


Access to health services for people with disabilities: the perspective of primary health care providers and managers¹


O acesso das pessoas com deficiência aos serviços de saúde: a percepção de profissionais e gestores da atenção primária à saúde

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Abstract

This study describes findings from a case study conducted on access to healthcare for people with disabilities based on the perspective of primary care unit professionals and managers in three Brazilian municipalities, considering the dimensions of Availability and Accommodation and Appropriateness. A total of 16 primary care unit healthcare providers and managers were interviewed in Brasília - Federal District, Arcoverde - Pernambuco, and Santos - São Paulo. The Availability and Accommodation dimension showed architectural and urban barriers, lack of healthcare services, geographical concentration of infrastructure, and difficulty coordinating care. The Appropriateness dimension evinced a lack of healthcare provider training, which contributes to communication barriers between healthcare providers and people with disabilities. Interviewees also pointed to a fragile link between the health services that make up the care network. On the other hand, participants deemed professionals' attitude and the bond built with people with disabilities as facilitators to accessing care. It was expected that the more developed areas within Brazil would have less barriers to access. However, this study showed challenges to accessing health in all settings, including the richest region of Brazil, its poorest region (the Northeast), and its capital.

Keywords: Disabled Persons, Health Services Accessibility, Primary Health Care.

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Resumo

Este artigo aborda o acesso das pessoas com deficiência às ações e serviços de saúde a partir da percepção de profissionais e gestores de unidades de atenção primária de três cidades do país, considerando as dimensões “Disponibilidade e acomodação” e “Adequação”. Trata-se de um estudo de caso, que entrevistou 16 profissionais e gestores de unidades de atenção primária nas cidades de Brasília (DF), Arcoverde (PE) e Santos (SP). Na dimensão da Disponibilidade e acomodação, observaram-se barreiras arquitetônicas e urbanísticas, escassez na oferta de serviços, concentração geográfica dos equipamentos sociais e dificuldade de coordenação do cuidado. Na dimensão Adequação, percebeu-se uma ausência institucional de formação, o que contribui para dificuldade de interlocução entre os profissionais de saúde e as pessoas com deficiência. Além disso, os entrevistados apontam para a fragilidade na comunicação entre os serviços de saúde que compõem a rede de atenção. Por outro lado, a postura dos profissionais e o vínculo construído com as pessoas com deficiência se apresentaram como facilitadores do acesso. Esperava-se que os espaços mais desenvolvidos apresentassem mais possibilidades de acesso, mas seja na capital do país, na região mais rica do Brasil ou no sertão nordestino, essa é ainda uma luta que precisa resistir.

Palavras-chave: Pessoas com Deficiência; Acesso a Serviços de Saúde; Atenção Primária à Saúde.

Introduction

The preface to the World Report on Disability, published by the World Health Organization in 2011, found that more than one billion people lived with some kind of disability, of which 200 million showed considerable functional difficulties (WHO, 2011). Data from the latest National Health Survey, conducted by the Brazilian Institute of Geography and Statistics, found that 8.4% of its population in 2019 had a disability related to at least one of their functions (IBGE, 2021).

Historical moments, political scenarios, and theoretical disputes have always influenced the understanding of what configures disability. Historically, the biomedical and social models have prevailed (Borges, 2018). According to Diniz (2007), the biomedical concept deems disability as exclusively related to disease. Pereira and Barbosa (2016) state that the social model—adopted in this study—deems disability as a socio-historical product, the result of interactions between a diverse body and a society that is unprepared for diversity.

For Shakespeare and Watson (2001, p. 19), disability constitutes a complex and variable postmodern concept situated at the intersection of biology and society, agency and structure. “Disability cannot be reduced to a singular identity: it is a multiplicity, a plurality.” (Shakespeare; Watson, 2001, p. 19).

These concepts strongly influence the way in which the state responds to the diverse health needs of people with disabilities. According to Othero and Ayres (2012), such needs have nuclei that are specifically related to health as well as other nuclei consisting of rights, citizenship, education, transportation, and leisure, which require intersectoral interventions.

