

Accessibility to the treatment of hypertension in the family health strategy



Acessibilidade ao tratamento da hipertensão arterial na estratégia saúde da família
Accesibilidad al tratamiento de la hipertensión arterial en la estrategia de salud familiar

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ABSTRACT

Objective: To analyze the satisfaction about the accessibility to the treatment of people with hypertension accompanied by the Family Health Strategy.

Method: Cross-sectional study, conducted with 417 people living in a city in the state of Paraná, Brazil. The data collection was performed between February and June of 2016, using a satisfaction instrument regarding the services provided by the Primary Health Care, using issues related to treatment accessibility. A descriptive and inferential analysis to treat the variables was adopted.

Results: 417 people participated in the study, from which 62.4% were elderly, 67.8% were female and 55.2% were retired/pensioners. The economic accessibility was the best evaluated indicator. The regular evaluation of the services characteristic of the geographical and organizational accessibility was significantly associated to the inadequate monitoring of these users in the Family Health Strategy.

Conclusion: The services offered to people with arterial hypertension were evaluated as regular, presenting the main barriers related to geographical and organizational aspects.

Keywords: Primary Health Care. Health services research. Nursing. Family Health Strategy. Adult health. Hypertension.

RESUMO

Objetivo: Analisar a satisfação acerca da acessibilidade ao tratamento de pessoas com hipertensão arterial acompanhadas pela Estratégia Saúde da Família.

Método: Estudo transversal, realizado com 417 pessoas residentes em um município do estado do Paraná, Brasil. A coleta de dados foi realizada entre fevereiro e junho de 2016, utilizando instrumento de satisfação com serviços prestados pela Atenção Primária à Saúde, empregando questões referentes à acessibilidade ao tratamento. Adotou-se análise descritiva e inferencial para tratamento das variáveis.

Resultados: Participaram do estudo 417 pessoas, em que 62,4% eram idosos, 67,8% do sexo feminino, e 55,2% aposentados/pensionistas. A acessibilidade econômica foi o indicador melhor avaliado. A avaliação regular dos serviços característicos da acessibilidade geográfica e organizacional foi significativamente associada ao acompanhamento inadequado desses usuários na Estratégia Saúde da Família.

Conclusão: Os serviços ofertados às pessoas com hipertensão arterial foram avaliados como regular, apresentando principais barreiras referente a aspectos geográficos e organizacionais.

Palavras-chave: Atenção Primária à Saúde. Pesquisa sobre serviços de saúde. Enfermagem. Estratégia Saúde da Família. Saúde do adulto. Hipertensão.

RESUMEN

Objetivo: Analizar la satisfacción acerca de la accesibilidad al tratamiento de personas con hipertensión arterial acompañadas por la Estrategia de Salud de la Familia.

Método: Estudio transversal, realizado con 417 personas residentes en un municipio del estado de Paraná, Brasil. Se realizó la recolección de datos entre febrero y junio de 2016, utilizando instrumento de satisfacción con servicios prestados por la Atención Primaria a la Salud, empleando cuestiones referentes a la accesibilidad al tratamiento. Se adoptó el análisis descriptivo e inferencial para el tratamiento de las variables.

Resultados: Participaron del estudio 417 personas, en las que el 62,4% eran ancianos, el 67,8% del sexo femenino y el 55,2% jubilados/pensionistas. La accesibilidad económica fue el indicador mejor evaluado. La evaluación regular de los servicios característicos de la accesibilidad geográfica y organizacional fue significativamente asociada al seguimiento inadecuado de estos usuarios en la Estrategia de Salud de la Familia.

Conclusión: Los servicios ofrecidos a las personas con hipertensión arterial fueron evaluados como regular, presentando principales barreras referentes a aspectos geográficos y organizacionales.

Palabras clave: Atención Primaria de Salud. Investigación en servicios de salud. Enfermería. Estrategia de Salud Familiar. Salud del adulto. Hipertensión.

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■ INTRODUCTION

Chronic non-communicable diseases (CNCD) are considered challenges for the public health worldwide due to its high prevalence of deaths and physical disability, resulting in large costs to health services for the hospitalizations arising from complications of these diseases. Among the CNCD, the cardiovascular diseases (CVD) are more prevalent, with hypertension (HBP – High Blood Pressure) being responsible for 63% of a total of 38 million deaths worldwide. In Brazil, the prevalence of this morbidity in the adult population is on average 20%⁽¹⁻²⁾.

