


Focus on client satisfaction as a participatory strategy to promote access and quality of Primary Health Care in the Federal District


Foco na satisfação dos usuários como estratégia participativa para fomentar o acesso e a qualidade da Atenção Primária à Saúde do Distrito Federal¹

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Abstract

Quality in Primary Health Care can only be endured by considering essential attributes and social participation. This study, guided by collective health and its commitment to foster co-management processes based on participatory strategies, examined user perception regarding the care received and the functioning of their Basic Health Unit. A cross-sectional, qualitative, descriptive exploratory study was conducted with data collected at 25 urban and rural Primary Health Units in the Federal District, between August 2018 and February 2019, using a validated semi-structured questionnaire. Answers were analyzed using the AtlasTI software and grouped into the following thematic categories: professional staff, working shifts, available services and infrastructure. Qualified listening to users allows us to know the singularities of the services for planning and building a care model committed to the act of caring, from the perspective of health care users.

Keywords: Primary Care; User Satisfaction; Access to Health Services; Health Planning.

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Resumo

Para construir uma Atenção Primária à Saúde de qualidade deve-se considerar atributos essenciais e participação social. Este estudo, norteado pelo compromisso da saúde coletiva de fomentar processos de cogestão a partir de estratégias participativas, teve como objetivo compreender a percepção dos usuários sobre o atendimento recebido e o funcionamento de sua Unidade Básica de Saúde. O estudo transversal, qualitativo, de caráter exploratório-descritivo realizou a coleta de dados em 25 unidades de saúde urbanas e rurais do Distrito Federal, entre agosto de 2018 e fevereiro de 2019. Para elaborar este artigo, foram utilizadas as respostas a uma pergunta aberta de um questionário semiestruturado. Nelas, os usuários fizeram sugestões ou queixas a respeito dos serviços de saúde prestados. As respostas foram analisadas utilizando o software AtlasTI e sistematizadas em categorias temáticas. Ao final, foram organizadas nas seguintes categorias: elenco de profissionais, turnos de funcionamento, serviços disponíveis e infraestrutura. A escuta qualificada dos usuários permite conhecer as singularidades dos serviços para o planejamento e a construção de um modelo de atenção comprometido com o ato de cuidar, na perspectiva dos atores que compõem os territórios de saúde.

Palavras-chave: Atenção Primária; Satisfação dos Usuários; Acesso aos Serviços de Saúde; Planejamento em Saúde.

Introduction

Primary health care (PHC) is considered the main “gateway” for health service users (Starfield, 2002). However, in recent years, this level of care has undergone changes in its structure, organization, and financing that compromised the functioning of the Brazilian National Health System (SUS) and jeopardized care comprehensiveness and users’ access to health services.

In 2022, according to the Brazilian Transparency Portal, primary health care received 26.15% of the total expenditure on health. Compared to hospital and outpatient care (46.18% of the total health resources), primary care showed a considerably lower investment, which suggested the COVID-19 pandemic as the causal factor. However, analysis shows that primary care already received less spending than secondary and tertiary care (outpatient and specialized services in hospitals, respectively) in 2019 (Brasil, [20-]).

Understanding care comprehensiveness requires defending and improving the essential attributes of primary care: first contact, longitudinality, care coordination, and comprehensiveness (Starfield, 2002). Users’ first contact with the health system is essential to welcome them and listen to their demands (Cunha; Giovanella, 2011). Longitudinality presupposes continuity of care over time (Cunha; Giovanella, 2011; Starfield, 2002). Care coordination advocates the system functioning as a network. Finally, comprehensiveness proposes that health services act in an integrated manner, enabling citizens to be referred to the appropriate level of care and accessing the proper service to their demands (Araujo et al., 2014).

Evaluations of health technologies (medicines, materials, equipment, care programs, organizational systems, among others) also serve to achieve the aforementioned attributes. By applying their results, these assessments can enhance available resources and guarantee effective and safe technologies to the population under conditions of equity. Thus, “safety, accuracy, efficacy, effectiveness, costs, cost-effectiveness, and aspects of equity, related ethical, cultural, and environmental impacts” should be considered (Brasil, 2010, p. 17).