In public health, aid to people with disabilities was limited to specific preventions and rehabilitations attributed to philanthropy and charity (Othero; Dalmaso, 2009). It neglected the health of people with disabilities and had no connection with the principles of the Brazilian Unified Health System (Campos; Souza; Mendes, 2015). Militant movements and the influence of international norms on the rights of people with disabilities managed to insert the needs of these individuals into the Brazilian legal framework as an object of public health policies (Dubow; Garcia; Krug, 2018).

The presidency of the republic launched the *Viver Sem Limite: Plano Nacional de Direitos da Pessoa com Deficiência* (Living Without Limits: National Plan on the Rights of Persons with Disabilities) as a government priority in 2011. It involved over 15 ministerial portfolios and had planned investments, up to 2014, of around R\$ 14 billion in actions divided into priority axes. In 2012, Brazil created the *Rede de Cuidados à Saúde da Pessoa com Deficiência* (Health Care Network for People with Disabilities) as a priority health network (Campos; Souza; Mendes, 2015), instituting the *Plano Nacional dos Direitos da Pessoa com Deficiência - Novo Viver sem Limite* (National Plan on the Rights of Persons with Disabilities - New Living without Limits) in November 2023.

Strong evidence worldwide suggests that people with disabilities face difficulties accessing health services (as does the scarce data regarding Brazil). For example, the Brazilian National Health Survey found people with disabilities have poor access to rehabilitation services (IBGE, 2014). The potential challenges they face in accessing health care include discrimination, physical inaccessibility, and information inaccessibility and unavailability (WHO, 2011).

Cunha et al. (2022) showed that the political framework in Brazil supports the inclusion of people with disabilities in health but fails to ensure this right. For the authors, the health system and factors such as poverty, behavior, and transportation determine access to these health actions and services.

Access to healthcare constitutes a polysemic concept. According to Travassos and Martins (2004), despite lacking a consensus on its definition, the literature shows the distinct and similar aspects between understandings. Still, most concepts refer to the provision of health services, relate to the impact produced on the health of the population, and depend on the adequacy of the provided services.

The concept of access this study adopted follows Levesque, Harris, and Russell (2013) and includes the entire path people take to obtain health care, from the perception of care must the intensity of the received services. This study analyzed this concept based on five dimensions related to services (approachability, acceptability, availability and accommodation, affordability, and appropriateness)

and five capacities related to individuals (to perceive, to seek, to reach, to pay, and to engage).

This study addresses the access of people with disabilities to health actions and services based on the perspective of primary care unit professionals and managers in three municipalities in the country, considering the dimensions “Availability and accommodation” and “Appropriateness.” It is based on the assumption that, although the Care Network for People with Disabilities has been implemented since 2012, its implementation is still fragile, with primary care facing barriers related to the structure, supply, and adequacy of services, regardless of location.

Methodology

An exploratory, qualitative case study was carried out to analyze the factors that promote or hinder the access of people with disabilities to health services based on the perception of primary care unit professionals and managers in three Brazilian municipalities.

A case study can be used when the object of study refers to a contemporary phenomenon in a natural context, a strategy to broaden the understanding of complex social phenomena (Yin, 2005).

The analysis of the perception of healthcare providers constitutes an important tool to better understand the practice and outcome of the care provided to the various populations that seek care in the Brazilian Unified Health System. Knowledge on how professionals perceive disability, care needs, and diversity of this group importantly highlights communication and the information issues and barriers in access for people with disabilities that can affect or promote disparities in the way people with disabilities experience health services (Iezzoni et al., 2021). The understanding of care providers regarding disability is a key element for access and quality of the offered service (Duckworth, 1988). Thus, to guarantee access we must address the representations of providers that generally tend to reflect the structural ableism within our society (Antonak; Livneh, 2000).

Semi-structured interviews were conducted addressing the capacities of the health system in being close and accessible to users and offering the necessary care in a flexible and appropriate

way according to the types and natures of needs (including barriers and facilitators) and perspectives on disability, the health needs of people with disabilities, and the regular functioning of services.

