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Evaluation of accessibility to Primary Health Care services in the view of health personnel

Avaliação da acessibilidade aos serviços de Atenção Primária à Saúde na perspectiva dos profissionais

Evaluación de la accesibilidad a los servicios de Atención Primaria de Salud desde la perspectiva de los profissionales

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ABSTRACT

Objective: to assess the accessibility of Primary Health Care to the population covered by the Family Health Strategy in the city of Rio de Janeiro, Brazil, in the view of the health personnel involved. **Method**: this cross-sectional study was conducted with 349 family health team members. Data was collected using the Primary Care Assessment Tool (PCATool) questionnaire. **Results**: performance, as evaluated by the accessibility indicator, was not good. Unit uptime, staff availability to provide telephone guidance or assistance when the service was closed, and user waiting times were all reported to be unsatisfactory. **Conclusion:** these results show where the primary health care system is weak in guaranteeing the public's access to services and enabling Family Health Strategy personnel to provide effective, comprehensive care.

Descriptors: Primary Health Care; Family Health Strategy; Health Services Accessibility; Nursing.

RESUMO

Objetivo: avaliar, sob a ótica do profissional, a acessibilidade à atenção primária à saúde pela população coberta pela Estratégia Saúde da Família no município do Rio Janeiro, Brasil. **Método:** estudo transversal realizado com 349 profissionais de equipes de saúde da família. Para a coleta de dados, utilizou-se o questionário Primary Care Assessment Tool PCATool. **Resultados:** o indicador de acessibilidade não foi bem avaliado. O período de funcionamento da unidade, a não disponibilidade de profissional para dar orientações por telefone ou para prestar assistência quando o serviço está fechado e o tempo de espera para o usuário ser atendido, foram relatados como insuficientes. **Conclusão:** tais resultados mostram as fragilidades na rede de atenção primária à saúde no que tange a garantia do acesso da população aos serviços e a possibilidade dos profissionais da Estratégia Saúde da Família prestarem um cuidado integral e resolutivo.

Descritores: Atenção Primária à Saúde; Estratégia Saúde da Família; Acesso aos Serviços de Saúde; Enfermagem.

RESUMEN

Objetivo: evaluar la accesibilidad de la Atención Primaria de Salud a la población cubierta por la Estrategia de Salud de la Familia en la ciudad de Río de Janeiro, Brasil, a la vista del personal de salud involucrado. **Método:** este estudio transversal se realizó con 349 integrantes del equipo de salud familiar. Los datos se recopilaron mediante el cuestionario de la herramienta de evaluación de atención primaria (PCATool). **Resultados:** el desempeño, evaluado por el indicador de accesibilidad, no fue bueno. Se informó que el tiempo de actividad de la unidad, la disponibilidad del personal para brindar orientación o asistencia telefónica cuando el servicio estaba cerrado y los tiempos de espera de los usuarios no eran satisfactorios. **Conclusión:** estos resultados muestran dónde el sistema de atención primaria de salud es débil para garantizar el acceso del público a los servicios y permitir que el personal de la Estrategia de Salud de la Familia brinde una atención integral y eficaz.

Descriptores: Atención Primaria de Salud; Estrategia de Salud Familiar; Accesibilidad a los Servicios de Salud; Enfermería.

INTRODUCTION

Primary Health Care (PHC) is the level of care considered as a gateway to the health services in Brazil and was one of the main technological innovations of the 20th century, bringing important epistemological and conceptual transformations to the health field[1].

The concept of primary health care in *Alma-Ata* contemplates three essential components: universal access and first point of contact with the health system; inseparability between health and economic and social development, recognizing the social determinants; and social participation[2].

According to Ordinance No. 2,436 of September 21st, 2017, which approves the National Primary Care Policy (*Política Nacional de Atenção Básica*, PNAB), and sets up the review of the guidelines for organizing Primary Care within the scope of the Unified Health System, primary care is characterized by a set of health actions, at the individual and collective levels, which covers health promotion and protection, disease prevention, diagnosis, treatment,

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rehabilitation, harm reduction, palliative care and health surveillance, being the main gateway and communication centre of the Health Care Network, care coordinator and organizer of the actions and services available in the network[3].

