DOI:http://dx.doi.org/10.18569/tempus.v11i3.2443

A perspectiva do usuário sobre o acesso aos serviços da atenção primária à saúde

Health services users' perspective regarding their access to primary health care

La perspectiva del usuario sobre el acceso a los servicios de atención primaria a la salud

Patricia Tavora Bulgarelli[1]
Alexandre Favero Bulgarelli[2]
Camila Mello dos Santos[3]
Juliana Balbinot Hilgert[4]
Rafaela Rech Soares[5]
Fernando Neves Hugo[6]

RESUMO: O acesso aos serviços básicos de saúde mostra-se, ainda, como um processo em construção e que necessita de esforços conjuntos do poder público, dos profissionais e de pesquisadores da saúde coletiva para descrever, traçar planos para o enfrentamento dos problemas e construir acesso universal ao que se considera, dentro das políticas públicas, como essencial a saúde do cidadão brasileiro nos grandes centros urbanos. Nestes pressupostos, o objetivo deste estudo foi analisar o acesso aos serviços de Atenção Primária à Saúde (APS) por meio da percepção do usuário adulto em três Gerências Distritais de Porto Alegre/RS. Estudo de base populacional realizado com 214 usuários. Utilizou-se questionário construído especificamente para a pesquisa contendo o atributo Acesso de Primeiro Contato do *Primary Care Assessment Tool*/PCATool, versão adulta, que foi aplicado por meio de um aplicativo para tablets. Como resultado 65,0% dos participantes eram usuários dos serviços básicos de saúde ofertado no Sistema Único de Saúde. No geral, o acesso foi insatisfatório. Em contraste, Acesso de Primeiro-Contato/Utilização foi percebido como satisfatório. Além disso, Acesso de Primeiro-Contato/Acessibilidade e o Escore Acesso apresentaram um desempenho insatisfatório. Destaca-se a importância de analisar dados sociodemográficos para o funcionamento da APS. Enfatiza-se a necessidade do município em direcionar esforços para a parte da população que percebeu o acesso como um atributo insatisfatório.
Palavras-Chave: Atenção Primária à Saúde, Acesso aos serviços de saúde, Avaliação.

RESUMEN: El acceso a los servicios básicos de salud todavía se muestra como un proceso

1 Mestranda do Programa de Pós-Graduação em Saúde Coletiva da Universidade Federal do Rio Grande do Sul. (UFRGS). Porto Alegre, Rio Grande do Sul, Brasil. E-mail: prtavora@hotmail.com
2 Professor permanente do Programa de Pós-Graduação em Saúde Coletiva-PPGCol. Universidade Federal do Rio Grande do Sul (UFRGS). Porto Alegre, Rio Grande do Sul, Brasil. E-mail: alexandre.bulgarelli@ufrgs.br
3 Professor permanente do Programa de Pós-Graduação em Saúde Coletiva-PPGCol. Universidade Federal do Rio Grande do Sul (UFRGS). Porto Alegre, Rio Grande do Sul, Brasil.
4 Faculdade de Odontologia da Universidade Federal do Rio Grande do Sul. (UFRGS). Porto Alegre, Rio Grande do Sul, Brasil.
5 Faculdade de Odontologia da Universidade Federal do Rio Grande do Sul. (UFRGS). Porto Alegre, Rio Grande do Sul, Brasil.
6 Faculdade de Odontologia da Universidade Federal do Rio Grande do Sul. (UFRGS). Porto Alegre, Rio Grande do Sul, Brasil.

en construcción y que necesita esfuerzos conjuntos del poder público, de los profesionales y de investigadores de la salud colectiva para describir, trazar planes para el enfrentamiento de los problemas y construir acceso universal al que se considera, dentro de las políticas públicas, como esencial la salud del brasileño en los grandes centros urbanos. En estos supuestos, el objetivo de este estudio fue analizar el acceso a los servicios de Atención Primaria a la Salud (APS) por medio de la percepción del usuario adulto en tres Gerencias Distritales de Porto Alegre / RS. Estudio de base poblacional realizado con 214 usuarios. Se utilizó un cuestionario construido específicamente para la investigación que contenía el atributo Acceso de primer contacto del Primary Care Assessment Tool / PCATool, versión adulta, que se aplicó a través de una aplicación para tabletas. Como resultado el 65,0% de los participantes eran usuarios de los servicios básicos de salud ofrecidos en el Sistema Único de Salud. En general, el acceso fue insatisfactorio. En contraste, Acceso de primer contacto / uso se percibió como satisfactorio. Además, el acceso de primer contacto / accesibilidad y el acceso de escenarios han mostrado un rendimiento insatisfactorio. Se destaca la importancia de analizar datos sociodemográficos para el funcionamiento de la APS. Se enfatiza la necesidad del municipio de dirigir esfuerzos a la parte de la población que percibió el acceso como un atributo insatisfactorio
Palabras clave: Atención Primaria a la Salud, Acceso a los servicios de salud, Evaluación.