An intentional and heterogeneous sample was carried out with 16 primary health care unit professionals and managers in Brasília (Federal District), Arcoverde (state of Pernambuco), and Santos (state of São Paulo). In July 2022, Brasília had 3,094,325 inhabitants and a 60.95% primary care coverage, with 596 family health teams, Arcoverde had 75,295 inhabitants and 25 family health teams, serving all its population, and Santos had 37 family health teams, serving only 30.76% of its 433,991 inhabitants (Brasil, 2023).

We opted for a comparative analysis between different primary health care (PHC) contexts to verify to what extent the similarities and differences in the context would affect the perception of professionals. At the time of the research, the territories had a minimally constituted care network, including basic health units and family health support centers.

The interviews, conducted from May to November 2021, were recorded and transcribed, lasting an average of 40 to 60 minutes. Some were held in-person, obeying all safety protocols required due to the COVID-19 pandemic. Other interviews were conducted virtually on Google Meet. Authorization for them were obtained from subjects by an informed consent form.

The content of the interviews was analyzed by meaning condensation (Kvale, 1996), i.e., reading the transcripts, finding natural units, defining central themes and, finally, organizing theme descriptions according to the analyzed dimensions.

In total, two of Levesque, Harris, and Russell's (2013) access dimensions were defined as categories of analysis: "Availability and Accommodation" and "Appropriateness." The first one is related to the physical existence of health resources with sufficient capacity to produce services and the second, to what services are provided and how they are provided to evaluate their integrated and continuous nature.

This study belongs to the research "*Fortalecendo a inclusão de pessoas com deficiência no Sistema de Saúde no Brasil: explorando o acesso das pessoas com deficiência aos serviços de saúde em*

Pernambuco" (Strengthening the inclusion of people with disabilities in the Health System in Brazil: exploring the access of people with disabilities to health services in Pernambuco), developed by Instituto Aggeu Magalhães - Fundação Fiocruz/Pernambuco, Universidade Federal de Pernambuco (UFPE), Fiocruz Brasília, Universidade de São Paulo, and the London School of Hygiene and Tropical Medicine, with funding from the Medical Research Council, submitted and approved by the Human Research Ethics Committees of Recife, Brasília, Federal District, and São Paulo (CAAE 25888219.3.0000.5190, 26432619.5.1001.8027, and 26306519.4.0000.0065, respectively).

Results and discussion

This study describes the agreements and disagreements in the interviewees' narratives based on two analytical dimensions: Availability and Accommodation and Appropriateness.

Availability and accommodation

Levesque, Harris and Russel (2013) consider that the Availability and Accommodation dimension is related to the physical existence of health resources, the most important aspects of which include their material presence and their capacity to produce services. The dimension involves aspects such as the characteristics of facilities (geographical accessibility) and urban (decentralization and transport system) and individual contexts (working hour flexibility and length).

Most interviewees agree on the need for organizing access to health units to adapt their physical structure, pointing out that only the recently built units ensure access to people with disabilities. They also reported the lack of investment in urban structures that ensure this access, a barrier that reduces the ability of users to reach health units.

[...] Things aren't made to welcome you, starting at the entrance door, at the reception. (For example) Sometimes, when a person arrives on a wheelchair or has difficulty moving, walks on crutches or something like that, we have to remove all the

furniture so they can enter the doctor's office or our first aid room [...] Sometimes we even tend to these people in their car. (E1 - Brasília, DF)

[...] The newer units have a better structure. The older units leave something to be desired, which sometimes makes it difficult for people to get to the service. [...] The newer units have access ramps, but the older ones don't. (E1 - Arcoverde)

Although the Family Health Strategy has been promoted as a tool to reorient the care model in country and as a main space to materialize primary health care, the structure of many units still faces challenges regarding accessibility and their capacity of offering comprehensive care without barriers, which compromise first access by interfering with the role units play as a preferential gateway to health services people with disabilities must access to meet their needs.

Nicolau, Schraiber, and Ayres (2013) found that physical street access, transportation, and the structure of primary care units represent important barriers to the access of people with disabilities to health actions and services. Castro et al. (2022) point to the need to direct efforts toward improving the accessibility of primary health care facilities. Addressing these architectural and urbanistic barriers represents the possibility of offering effective access to people with disabilities.