The debate on primary health care remains current, given the incorporation of universal health coverage in the 2030 Agenda, as one of the Sustainable Development Goals (SDGs), and the primary care advocated as a strategy for universal coverage[2].

In Brazil, the main strategy for implementing primary health care has been the Family Health Strategy (FHS).

The access to PHC services with expansion of population coverage by the Family Health Strategy teams throughout the Brazilian territory has been increasing in the last three decades, reflecting public investments made to strengthen PHC as an organizer of care in the Unified Health System (*Sistema Único de Saúde*, SUS)[4].

However, the advances made in expanding access and improving quality in primary care are still far from what could be expected for a universal health system. Hence the need for studies aimed at evaluating the quality of the services offered and, in these research studies, the view of the professionals who work in these services may support the identification of problems and the reorientation of the care model provided.

Accessibility is an essential attribute of primary health care services and remains a critical node of Brazilian PHC, with several associated problems, being an important indicator of the quality of such services[5-6].

This attribute is conditioned by organizational and geographical characteristics, which can facilitate or hinder the entry of individuals to the health services. It covers characteristics of the individuals and of the services, which may or may not enable the use of services and continuity of care[5].

Despite the significant increase in the number of research studies on the relevance of the services offered by the primary health care network, there are gaps in the literature regarding the professionals' perception on the population's access to the services and the quality of care provided at this level of care.

Given the above, this study aimed to evaluate, from the perspective of the professional, the accessibility to primary health care by the population covered by the Family Health Strategy in the city of Rio Janeiro, Brazil.

METHOD

This is a sectional study, developed through a survey with health professionals from family health teams in the Area of Planning (AP) 3.1 in the city of Rio de Janeiro and through the application of a questionnaire with the presence of the interviewer, in a sample of health professionals: physicians, nurses, dentists, nursing assistants/technicians and community health agents.

The study setting was constituted by the twenty Family Health Units of type A and seven Units of type B, distributed in the six Administrative Regions of AP 3.1, namely: Ramos, Penha, Vigário Geral, Ilha do Governador, Complexo do Alemão and Complexo da Maré, with these neighborhoods being characterized by high demographic density, vulnerability and social inequality[7].

Type A family health units are composed of family health teams, while type B units are represented by Municipal Health Centers that present the traditional care model performed by other primary care professionals in addition to family health teams serving part of the territory.

In the data collection period, the AP 3.1 had in these units a total of 134 family health teams with 1,167 health professionals.

In order to ascertain more comprehensively, the time of the study was chosen, considering the entire FHS team in the territory, the option for using the instrument was due to considering essential issues for the assessment of the professionals, once it was being used, initially, for the evaluation of the FHS professionals.

For defining the sample by convenience, the percentage of 50% of the types A and B units in the aforementioned Planning Area was initially considered, with 642 health professionals identified, based on the registration form of the Coordination Office of Planning Area 3.1 of the Municipal Health Secretariat.

The following were considered as inclusion criteria: professionals who were providing assistance in family health teams, with an employment period of more than four months, in order to allow for greater time contact between such professionals and the population served in these units. Professionals who, during the data collection period, were on vacation, sick leave or maternity leave, and those who were not found after three visits by the researchers to the unit were excluded. Professionals from health units located in regions where the researchers were unable to go due to the insecurity resulting from the situation of violence and social conflicts were also excluded.

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Thus, 349 health professionals participated in the study, 86 nurses, 24 physicians, 16 dentists, 30 assistants and technicians, 180 CHAs, and 13 oral health technicians.

Data collection took place from January to December 2014, through an interview based on the PCATool Primary Care Assessment questionnaire called *Primary Care Assessment Tool* - Professional version, validated for use in Brazil[8]. From this questionnaire, questions related to the attribute of primary health care called first contact access – accessibility were selected. In addition to these questions, sociodemographic and occupational variables were added to the instrument to enable the characterization of the participants.

