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Access by workers of a territory to the services offered by the primary care unit

Acesso de trabalhadores de um território aos serviços ofertados pela unidade básica de saúde

Acceso de los trabajadores de un territorio a los servicios ofrecidos por la unidad de atención primaria

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ABSTRACT

Objective: to examine the conditions of outsourced workers' access to health activities carried out in the catchment territory of a primary care facility. **Method:** in this qualitative, descriptive study, after research ethics committee approval, data were collected in the second half of 2018 by semi-structured interviews of 15 workers, and analyzed within the theoretical-conceptual framework of thematic-category content analysis. **Results:** after analysis, two thematic categories emerged: barriers to health units' absorbing workers from the territory; and strategies for seeking out health services: private and emergency services as gateways. **Conclusion:** the participants were found to face major challenges in reaching the public health service (SUS) gateway, particularly due to health services' inability to provide care to individual workers in the health territory under their responsibility.

Descriptors: Primary Health Care; Health Services Accessibility; Occupational Health; Health Promotion.

RESUMO

Objetivo: analisar as condições do acesso de trabalhadores terceirizados às atividades de saúde realizadas em uma Unidade Básica de Saúde em seu território de abrangência. **Método:** estudo de natureza descritiva e qualitativa, com coleta de dados realizada por meio de entrevistas semi-estruturadas com 15 trabalhadores, no segundo semestre de 2018, após autorização do comitê de ética em pesquisa. A análise foi realizada a partir do referencial teórico-conceitual da análise de conteúdo temático-categorial. **Resultados:** após análise, emergiram duas categorias temáticas, a citar: Entraves na absorção de trabalhadores do território nas unidades básicas de saúde e Estratégias para a busca de serviços de saúde: serviços particulares e emergências como porta de entrada. **Conclusão:** percebeu-se que os participantes enfrentam grandes desafios para alcançar a porta de entrada do SUS, sobretudo, devido a inabilidade dos serviços de saúde no atendimento a indivíduos trabalhadores inseridos no território de responsabilidade sanitária.

Descritores: Atenção Primária à Saúde; Acesso aos Serviços de Saúde; Saúde do Trabalhador; Promoção da Saúde.

RESUMEN

Objetivo: analisar las condiciones de acceso de los trabajadores subcontratados a las actividades de salud realizadas en el territorio de captación de uma unidad de atención primaria. **Método:** en este estudio cualitativo, descriptivo, luego de la aprobación del comité de ética de la investigación, se recolectaron datos en el segundo semestre de 2018 mediante entrevistas semiestructuradas a 15 trabajadores, y se analizaron dentro del marco teórico-conceptual del análisis de contenido de categorías temáticas. **Resultados:** luego del análisis, surgieron dos categorías temáticas: barreras para que las unidades de salud absorban trabajadores del territorio; y estrategias de búsqueda de servicios de salud: servicios privados y de emergencia como pasarelas. **Conclusión:** se encontró que los participantes enfrentan grandes desafíos para llegar a la puerta de entrada del servicio público de salud (SUS), particularmente debido a la incapacidad de los servicios de salud para brindar atención a los trabajadores individuales en el territorio de la salud bajo su responsabilidad.

Descriptores: Atención Primaria de Salud; Accesibilidad a los Servicios de Salud; Salud Laboral; Promoción de la Salud.

INTRODUCTION

Primary Health Care (PHC) aims to promote a set of individual and collective health care actions to ensure health promotion, disease prevention, diagnosis, treatment, rehabilitation, reduction of harms, and health maintenance, with the purpose of developing comprehensive care to intervene in the individuals' health situation and autonomy and in the determinants and conditioning factors of collective health[1].

When analyzing the workers' access to this service, low adherence is verified, thus hindering the effectiveness of disease prevention and health promotion actions. Therefore, the Workers' Health National Policy was created to ensure their access to PHC actions[2]; the policy considers all the workers' safety needs and their right to health by means of comprehensive care, which makes surveillance actions increasingly more effective and reduces morbidity and mortality

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related to this environment. This policy also emphasizes that all Brazilian workers have the right to health, as provided in the Federal Constitution[3], indicating that, whether urban or rural, employed or unemployed, men or women, workers have the right to access health care services.