Still regarding the development of a problem-solving PHC, Bousquat et al. (2017), in a study that proposes

a typology of basic health units (UBS), list five dimensions to stratify their structure: types of staff, professional staff, working shifts, available services, and infrastructure. Each dimension the authors evaluated has a reference standard to be achieved that indicates the minimum conditions for good primary care based on data from the Brazilian Census of UBS Infrastructure, carried out in cycle 1 of the National Program for Improving Primary Care Access and Quality (Pmaq-AB) (Bousquat et al., 2017).

Building a consistent, powerful, and good PHC requires considering the aforementioned attributes and the UBS structure and encouraging SUS users' participation. Their reports enable the understanding of the points that require attention and improvement (Brasil, 2017). Thus, the surveys on SUS users' satisfaction stand out as they favor social participation and complement quantitative studies that analyze the problem-solving capacity of the health services offered to the population. They enabled the use of scientific evidence to support public administrators' decision-making (Makdisse; Katz, 2013). In public health planning and management, evaluating satisfaction is a fundamental tool to structure co-management processes to adapt services to local realities as it can identify users' experience.

Based on user satisfaction surveys, it is possible to expand the instruments of popular participation in the evaluation of PHC and contribute to the elaboration process of future health public policies, prioritizing actions that privilege directly listening to users about

service quality and that can increase social participation (Brasil, 2017).

This study aimed to understand users' perception of the care they received and the functioning of their reference UBS, analyzing how their dimensions - professional staff, working shifts, available services, and infrastructure - interfere in the access and quality of care and in the adherence of users to PHC.

Methodology

This is a cross-sectional, qualitative, exploratory-descriptive study with part of the data from a project whose general objective was to investigate user satisfaction and some aspects of the responsiveness of services, such as waiting time, privacy, and user autonomy, were analyzed.

Data were collected in 25 UBS by interviews with users in rural and urban areas of a health region in the Federal District from August 2018 to February 2019. This research was carried out at places at the chosen Basic Health Units that guaranteed respondents' autonomy and privacy.

The developed and validated semi-structured questionnaire (Xavier, 2019) had a set of closed questions and the following open-ended question: "Would you like to make any suggestions or complaints regarding the operation and care received at this Basic Health Unit?" Only the answers to the open-ended question were analyzed in this study. All asked questions are shown in Chart 1. Only the latter were analyzed in this study.

Chart 1 – Validated instrument to assess Primary Health Care users' satisfaction, Brasília, DF, 2019

1. Social and demographic data (age, sex, race/color, education, work, income, social benefits, family composition)
2. What was the main reason for your visit to the Basic Health Unit (UBS) today?
3. How long have you been seeking the care that motivated your visit to the UBS? () Days () Months () Years
4. Were you able to receive the service that motivated your visit? () Yes () No
5. How would you rate the waiting time for today's service? () Very good () Good () Fair () Poor () Very bad () Don't know/didn't want to answer
6. How do you classify the physical structure, furniture, and equipment of this UBS? () Very good () Good () Fair () Poor () Very bad () Don't know/didn't want to answer
7. How do you rate the comfort of the waiting room, exam room, and office? () Very good () Good () Fair () Poor () Very bad () Don't know/didn't want to answer

continues...

Chart 1 – Continuation

8. How would you rate the signage of the UBS spaces? () Very good () Good () Fair () Poor () Very bad () Don't know/didn't want to answer
9. How would you rate the cleanliness of the bathrooms at this UBS? () Very good () Good () Fair () Poor () Very bad () Don't know/didn't want to answer
10. How would you rate the cleanliness of the other spaces at this UBS? () Very good () Good () Fair () Poor () Very bad () Don't know/didn't want to answer
11. What is your opinion of the time you had to ask questions or state your concerns about your health problem or treatment in the care you received today? () Very good () Good () Fair () Poor () Very bad () Don't know/didn't want to answer () I didn't have any doubts/I didn't ask questions () Received no care
12. How would you rate the clarity of the information provided by the professionals who received you? () Very good () Good () Fair () Poor () Very bad () Don't know/didn't want to answer () I didn't have any doubts/I didn't ask questions () Received no care
13. Regarding the experience of healthcare providers who cared for you today attentively listening to you, what is your assessment? () Very good () Good () Fair () Poor () Very bad () Don't know/didn't want to answer () I didn't have any doubts/ I didn't ask questions () Received no care
14. How do you rate the respect with which professionals treated you today? () Very good () Good () Fair () Poor () Very bad () Don't know/didn't want to answer
15. What is your assessment of the way in which the healthcare providers who cared for you today asked for your permission before performing health treatments, exams, or procedures? () Very good () Good () Fair () Poor () Very bad () Don't know/didn't want to answer () Received no care/didn't have any tests or procedures
16. Would you recommend the services of this unit to friends and family? () Yes () No () Did not want to answer
17. In general, what grade, from 1 to 5 (with five being the best), would you give to the care you received today at this UBS?
18. Would you like to make any suggestions or complaints regarding the functioning and care received at this UBS? What suggestion(s)?