Regarding accessibility, the professionals were asked about the operating times and days of the Basic Health Unit, including weekend and night hours; if, when the health service is closed, there is someone to assist the patients if they becomes ill; whether the service offers quick telephone advice when the patients deem it necessary; if the patient has the practicality to schedule an appointment at the service; and if, on average, the patient needs to wait more than 30 minutes to be seen by the physician or nurse[8].

Data was processed and analyzed with the aid of Epi-Info version 3.5 and of the *Statistical Package for the Social Sciences* (*S*PSS), version 21.

The calculation of the scores arranged on a Likert-type scale was performed according to the steps described in the PCATool instrument manual. The possible answers for each of the items are: “certainly yes” value = 4, “probably yes” value = 3, “probably not” value = 2, “certainly no” value = 1 and “I don't know/don't remember” value = 9[8].

Thus, initially, the inversion of the score values was performed, when indicated. For each component, a mean score was calculated, based on the quotient between the sum of the items' value and the number of items.

The scores were converted into a scale from 0 to 10 using the following formula: [score obtained – 1 minimum value] X 10/4 maximum value – 1 minimum value. Values equal to or greater than 6.6 indicated a positive evaluation with the particular attribute of primary care, reflecting the quality of the service provided[8].

This research is linked to the Research Project entitled: “Primary Health Care Services in the municipality of Rio de Janeiro: An analysis regarding the dimensions and potentialities of the Family Health Strategy”, carried out by the Collective Health Research Center of the Anna Nery School of Nursing at the Federal University of Rio de Janeiro.

The ethical and legal aspects required by Resolution 466/2012 were respected and the study was approved by the Research Ethics Committee of the Municipal Health Secretariat of Rio de Janeiro, under protocol number 90/13, and authorized by the Coordination Office of Programmatic Area 3.1 of the municipality of Rio de Janeiro.

RESULTS

Table 1 shows the sociodemographic and occupational characteristics of the study participants.

TABLE 1: Sociodemographic and occupational characteristics of the professionals from the Family Health Units (n=349). Rio de Janeiro, RJ, Brazil, 2014.

Characteristics	Professional Category					
	ACS	Dentist	Nurse	Physician	Nursing Technician	Oral Health Technician
	%	%	%	%	%	%
Age (years)						
≤34	47.2	60.0	60.5	75.0	44.8	38.5
>34	52.8	40.0	39.5	25.0	55.2	
Gender						
Female	83.3	87.5	89.7	62.5	86.2	100
Male	16.7	12.5	10.3	37.5	13.8	0.0
Schooling						
Up to High School	91.7	0.0	0.0	0.0	96.7	92.3
Higher Education	7.2	12.5	26.7	45.8	3.3	7.7
Post-graduation	1.1	87.5	73.3	54.2	0.0	0.0
Time of experience in Family Health (years)						
≤ 3	69.9	37.5	44.2	70.8	56.7	23.1
>3	30.6	62.5	55.8	29.2	43.3	69.2
Time of experience in the current Family Health Unit (years)						
≤ 2.5	39.5	28.5	63.4	85.7	48.3	38.5
>2.5	60.5	71.5	36.6	14.3	51.7	61.5

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According to Table 1, most of the professionals interviewed were below 34 years old and female. Regarding schooling, there was predominance of professionals with complete high school. As for the time of experience in the Family Health Strategy and in the current Health Unit, the mean values were 4.2 years and 2 years, respectively.

Based on the scores attributed by the professionals to the attribute of user accessibility to the PHC service, it was possible to analyze the quality of the service provided by them, considering it to be adequate when the mean scores were above 6.6 and inadequate when the values were below 6.6 (Table 2).

TABLE 2. Result of the scores: essential, derivative and general, according to PCATOOL, by professional category (n=349). Rio de Janeiro, RJ, Brazil, 2014.

Scores	Health professionals with higher education	Technical or assistant professionals, with mid-level education	Overall result
Essential score			
Mean (SD)	7.34 (0.79)	6.67(0.98)	6.91(0.97)
Derived score			
Mean (SD)	8.41(1.18)	7.97(1.50)	8.12(1.41)
Overall score			
Mean (SD)	7.87(0.90)	7.32(1.09)	7.52(1.06)

Table 3 shows that criteria related to the structure and work process were negatively evaluated, as only questions A1, A3 and A8 were above the mean. The results also showed that questions A2, A5, A6 and A7 received a higher percentage of negative answers, showing that the service works a few hours a day, leaving something to be desired in terms of telephone and/or other means for communication with the professional.

