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Population perception of the Unified Health System services

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ABSTRACT

OBJECTIVE

To assess the perception among users served by an outreach project regarding SUS's field of action.

METHODOLOGY

A cross-sectional study was conducted using a questionnaire that included socioeconomic determinants and services that are or are not part of SUS. A quartile method was subsequently applied to analyze levels of public knowledge.

RESULTS

There is low public knowledge regarding health surveillance, which hinders its development and funding. There is greater understanding of healthcare services across the three levels of complexity, with primary care being more prominent. Management is moderately understood but faces regional and bureaucratic barriers. The National Health Education and Popular Education in Health policies are crucial to improving public knowledge and encouraging active participation in the management of their health.

CONCLUSION

There is an unequal understanding of SUS services, with areas such as surveillance and management being less recognized, affecting their development and funding, while the focus remains more on healthcare services. Strengthening health education policies could help increase public knowledge about their rights and available services.

DESCRIPTORS

Unified Health System, Health services, Perception, User.

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INTRODUCTION

The Unified Health System (SUS) is one of the largest and most complex public health systems in the world, serving over 190 million people, of whom 80% rely exclusively on public services[1]. Following the promulgation of the Federal Constitution in 1988 and the establishment of Article 196, ensuring universal health coverage for all Brazilians became a responsibility of the State[2].

This initiative was implemented in 1990 with the law 8,080, known as the Organic Health Law, which regulated healthcare service actions nationwide, establishing SUS's doctrinal and organizational principles[3]. The doctrinal principles include universality, equity, and comprehensiveness, while the organizational principles are regionalization and hierarchy, decentralization, and social participation[4].

The Law 8,080, Chapter I, Article 5, defines three objectives: identifying and disseminating health determinants and conditioning factors; formulating policies aimed at reducing health risks and ensuring universal and equitable access to health actions and services[2]. Article 6 specifies the attributions, in other words, the actions that constitute SUS's scope of activities. Among these are implementing actions related to surveillance, management, and healthcare delivery[2].

Surveillance in SUS is divided into areas such as sanitary, epidemiological, environmental, and occupational health surveillance. Sanitary surveillance aims to eliminate, reduce, and prevent health risks through interventions addressing sanitary issues related to the environment, production, circulation of goods, and provision of services that may impact collective and individual health, monitoring from production to final consumption. Epidemiological surveillance monitors health determinants and implements disease prevention and control measures. Environmental surveillance monitors and identifies changes in various environmental factors that may affect human health and environmental balance. Occupational health surveillance focuses on promoting safe and healthy work environments[2].

Following the parameters of the World Health Organization and to uphold SUS's principles, healthcare services have been organized into three levels of care: primary, secondary, and tertiary[5]. Primary care, capable of addressing most health problems, serves as the preferred entry point for SUS users. Secondary care provides medium-complexity services and medical specialties, such as in Emergency Care Units, Mobile Emergency Care Services, polyclinics, and smaller hospitals. Lastly, tertiary care involves high-complexity procedures carried out by University Hospitals and research and teaching units[5].

Health management encompasses practices aimed at planning, organizing, coordinating, and evaluating actions and services to ensure access to healthcare principles. It is responsible for integrating the different levels of care, coordinating public policies, and efficiently allocating resources[6,7]. Furthermore, it has evolved through the adoption of participatory models, such as communicative strategic planning, which promotes dialogue between professionals and the population, resulting in more inclusive decisions centered on community needs[6,8].

Although its importance is widely recognized, public perception of SUS is not always positive, with complaints of long lines and waiting times being common9. In a 2014 survey conducted by Datafolha in collaboration with the Federal Council of Medicine and the São Paulo Medical Association, 92% of respondents rated healthcare in Brazil between 0 and 7, with 60% assigning scores between 0 and 4. For SUS specifically, 87% rated it between 0 and 7, with 54% giving scores between 0 and 4 on a scale of 0 to 10[7]. Evaluating users perceptions of SUS is essential given its crucial role in public health and the satisfaction challenges reported. This study aims to assess the perceptions of users served by an extension project regarding SUS's scope of action[7].