ABSTRACT: The access to primary health services is still a process under construction and requires efforts of government authorities, professionals and collective health researchers to describe, plan for addressing the problems and build universal access to what is considered, within public policies, as essential to the health of the Brazilian citizen in large urban centers. Toward this, the objective of this study was to analyze the access to Primary-Health-Care (PHC) services by means of the adult user perception in three administrative-districts in the city of Porto Alegre/RS. This is a population-based study carried out with 214 service users. A questionnaire was constructed specifically for the research containing Access attributes of the *Primary-Care-Assessment-Tool/*PCATool, adult version, which was applied through a tablet. As a result, 65.0% of the participants were users of the primary care services offered in Unified Health System. Overall, access was unsatisfactory. In contrast, First Contact Access/Utilization was perceived as satisfactory. Furthermore, 'First Contact Access/Accessibility' and 'Overall Access Score' presented an unsatisfactory performance. This study highlights the importance of analyzing sociodemographic data for the functioning of PHC. Findings emphasize that the city direct efforts to the part of the population that perceived Access as an unsatisfactory attribute.
Key-Words: Primary Health Care, Health Services Accessibility, Evaluation.

INTRODUCTION

Primary Health Care (PHC) is a strategy for organizing health care in networks. In this way, there is a sharing of the capacities of the system to respond to the health needs of the population. It is constituted by essential attributes that are access of first contact, longitudinality, integrality of the attention and, also, the coordination of the assistance.[1] It is necessary to characterize PHC as the preferential door of entrance to the public health system, aiming at the attendance of the health needs in order to improve access.[2]

The concept of access to health has changed over time, incorporating a more complex form. Access to health services is linked to the principles of equity, integrality and universality of the

Unified Health System (SUS). Most literature agrees that access is not equivalent to simple use of the health service.[3] There is a differentiation between access and accessibility, and accessibility refers to the possibility of the individual reaching the health service, since access refers to the use of the service, taking into account the need of the individual.[1]

Access to health should range from socio-organizational issues to interpersonal relationships to favor people's entry into the public health system.[2] Access is also a multidimensional issue that involves economic, political, social, technical, and organizational aspects, in establishing ways to universalize their attention. In Brazil, access to health services is influenced by the social condition of the people and the place where they live.[4] The difficulty of access is a problem to be faced in order for health systems, as well as the SUS, to perform their effectively.[5]

The perspective of the user can be an important source of information for the construction of assessments of the care process as well as results obtained with the applicability of certain care models. It is known that the concept of access is complex, because it is sometimes used inconsistently and not very explicitly in relation to its use in health services.6 As a way to evaluate the structure and process of health services, the Primary Care Assessment Tool/PCATool tool, was developed to measure the attributes of the PHC from the perspective of the user and the health professionals.[7] PCATool-Brazil has adequate reliability and validity, and can be an evaluation resource of PHC.[8]

The objective of the present study was to analyze access to PHC services through the adult user perception of the city of Porto Alegre/RS. With this, it is necessary to identify the conditions that favor or hinder the quality of access of PHC services in order to be able to invest in a model that better contemplates the users of the municipality. Porto Alegre has 55 Basic Health Units (BHU), 88 Family Health Units (FHU), and at present they are the main access points for the search for primary health care in the municipality. BHU and FHU have health services that include a general practitioner, gynecologist or pediatrician, nursing care, nutrition and vaccination, among other services.[9]