That said, the need is perceived to perform actions that promote integrality and workers' health surveillance (WHS), namely: identification of the work routine; analyses of the risks and vulnerabilities imposed by the work; survey of health care demands in a territory; and environment analysis, intervening when necessary[4].

Although being tangible actions that have a great impact on workers' health, the WHS practice is still permeated by hindering factors, such as the world of work itself, because long workdays and distance from the workers' place of residence prevent them to be followed up by their reference Basic Health Unit (BHU)[5].

It is noteworthy that difficulties are even more significant when it comes to outsourced workers, since they historically have employment contracts involving long workdays, low wages, and high rates of illnesses. This vulnerability was observed in all the sectors, especially in security, cleaning, and maintenance services[6].

In this sense, the general objective proposed is to analyze the access conditions of outsourced workers' to the health care activities conducted in a BHU within its coverage area.

The present study is believed to contribute to the improvement of the workers' access to the PHC services, as well as to discuss strategies specific for this population, improving the knowledge of the professionals and scholars, providing the necessary basis for the continuous evolution of the Unified Health System (*Sistema Único de Saúde*, SUS) and the application of its principles, allowing all workers to access the health care services.

METHOD

A qualitative, descriptive and non-experimental research study. Data collection was conducted with outsourced workers from a higher education institution in the state of Rio de Janeiro, Brazil. The total population consisted of 35 workers, but only 15 decided to participate in the research. It is noted that there was no sampling technique. The patients were selected by means of a non-probabilistic sampling method that uses reference chains, commonly known as “snowball”[7].

Data was collected by means of a semi-structured interview consisting of ten questions. The interviews were recorded on an MP3 recorder and later transcribed. The analysis of the interviews were conducted using theme/category-based content analysis, which includes the following stages: 1. Pre-analysis, 2. Exploration of the material; 3. Treatment of the results[8].

This research was submitted to Plataforma Brasil, with subsequent approval by a Research Ethics Committee, observing all the ethical criteria set forth in the current Brazilian legal provisions[9]. In this sense, it is noted that the data were collected and analyzed in the second semester of 2018, after approval of the project under opinion number 2,582,140.

RESULTS

Among the study participants, it was observed that 40% were general services and maintenance assistants, 40% worked in property security services, 13% worked as elevator operators, and 7% belonged to the technical-administrative staff. The most prevalent age group was from 35 to 44 years old, which accounted for 47% of the workers. In addition, 67% of the respondents were female, and only 40% had the highest schooling level found in the research, that is, complete high school education. Approximately 60% of the respondents reported not taking weekly days off due to the execution of other paid activities during the days off provided by the data collection institution.

It was observed that the workers had different shifts and working hours, depending on their position. It was identified that the security professionals work twelve-hour shifts followed by thirty-six hours off, which allows greater schedule flexibility for other activities, from medical consultations or leisure activities, as well as adding a second workday. The elevator operators worked six-hour a day in rotating shifts and, for that reason, when one of them needs to be absent for some reason, the on-duty professional must stay in the second workday. The professionals working in maintenance, cleaning, and secretary services are the most affected, because they work eight hours a day, including weekends, and thus find it more difficult to seek for any health monitoring service.

With regard to the presence of a BHU near their workplace, 87% of the respondents reported knowing the BHU located a few meters from the institution. However, only 20% reported frequenting a PHC unit, with all the answers

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aimed at the reference unit close to their homes. Of the total interviewees, 45% reported preferring to use the private health network, essentially due to difficulties in accessing the public health network.

Based on professionals' discourse, the analysis resulted in the construction of two thematic categories, namely: Obstacles in the integration of workers of the territory into the BHUs, and Strategies to seek health care services: private services and emergency services as gateways.

