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THE QUALITY OF PRIMARY HEALTH CARE IN THE COLUMBIA NEIGHBORHOOD – COLATINA, BRAZIL, FROM THE PERSPECTIVE OF ADULT USERS

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Abstract: The Pan American Health Organization (PAHO) together with the World Health Organization (WHO) refers to Primary Care as the first level of care and the main gateway into the health system. For Starfield, there are four essential attributes for evaluating PHC, which are: access to the individual's first contact with the health system, longitudinality, comprehensiveness and coordination of care. In addition to these, there are qualifiers, called derived attributes, which are: family-centered health care, community orientation and cultural competence. The objective of this study was to evaluate the profile of users and the quality of Primary Health Care in the Basic Health Unit in the Columbia neighborhood, Colatina - ES. A descriptive study, with a quantitative approach, was carried out with adult users of the service, using a questionnaire based on the Primary Care Assessment Tool (PCATool-Brazil) – adult instrument. In relation to the PHC attributes evaluated, it was seen that "affiliation", "access to first contact", "longitudinality" presented a positive evaluation based on the responses of the majority of users. However, the other attributes "coordination", "integrality", "family focus" and "community orientation" demonstrated deficiencies. The majority of participants reported lack of knowledge about mental health counseling, smoking cessation, changes with aging or prevention of falls at the USF, there is a failure to integrate the patient into their care or that of their family, and 74% reported that they are not done research to find out whether your health needs are being met. In view of this, it is understood that there is a need to develop public policies that seek greater involvement of the family and the community in the search for the right to citizenship and improved quality of life.
Keywords: Primary Health Care; Public health; Health Services Research.

INTRODUCTION

The Pan American Health Organization (PAHO) together with the World Health Organization (WHO) refers to Primary Care as the first level of care and the main gateway into the health system. It is characterized by a set of actions at the individual and collective level, namely the promotion and protection of health, the prevention of injuries, diagnosis, treatment, rehabilitation, harm reduction and health maintenance. Through these actions, 80% to 90% of the population's needs must be addressed and resolved at this level, thus creating deep connections with the community and other sectors, which encourages social participation and intersectoral action (OPAS, 2023; STARFIELD, 2002).

Still in 1920, scientific medicine, based on individualism, specialization and with a strong emphasis on curative aspects and the hospital as its main locus of action, was already criticized by authors. One of them was the Englishman Bertrand Dawson. He proposed a reorganization of health services, based on generalist professionals who would be responsible for implementing both curative and preventive actions, with services organized locally and regionally, by levels of care. Dawson's ideas were crucial in developing a new health service model. These same ideas would serve as the basis for the principles of primary health care that would be implemented decades later (NARVAI, 2022; CALDAS et al. 2018).

In 1977, the World Health Assembly decided that the main goal for participating governments would be: "Health for all by the year 2000". This declaration triggered activities that had a great impact on thinking about Primary Care. The principles were enunciated at a Conference in Alma-Ata in 1978 and from then on, in different places around the world, the precepts of primary care were adopted by faith (NARVAI, 2022; HARTZ et al. 2020).

According to Starfield (2002), the Alma Ata Declaration of 1978 codified the "sanctity" of primary health care as a principle for all health systems in the world. And it was for this reason, more recently in the historical context, that scientific evidence of the benefits of primary care was sought and found. Starfield showed that countries with higher Primary Care scores have effects on effectiveness, efficiency and equity, with better results.

In Brazil, the adoption of these ideas only began to occur in 1988, when the Federal Constitution defined three major references for the Brazilian health system: an expanded concept of health; health as a duty of the state and a right of the citizen; and the establishment of a Unified Health System (SUS). But Primary Health Care only became an organizational strategy for the SUS from the 1990s onwards, with the implementation of the Family Health Strategy (ESF) (BUSS et al., 2019).

According to Starfield (2002), there are four essential elements, called essential attributes, for evaluating PHC, which are: the individual's first contact access to the health system, longitudinality, comprehensiveness and coordination of care. In addition to these, there are qualifiers, called derived attributes, which are: family-centered health care, community orientation and cultural competence.

A primary care service aimed at the general population can only be considered a primary care provider when it meets the four essential attributes, and the derived attributes increase its power of interaction with individuals and the community. The identification of these attributes is important to define whether the service is truly based on PHC, and they serve as a basis for the development and elaboration of instruments that are capable of evaluating Primary Health Care in a given location (MASOCHINI, FARIAS and SOUSA, 2018).