Source: Xavier (2019).

This project was approved by the Fundação Oswaldo Cruz Ethics Committee - Brasília, DF - and the Foundation for Teaching and Research in Health Sciences (Fepecs-DF), opinion 3.164.060. Informed consent forms were shown to users and only after receiving their consent and signature, the interview and completion of the instrument were initiated, which took place on tablets handled by a team with 12 health undergraduate scholarship holders. The procedure was coordinated by four experts in data collection in the research field.

The suggestions and complaints in the open responses to the instrument were analyzed in this study. These reports were contained in 1,674 questionnaires and were exported to AtlasTI, on which another reading was performed to find and examine users' answers. After review and analysis, participants' opinions

were organized into the following final categories (systematized based on the literature): professional staff, working shifts, available services, and infrastructure.

These categories were analyzed in dialogue with the framework of Bousquat et al. (2017), which supported the understanding of users' suggestions or complaints about the health services provided by UBS in the investigated region and fostered inferences about the strengths and weaknesses of PHC in the studied location.

User responses were categorized into four of Bousquat's five dimensions: professional staff, work shifts, available services, and infrastructure. Users' statements failed to address the "type of team" dimension and will be ignored in this study. The review also found consonances between the standards evaluated by Bousquat et al. (2017) and spontaneous

perceptions expressed by interviewees, which may indicate coincidental problems users face in accessing health services in different locations in Brazil.

Finally, authors in the scientific literature who also dialogued with the central points raised by the excerpts from users' answers were searched. In this study, participants are identified with fictitious names to preserve their anonymity. The excerpts cited throughout this study highlight the central ideas in users' reports and are thus sometimes located at the beginning, middle, and end of the answer to an open question. The omitted passages lacked interest for this analysis and are marked with an ellipsis in square brackets.

Results and discussion

Given the consonances between the problems evinced in the statements of users interviewed in 25 UBS in eastern Federal District and the dimensions analyzed by Bousquat et al. (2017), this study considered the answers that expressed desires resembling those of authors as they addressed ideal PHC quality standards. This study explains its analysis below, in dialogue with interviewees' demands and each dimension in Bousquat et al. (2017).

Professional staff

Users stated a lack of physicians, nurses, dentists, community agents, among other professionals, influencing the quality and problem-solving capacity of access to health services, as recommended by Giovanella et al. (2015) and the National Primary Care Policy (PNAB) (Brasil, 2017).

Users reported that the number of professionals in health services fails to meet the demands of the population. A participant reported: "*The unit has a constant lack of doctors in its teams. This gets in the way because it prolongs a treatment that I could do faster*" (Clarice). Another reported: "*The unit operates with a shortage of doctors. This is very bad [...]*" (Heitor).

Thus, having enough professionals to care for all service users is essential as they are important to produce and influence care and the quality of the provided services. Thus, all healthcare providers are relevant for comprehensive health care, i.e., health

teams as a whole think of strategies/actions to meet and solve the population's problems (O SUS..., 2013).

According to the Brazilian Center for Health Studies (O SUS..., 2013), lack of physicians is a chronic symptom of government officials' neglect of SUS, which was reinforced by users' statements: "[...] *care provided by a nurse. No doctors since December [...]*" (Benjamin); "[...] *most of the time, care is not possible due to lack of doctors*" (Aurora); "*there are no doctors*" (Alana). The lack of doctors in some regions stems from inequalities in their geographical distribution. Certain areas show a large supply of workers but others are unable to meet users' basic needs, constituting a barrier to health services accessibility.