Of multifactorial origin, the HBP has specific treatment and needs constant evaluation, and actions must be taken so that the pressure and symptomatic control of the disease is resolute. In this respect, care strategies to morbidity are created and recommended by the Ministry of Health and other public bodies in various countries, responsible for promoting health and preventing aggravations since, in most cases, the HBP can be diagnosed and treated by the Primary Health Care network (PHC)⁽²⁻³⁾.

In Brazil, the health services that are a characteristic of the PHC are in high growth since the implementation of the Family Health Strategy (FHS), which aims at ensuring attendance to the whole population, reducing access inequalities⁽³⁾. In addition, the FHS favors the expansion and consolidation of the PHC, being the gateway to the diagnosis of health needs and responsible for incorporating health actions and access to therapeutic continuity, with the management of health actions based on the solution of the health needs of the population⁽⁴⁻⁵⁾.

For the care of the person with HBP, the Ministry of Health advocates the adoption of strategies, mainly educational, with therapeutic schemes based on consultations and equitable actions performed by health professionals⁽⁵⁾. These actions can enhance the accessibility to the treatment of the disease, stimulate the participation of the user in the control of health problems, according to the organizational, economic and geographical dynamics established by the health management of the municipalities⁽⁶⁻⁷⁾.

The evaluation of the satisfaction with the health services is increasing in the country and can provide indicators for the elaboration of new public policies and the qualification of the existing ones, implementing the guidelines of the PHC, focused on the care at first contact, longitudinality, comprehensiveness, coordination, cultural competence, community and family orientation⁽³⁻⁴⁾. The participation of the user in the evaluation of the services can favor the understanding of the different pers-

pectives of those involved in the service, incorporating them in the decisions and planning of a Care Plan⁽⁷⁾, based on the guidelines of the Unified Health System (SUS – *Sistema Único de Saúde*) of universal, comprehensive and equitable service^(2,6).

Based on the above, aiming at the needs of the people under treatment of the disease in the face of the services offered by the FHS and the assumptions of the PHC, the question is: what is the level of satisfaction with the treatment of people with HBP monitored by the FHS? Thus, this study aimed at analyzing the satisfaction about the accessibility to the treatment of people with HBP monitored by the FHS.

■ METHOD

Transversal study, carried out with people under treatment for HBP, registered in 34 Basic Health Units (BHU) and monitored by 74 teams of the FHS, with population coverage of 68.01%⁽⁸⁾, in a municipality located in the northwest region of the state of Paraná, Brazil.

The inclusion criteria were: to have at least 18 years old, to live in the urban area of the municipality, to be registered in the HIPERDIA program and to have been attended by health professionals of the BHUs in the last six months prior the beginning of the data collection. The exclusion criterion adopted was to be pregnant at the time of the interviews, for being monitored by another program, withdrawing from HIPERDIA and due to the need of data collection related to anthropometric variables.

For the definition of the sample size it was considered the total number of 27,741 individuals registered in the HIPERDIA program until the year 2014, with an estimated error of 5% and 95% confidence interval, and plus 15% for possible losses, resulting in 437 individuals. For the selection of the participants, the simple process of random sampling was used, and subsequently, it was stratified according to the number of patients attended in each BHU of the municipality. Considering the losses due to death or change of address and the refusals, the final sample of the study was composed of 417 people.

The data collection stage was held between February and June 2016, during the working hours of the BHUs and group meetings of people belonging to the HIPERDIA program, through an individual interview. The main author of this study and three nurses linked to a postgraduate program participated in the data collection.

Two instruments were used for data collection, which passed through the pilot test to ascertain the need to adapt to the studied population, not being necessary any

corrections as to the structure of both. The first instrument refers to the evaluation of the economic class, classifying the purchasing power of the individual and their family⁽⁹⁾, grouped in this study in AB, C and DE.