Thus, due to the lack of tools to measure

these interactions in the context of PHC in our country, the use of the Primary Care Assessment Tool Manual, the Primary Care Assessment Tool (PCATool – Primary Care Assessment Tool) was implemented.) created by Starfield & cols, originally presents self-administered versions aimed at children (PCATool Child version), adults over 18 years old (PCATool Adult version), health professionals and also the coordinator/ manager of the health service, the which measures the extent of the 4 essential attributes and the 3 attributes derived from PHC, recommended by Starfield (BRASIL, 2020).

However, De Oliveira, et al., (2013) believes that to optimize the process of application and use of results in strategic actions, a reduced version of this instrument is necessary. For this purpose, the PCATool-ADULTO-BRASIL (short version) was developed. It presented adequate validity and reliability and could be adopted as a rapid assessment tool for guidance for PHC in Brazilian services, allowing managers to make decisions guided by evidence to develop actions to improve the quality of care offered to the population.

Although it is essential to establish a process for evaluating and monitoring the quality of PHC in Brazil, this is still a challenge. In this sense, this study aims to evaluate the quality of Primary Health Care in the Colúmbia neighborhood, Colatina-ES, from the perspective of adult users.

MATERIALS AND METHODS

This is a descriptive, cross-sectional, quantitative study with independent random samples. The instrument used to evaluate the quality of services provided was the Primary Care Assessment Tool – adult (short version).

The sample consisted of 204 adult users of Primary Health Care in the Columbia neighborhood. Columbia is one of 67 neighborhoods belonging to the city of Colatina in the state of Espírito Santo. Located on the banks of the Doce River, Columbia has an estimated population of 4,012 inhabitants, made up of 1,932 men and 2,080 women, according to IBGE (2010) (Figure 01).

To be part of the sample, users of the health service must be adults aged 18 or over, with at least one medical consultation prior to the date of application of the instrument at the health service in question. The exclusion criteria included those who do not have the physical and mental conditions to respond to the questionnaire or who have not had a medical consultation at the health service in question.

Prior to each interview, participants were provided with explanations about the objectives, possible risks and benefits of the study. All doubts raised were resolved. Participants who agreed to voluntarily participate in the research signed an Informed Consent Form (TCLE).

Affirmative consent to participate in the interview was followed by the oral application of a questionnaire based on the PCATool-Brasil-adults instrument (reduced version), an electronic recording questionnaire composed of 28 objective questions with their respective alternatives.

The questionnaire was administered by the attendants themselves at the end of each medical consultation. The 28 questions addressed topics related to the 7 attributes of PHC.

The answers to these questions were tallied and formed an average score for each attribute. The attributes that reached a minimum score of 6.6 were considered to be part of the PHC in question and efficient in that context.

To collect data, an electronic form structured in 2 parts was used: I- Sociodemographic data about the PHC user; II- questionnaire based on the PCAtoll-Adult instrument (reduced

version) (table 1).

Once all questions were answered objectively, the response data was automatically sent and organized to a database on the Google Forms platform (GOOGLE, 2018), where it was stored. To analyze the results, the IBM SSP Statistics 20.0.0 2011 software was used.

Figure 01: Columbia Neighborhood Satellite View

Source: Available at:<https://cidades.ibge.gov.br/brasil/es/colatina/panorama> Accessed on: March 28, 2023.

APS attribute	APS component	Items
Affiliation	Affiliation	A1, A2, A3
First contact access	Use	B2
First contact access	Accessibility	C4, C11
Longitudinality	Longitudinality	D1, D6, D9, D14
Coordination	Care integration	E2, E6, E7, E9
Coordination	System of information	F3
Completeness	Available services	G9, G17, G20
Completeness	Services supplied	H1, H5, H7, H11
Family guidance	Family guidance	I1, I3
Community orientation	Community orientation	J4

Table 01: PCAToll-adult (reduced version)

Source: Ministry of Health, 2020.

RESULTS

The average time for each interview was 32 minutes. Regarding sex, the majority of adults were female (74%). In the Columbia neighborhood, 69.1% of people were married or had a partner; 7.8% were illiterate and only 21.1% had completed high school. As for age, the majority were between 40 and 49 years old. 99.5% of the population had a SUS card (Table 02).

The attributes "coordination", "integrality", "family focus" and "community orientation" demonstrated deficiencies. The majority of participants reported lack of knowledge about mental health counseling, smoking cessation, changes with aging or prevention of falls at the USF, there is a failure to integrate the patient into their care or that of their family, and 74% reported that they are not done research to find out whether their health needs are being met (Table 03).