An adequate structure to meet health needs must also sufficiently supply actions and services, the scarcity of which results in a barrier to access. Its insufficiency is expressed in longer waiting for health care.

I think it has a lot to do with the services not being able to meet, absorb all the demand, which ends up generating a delay in the supply of services. That is when you'll always have to wait for longer. (E2 - Santos)

We have equipment, including to assess the disabled in their most varied types of needs, we have new equipment [...] If I'm not mistaken, it opened about two years ago and it is already practically exhausted. I mean, there was no such service in a

peripheral region like this. When this service was installed, it was a necessity and after two years it is already clear that there is a situation of absolute..., it works in full capacity. We already have a waiting list for the services. (E6 - Santos)

It is necessary to assess the needs and program a supply with sufficient installed capacity to meet the diverse and complex demands of people with disabilities requiring continuous care. Souza et al (2014) found, among the obstacles health system users face, the insufficient provision of specialized consultations and exams, the long interval for specialized care, and the absence of communication between services at different levels of care. Clemente et al. (2022) also showed that the barriers to access for people with disabilities include the scarce supply of services.

This offer must consider the singularities that permeate the health needs of people with disabilities; equity must be included when planning the services offered. Studying the implementation and constraints of the Care Network for People with Disabilities in a health region in the state of São Paulo, Mota and Bousquat (2023) found that health needs failed to guide the organization of the structure of rehabilitation services, except for its specialized rehabilitation center. The authors pointed out important challenges to ensure the right to health, recognizing that these barriers crystallize the inequalities experienced by people with disabilities.

All studied municipalities evinced the difficulty of access to specialized services either due to the low supply (with longer waiting times) or the geographic location (concentration in a certain geographic area), implying a greater need for financial expenses with transportation and longer travel time.

MensSana doesn't serve just Arcoverde. It also serves some cities in the region. So, the difficulty has really to do with scheduling when the patient arrives at MensSana because it is a specialized service with a speech therapist, an occupational therapist... So, the difficulty is scheduling. (E2 - Arcoverde)

The continuous need for specialized services sometimes consists of the main loci of care for people with disabilities due to their multiple and complex

demands, which can compromise the principle of equity, especially under the absence of actions and services for more vulnerable populations that need it most. Castro et al. (2021) found that the insufficient supply of actions and services materializes itself in long waiting lines in the daily life of the health system, representing an important barrier to access to care.

To improve access to and quality of care, interviewees believe that primary care should make professionals available to ensure timely care, reporting that PHC has no governance over the scheduling system, evincing difficulties scheduling specialized care beyond primary care units, which ultimately lies under users' responsibility.

[...] Since they are family doctors, they need the network support with specialties [...] to be able to have a greater knowledge of how to provide care since they have trouble going to these institutions [...]. (E3 - Brasília, DF)

[...] we find many barriers in the issue of access to other services, which sometimes makes us indignant. For example, a visually impaired person. They come to the unit, we aid them, but what about scheduling a specialty? That's with the vacancy center, it is no longer with the health unit. What do we do? So, the person who attends to them are often the one that helps them with that. As I said, our team is very good, thank God, I'm not bragging. But the Community Health Agent often plays this role of scheduling. Many times, we accompany the patient, which isn't necessarily in our job description. But, depending on their limitation, we accompany them. (E4 - Santos)

Communication between health services and integration between the subjects involved in care coordinates care, contributing to continuous, supportive, and timely care. Under unavailable offer and bureaucratic regulation, health teams feel unable to coordinate patients' care and monitor their therapeutic path within the health system.

According to Castro et al. (2021, p. 11) when regulation constitutes a bureaucratic element, materialized in "complex, disconnected, and confusing flows," people with disabilities have to access "different

services to reach the point in the network that meets their health needs." These barriers (traveled distances and long waiting times) can keep people with disabilities away from services and increase waiting lines, "characterizing a lack of care, especially in specialized care services, generating an increase in waiting time for care and absenteeism" (Castro et al., 2021, p. 11; free translation).