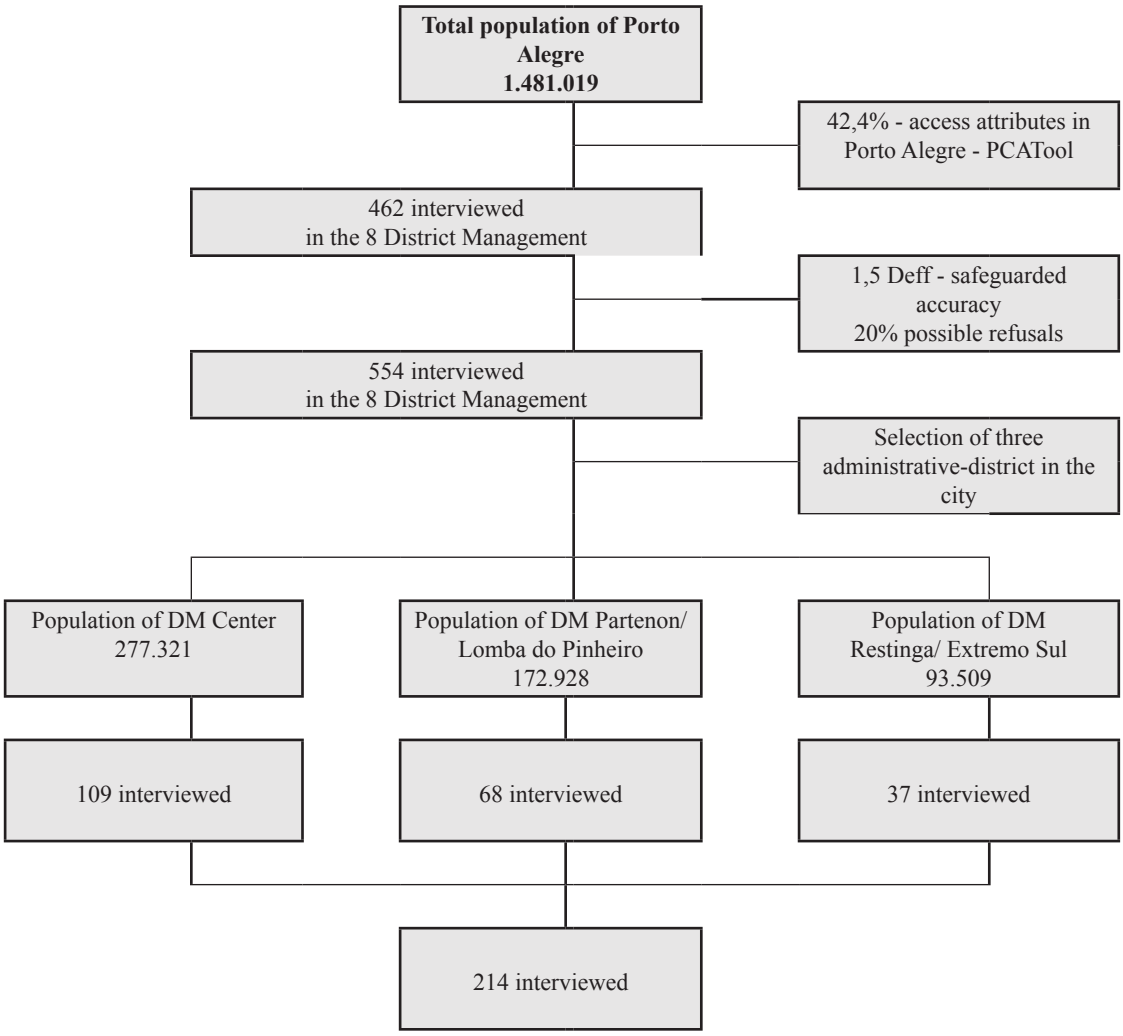
METHODOLOGY

This is a population-based study, carried out in three District Managements (DM) in the city of Porto Alegre/RS, from September 2016 to May 2017, on access to these services. In this study the perceptions of the users of the health services were evaluated. The municipality studied has a population of 1.481.019 inhabitants and has eight district managements, which are regional administrative and management structures. These administrative structures are now, also, spaces for discussion and practice where all the strategies for health care in the SUS sphere are operationalized. They are composed of Health Units, Specialized Centers and Specialized Ambulatory and Substitutive Services.[9] Of the 8 DM, only three managements were selected for the study: Center (population 277.321); Management Partenon-Lomba do Pinheiro (population 172.928) and Management Restinga-Extreme South (population 93.509).

The eligibility criteria of the subject participants were: adult individuals, with at least 18 years of age and resided for at least 12 months at the household sampled by lot of census tracts referring to the territory of the selected management. Following the proportionality in the distribution by District Management/DM, the final sample size was 214 respondents (Figure 1).

The calculation of the sample was estimated considering the prevalence of 42.4% of the access attribute, as measured between users of primary care services and residents of the area covered by the District Management/DM Partenon-Lomba do Pinheiro in the year 2012, measured by means of PCATool-Brazil.[10] A 9% error was used and, therefore, a range of 0.33-0.51 was estimated. The sample was calculated proportionally in all eight DM of the municipality and was estimated in 462 respondents. In each management, 20% were added for eventual refusals and a deff of 1.5 in order to preserve accuracy, considering the structure of the sample plan, totaling 554 respondents for the 8 DM. After that, three district managers were selected that were similar to the others in relation to the socioeconomic level, age distribution and social vulnerability. In each one of them, the sample was calculated (95% confidence level), obtaining representative numbers of each management and a total of 214 interviewees.

Figure 1. Sample construction process to study the access to PHC services. Perspective of users. Porto Alegre, 2017.



The analysis methodology of the access attribute was given according to the PCATool-Brazil manual.[11] In module VII, of the access attribute of the PCATool-Brazil questionnaire used, questions 09 to 12, referring to the dimension First Contact Access/Accessibility were formulated so that the higher the value assigned to the response, the lower the PHC orientation. Therefore, according to the PCATool-Brazil manual, the value 4 is equal to 1, value 3 equals 2, value 2 equals 3, and value 1 equals 4. Through these answers a score can be calculated for each attribute of PHC.[8, 11]

To evaluate the PCATool-Brazil domains, a reference value of cutoff point of 6.6 was used, and values >6,6 (in a range of 0 to 10) were considered high scores and automatically effectiveness of primary care in relation to attributes and, also, that the services present orientation for PHC. However, values <6.6 are considered low score.[08,11,12,13]

The data were collected by a questionnaire constructed specifically for the research containing proxies from the National Household Sample Survey/PNAD[14] and National Health Survey/PNS.[15] Part of the questionnaire was also composed by the PCATool-Brazil access attribute[11],

which is an instrument capable of measuring the presence and extension of PHC by means of responses of the likert type, with scores from 1 to 4 for each item, 1=”Certainly not”; 2=”Probably not”; 3=”Probably yes”; 4=”Certainly yes” and 9=”I do not know”. The access attribute has two dimensions in PCATool-Brazil: First Contact Access/Use and First Contact Access/Accessibility. From these two dimensions, the Score of the attribute Access was constructed.

The above-mentioned questionnaire was applied to users through the Open Data Kit Collect/ ODK-Collect tool as a mobile and tablet application. The collected data was sent to the database via the internet. The questionnaires were applied by eleven undergraduate and postgraduate students from the health area, previously trained and calibrated through workshops.