METHODS

This cross-sectional study was conducted as part of the activities of the extension project "Hospital a Céu Aberto" promoted by the International Federation of Medical Students Association (IFMSA) Brazil, under the committee of the Santo Amaro Medical University (UNISA). The event took place at the Social Service of Commerce (SESC) Interlagos unit, with participation from various academic leagues. The study was approved by the Research Ethics Committee (CEP) under protocol number 6.754.133.

The study participants signed the Commitment and Confidentiality Agreement as well as the Free and Informed Consent Form, in compliance with the December 12, 2012 resolution of the National Health Council. Only individuals aged 18 years or older were included. There were no direct benefits to the participants.

Data collection was performed using a printed questionnaire administered after the consultation. The following personal information was requested: age, gender, educational level, income range, residential neighborhood, and whether they used private healthcare, the public healthcare system, or both. Participants were also asked to indicate which healthcare services they believed were part of SUS. These items were selected based on Article 6, Chapter I of Law 8,080, ensuring the inclusion of at least one activity related to surveillance, healthcare, and health management in the questionnaire. Additionally, items not associated with SUS, such as filing a police report, cosmetic Botox applications, and dental veneer procedures, were included.

Following data collection, analysis was conducted using the Quartile Methodology, which categorized frequencies into four equally distributed intervals to identify patterns of clustering. Initially, the data were organized in ascending order, with the least selected item accounting for 4.44% and the most selected item accounting for 86.67%. The 25th, 50th, and 75th percentiles were then calculated. The first quartile (Q1), with a value of 26.7%, indicates that 25% of the data fall below this point. The second quartile (Q2), at 44.15%, separates the lower 50% from the upper 50%. The third quartile (Q3), at 69.275%, indicates that 75% of the data fall below this percentage.

From that, items were classified into four groups: Q1 as low knowledge level (4.44% - 26.7%), Q2 as medium-low knowledge level (26.7% - 44.15%), Q3 as medium-high knowledge level (44.15% - 69.27%), and Q4 as high knowledge level, with percentages ranging from 69.27% to 86.67%.

The other determinants were analyzed together for a better understanding of the respondents' profile.

RESULTS AND DISCUSSION

A total of 167 valid responses were collected at the event. The items from the questionnaire (Table 1) were categorized into the areas of surveillance, healthcare attention, and management, and subsequently linked to variables related to socioeconomic profile. Finally, the population's perceptions described were associated with the public health education policies of SUS.

Table 1 - Questionnaire Items by Category, Percentage, and Quartile.

Questionnaire Questions	Questionnaire Categories	% of responses	Quartile
Provision of Basic Medications	Attention	86,67%	4
Medical Consultation	Attention	85,00%	4
Human Vaccination	Attention	84,44%	4
Prenatal Care	Attention	83,89%	4
Psychologist Services	Attention	83,33%	4
Community Health Agent Services	Attention	83,33%	4
Social Worker Services	Attention	81,67%	4
Surgical Procedures	Attention	81,11%	4
Physiotherapy	Attention	80,56%	4
Speech Therapy	Attention	75,00%	4
Blood Transfusion	Attention	73,33%	4
Human Milk Bank	Attention	73,33%	4
Chemotherapy	Attention	72,78%	4
Organ Transplantation	Attention	69,44%	4
Comprehensive Assistance for Autistic Individuals	Attention	68,89%	3
Nutritional Interventions	Attention	66,11%	3
Insertion of Copper IUD	Attention	65,56%	3
Care for Vulnerable Populations	Attention	62,78%	3
Home Care Services	Attention	61,67%	3
Auditory, Physical, and Visual Rehabilitation	Attention	61,11%	3
Provision of Prostheses and Walkers	Attention	57,22%	3
HIV Pre-Exposure Prophylaxis (PrEP)	Attention	57,22%	3
Reporting of Violence Against Women	Attention	54,44%	3
Legal Abortion	Attention	38,89%	2
Breast Implant Following Mastectomy	Attention	37,22%	2
Gender-Affirming Surgery	Attention	22,22%	1
Family Constellation Therapy	Attention	20,00%	1
Yoga and Meditation	Attention	18,89%	1
In Vitro Fertilization (IVF)	Attention	11,11%	1
High-Cost Medications	Management	66,11%	3
Promotion of Scientific Development	Management	31,11%	2
Quality Control of Medications	Surveillance	57,22%	3
Basic Sanitation Initiatives	Surveillance	45,00%	3
Monitoring of Water and Food Safety	Surveillance	43,33%	2
Health Risk Elimination for Workers	Surveillance	37,22%	2
Maternal Death Investigations	Surveillance	36,11%	2
Accident Information Dissemination	Surveillance	33,33%	2
Assessment of Human Exposure to Chemical Contaminants	Surveillance	32,78%	2
Environmental Protection	Surveillance	31,11%	2
Blood Policy Formulation	Surveillance	31,11%	2
Sanitary Control of Borders, Ports, and Airports	Surveillance	28,33%	2
Risk Management for Natural Disasters	Surveillance	26,67%	1
Inspection of Radioactive Products	Surveillance	25,00%	1
Workplace Environment Protection	Surveillance	23,33%	1
Cosmetics Monitoring	Surveillance	10,56%	1
Animal Sterilization Procedures	Not Applicable	29,44%	2
All Animal Vaccinations	Not Applicable	26,67%	1
Filing of Police Reports	Not Applicable	22,22%	1
Preventive Detention	Not Applicable	15,00%	1
Dental Veneers	Not Applicable	10,56%	1
Surrogacy	Not Applicable	7,22%	1
Botox for Aesthetic Purposes	Not Applicable	6,11%	1
Tattoo Removal	Not Applicable	4,44%	1