The second instrument evaluated the satisfaction with the services provided by the PHC; it was adapted and validated by Paes⁽¹⁰⁾ in two cities in the state of Paraíba, based on the Primary Care Assessment Tool (PCAtool), according to the assumptions of Starfield⁽¹¹⁾. This instrument includes questions related to identification, sociodemographic profile, anthropometric data, presence of concomitant diseases and associated with HBP-related complications, as well as attributes pertaining to the PHC, which are: accessibility to treatment, adhesion/affiliation, catalogue of services, coordination of care, family focus and community guidance. They can be evaluated separately or together.

Due to the extension of the instrument, for this study, the domain accessibility to the treatment of HBP (geographical, economical and organizational accessibility) was evaluated, as well as 13 variables that compose it. The geographical accessibility has been characterized by issues related to the average distance between the population and the BHUs that offer the health services. The economic accessibility establishes a relationship between the use of financial resources to obtain treatment assistance, as well as prejudice for the loss of the day of work. The organizational accessibility represents the barriers of the services originated internally, related to the way in which the professionals organize and establish the attendances.

Each variable was composed of questions with answers corresponding to a Likert scale, attributing values between one and five for the answers "never", "almost never", "sometimes", "almost always" and "always", in addition to the options "does not apply" and "does not know/did not answer" to enable all the possibilities of answer⁽¹⁰⁾. Moreover, the data regarding the pressure value and adequate monitoring by the teams of the FHS were used for the characterization of the investigated individuals.

The pressure values measured during the data collection procedure, with duly revised and calibrated equipment were used. The values were encoded in "Inadequate Pressure Control" when the systolic blood pressure values (SBP) were lower than 140 mmHg, and the diastolic blood pressure (DBP) was higher than 90 mmHg, considering the criteria of the VII Brazilian Guideline of Arterial Hypertension⁽¹²⁾.

To analyze the adequacy of the monitoring by the FHS team, the electronic records were analyzed after the interviews were carried out or on days previously scheduled, according to the availability of the nurse responsible for the

team. For the classification of the monitoring, it was considered the criteria proposed by the Ministry of Health⁽⁷⁾, which establishes as the regular monitoring the patient that goes to the BHU at least three times a year, with pressure values evaluated and recorded in the chart. For this study, the period of 2015 was evaluated.

The data were tabulated twice on the Microsoft Office Excel 2013 spreadsheet and statistical analysis procedures were carried out in the IBM SPSS software version 19.0. The Kruskal-Wallis test was used for analysis of the variance and obtaining the mean, as well as a confidence index at 95% and standard deviation of the indicators scores. Subsequently, they were classified from the cutting point of the means given by the test, dividing in satisfactory (equal to or above 4), regular (less than 4 and equal to or above 3) and unsatisfactory (less than 3), according to the study carried out by the authors of the instrument⁽²⁾.

For the association, the logistic regression model was used with the Forward method, considering the variables that resulted in the value of $p < 0.20$ in the gross analysis. The magnitude of the associations was estimated by the calculation of the Odds Ratio (OR), adopting the confidence interval of 95% as a measure of accuracy, considering the value of $p < 0.05$ between the tests performed. The variables used were the classification of the mean of the evaluation of accessibility indicators, and the categorized result of the blood pressure values measured in the interviews with the monitoring resulting from the analysis of the medical records of the participants in the study.

This research followed the guidelines of the Resolution 466/2012 of the National Health Council. The project received a favorable opinion from the Standing Ethical Committee on Human Research, as Opinion n°. 1.407.687/2016, Certificate of Presentation for Ethical Appreciation (CAAE) n. 47380215.6.0000.0104 and authorization of the Municipal Department of Health of the municipality of reference. The Free and Informed Consent Term (FICT) was signed in two copies by all participants in the research.

■ RESULTS

Participated in the study 417 people with HBP, linked to 34 BHUs and monitored by the PHC. Most of the participants were elderly (62.4%), female (67.9%), white (62.3%), attended up to elementary school (61.1%) and belonged to the economic classification Class C (43.9%). Of the respondents, 62.8% were classified as adequate monitoring and 53.7% presented an adequate pressure value (Table 1).