To verify the statistical significance of the distribution of the means of the components and of the attribute the Kolmogorov-Smirnov test was carried out. In the cases of normal distribution (Access Score), the Student’s t and Anova tests were used. In case of rejection of the normality hypothesis (Utilization/Accessibility), non-parametric Mann-Whitney and Kruskal-Wallis tests were used. The value for rejection of the null hypothesis was $p < 0.05$ (95%CI). The analyzes were performed using the Statistical Package for the Social Sciences/SPSS software, Version v.21 (Chicago: SPSS).

An initial descriptive analysis was carried out to observe the use of health Units of the municipality in relation to the variables Sex, Age group categorized according to IBGE, [16] Schooling which was re-categorized according to the sample distribution[14] (up to elementary school=1, elementary to high school=2, technical=3, superior or post-graduation=4) Marital status and self-declared Color/Race, with possibility of response dark/black=1, white=2, yellow=3, brown=4 and indigenous=5, and it was, also, re-categorized according to the sample distribution (White=1 and No white=2). In a second moment the components First Contact Access/Utilization, First Contact Access/Accessibility and the Access Score were analyzed. These components were analyzed with Listening Time, Direct Care, Diagnosis with Chronic Diseases and Scheduling. The variable, Listening Time was accessed by the question: “When you arrive at the Unit/Health Post is there a professional that gives you time to listen to you? With possibilities of answer yes=1, no=2, I do not know=3”. The direct Care was accessed by the question: “The last time you came to the Unit/ Health Post, were you taken care of? with possibilities of answer yes=1 and not=2”. The Diagnosis of Chronic Diseases was accessed by the question: “Has any doctor ever diagnosed any chronic, physical or mental illness or long-term illness? With possibility of answer yes=1 and no=2”. The Scheduling was accessed by the question: “How do you make an appointment at the Health Unit/ Post? With possibility of answer by phone=1, get a ticket=2, direct at the Health Unit=3”.

The Utilization dimension was accessed through the following questions: “When you need a review consultation (routine consultation, check-up), you go to your “health service name/or medical name/nurse” before you go to another health Service?”; “When you have a new health

problem, do you go to your "health service name/or medical name/nurse" before going to another health service?"; "When you have to consult a specialist, does your "health service name/or medical name/nurse" have to refer you, obligatorily?" With the possibility of answers Certainly yes=4, Probably yes=3, Probably not=2, Certainly not = 1, I do not know = 9.

The Accessibility dimension was accessed for questions related to the days and shifts of care, if there is a possibility of communication with the health team if the individual finds it necessary, if there is an easy way to mark a review visit and if there is a need to miss work or school to go to the health service.[11]

The present research was approved by the Research Ethics Committee of the Municipal Health Department of Porto Alegre with the Opinion nº 1.670.384 and, also, of the Research Ethics Committee of the Federal University of Rio Grande do Sul, with the Opinion nº 1.716.586. Participants were informed about the research objectives and asked to read and sign the Informed Consent Form before applying the data collection questionnaire.

RESULTS

In the present study 65.0% of the participants were users of basic health services offered at the Health Units of the SUS of Porto Alegre/RS. As socio-demographic characteristics of these research participants, a higher prevalence of women (66.0%) was observed, age group above 60 (68.6%), schooling from elementary school to high school (68.5%), married (64.2%) and white self-declared race (59.8%) (Table 1).

Table 1. Distribution of frequencies of the independent variables regarding the studied outcome. Porto Alegre, 2017

		Use of the Health Center in the city of Porto Alegre		
		Yes n(%)	No n(%)	Total n(%)
Sex	Male	44(62,8%)	26(37,2%)	70(100%)
	Female	95(66,0%)	49(34,0%)	144(100%)
Age Range	18-39	31(54,3%)	26(45,7%)	57(100%)
	40-59	40(70,0%)	18(30,0%)	58(100%)
	60 or more	68(68,6%)	31(31,4%)	99(100%)
Schooling	Elementary School	33(75,0%)	11(25,0%)	44(100%)
	Fundamental to Medium	61(68,5%)	28(31,5%)	89(100%)
	Technician	11(78,5%)	3(21,5%)	14(100%)
	Superior or postgraduate	34(50,7%)	33(49,3%)	67(100%)
Situação states	Married	61(64,2%)	34(35,8%)	95(100%)
	Single	42(62,6%)	25(37,4%)	67(100%)
	Separated	12(66,6%)	6(33,4%)	18(100%)
	Widower	24(35,2%)	10(64,8%)	34(100%)
Color/Race	Black	21 (77,7%)	6(22,3%)	27(100%)
	White	94(59,8%)	63(40,2%)	157(100%)
	Brown	23(85,1%)	4(14,9%)	27(100%)
	Indigenous	1(33,3%)	2(66,7%)	3(100%)
Total		**139 (65,0%)**	**75 (35,0%)**	**214 (100,0%)**

The average distribution of the PCATool-Brazil attributes in relation to the users that use the Health Units indicate unsatisfactory results=5.36 (low score) compared to the domains analyzed (Table 2). This way, means with values equal or above 6.6 reflect satisfactory aspects of the PHC attribute in the association studied. In the Utilization questions, it can be noted that the mean presented a satisfactory performance (>6,6). In the Accessibility and the Access Score questions the same presented an unsatisfactory performance (<6,6) (Table 2).