TABLE 3. Mean scores for each question of the accessibility attribute, analyzed by professionals with a higher or mid-level education, from Family Health units (n=349). Rio de Janeiro, RJ, Brazil, 2014.

Questions	Mean Score (SD)		
	Higher level professional	Mid-level professional	Overall result
A1. Is your healthcare service open on Saturdays or Sundays?	7.70(3.42)	7.19(368)	7.37(3.59)
A2. Is your healthcare service open until 8 pm at least some days of the week?	3.06(4.41)	4.10(4.36)	3.73(4.40)
A3. When your health service is open and there is a sick patient, does someone from your service assist them on the same day?	9.30(1.35)	8.61(2.21)	8.86(1.97)
A4. When your health service is open, can patients quickly obtain advice over the phone when deemed necessary?	6.29(3.05)	5.85(3.38)	6.01(3.27)
A5. When your health service is closed, is there a phone number that patients can call when they get sick?	2.08(3.12)	2.25(3.39)	2.19(3.29)
A6. When your health service is closed on Saturdays and Sundays and a patient gets sick, does someone from your service assist them on the same day?	1.30(2.60)	0.85(1.94)	1.01(2.21)
A7. When your health service is closed at night and a patient gets sick, does someone from your service assist them that night?	0.45(1.36)	0.89(1.94)	0.74(1.76)
A8. Is it easy for a patient to make an appointment for a checkup (routine consultation) at your health service?	7.76(2.60)	7.22(2.82)	7.41(2.75)
A9. On average, do your patients have to wait more than 30 minutes to be seen by the physician or nurse (not including screening or reception)?	5.06(2.73)	5.95(3.23)	5.64(3.09)
General Accessibility score (Standard Deviation)	4.78(1.20)	4.77(1.33)	4.77(1.29)

DISCUSSION

There is consensus in the different spheres of government, and in the SUS management for the human and professional resources, that the investment in the qualification of health professionals is closely related to the success

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of the Family Health Strategy. The approach to permanent education with this focus is essential for the health model in question. Thus, the need to create permanent education poles, for improving the reception, the approach to the user, and the understanding of the disease process, as well as managerial strategies that may come to be executed in the territories. In this way, the articulation between service and universities would be a possibility for the improvement of professionals in the access of users in the FHS and the management of the professionals' work in this context.

The work management in the FHS is still a great challenge, since it finds interference from macro-politics, in budgetary issues, and deficient assistance networks, among others. The innovation of actions, through the stimulation of workers' power, must be adopted in dialogical spaces, boosting democracy to solve the problems inherent to the work process in the units. In this context, enforcing the value of taxpayers' taxes, investing in professional qualification and technologies.

Although defining access, as well as what would be a high degree of accessibility, is a difficult task, it could be said that good access is one in which the patient is able to obtain the correct health service, at the right time and place, that is, where the users get the care they need when they need it[9].

In this perspective, it is clear that the user-team relationship is still inconsistent with regard to the users' search for primary care professionals, due to the fact that the opening hours are limited to approximately 12 hours a day and to the lack of guidance on the part of the professional responsible for the user, outside the institutional scope, as well as for the delay in calls, set up in more than 30 minutes.

The waiting time for care shows a devaluation of the principles of primary care, as well as the lack of bond and continuity of care. It would be opportune to rethink innovative access strategies, since the organization of primary care work and management could count on the support of technology and the use of media to bring the user and the unit closer.

Ensuring that the population's access to health services and actions is effective and efficient can have a positive impact on health indicators and a better quality of life for the collectives[10]. The challenge is large; however, it is necessary to face the issues inherent to health promotion and disease prevention of the users in the territory.

Therein lies the potential of PHC services in the territory, among them, the Family Health Units (FHUs), which, by being responsible for the production and offer of health actions and services, assert themselves as an important and efficient gateway to the SUS[10].