Source: Prepared by authors (2024)

Surveillance

The analysis revealed that the public has a relatively low level of knowledge regarding health surveillance within SUS[11]. While 4 items were classified as Q1 and 8 as Q2, no items were rated as Q4, and only two (basic sanitation actions and medication quality control) were classified as Q3.

This limited public knowledge negatively impacts the development and financing of the sector. Although health surveillance has expanded its scope and enhanced its forecasting and intervention capabilities, this expansion has not been accompanied by a corresponding public understanding. As a result, this lack of awareness has led to the undervaluation of the sector, the creation of inequalities in the incorporation and decentralization of technologies between healthcare services and surveillance, and the development of a gap in strengthening the SUS's capacities in key areas such as health promotion, disease control, and responses to public health emergencies[12].

The increasing demand for medium and high-complexity services disproportionately redirects resources, undermining surveillance efforts and perpetuating the cycle of underfunding and structural fragility[12].

Healthcare Attention

Among the 53 items in the questionnaire, 29 pertain to healthcare attention across the three levels of complexity. Of these, 14 were classified as Q4, 9 as Q3, 2 as Q2, and 4 as Q1. It is noteworthy that 79.3% of the items were rated as Q3 and Q4, while only 13.7% were categorized as Q1, indicating that this sector represents an area of the SUS with a high level of

public knowledge among the population surveyed[13].

Among the analyzed items (Table 2), 21 pertain to primary healthcare, two to secondary healthcare, and six to tertiary healthcare. This distribution suggests that knowledge was relatively homogeneous across the three levels of healthcare attention within the SUS, with no significant factor found to influence knowledge about the availability of public health services[13].

It is essential that users have adequate knowledge of the services offered in order to utilize them comprehensively and appropriately, based on individual needs[18].

Table 2 - Healthcare Attention Items Classified by Level of Care and Quartile.

Health Attention Questionnaire Questions	Levels of Health Care	Level of Knowledge
Auditory, Physical, and Visual Rehabilitation	Primary	Medium-high
Family Constellation Therapy	Primary	Low
Provision of Prostheses and Walkers	Primary	Medium-high
Provision of Basic Medications	Primary	High
Care for Vulnerable Populations	Primary	Medium-high
Nutritional Interventions	Primary	Medium-high
Insertion of Copper IUD	Primary	Medium-high
Yoga and Meditation	Primary	Low
Prenatal Care	Primary	High
Human Vaccination	Primary	High
Psychologist Services	Primary	High
Home Care Services	Primary	Medium-high
Speech Therapy	Primary	High
HIV Pre-Exposure Prophylaxis (PrEP)	Primary	Medium-high
Human Milk Bank	Primary	High
Comprehensive Assistance for Autistic Individuals	Primary	Medium-high
Social Worker Services	Primary	High
Medical Consultation	Primary	High
Reporting of Violence Against Women	Primary	Medium-high
Physiotherapy	Primary	High
Community Health Agent Services	Primary	High
Blood Transfusion	Secondary	High
Legal Abortion	Secondary	Medium-Low
In Vitro Fertilization (IVF)	Tertiary	Low
Breast Implant Following Mastectomy	Tertiary	Medium-Low
Chemotherapy	Tertiary	High
Gender-Affirming Surgery	Tertiary	Low
Organ Transplantation	Tertiary	High
Surgical Procedures	Tertiary	High