Table 2. Distribution of PCATool-Brazil attributes regarding the use of Health Centers. Porto Alegre, 2017.

	Users who use Health Centers		*p-value*
	Yes		
	n(%)	Average (+Standard Deviation)	
Access/Utilization +	203(94,8%)	6,86(±3,52)	<0,00*
Access/Accessibility +	139(64,9%)	4,89(± 2,24)	<0,00*
Overall Access Score	135(63,0%)	5,36(± 1,94)	<0,00*

+Domínios do PCATool-Brasil, * Test t de student.

When analyzing the relationship between the calculated means of the PHC domains and the exploratory variables, the results point to some important distributions with a significant difference (Table 3). It was observed that there was statistical significance in the Utilization score for age group (p=0.00), marital status (p=0.02) and schooling (p=0.00). Such findings show that, elderly, separated and level of schooling until elementary school are variables present high score in relation to the Utilization score.

When analyzing the Accessibility score, it was found that there was a significant association for the variable Schooling (p= 0.00) and for the exploratory variable, Direct Care (p=0.00), showing that users which even have elementary school and who were attended the last time they went to the Health Unit presented satisfactory performance in relation to the Accessibility score. In relation to the single Score, constructed for the access attribute, it was observed that only the age group was associated (p=0.02), where elderly users present a satisfactory association in relation to access in Porto Alegre (Table 3).

Table 3. Distribution of domains and attributes of access to Primary Health Care services regarding the independent and the exploratory variables under study. Porto Alegre, 2017.

		First Contact Access/Utilization		**First Contact Access/Accessibility**		**Overall Access Score**	
		Average (±SD)	*p-value*	Average (±SD)	*p-value*	Average (±SD)	*p-value*
Sex	Male	6,71(±3,57)	0,52*	5,00(±2,30)	0,81*	5,48(±1,80)	0,63*
	Female	6,93(±3,50)		4,84(±2,22)		5,30(±2,00)	

Ace Range	18-39	5,09(±3,92)	0,00**	4,42(±2,39)	0,31**	4,65(±1,98)	0,02**
	40-59	6,32(±3,45)		4,79(±2,19)		5,13(±1,90)	
	60 ≥	8,11(±2,81)		5,15(±2,20)		5,78(±1,90)	
Color/Race	White	6,71(±3,52)	0,96*	5,00(±2,21)	0,97*	5,36(±1,98)	0,98*
	Not White+	7,29(±3,50)		4,57(±2,34)		5,35(±1,84)	
Marital Status	Married	7,04(±3,36)	0,02**	4,91(±2,28)	0,71**	5,31(±2,03)	0,80**
	Single	5,88(±3,93)		5,00(±2,47)		5,35(±2,04)	
	Separated	7,83(±2,62)		5,21(±1,67)		5,82(±1,36)	
	Widower	7,81(±3,11)		4,40(±2,11)		5,18(±1,90)	
Schooling	Elementary School	8,21(±2,92)	0,00**	3,84(±2,11)	0,00**	4,83(±1,87)	0,34**
	Fundamental to Medium	7,40(±3,38)		4,90(±2,32)		5,48(±2,01)	
	Technician	6,94(±3,38)		4,44(±1,68)		4,92(±1,56)	
	Superior or Postgraduate	5,31(±3,56)		5,73(±2,00)		5,62(±1,91)	
Listening time	Yes	7,83(±3,01)	0,31**	4,85(±2,13)	0,67**	5,42(±1,95)	0,57**
	No	7,42(±3,56)		4,41(±2,81)		4,83(±2,30)	
	Do not know	6,78(±3,77)		4,47(±2,24)		5,04(±1,84)	
Straigth attendance	Yes	7,16(±3,57)	0,08*	4,45(±2,21)	0,00*	5,04(±1,85)	0,15*
	No	8,08(±2,77)		5,63(±3,46)		6,15(±3,01)	
Diagnosed with chronic diseases	Yes	7,30(±3,32)	0,10*	5,17(±2,18)	0,38*	5,62(±1,85)	0,06*
	No	6,32(±3,70)		4,51(±2,30)		5,00(±2,02)	
Scheduling	By phone	9,50(±0,80)	0,26**	3,37(±1,30)	0,95**	4,71(±1,21)	0,92**
	By ticket	8,84(±1,92)		3,70(±2,46)		4,71(±2,10)	
	On the Center	8,07(±3,20)		3,66(±2,24)		4,48(±2,10)	

*Teste t de student **One way Anova +Not White = clustered black, yellow, brown, indigenous SD= Standard Deviation

DISCUSSION

To ensure the quality of PHC, a number of aspects are key for further evaluation. An important aspect to be measured and corroborating the quality of PHC is the access to the services effectively operationalized. The PHC has proved successful as a public policy, as it promotes a

reduction in maternal and infant mortality, has a positive impact on morbidity of several diseases, has allowed for better and equitable access and use of primary care, reduced hospital admissions and presented improvements in continuing education.[17,18,19,20]

The present study points out important results regarding the access to the health services of Porto Alegre, from the perspective of the user, in order to contribute to questions about the quality of PHC in the municipality. Even performed in three different managements out of a total of eight, it is believed that the results of the present study reflect the performance of attributes of access in the municipality.