An interviewee in Santos stresses that, in addition to supply availability, the difficulty of access to specialized services is worsened under social vulnerability or the geographic concentration of services.

[...] We end up scheduling for the patient, but they won't always be able to access it for lack of money or other issues. Due to immobility, if the patient is handicapped... how do you say it? Physically disabled. Thank God they have the buses they have, which are accessible, to the other part of the seacoast, because these specialty services are usually located on the seacoast. It's more accessible over there. Here, things are pretty complicated. (E2 - Santos)

Fineman (2010, p. 1) finds that vulnerability can be considered a result of the interaction of institutional and economic aspects based on the quality and quantity of actions and services available to individuals. For the author, vulnerability "suggests a relationship of responsibility between state and individual." In the case of people with disabilities, this relationship is weakened and intensifies an already present vulnerability that makes access to their rights unfeasible.

Clemente et al. (2022, p. 12) reinforce the need to direct efforts to reduce barriers, making access to health actions and services equitable. According to the authors, aspects related to access for more vulnerable populations amplify the difficulties to access for people with disabilities, "who often experience poverty more than any minority or ethnic group" (Clemente et al., 2022, p. 12; free translation).

Appropriateness

Appropriateness refers to which services are provided and how they are provided, relating to aspects such as technical and interpersonal quality and care coordination and continuity. As a skill

corresponding to the population, it refers to users' ability to engage and empower themselves (Levesque; Harris; Russell, 2013).

Regarding technical and interprofessional quality the interviewees highlight the weak institutional offer of professional training toward aiding people with disabilities since their training mostly result from personal initiatives and their own investment. When existent, the offer of institutional training fails to focus on the care of people with disabilities.

I think you need qualified people to be able to do this type of service. I think the state forgets this a lot. [...] For example, you passed a public tender, you enter, and you don't have that training. (E4 - Brasília, DF)

[...] I tell you that there is a formal path to training. For example, specialization or continuing education by the municipality does not exist, formally it does not exist. [...] Since I want this to happen and put it in my actions, I sometimes look for it by other means [...]. (E2 - Santos)

In an integrative review on the ways in which people with disabilities access primary health care services in Brazil, Bezerra, Silva, and Maia (2015) found, that despite the achievements related to the right to health, access to PHC still faces difficulties due to failures in physical accessibility and in the skills of professionals in caring for people with disabilities. The authors highlight the need to invest in the physical structure and professional training to ensure comprehensive care. Dubow, Garcia, and Krug (2018) also identified the shortcomings of continuous education as one of the difficulties in building and ensuring effective and comprehensive health practices for people with disabilities.

Possibly as a result of insufficient training, all interviewees perceive a difficulty communicating with people with disabilities and point it as a barrier to access to health actions and services.

So, I can't talk to him, and he doesn't know sign language either. So, you can't talk to him about a consultation because he doesn't understand sign language either, the family doesn't understand what he says either, so he doesn't have an appointment.

He doesn't attend a consultation because we can't have access to it. (E3 - Santos)

[...] I don't think any server is prepared to serve a person who is deaf, for example. No one here knows sign language to be able to talk and dialogue with a person who has this disability. (E1 - Brasília, DF)

The difficulty of communication, more than limiting access, makes it impossible to build the bond between subjects and health teams, who are unable to accommodate demands and meet needs. Wieganda and Meirelles (2019) observe that many elements bar accessibility for people with disabilities, including communication.

Othero and Ayres (2012, p. 228), in their life-history study on the identification of the health needs of people with disabilities, report that a participant has the "non-construction of an (a) effective relationship with doctors and healthcare providers who care for them" in "their great difficulty in communication due to their hearing impairment" (free translation).

Still from the perspective of communication, but now in the relationship between the services, the participants highlighted the fragility in this area and point out the important role of community health agents in the follow-up of cases, especially due to the incipient counter-referral mechanisms.