Obstacles in the integration of workers of the territory into de BHUs

This theme addresses the difficulties in establishing the legal principles of the provision of services for all the workers of the national territory. Therefore, the workers reported already been interested in registering in the BHU near they workplace; however, they were not registered because they did not live in the territory:

> *They request proof of residence, because if you don't live here but work here, there's great bureaucracy for them [...] I live in another city and work here, but if I'm working here, it would be much easier if I get care here, I wouldn't need to take time off from work, I could just leave work and be seen at the clinic (R4).*

It is also observed that, according to the participants, the political differences in the PHC structure and offer interfere with care:

> *It's a little difficult where I live, because there where I live there's no family clinic but a little center, but here where I work is closer, but they don't receive us (R12).*

In this sense, the actions of the BHU workplace territory are basically limited to vaccination campaigns:

> *I only go there to have a vaccine (R11). This here has nothing for us who work and near my house I only go to get medicines. Family clinics are only for that, to get medicines (R6).*

Another issue to be observed is work inflexibility, which prevents workers from seeking health monitoring services. Therefore, there is a deficit in the offer of activities for health care promotion and disease prevention. This is related to insecurity in the work environment and to the fear that work absences may become a problem in the worker's performance assessment.

> *Only when I'm not feeling well, not periodic (R2).*
>
> *I don't have the time, you know, because I'm not released from work, only in case of emergency (R11).*

The precariousness of the health services is another important point that has to mentioned as a discouraging factor of access to these services since, even with the possibility of resorting to a BCHU, many times the worker cannot receive care due to lack of professionals, to the large demand, or to lack of follow-up care.

> *I had a mammography scheduled three or four times, where they sent me the tomography scanners were broken, so I haven't done the mammography yet (R6).*

Strategies to seek health care services: private services and emergency services as gateways

The difficulties in accessing the PHC services have in impact on the search for alternative health care strategies. In this sense, the establishment of two main sources of health sources was observed: private services and emergency services. This category will discuss their impact from the workers' perspective.

The difficulty in accessing the PHC services keeps workers away from what would be their main gateway to the SUS, bringing them closer to the private health network, and encouraging them to search for it, As it is reported by the participants as being more flexible and resolute:

> *I've already had health insurance of the other company I worked in, but I had to cancel the situation [...] because it was becoming too expensive. If later we can return, we buy a family plan again (E15).*
>
> *If we have to say something, the private network is much better, but we can't, I can't afford a plan, so I have to stay in the family clinic, where I don't have time to go and rely on the SISREG which operates 24x7 (R13).*

It is important to emphasize that the harms to the worker's worsen in view of the lack of effective monitoring, because the person is in a situation of vulnerability, defined by the countless existing occupational risks, previous and current diseases, risk factors external to the work environment, absence of WHS services, and limited integration of the health services.

Thus, the ideal situation would be the implementation of activities based on health promotion, but it is not the reality:

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> *I haven't seen a doctor for more than three years, only when I'm dying, feeling sick, then I have to go, there's no way (R4).*

It can be inferred that workers are unable to access the BHU services, meaning that the care they need will be provided only as a last resort, in case of disease worsening:

> *It's easier to pay an emergency and even so it takes a little while, but we're treated better than in the public system (R13).*

Prioritizing the emergency services as the core component of health care interferes directly in the work routine, often hindering workers to continue performing certain activities in the workplace and affecting the entire work system:

> *The problem with my foot, I already wasn't able to put my foot on the floor, then I had no way to go, but fortunately everybody here knows I have this problem and when I can't really work, I don't come (R6).*

It is observed that the workers perceive that this is not the ideal way to enter the health service, but time incompatibility signals it as the only alternative:

> *Because I work non-stop, I generally forget, I don't find time to got to the doctor, I only remember when I'm dying, then I go to the emergency (R4).*
>
> *I think it's better to go to the family clinic than to go to the emergency, because sometimes you go there and don't find a solution and there in the clinic, they assist you and, if I have something serious they refer you to a hospital. The problem is getting care (R10).*

DISCUSSION

PHC is responsible for providing health care to the users, by means of individual and collective health actions and, despite contributing to improving the individuals' accessibility, the disproportion between offer, service capacity, and demand is observed. In addition to that, factors such as access, booking of appointments, excessive demand and long waiting time, satisfaction level of the suer, bond, lack of articulation in integrated networks, and actions based on the hegemonic biomedical model are reported as limitating factors for the good functioning and use of the network[10-11].