The use of the access attribute of PCATool-Brazil, as a way of accessing the attributes of PHC from the perspective of the user in the construction of the questionnaire of the present research, was adequate for the proposed objectives, since the applicability of this tool is functional and competent to raise and evaluate the PHC access attribute[21]. Although the evaluation of the Utilization score presented a satisfactory above-average result (94.8%), when the Access Score was constructed, it was found to be unsatisfactory (63.0%) in perception of users. Such results were considered in this way considering the value 6.6 as the point that corresponds to the adjustment of the scores according to the Manual of PCATool-Brazil and recent studies.[08,11,12,13] In this context, it is observed that the first contact, according to the needs/expectations of the users, was not satisfactorily achieved. The needs of the users must be met through the orientation and qualification of the PHC services articulated with the network, in order to provide improvements in access attributes.[22,23,24,25]

The strengthening of PHC in the municipality is fundamental for improving access to health services for the elderly population, since this population projects a broad demand for basic health services. The present study indicates that the age group of elderly individuals is associated to the Utilization score ($p=0.00$) and also to the Access Score ($p=0.02$). In this way, it can be suggested that elderly people who access the service, described the attributes as satisfactory, since they access the unit more easily since they are accompanied by it over time. It is believed, also, that this age group attributes satisfaction, because they have more time available to go to the health unit and due to the policies that recommend their care as a priority.[25] This aspect is consistent with the assumption of access and continuity of PHC care.[23] The present study indicates that due to these aspects, the elderly people have attributed satisfactory results to these attributes. Studies show a greater use of PHC services by the elderly due to the search for services that meet them by free demand, by age being a predisposing factor to the use of health services, as well as the high prevalence of chronic-degenerative diseases in this population.[26, 27, 28, 29] In addition to this aspect, the greater use and resolution of these problems may suggest that this population qualifies the Utilization score as satisfactory.

Accessibility is the absence of organizational barriers to get health care, such an increase in

the availability of days and hours of operation of the health units. These aspects are evaluated by PCATool-Brasil[23, 28] and the elderly evaluated the Accessibility score as unsatisfactory. This aspect is elucidated in the literature, where the accessibility attribute, also, was perceived by the elderly as unsatisfactory.[28] Perhaps, this result is a reflection of the distance from the home of the elderly to the Health Unit, and, also, by the fact that there is no Community Health Agents available in all the territories studied. In addition, there are the urban conditions of the cities themselves and the barriers that exist in health services that act by making accessibility of the elderly difficult such as, the presence of stairs, lack of banisters, inadequate waiting rooms, unidentified facilities, among others.[10] Regardless of age, the accessibility attribute is evaluated as unsatisfactory in Brazil.[30]

When observing the marital situation, it is important to highlight, at the sociodemographic level, that separated and widowed individuals presented a perception that the Utilization score (p=0.00) performed satisfactorily. This attribute, referring to priority issues in the search for the same Health Unit, shows that this user is more linked to it. No evidence was found in the literature to justify this association. It is believed that with the increase in the number of people living alone, because they are separated or widowed, PHC health services must be organized for that fact, so investments in Family Health Units should focus on the care of these people.[31] Probably, these subjects easily access the PHC service in the managements studied and for that reason the satisfactory result.

The Schooling presented association in a significant way with the First Contact Access attribute, both Utilization (p=0.00) and Accessibility (p=0.00) so that individuals with elementary school education presented a more satisfactory perception regarding Utilization [8,21 (+2,92)]. In the Accessibility score, the most satisfactory perception came from individuals with higher schooling [5,73 (+2,00)]. The issue of schooling in the present study is similar to another study developed in the state of Rio Grande do Sul, which pointed out that there is an inverse association between the use of public health services and schooling.[32] The present study showed that individuals with low levels of schooling are those who use the PHC services most and attribute satisfactory performance to the Utilization score. This finding can be explained by the fact that users with low levels of education are the ones who access PHC services most.[30,32,33] It is also believed, that, just because this user has access to a health service, it shows that he is already satisfied.

In the understanding of the access attribute as the possibility of timely use of the service, as well as the way the user experiences this service[34], the Direct Assistance variable was considered in order to observe whether or not there was a resolution of the need of the user when the same sought the Health Unit. To verify this characteristic of the units, it was observed that going to it and being attended directly, was associated to the accessibility score. However, it was not possible to explain such relationship due to the distribution of the means of answers, since the accessibility performance was unsatisfactory in this context. Not every user who was attended on the unit showed that attribute with satisfactory performance. However, it is known that the quality of a PHC service

is also associated with the resolution of direct care and accessibility needs.[34,35]

As limitations of this study, it is important to highlight intrinsic and extrinsic aspects. In the intrinsic condition it should be clarified that, even reaching the number established by the calculation of the sample, only three managements were searched. In view of this fact, it should be emphasized that the statistical power of the sample was reduced, thus not allowing robust associations with other questions represented by the variables "listening time", "diagnosed with chronic diseases" and "scheduling". In addition to this fact, it is a cross-sectional study that did not allow affirmations of causality. In addition, the profile of the interviewees was mostly elderly individuals, perhaps due to the fact that in Porto Alegre there is a Law that provides preferential and obligatory care to the elderly at all levels of health care by SUS.[36] As extrinsic limitations, there were several denials due to the fear of the population of the municipality against urban violence, so that the approach of the interviewers and researchers with the possible participants did not always happen. In case of denials due to lack of time or unavailability at the time, two more attempts to approach on different days and times occurred. Even with all the interviewers properly identified with badges of the University and approaching the residences in a cautious and friendly manner, the success of acceptance in participating in the survey was not imperative.