[...] We refer the patient through the regulation itself now for prosthesis, these things, and there the patient has to go personally [...] If it is a case of prosthesis, they must have had an appointment with the specialist, so that the specialist can give the type of prosthesis, the size, all referenced. So, it's something that takes time, so we had a patient who died and never got a prosthesis. (E1 - Brasília, DF)

I'll tell you that we follow exactly how it is there, what happens, it's not up to us. Really, our role is referral. [...] And we bring a lot of feedback from community health agents. How are they? What happened? Did it work, did it not work? (E4 - Santos)

[...] The only information we often exchange, if we do, is by the referral. In the case of our electronic

medical records, they do not have access to the information that is available in the specialized service, and it seems that the specialized service also does not have information on what is done in primary care. This is very bad as it makes it hard to have a global understanding of the user's situation, right? (E3 - Arcoverde)

Communication between healthcare providers and services is essential to consolidate the care network and to ensure continuity of care. Clemente et al. (2022) claim that the absence of this communication offers an element that inhibits access to the health system and represents a weakness in the health care network.

Effective communication between the elements that make up this network, recognized here as subjects, teams, services, and territories, must happen harmoniously to ensure supportive and efficient therapeutic itineraries. A flow failing to occur weakens the coordination of care and is compromises another important attribute of primary care, longitudinality.

Notably, the main barriers related to accessibility in primary care are associated with architectural issues and the physical structure of health units. Santos et al. (2020) analyzed the National Census of basic health units and found worrying architectural and communication barriers in Primary Care throughout Brazil. Their findings showed a lack of accessibility throughout the national territory, weakening the role of primary care, which, as a coordinator, compromises access, care, and problem-solving capacity of the provided care.

The interviewees reinforce that PHC has no governance over the availability of the regulated supply, compromising care coordination. Answers reported the frail relationship between PHC and the specialized network and scarce supply.

[...] we find many barriers in the issue of access to other services, which sometimes makes us indignant. For example, a visually impaired person. they come to the Unit, we aid them, but what about scheduling a specialty? That's with the vacancy center, it is no longer with the health unit. (E4 - Santos)

People depend on the number of vacancies, if there is an open or closed vacancy and there is another follow-up that is for AME which is through CROSS (which has to be in the system) and there is a vacancy (which is sent to the unit), the Unit can schedule it. We don't have access to this other 0800 number, it's a vacancy center, so the patients themselves have to schedule it. (E5 - Santos)

Dubow, Garcia, and Krug (2018) found that the difficulty of access and long waiting lists for specialized services feature among the elements that restrict the health care of people with disabilities. To them, the therapeutic trajectory of people with disabilities in the health network is influenced by what is offered, rather than by their health needs, fragmenting care and compromising the coordination of comprehensive care.

Farias et al. (2023) found that the constitution of the care network for people with disabilities in the capital of the state of Pernambuco lacks a configuration that favors the functioning of network services. For them, the insufficient services in the care network impairs the continuity of care and hinders the regulation of vacancies. Thus, a weakened regulation and support system interfere with the appropriateness of the provided service.

In fact, an interviewee from Santos reinforces the difficulty of communicating with other health services and social facilities that hinders the collective and efficient construction of access to health actions and services and other intersectoral public policies.

We did a project with a young adult who had a hearing impairment and a mental health issue. We tried to include him in a lot of things. One of them was to have him join a sport. We went to a team that had a teacher who was theoretically able to deal with the condition. But so many obstacles arose that even we could not make it happen together with the user... this with other professionals who have been around for some time, who are thinking about it, who are acting on it. Imagine if a user goes by themselves. When you're not alone, you're with your family, you have a disability, a mental health issue, a certain social vulnerability, right? So, I think there are barriers. (E2 - Santos)

Due to the complex specificities of people with disabilities, according to Othero and Ayres (2012, p. 221), their needs exceed the field of health, requiring intersectoral actions to ensure comprehensive care for them. For the authors, “the needs are not limited to the disease; prevention and care must be articulated, the problems are complex and involve the sociocultural context, the user is a subject (with history, values, desires)” (free translation).

On the other hand, we observed that, in all participating municipalities, access was facilitated because of the attitude of professionals who seek to overcome architectural barriers and institute work processes with the objective of ensuring access to care actions in health unit.