However, as limitations, there are still issues related to the work process of the professionals in family health units, who, in general, act in accordance with the imposed rules and flows, without being able to take into account what is implied in the needs of each user who seeks care, presenting difficulty in planning care in order to reduce waiting times and organize the reception and flow of users, which can also be justified by work overload, reflecting the great demand for care, and by the countless bureaucratic activities required in the service[11,12].

Even though the access to the basic network has been expanded, difficulties related to the reception and fragmentation of health care still remain. Thus, to guarantee access to health care in the public services, both interpersonal and socio-organizational relationships must be considered[12].

If the user needs, for example, assistance after 20 hours or needs to call one of the team's professionals, they will not have this possibility. Therefore, it is necessary to rethink strategies for shortening the distance between the service and the user. Perhaps having the means of communication via institutional cell phones and social media, presents itself as a promising possibility. Also regarding work organization, it is necessary to expand the service hours at the units,

In case the work organization of the units is not rethought. This situation can generate an increase in the population's demand for hospitals, as there is still the belief that, in the hospital environment, the person can find professionals capable of solving health problems at any time of the day.

The biologicist view, centered on the medical perspective, needs to leave the scene and Primary Care must be placed as a potential force to cause the expansion of the perspective, requiring the leading role of human beings in relation, in a circle of new reflections[13].

Among the limitations of the present study, the fact that the results obtained express the specific reality of professionals working in family health units in one of the ten planning areas in the city of Rio de Janeiro must be considered. In addition, the situation of urban violence and work overload made it impossible for data collection to be carried out with all of the identified professionals. The type of design of this research, being cross-sectional, can also be considered a limitation, since it did not allow for some correlations and causal inferences in the analysis of

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the scores attributed by the professionals to the quality of the services provided in the family health unit. Thus, the need is highlighted to develop other more comprehensive research studies that allow for the generalization of results and for filling the existing gap in the production of knowledge on the theme of the evaluation of Primary Health Care in Brazil.

Corroborating with the findings of this study, however, a survey conducted in Fortaleza, in 2019, shows that the "First contact accessibility" attribute obtained a mean score of 2.99, configuring itself as low and being evaluated by the health professionals as unsatisfactory in the FHS. In a study that was carried out in the same year, in Juiz de Fora, Minas Gerais, accessibility was unsatisfactory in all the analyses, with a better assessment by the Family Health teams (p=0.375), in the rural area (p=0.528), among professionals who specialize in family health (p=0.685) and residency in family health (p=0.196), pointing out structural weaknesses in the service with regard to accessibility and identifying the importance of investments in the qualification of the professionals as a factor that promotes better access to the service[14,15].

In a study carried out in 2017 in the city of Macaé, Rio de Janeiro, the results indicate satisfactory use of the units with regard to first contact access and unsatisfactory regarding accessibility to the services, which shows the need for investments in the reorganization of the service process to the demands and priorities of the users[16].

CONCLUSION

Considering the results of this study, it is verified that there was a deficiency in the accessibility of users to primary health care services, more precisely to family health units. The period of operation of the unit, the non-availability of professionals to give guidance by phone or to provide assistance when the service is closed, and the waiting time for the user to be served were aspects reported as insufficient.

In this sense, weaknesses in the primary health care network were evidenced regarding the guarantee of the population's access to the services and the possibility of the Family Health Strategy professionals to provide comprehensive and resolute care.

In order to guarantee comprehensive care in a qualified manner, it is necessary that the teams strive to create an individual and collective bond with the families, seeking alternatives to facilitate access to the service. The increase in the number of family health units or the extension/flexibility of opening hours can be seen as alternatives. Work organization, as well as the work processes in the FHS, need to be periodically evaluated to improve access and health promotion for users of the System, in order to generate subsidies for the decisions of managers in the scope of macro- and micro-politics.

Considering the creation of structuring nuclei to support management, through the permanent education of professionals, through partnerships with universities, is characterized as relevant in the territories. Mainly in those most vulnerable, with a low human development index.

It is also noteworthy that the periodic evaluation of primary care services can support the implementation of inter-sectoral actions that aim at continuity of care in a comprehensive manner and that favor equitable access and the flow of users in the Health Care Network.

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