CONCLUSIONS

The information presented in this study stresses the importance of analyzing sociodemographic data for the functioning of PHC and show that the municipality should direct efforts for the portion of the population that presented Access as an unsatisfactory attribute, and continue investments to further qualify the presented attributes satisfactory. According to the results obtained, the access studied was generally presented with an unsatisfactory performance by the studied population. With this, there is potentially useful information for the municipal management of the SUS in order to advise on the daily in the search for the best qualification of access to health services.

In this context, it is considered that the perception of the user is relevant to understand the dynamics of the service provided, and in this way is directly related to the quality of the service. Therefore, the importance of evaluation studies such as this one in decision-making processes, in the form of reconsidering professional practices, restructuring the work processes and in the resolution of the access to PHC, is perceived.

REFERENCES

1. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: Unesco, Ministério da Saúde; 2002.

2. Barbosa SP, Elizeu TS, Penna CMM. Ótica dos profissionais de saúde sobre o acesso à atenção primária à saúde. Cien Saude Colet 2013; 18(8): 2347-2357.

3. Sanchez RM, Ciconelli RM. Conceitos de acesso à saúde. Rev Panam Salud Pública, Washington 2012; 31(3): 260-268.

4. Travassos C, Oliveira EXG, Viacava F. Desigualdades geográficas e sociais no acesso aos serviços de saúde no Brasil: 1998 e 2003. Cien Saude Colet 2006; 11(4): 975-986.

5. Assis MMA, Jesus WLA. Acesso aos serviços de saúde: abordagens, conceitos, políticas e modelo de análise. Cien Saude Colet 2012; 17(11): 2865-2875.

6. Travassos C, Martins M. Uma revisão sobre os conceitos de acesso e utilização de serviços de saúde. A review of concepts in health services Access and utilization. Cien Saude Colet 2004; 20 (Supl. 2): 190-198.

7. Shi L, Starfield B, Xu J. Validating the Adult Primary Care Assessment Tool. J Fam Pract. 2001; 50 (2): 161-175.

8. Harzheim E, Starfield B, Rajmil L, Álvarez-Dardet C, Stein AT. Consistência interna e confiabilidade da versão em português do Instrumento de Avaliação da Atenção Primária (PCATool-Brasil) para serviços de saúde infantil. Cad Saude Publica 2006; 22(8):1649-1659.

9. Porto Alegre. Prefeitura Municipal. Secretaria Municipal de Saúde. [online]. [acessado 06 agosto 2017]. Disponível em: http://www2.portoalegre.rs.gov.br/sms/default.php?p_secao=808.

10. Martins AB, Pereira DAO, Balbinot HJ, Neves HF. Atenção Primária a Saúde voltada as necessidades dos idosos: da teoria à prática. Cien Saude Colet 2014, 19(8): 3406-3416.

11. Brasil. Ministério da Saúde. Secretaria de Atenção em Saúde. Departamento de Atenção Básica. Manual do instrumento de avaliação da atenção primária à saúde: primary care assessment tool PCATool - Brasil / Ministério da Saúde, Secretaria de Atenção em Saúde, Departamento de Atenção Básica. – Brasília: Ministério da Saúde, 2010.

12. Harzheim E, Oliveira MMCD, Agostinho MR, Hauser L, Stein AT, Gonçalves MR, Starfield B. (2013). Validação do instrumento de avaliação da atenção primária à saúde: PCATool-Brasil adultos. Rev Bras de Medicina de Família e Comunidade 2013; 8 (29): 274-284.

13. Chomatas ERDV, Vigo A, Marty IK, Hauser L, Harzheim E. (2013). Avaliação da presença e extensão dos atributos da atenção primária em Curitiba. Rev Bras de Medicina de Família e Comunidade 2013; 8 (29): 294-303.

14. Brasil. Ministério da Saúde. Pesquisa Nacional por Amostra de Domicílios. Brasília: Ministério da Saúde; 2011. [online]. [acessado 12 abril 2016]. Disponível em: http://www.ibge.gov.br/home/estatistica/pesquisas/pesquisa_resultados.php?id_pesquisa=149.

15. Brasil. Ministério da Saúde. Pesquisa Nacional de Saúde. Brasília: Ministério da Saúde; 2013.[online]. [acessado 12 abril 2016]. Disponível em: http://www.pns.icict.fiocruz.br/.

16. Instituto Brasileiro de Geografia e Estatística. [online]. [acessado 06 maio 2017]. Disponível em: http://vamoscontar.ibge.gov.br/atividades/ensino-fundamental-6-ao-9/49-piramide-etaria.html.

17. Giovanella L, Mendonça MHMD, Almeida PFD, Escorel S, Senna MDCM, Fausto MCR, Delgado MM, Andrade CLT, Cunha MS, Martins MIC, Teixeira CP. (2009). Family health: limits and possibilities for an integral primary care approach to health care in Brazil. Ciência & Saúde Coletiva 2009; 14(3), 783-794.