Table 04 presents the average scores obtained for both essential attributes and derived attributes with a 95% confidence interval in the experience of adult users of Primary Health Care in the Columbia neighborhood.

Among those evaluated by the PCAToll-Adult instrument, the attributes first contact access (use), longitudinality and coordination of care (information system) presented means greater than 6.6, being 8.0 (95%CI: 7.6 - 8.4), 7.3 (95%CI: 6.9 - 7.7) and 9.3 (95%CI: 8.8 - 9.8) respectively. It must also be said that utilization, longitudinality and information systems were the only attributes that were considered to have a strong degree of service orientation in relation to PHC attributes (≥ 6.6). On the other hand, all other attributes presented average scores lower than 6.6, with the attribute's community orientation, comprehensiveness (services available), and family orientation being the lowest, presenting 1.7 (95% CI: 1.6 – 1.8), 3.3 (95%CI: 3.1 – 3.5) and 4.7 (95%CI: 4.5 – 4.9) mean score respectively.

AGE	(%)
18 to 29 years	14,7
30 to 39 years	21,1
40 to 49 years	22,1
50 to 59 years	18,6
60 to 69 years	14,2

Over 70 years	9,3
MARITAL STATUS	**(%)**
Single	18,6
Widow	5,9
Married	59,8
Divorced	6,4
Stable union	9,3
EDUCATION LEVEL	**(%)**
Illiterate	7,8
Incomplete primary education	42,6
Complete primary education	9,8
Incomplete high school	10,3
Complete high school	21,1
Incomplete Higher Education	3,9
Complete Higher Education	3,9
Post-Graduation	0,5
GENDER	
Male	26
Female	74
THE PERSON HAS card of S.U.S. (Unified Health System)	
Yes	99,5
No	0,5

Table 02: Sociodemographic Characteristics – N= 204

Source: Data generated from research

Attributes of Primary Health Care	n	Average (IC 95%)
Use	204	8,0 (7,6 - 8,4)
Accessibility	204	5,3 (5,0 - 5,6)
Longitudinality	204	7,3 (6,9 - 7,7)
Coordination - Care integration	204	5,0 (4,8 - 5,3)
Coordination - Information system	204	9,3 (8,8 - 9,8)
Comprehensiveness - Available services	204	3,3 (3,1 - 3,5)
Comprehensiveness - Services provided	204	5,7 (5,4 - 6,0)
Family Guidance	204	4,7 (4,5 - 4,9)
Community Guidance	204	1,7 (1,6 - 1,8)
General score	**204**	**5,6 (5,3 - 5,9)**

Table 04. Average scores and confidence intervals (95% CI) of Primary Health Care attributes in the experience of adult users.

Source: Data generated from research

DISCUSSION

There are different variables when discussing the evaluation of PHC attributes, the use of health services is related to several factors, such as the perception of the disease, the users' needs, the availability of the services offered, or even sociodemographic characteristics, such as also limited family resources (BRITO et al., 2021; BERNAL et al., 2020).

In the first analysis, in relation to sociodemographic data, it was found that PHC users in the Columbia neighborhood are mostly women, 74% of participants are older adults, 85.3% are over 30 years old, with low education, 70.5% do not have completed secondary education. The greater use of PHC services by women may be related to the search for specific exams from pre-adolescence, the habit of going to the gynecologist to deal with issues such as the first menstruation and guidance on the use of contraceptive methods (BERNAL et al, 2020).

The attributes community guidance, comprehensiveness (available services) and family guidance presented average scores below 6.6, recommended by the Ministry of Health, presenting 1.7 (IC95%: 1.6 – 1.8), 3.3 (IC95 %: 3.1 – 3.5) and 4.7 (95%CI: 4.5 – 4.9) mean score respectively. These results corroborate the studies by Grendene, Tolazzi and Vinholes (2022), Bernal et al., (2020) and Bispo et al., (2019), highlighting the importance of frequent assessment of the quality of health services in APS from the users' point of view, since the evaluation carried out by users tends to be more rigorous than that of managers and professionals, so that it is possible to meet the demands of users or refer them to another point in the health care network.