Integrality defends the user' right to access the health services in all levels of care, in addition to referring to the articulation between disease prevention, health promotion and assistance, considering the individuals' objective and subjective demands in their social context[12-13]. Moreover, the FHS, in addition to enabling universal and continuous access to high-quality and resolute health services, must welcome the users. It is based on the principle that the BHU must receive and listen to all the individuals who seek its services[1,14]. However, the principles of integrality, universality, and welcoming are faced with the argument that the FHS operates based on defined geographical areas, that is, each BHU is attached to a certain population and does not provide care beyond this population. Nonetheless, it is reiterated that the coverage area of the FHS is not only “depositary of the population attributes; it would also be the place of responsibility and of shared action”[15].

Thus, a large obstacle is observed; on the one hand, workers are not accessing the network as they should, since public policies ensure access to all levels of health services, regardless of the territory where the individuals live[2] but, on the other hand, lack of knowledge about the right to universal, equanimous, and comprehensive access to health hinders claims to these services[16].

Notwithstanding the rights to health, it is necessary to highlight that the PHC, especially the FHS, is responsible for organizing the sanitary territory whose service offer must be compatible with the users' needs, in terms of the demands for health promotion actions, disease prevention, and healing activities[1]. However, few initiatives have been implemented for the provision of care to individuals outside their territory of residence, even it this is the place where they spend most of their day. In this sense, it is observed that only the notifications of work-related harms (work accidents and occupational diseases) are often the only actions aimed at workers' health in PHC[17].

To meet the needs arising from this care deficit, the workers primary seek care in emergency units. This is a trend seen throughout the national territory; however, it is observed that the majority of these services is classified as outpatient care, that is, they could be provided in PHC itself[18-19].

With regard to the search for the private sector, this is mostly motivated by delays in the public service, whether in terms of waiting time of of demand resolution. The historical line of the SUS indicates that the number of physicians working in PHC had a four-fold increase over the last 30 years; however, this number is still incompatible with the population needs[20]. Hence, the SUS has been consolidated as a public system that coexists with a solid supplementary and complementary private health system[21].

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Nevertheless, it is noted that the profound economic and budgetary recession within the SUS, felt in recent years in all the health areas and, in PCH with absence of supplies, professionals, and medications, culminating in reduced teams and increased workload of the acting professionals[22].

In this sense, the growth can be perceived of the private sector in the search for health actions, which are often inserted in the public context in a predatory and almost imperceptible manner[23]. In addition to that, people strongly tend to associate the public free health service to ineffective actions, generally based on situations of scrapping or deficient public management of resources[24].

Access to health is not restricted only to using the services, since it concomitantly includes the use of quality services that are timely provided and that resolutely meet the population demands[25].

When disease prevention and health promotion are assumed in their real role, they positively interfere in the users' reality, since they prevent worsening of health damages[26], even when the notification services are used, as well as those employed by the WHS, epidemiological surveillance, among others. These surveillance services can assertively direct strategies to welcome and assist these users, understanding that the work environment is an important factor that will influence the way in which those workers are going care for themselves.

It is worth stressing that the differentiated view of the health teams, together with the elaboration of strategies that enable better care provision in the sanitary territory, is still a challenge, which hinders the ability to improve prevention, promotion, and notification, directly interfering in the understanding of the work routines. It is necessary to develop strategies and interventions that generate changes in the factors which are detrimental to the workers, thus reducing their vulnerability[16].

Regarding the issue of work as a hindrance for access to the health services, it is perceived that the employers propose few actions to overcome these barriers, such as flexibilization of working hours, scheduling of days off according to the worker's demand, and implementation of health promotion activities in the work environment. It is important for employers to understand that promoting health and preventing diseases in the workers result in collective well-being, which has a positive repercussion on the productivity and the development of the company[26].

CONCLUSION

It was observed that the participants face significant challenges to reach the entrance gateway of the SUS, especially due to the inability of the health services to assist workers inserted within a given sanitary territory.

These difficulties lead to the use of alternative strategies to overcome the lack of PHC services. The first strategy is seeking private health services, which generate financial repercussions for the workers. In addition to that, the workers also seek health services only in cases of emergency, a strategy that culminates in discontinuities in the integrality of care and in the worsening of conditions that could be controlled with health promotion actions.

PHC must manage the health networks in an articulate manner, considering the policies and guidelines that were implemented to reach the entire population, including the workers. In this sense, a transformation of the work process is necessary, directing care to the original focus of the FHS based on the sanitary responsibility over the territory.

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