The More Doctors Program (PMM) was created in 2013 to reduce physician shortage in priority regions for SUS and reduce regional inequalities in meeting the population's health needs (Pereira; Pacheco, 2017). Lack of coverage and access configured aspects of primary care that required improvement. An option to solve this problem involved hiring more than 18,000 Brazilian and foreign professionals to work in the regions with the greatest need and vulnerability. Thus, the PMM sought to reduce inequalities and strengthen health care comprehensiveness (Oliveira et al., 2019). A robust study in all 5,565 Brazilian municipalities employed a quasi-experimental design and showed the impact of the program on significantly reducing mortality from preventable causes (Hone et al., 2020).

It is reiterated that interviewees' reports occurred from August 2018 to February 2019, thus, after the implementation of the More Doctors Program, which was still unable to fully solve the problem of the lack of SUS professionals.

It is important to emphasize that maintaining an adequate number of physicians to serve the population should be a policy of the State, rather than the government. However, in 2019, with the change of direction within the Federal Government, the Doctors for Brazil Program was created in December of that year to replace the PMM.

The new program opened its first call for physicians in January 2022 (two years after its institution), calling 529 doctors and tutors (Gomes, 2022) - a derisory number compared to the 8,300 Cuban doctors who left the country at the end of 2018 (Dyer, 2018).

A framework was also created to implement this new program, establishing and operationalizing the Primary Health Care Development Agency. Its management model impacted primary health care services as it enabled the privatization of SUS and restricted the action of the State and society to promote access and social control over the offered services (Melo Neto; Barreto, 2019).

Another category, nurses, plays an important role in primary health care. However, according to users' reports, these professionals are in deficit and/or overworked. As a user reported: "[...] *too much demand for too little supply of doctors and nurses*" (Bela).

The Family Health Strategy (FHS) includes dental healthcare providers who aim to promote health and prevent oral diseases. They also show insufficient numbers, compromising the access of the Brazilian population to dental services (Matos et al., 2020), in line with interviewed users' statements. During this research, participants reported that the number of dentists fails to serve the population: "*the demand in dentistry is high and it is very difficult to get care*" (Pedro); "*lack of dental services*" (Carlos).

A user also reported that "*there should be more dental care*" (Melinda). Another finds "*a lack of dentists because there is never a vacancy*" (Pérola). The lack of dental professionals hinders users' first contact with health services as they encounter a barrier when they seek an UBS and receive no care.

Still regarding team completeness, it is necessary to highlight community health agents (CHA) as they are a fundamental figure that enables the population's needs to reach the teams (Costa, et al., 2013). Interviewed users reported: "*they no longer do home visits and it would be important for them to do so again*" (Luana); "*there is a lack of home visits for the elderly and people with depression*" (Manuela); "[...] *I would like to have home visits*" (Carolina); "*more visits from CHAs*" (Joaquina). It is possible, therefore, to infer that reports indicate an insufficient number of professionals. It is worth remembering that the new PNAB, reduced the minimum number of CHAs per team to only one from 2017 onward, i.e., teams, which no longer had enough CHAs to support FHS activities, tend to reduce this number even more over the years (Brasil, 2017). A recent study with 4,476 SUS users in Brasília pointed to the importance of home visits as a factor related to user satisfaction (Furlanetto et al., 2020).

In addition to the aforementioned professionals, users reported a lack of professionals without specifying their area of activity, for example: "[...] *to have more service employees*" (Marcos); "*increase the number of employees [...]*" (Paulo Henrique). All professionals are essential for users to feel welcomed and be able to develop a bond with service. Thus, it is important for health teams to be complete so they can provide the best care to the population. Lack of professionals affects care coordination since users suffer from the rupture of the capacity of the service to guarantee care continuity and comprehensiveness (Starfield, 2002).

In addition to a sufficient number of certain categories of professionals, reports also evince the importance of multidisciplinary teams to more fully meet the population's health demands. A team consisting of professionally trained individuals in different areas offers greater chances of success in the face of various social and cultural determinants, especially in a diverse country such as Brazil.

Thus, it is necessary to recognize the various social determinants that influence a multiplicity of diagnoses and PHC professionals must consider users' individual characteristics at the time of care. Thus, it is necessary to develop humanized care that places the individual at the center of care.