The most vulnerable people, those who have no support and for whom we end up reaching out. We also call, tell the whole story, when things get a little hard, we call the services to talk to each other, to be able to provide a more comprehensive service [...] tag. (E2 - Santos)

Accessibility is what it is to make accessible [...] make accessible both the issue of those who have priority, as well as the physical space and the attention of the team [...] an attention toward those specificities of the person. Sensibility in every sense is the question of the bond [...] to really know that person and the whole environment that surrounds their entire context. (E2 - Brasília, DF)

[...] In my area there was a patient who had such severe disorders that only one doctor from the unit could treat him. He alone measured, weighed, listened. So that was love, patience, and a special way to serve and gain the patient's trust. (E4 - Arcoverde)

For Othero and Ayres (2012, p. 227), observing the need for care of people with disabilities, “the social and cultural imaginary permeated by prejudices and stereotypes contributes to the health care of this population becoming even more complex” (free translation). The encounter between persons with disability and professionals must take place in a scenario of respect for differences since health

care in this case falls into a “context in which the devaluation and stigma of the person with disabilities predominates” (Othero; Ayres, 2012, p. 227; free translation).

The bond between professionals, families, users, and communities is an essential for care in the face of adversity.

Accessibility also with professionals, trust [...] sometimes even the patient's family doesn't believe that they can have good care because of their disability. (E4 - Arcoverde)

I observe that the units, our doctors, who are all doctors of the family health strategy, the nurses and the technical team as well, are very attentive, even the security guards, I see the interaction with the unit in this way. It's really interactive and really tries to give this assistance according to the needs of the person with disabilities, the users themselves [...] (E3 - Brasília, DF)

The bond and trust established in the daily routine of health services are essential elements to ensure access to the health system. The relationships that are formed, the respect for singularities, and the diversity and complexity of health needs strengthen the bond and help longitudinal follow-ups, which are necessary for the care of people with disabilities.

Castro et al. (2021, p. 17) recognize that bonding is located as a relationship technology that contributes to the production of more effective care for people with disabilities and to “the production of greater autonomy for health and life” (free translation).

Final considerations

Results indicate important challenges for people with disabilities to access health actions and services. The Availability and Accommodation challenges refer to architectural and urban barriers, service supply, the geographical concentration of social facilities, and the difficulty coordinating care. The social vulnerabilities that mark the lives of this population enhanced these shortcomings.

The second studied dimension, Appropriateness, showed the institutional absence of qualification

that contributes to communication difficulties between healthcare providers and people with disabilities. Interviewees also pointed to the fragility in the communication between the health services that make up the care network and in the implementation of intersectoral actions that encompass the breadth of health needs.

On the other hand, the attitude of the professionals and the bond they build with people with disabilities facilitated access. The establishment of a work process that encompasses the singularities of people with disabilities and ensures the construction of supportive care aim to overcome the barriers that hinder access.

This study has some limitations, one of which refers to the need to incorporate people with disabilities and/or professionals from other services in the care network as interviewees. Therefore, other studies may consider the importance of a more comprehensive analysis to overcome access barriers.

Health facilities must have an adequate physical structure and municipalities must be accessible. Health teams, in turn, must be complete and have access to a broad education that can encompass the breadth of care for people with disabilities. Healthcare services must communicate, reducing waiting times and ensuring continuity of care. Solid foundations must strengthen the bond, commitment, and communication between subjects, whether those who care or those who are cared for.

Access to health care for people with disabilities is an achievement of a social movement that has historically occupied spaces and fights to guarantee fundamental rights. Brazil resumes this path and shows the need to face the barriers that are imposed on their daily lives based on the institution of the *Novo Viver Sem Limites* (New Living Without Limits).

It was expected that the more developed spaces would offer more possibilities of access but, whether in its capital, its richest region, or in its northeastern hinterland, Brazil still faces a struggle that requires resistance. The Brazilian state has a duty to guide the formulation of public policies aimed at people with disabilities based on their right to health, ways of living, and dignity.

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