between professionals and users allows individuals to signify and reframe their perspectives in relation to care and, thus, progressively, these perspectives lead and help decision making about health care.<sup>21</sup>

Concerning professional practice, this study reinforces the importance of welcoming, listening and trying to solve the needs of users, so that they seek PHC as a gateway to the System and not other services of greater technological/diagnostic complexity, if there is no need. Considering accessibility in health, when users seek health services, they expect professionals to resolve or, at least, minimize the problem that led them to seek that service.<sup>20</sup>

The results of this study reinforce the importance of bonding with users, providing safe and quality care. This emerges as essential to the demands of care, enabling continuous and comprehensive care, individual and collective. Continuity of care and resolution of health demands in PHC are essential for the bond to be established. In cases of non-compliance with needs, users' relationships with professionals are impaired.<sup>20,25,32</sup>

The predominance of spontaneous demand becomes a hindrance in the daily lives of participants, since the population is unaware of the assumptions of PHC and medium and high complexity services, contributing to the disorganization of the System by entering spontaneously in places where demand does not is prioritized.

Studies carried out in Recife, PE and in Cocal do Sul, SC, Brazil, respectively, demonstrate that overwork impairs the acceptance of demands, that users are unaware of the services provided by PHC and which flow or unit they should look for in according to your needs. Consequently, the professional is unable to provide quality assistance to users.<sup>6,33</sup>

The high turnover of management representatives, declared in this study, harms professionals in the performance of their duties; their replacement implies the discontinuation of the proposed actions. Work management in the SUS and, therefore, the performance of health professionals, is configured as a central element for the effectiveness of the entire health system, through its role as a transforming agent and, as it allows, in the work process, bonds that will favor mutual participation and commitment.<sup>25</sup>

Despite the fact that the FHS is designed to implement the expanded clinic, the logic of a curative model still exists, where there is a common sense of a culture centered on curative, medical/hospital aspects with practices based essentially on the biomedical model of health.<sup>33,34</sup>

Physicians participating in this research see judicialization as a tool to enforce the right to health, however, they feel insecure when questioned in relation to the instituted therapy, but this is not an impediment to the prescription.

Lawsuits ensure the right to pharmaceutical assistance for some people, but compromise the access of the general population by imposing excessive expenditures on the public system that are inconsistent with the financial reality destined to carrying out public health policies, often disregarding the fundamental principles of universality, comprehensiveness and equity that are the mainstay of SUS.<sup>35</sup>

According to the interactionist approach, people guide their actions towards the facts/phenomena of everyday life because of what they represent to them. The meaning of such facts/phenomena is a consequence of the social interaction that each professional maintains with his neighbor in the daily life of PHC, and these meanings are manipulated and modified as the interactive process between professionals develops.<sup>15</sup>

Participants present in their testimonies what is the daily practice of PHC at 30 years of SUS. They report facts/phenomena and experiences, interrelations established in the context of services and lives, which are intertwined in the function of caregivers and cared beings, expressing meanings about the daily practice in the SUS and the representativeness of the lack of resources in the System, showing that it is not able to solve all the population's health demands in time necessary to each one in its uniqueness and equity.

## FINAL CONSIDERATIONS

The reality experienced by the 82 PHC health professionals in three cities in Minas Gerais, Brazil, made it possible to understand the daily practice of professionals for three decades with SUS. The experience is characterized by (de)motivation, (de)valuation, work overload, poor infrastructure, difficulty in referring users to other levels of care, low resolution due to resources and little involvement of professionals in their practice, difficulty in effective co-responsibility, and impaired interrelations when users do not have their needs met. These factors interfere with professional practice, causing insecurity, anguish and moral suffering, which can impact the quality of care. On the other hand, the bond and interdisciplinarity provided a safe and quality care.

A limitation of the study is considered to not include managers as participants in the research. Reflecting on this theme is essential, since PHC, despite being considered a gateway to SUS, still cannot meet all the health needs of users who seek assistance, either to solve problems or to refer to them to other levels of attention. This reality, linked to precarious working conditions of professionals, causes insecurity for their performance.

However, changes must occur in this setting, for this, it is necessary to act in face of factors that interfere in this daily life, with the participation of all professionals involved in health care and management. This study may contribute to the reflection of professionals, managers and users on the relevance of proactivity in popular participation so that changes may occur in the face of PHC, enabling professionals more safety in their actions and improvement in the quality of health care to people, family members, and community.

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