Although throughout the course of this research, no user highlighted the need to consider cultural factors in the therapeutic approach, it is important to include them among the aspects related to humanized care. This is because individuals have specificities that can be better addressed when the elements of culture are contemplated in care.

Working shifts

The concept of access varies among authors and changes over time according to context. It can also change according to focus: for some, it lies on individuals (social determinants that influence people even before they seek health services); for others, it focuses on offer (available places and exams, for example); and others still defend combining both - "individuals and services (supply)" (Travassos; Martins, 2004, p. S191).

Regarding offer, it should be noted that during this research, some users reported the need to extend

the days and hours of care at basic units. A user suggested “*increasing the number of days of service*” (Maitê). Another asked to “*make more days available for appointments*” (Marina). A third reported: “[...] *The delivery of a password hinders the operation [...], because it has a fixed schedule and I can’t come on time*” (Gabriela). It is necessary to increase the flexibility of care in UBSs to accommodate users’ demands, facilitating the population and workers’ access to services and enhancing FHS (Cordeiro et al., 2014). However, only extending days and hours is unable to solve citizens’ demands, which requires resolute services that restore users’ health and accept their demands.

Available services

This category considered users’ reports on the need for care without prior scheduling, difficulty to receive care (including criticism about appointment scheduling), and access to medication dispensation.

The comprehensive care of users requires the health model to consider their real needs and demands as individuals who, seeking health services, arrive with their physical and psychological symptoms, culture, social history, and economic issues. However, the health system fragments the needs of these users under the current logic, i.e., they receive segmented care. Thus, the SUS model must undergo a reformulation so it can comprehensively meet users’ demands (Costa, 2014).

It is important to highlight that care for spontaneous demands was one of the main points raised: “*it should meet the demands even if it had not been scheduled*” (Guilherme); “*make more time for fits into available time slots*” (Alicia). Health teams must make available to the population a number of slots for scheduled appointments and spontaneous demands. The expression “spontaneous demand” in PHC is used for the unscheduled care of acute health problems, classified between mild and moderate in primary care units (Brasil, 2013a). This form of action will help to relieve the burden on urgent and emergency units, which will be able to focus their efforts on serious and complex cases.

The lack of organization at UBSs can directly influence the population’s access to SUS services

and the guarantee of care. For example, users reported difficulty to schedule appointments or their lack: “*the service should be more organized to schedule appointments*” (Paulo); “*difficulty making an appointment*” (Fernanda); “[...] *it’s very difficult to make an appointment*” (Patricia). Another stresses service disorganization: “[...] *lack of organization among professionals, disorganized care*” (Lucas). The problems related to access to primary care lead users to increasingly distrust SUS since they find no space to forward their demands during suffering (Azevedo; Costa, 2010).

‘Available services’ also analyzed access to medication. Despite appreciating the curative mentality instead of promoting and preventing diseases, participants’ extensively highlighted medication unavailability. Some of the searched literature also indicates this as good access to SUS. Citizens’ lack of access to medication compromises their amelioration, forcing them to return to health services and interfering with care comprehensiveness (Paniz et al., 2008; Starfield, 2002).

According to users’ reports, the UBSs in which they sought care fail to meet this dimension: “[...] *several medicines are in short supply and I haven’t been able to get my medicines for six months*” (Gustavo). Many respondents also reported “*lack of medication for chronic problems*” (Sarah) and “*lack of medications for diabetes and high cholesterol*” (Jorge). The health system has fundamental guiding principles (universality, equity, and comprehensiveness) that provide individuals with longitudinal care (Starfield, 2002). However, the system failing to give users their medications disrupts care longitudinality by interrupting the process of reestablishing their health (despite their efforts to make an appointment) and interfering with such attribute of primary care (Starfield, 2002). Thus, statements indicate the need to provide the population with access to medication in sufficient quantities, as per a user: “[...] *improve the amount of medicines in the pharmacy*” (Esther).

Infrastructure

This category included users’ statements related to lack of supplies, materials, and equipment and to room/office comfort. An interviewee reported, for example: “*there is a lack of material for the*

prevention exam” (Janaína). Another reported: “[...] *it has no materials*” (Maya). No single person holds the responsibility for infrastructure deficiencies given that all federated entities have explicit and concomitant attributions. The Ministry of Health is primarily responsible for planning, financing, and purchasing inputs. On the other hand, it is up to the states, municipalities, and the Federal District to receive, store, and distribute them (Brasil, 2017). Therefore, it is essential to ensure access to materials and supplies in sufficient quantity for all users of the health system.