It is also worth mentioning that the attributes first contact access (use), longitudinality and coordination of care

Questions	Surely, yes		Probably yes		Probably not		Surely not		I don't know or I don't remember	
	N	%	N	%	N	%	N	%	N	%
B2. Você vai à USF do seu bairro quando apresenta um novo problema de saúde? Utilização	131	64,2	42	20,6	13	6,4	18	8,8	-	-
C4. Can you provide quick telephone counseling when your neighborhood USF is open? Accessibility	74	36,3	12	5,9	3	1,5	36	17,6	79	38,7
D1. At the USF in your neighborhood, do you always receive care from the same healthcare team?	61	29,9	37	18,1	28	13,7	76	37,3	2	1,0
D6. Do you feel comfortable reporting your problems to your neighborhood health team?	163	79,9	17	8,3	17	8,3	7	3,4	-	-
D14. Would you choose to be treated at another USF if that were possible?	19	9,3	10	4,9	23	11,3	150	73,5	2	1,0
E2. Have you ever been referred to a specialized service by the team at your USF?	131	64,2	3	1,5	4	2,0	52	25,5	14	6,9
E6. In the referral, was there information for the specialist about the reason for the consultation?	82	40,2	17	8,3	7	3,4	17	8,3	81	39,7
E7. Does the USF health team in your neighborhood know what the results of this consultation were?	56	27,5	12	5,9	12	5,9	56	27,5	68	33,3
E9. Did the health team at the USF in your neighborhood ask you if you received quality care at the specialized service?	37	18,1	9	4,4	6	2,9	89	43,6	63	30,9
F3. When you go to the USF in your neighborhood, are your medical records always available at the appointment? Information systems	184	90,2	13	6,4	1	0,5	4	2,0	2	1,0
G9. Is there counseling for mental health problems at your USF?	26	12,7	23	11,3	6	2,9	35	17,2	114	55,9
G17. Is there advice to stop smoking?	41	20,1	18	8,8	6	2,9	24	11,8	115	56,4
G20. Is there advice on changes as you age?	20	9,8	21	10,3	3	1,5	52	25,5	108	52,9
H5. Is there advice on physical activity? Services provided.	90	44,1	10	4,9	7	3,4	55	27,0	42	20,6
H7. At USF, does the healthcare team check and discuss the medications you are using?	130	63,7	31	15,2	6	2,9	27	13,2	10	4,9
H11. Is there advice on how to prevent falls?	37	18,1	24	11,8	5	2,5	51	25,0	87	42,6
I1. Does the healthcare team ask for your opinion regarding the treatment and care for your health or that of your family members?	40	19,6	13	6,4	14	6,9	131	64,2	6	2,9
I3. Would the team hold a meeting with your family members if you thought it was necessary?	77	37,7	55	27,0	22	10,8	23	11,3	27	13,2
J4. Does the USF in your neighborhood carry out surveys with patients to find out if their needs are being met?	13	6,4	25	12,3	7	3,4	151	74,0	8	3,9

Table 03. Questionnaire answered by users, using the Likert scale

Source: Data generated from research

(information system) presented means greater than 6.6, being 8.0 (95%CI: 7.6 - 8.4), 7.3 (95%CI: 6.9 - 7.7) and 9.3 (95%CI: 8.8 - 9.8) respectively. It must also be said that utilization, longitudinality and information systems were the only attributes that are considered to have a strong degree of service orientation in relation to PHC attributes.

Finally, in relation to the general score found in the PCATool - adult (reduced version), the present study revealed a general score of 5.6 (95% CI: 5.3 - 5.9), falling below the range recommended by the Ministry of Health. It can be seen that the main problems that led to low scores were: a failure to offer advice on mental health problems, smoking, changes that occur with aging, on how to prevent falls, failures in informational communication and interaction with other levels and networks of assistance, little user participation in decisions about their treatment and health care and/or their family members and low user participation in social control.

A service can only be considered a primary care provider when it meets the four essential attributes, and the derived attributes increase its power of interaction with individuals and the community. The presence of these attributes promotes better health indicators, greater user satisfaction, lower costs and greater equity, generating a positive impact on the health of the population covered. The identification of these attributes is important to define whether the service is truly based on APS. Therefore, it remains to be admitted that there is a need to develop public policies that seek greater involvement of the family and community in the search for the right to citizenship and improved quality of life.

CONCLUSION

The research results show that, from the users' perspective, Primary Health Care in the Columbia neighborhood presented a low level of service orientation in relation to PHC attributes. Despite the impossibility of generalizing the results to the entire municipality of Colatina, these results can guide health professionals and local and national managers in the search for strategies to strengthen PHC.

It is recommended that more evaluative studies be carried out in which other agents are included, such as Family Health Strategy professionals, so that, from a new perspective, a comparison can be made between the two views, identifying the main needs of this population and suggest proposals for joint interventions that are more appropriate to the reality experienced by the user.

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