Source: Prepared by authors (2024)

Management

The questionnaire includes two items related to management: the provision of high-cost medications and the promotion of scientific development.

The first item received a Q3 classification, primarily due to the more developed regions, such as the South and Southeast, having greater access to these medications, whereas less advantaged areas face more significant challenges[19]. Despite the guaranteed access provided by law, bureaucratic barriers and regional inequalities contribute to this outcome[20]. The second item was classified as Q2 and highlights the role of programs such as the Research Program for SUS, which funded more than 3,700 scientific studies with an investment of R$343 million, thereby strengthening scientific research and combating misinformation[21,22,23].

Socioeconomic Profile

The study has a limitation related to the target population and the data collection site, as the findings indicate that most participants have low to moderate income, likely influenced by the free nature of services and the location in a socioeconomically disadvantaged neighborhood. A predominance of a young population is also observed, with 85.9% of participants aged between 18 and 49 years.

An analysis of educational background and gender showed a predominance of female participants. There were no illiterate respondents. Only women reported being able to read and write. Among those with completed primary education, there were 39 women and 16 men, and with incomplete primary education, 11 women and 4 men. The majority of participants had completed higher education (40 women and 21 men), while 25 women and 13 men had incomplete higher

education. These data indicate greater female participation in higher educational levels.

National Health Education Policies

Two national policies may play a significant role in improving the understanding of these findings in Brazil. Ordinance GM/MS No. 1,996, dated August 20, 2007, established the National Policy on Health Education, aimed at integrating education, healthcare, and management within the SUS, promoting improvements in the quality and humanization of the system[24]. The 2013 National Policy on Popular Education in Health, within the framework SUS, aims to enhance popular participation and strengthen participatory management, fostering closer connections between managers, healthcare professionals, and the population, based on shared knowledge and the construction of a democratic and popular project[25].

These policies are directly related to the study's results, which revealed that many participants did not correctly identify the services offered by SUS. For instance, animal castration was frequently mentioned, despite it not being a service provided by SUS, highlighting the need for a broader public understanding of the system[18].

In order for the population to actively engage and benefit from SUS, it is essential that they understand the available services as well as their rights and responsibilities within the public health system. The National Policy on Health Education plays a crucial role by training community agents to disseminate accurate information tailored to the population's needs, thus strengthening individuals' autonomy in making health-related decisions.

The Popular Education in Health policy, in turn, fosters an exchange of knowledge between professionals and the community, valuing local cultural practices, which encourages more active community involvement in managing their health[26,27].

Additionally, the guidelines of the National Policy on Permanent Health Education could promote the creation of projects that bridge the management of health services with the population's needs, disseminating lesser-known services such as yoga and meditation, which were classified as Q1 in the study, and implemented through the National Policy on Integrative and Complementary Practices[28].

CONCLUSION

This study revealed an unequal understanding among the population regarding the services offered by SUS. Although there is a good understanding of healthcare, particularly concerning the three levels of care complexity, areas such as sanitary and epidemiological surveillance remain poorly understood, which compromises the development and funding of these activities. Limited knowledge about these services and their management can contribute to the perpetuation of regional inequalities and difficulties in accessing high-cost technologies and medications.

Moreover, the study highlighted socioeconomic and regional disparities in accessing healthcare services, with greater female participation and a predominance of individuals with varying levels of education. To address these gaps and promote more active public participation in SUS, strengthening health education policies is essential. Initiatives such as the National Policy on Popular Health Education aim to empower citizens, raise awareness of their rights and available services, and consequently improve system management and access.

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