Infrastructure is the set of facilities, equipment, furniture, and services necessary for the effective functioning of health facilities (Brasil, 2017). Moreover, offering a service with good infrastructure is a PHC attribute (Starfield, 2002). However, the UBS infrastructure configures an issue users recurrently raised during this research. An interviewee reported: “*I would like the physical structure to improve*” (Maddalena). Another stressed: “*improvement in the conditions of the physical structure of the UBS*” (Batina). Users also asked for improvements in the waiting rooms: “*improve the waiting room*” (David); “*improve the physical structure, especially the waiting room*” (Ada); “*improve the waiting room, dental area, pharmacy area, front structure, because there is no coverage*” (Fernanda).

Some primary care units face problems in their facilities or physical structure, which fail to comply with Ministry of Health recommendations (Brasil, 2008). According to a user, “*the structure is terrible and without full coverage*” (André). Another stated that “*there should be an area so that there is no rain outside the unit*” (Afonso). Thus, interviewees claim being exposed to inappropriate environments, compromising their experience with the service. A 2014 study that analyzed data from the external evaluation of the second cycle of the Pmaq-AB found an association between the perception of a good UBS infrastructure and greater user satisfaction (Cantalino et al., 2021), corroborating our inference that the infrastructure of the basic units interferes with access to health services and compromises the development and quality of primary care actions.

The population has extensively sought SUS in recent months due to the COVID-19 pandemic.

This disease has infected, as of August 28, 2022, 34 million people and caused 682 thousand deaths in Brazil (Brasil, 2021). It has a very high degree of transmission, especially indoors (where air is unable to circulate) and crowded places. A user reported a deficient physical structure of the basic unit even before the pandemic since the system was already full and overloaded: “*outdated infrastructure. A lot of people crowding the same place*” (Pedro). Thus, it should be noted that the structure of that unit was no longer adequate for the population and probably worsened in the face of the pandemic. Another survey carried out from 2020 to 2021 in all 165 UBS in the Federal District analyzed their structure and capacity to respond to COVID-19, finding the following: readjustment of physical structures; provision of personal protective equipment and COVID-19 tests; active search for users with respiratory symptoms or suspected of having COVID-19; monitoring of transfer flows of respiratory symptomatic users; and telehealth services. The study concluded that UBS reorganized their services to meet the needs imposed by the pandemic (Furlanetto et al., 2022).

Another infrastructure sub-dimension refers to the availability of a computerized system that can better organize and streamline negotiations related to the service and follow-up of users. Thus, a user claimed that “*everything should be more computerized so I don’t have to come here to look for information, wasting a lot of time*” (Aline). Others reported: “[...] *needs to have an electronic medical record[...]*” (Sandra); “*better communication and information of the system*” (Carlos); “*I would like the system to be computerized in the pharmacy*” (Erick); “*improvement in the system, internet*” (Paula). Currently, the e-SUS system has a citizen’s electronic medical record in primary care. However, this instrument still faces difficulties as it works offline in many regions, i.e., the information is filled in without an internet connection and is then forwarded to the system database.

Final considerations

Listening to the demands of the population enables all SUS professionals, researchers, and managers to visualize the UBS characteristics that will enable comparison to a pre-established ideal standard in the

four analyzed dimensions and the identification of improvements in citizens' access to health services.

This study proves that the different contexts and places in which SUS is present requires the analysis of the perception of the target public regarding health services to find, by a broader view, what is unavailable and what can be improved in the UBS. Providing this evaluation to management will enable it to propose solutions to any problems reported by those who use the system.

Thus, listening to users configures an initiative that contributes toward the ideal UBS standard. It is important to highlight that rather than only listening, it is necessary to consider the opinions of the population in planning and proposals for local improvement initiatives. However, day-to-day management fails to always favor the construction of political-organizational processes that can encompass the participation of users in decision-making. This study highlights that moments of listening provide direct access to the perception of service users, and enable its acquaintance, and give visibility to demands that require improvement. By incorporating this perception into the political-organizational processes to improve access to health services, management consolidates the precepts that implement a powerful and responsive Unified Health System.

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