18. Macinko J, Dourado I, Aquino R, Bonolo PF, Lima-Costa MF, Medina MG, Mota E, Oliveira VB, Turci MA. Major expansion of primary care in Brazil linked to decline in unnecessary hospitalization. Health Affairs 2010;

29(12), 2149-2160.

19. Rasella D, Aquino R, Barreto ML. Reducing childhood mortality from diarrhea and lower respiratory tract infections in Brazil. Pediatrics 2010; 126(3), e534-e540.

20. Silva V, Sales R, Aragão K, Cavalcante AL. Uma avaliação econômica do programa saúde da família sobre a taxa de mortalidade infantil no Ceará. Fortaleza: Instituto de Pesquisa e Estratégia do Ceará (IPECE)2010.

21. D'Avila OP, Pinto LFDS, Hauser L, Gonçalves MR, Harzheim E. The use of the Primary Care Assessment Tool (PCAT): an integrative review and proposed update. Cien Saude Colet 2017; 22(3): 855-865.

22. Agostinho MR, Oliveira MC, Pinto MEB, Balardin GU, Harzheim E. Autopercepção da saúde entre usuários da Atenção Primária em Porto Alegre, RS. Rev Bras de Medicina de Família e Comunidade 2010; 5(17): 9-15.

23. Starfield B. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012. Gaceta Sanitaria 2012; 26: 20-26.

24. Vitoria AM, Harzheim E, Takeda SM, Hauser L. Avaliação dos atributos da atenção primária à saúde em Chapecó, Brasil. Rev Bras de Medicina de Família e Comunidade 2013; 8 (29): 285-293.

25. Melo Dotto J, de Camargo Ávila GA, Martins AB, Hugo FN, D'Avila OP, Hilgert JB. Avaliação da qualidade dos serviços de atenção primária à saúde acessados por idosos em dois distritos de Porto Alegre, RS, Brasil. Rev da Faculdade de Odontologia-UPF, 2016; 21(1): 23-30.

26. Firmo JOA, Barreto SM, Lima-Costa MF. The Bambuí Health and Aging Study (BHAS): factors associated with the treatment of hypertension in older adults in the Community. Cad Saude Publica 2003; 19(3): 817-827.

27. Travassos C, Castro MSM. Determinantes e desigualdades sociais no acesso e na utilização de serviços de saúde. In: Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI, organizadores. Políticas e sistema de saúde no Brasil. 2ª ed. Rio de Janeiro: Fiocruz, Cebes 2012.

28. Araújo LUA, da Silva Gama ZA, do Nascimento FLA, de Oliveira HFV, de Azevedo WM, de Almeida Júnior HJB. Avaliação da qualidade da atenção primária à saúde sob a perspectiva do idoso. Cien Saude Colet 2014; 19(8): 3521-3532.

29. Oliva ACD, Moura CMR, de Almeida Lima C, da Costa FM, Rocha JFD. Avaliação dos atributos do cuidado primário de saúde na perspectiva do usuário. Revista Uniabeu 2015; 8(18): 196-208.

30. Paula WKASD, Samico IC, Caminha MDFC, Silva SLD. Primary health care assessment from the users' perspectives: a systematic review. Revista da Escola de Enfermagem da USP 2016; 50(2): 335-345.

31. Moimaz SAS, Fadel CB, Yarid SD, Diniz DG. Saúde da Família: o desafio de uma atenção coletiva. Cien Saude Colet 2011: 965-972.

32. Bastos GAN, Duca GFD, Hallal PC, Santos IS. Utilization of medical services in the public health system in the Southern Brazil. Revista de Saúde Pública 2011; 45(3): 475-484.

33. Brol AM, Araújo G, Felchilcher E, de Mathia GB, Junior EL, Mergener CR, Traverso MED. Perfil dos Usuários de uma Unidade Básica de Saúde do Meio-Oeste Catarinense. Ação Odonto 2015; 3(1): 46.

34. Souza ECF, de Vilar RLA, Rocha NDSPD, da Costa Uchoa A, de Medeiros Rocha P. Acesso e acolhimento na atenção básica: uma análise da percepção dos usuários e profissionais. Cad Saude Publica 2008; 24 (Sup 1): 100-110.

35. Roberge P, Hudon C, Pavilanis A, Beaulieu MC, Benoit A, Brouillet H, Boulianne I, De Pauw A, Frigon S, Gaboury I, Gaudreault M, Girard A, Giroux M, Grégoire É, Langlois L, Lemieux M, Loignon C, Vanasse A. A qualitative study of perceived needs and factors associated with the quality of care for common mental disorders in patients with chronic diseases: the perspective of primary care clinicians and patients. BMC Family Practice 2016; 17(1): 134.

36. Rio Grande do Sul. Assembleia Legislativa. Gabinete de Consultoria Legislativa. Lei Nº 13.320, de 21 de dezembro de 2009. Consolida a legislação relativa à pessoa com deficiência no estado do Rio Grande do Sul. Assembleia Legislativa, 21dez. 2009. [online]. [acessado 10 agosto 2017]. Disponível em: http://www.al.rs.gov.br/filerepository/repLegis/arquivos/13.320.pdf.

Article submitted on 10/11/2017
Article approved on 12/03/2018
Artiicle posted in system on 20/04/2018