Table 1 - Demographic profile of people with arterial hypertension, users of the Family Health Strategy (n=417). Paraná, Brazil, 2016

	N (%)
Age Group	
20 – 29	15 (3.6)
30 - 39	25 (6.0)
40 – 49	37 (8.9)
50 – 59	80 (19.2)
60 – 69	127 (30.5)
≥ 70	133 (31.9)
Gender	
Male	134 (32.1)
Female	283 (67.9)
Education level	
No Education	32 (7.7)
Elementary school	255 (61.1)
High school	107 (25.7)
Higher education	23 (5.5)
Race/Color	
White	260 (62.3)
Black	65 (15.6)
Brown	92 (22.1)
Monitoring in FHS (2015)	
Adequate	262 (62.8)
Inadequate	155 (37.2)
Pressure Control	
Adequate	224 (53.7)
Inadequate	193 (46.3)
Economy Class	
AB	148 (35.5)
C	183 (43.9)
DE	86 (20.6)

Source: Research data, 2016.

FHS: Family Health Strategy; Adequate Pressure Control: pressure levels \leq 140/90mmHg; Inadequate monitoring of the FHS: Less than three annual consultations, considering the year 2015 as the basis.

Table 2 shows that in the geographical dimension, the need for using a transport for displacement until the BHU obtained the lowest mean (3.86 ± 1.48), which reflected in the evaluation of the economic dimension, in which the question had a lower score (4.04 ± 1.39). Regarding the organizational accessibility, the question with the highest score was the availability and delivery of medications since it was diagnosed with the morbidity (4.56 ± 0.95). However, the home visits (3.72 ± 1.39) and the wait for more than 60 minutes for the consultation (3.73 ± 1.51) received the lowest evaluation (table 2).

The overall rating of the indicators and evaluation of their mean can be observed in Table 3. The economic accessibility indicator was the best, followed by organizational accessibility. The overall mean of the attribute also resulted in a majority of the satisfactory evaluation. In the multivariate analysis, the users classified with inadequate monitoring have a chance of 1.96 times (IC95%: 1.23-3.10) to evaluate the organizational accessibility as regular and a chance of 1.46 times (IC95%: 1.27-1.78) to evaluate the services characteristic of geographic accessibility as regular.

Table 2 - Accessibility indicators by users with hypertension of the Family Health Strategy (n=417). Paraná, Brazil, 2016

Accessibility	Mean	SD	CI 95%
Geographic			
When you go to the BHU for a consultation about your HBP problem, do you need to use some type of motorized transport?	3.86	1.48	3.72 – 4.01
Are you treating the HBP at the nearest health service from your home?	4.29	1.14	4.18 – 4.40
Do you have difficulty to move to the BHU to be consulted?	4.00	1.40	3.86 – 4.13
Composite Index	4.05	1.34	3.72 – 4.13
Economic			
When you go to the BHU for a consultation about your HBP problem, do you miss your work shift or another appointment?	4.32	1.31	4.19 – 4.44
When you go to the BHU for a consultation, do you pay for the transport?	4.04	1.39	3.91 – 4.18
Composite Index	4.18	1.35	3.91 – 4.44
Organizational			
If feel bad due to the medication or HBP, can you schedule a consultation within 24 hours at the BHU where you are being treated?	4.05	1.27	3.92 – 4.17
Do the BHU professionals who follow up your HBP treatment usually visit you in your home?	3.72	1.39	3.59 – 3.83
From when you started your treatment for HBP, did you stay without the medication?	4.56	0.95	4.47 – 4.66
When you go to the BHU for the consultation, does it take more than 60 minutes to be attended?	3.76	1.51	3.61 – 3.90
Can you carry out the exams requested by the health care professional who follow up your treatment?	4.29	1.18	4.17 – 4.40
Can you receive the results of the exams requested by the health care professional that follows up your treatment within 10 days?	4.12	1.23	4.00 – 4.24
Can you find a professional at the BHU to attend you on every working day of the week?	4.14	1.21	4.02 – 4.26
Is your return consultation scheduled?	3.78	1.40	3.65 – 3.92
Composite Index	4.05	1.10	3.59 – 4.66

Source: Research Data, 2016.
 SD: Standard Deviation; CI95%: Confidence Index; BHU: Basic Health Unit; HBP: High Blood Pressure; Composite Index: mean of the questions related to geographic, economic and organizational accessibility.

Table 3 - Evaluation of accessibility indicators for treatment by users with arterial hypertension of the Family Health Strategy (n=417). Paraná, Brazil, 2016Source: Research data, 2016.

	Total	Monitoring		Univariate Analysis			Multivariate Analysis		
	N (%)	Adequate	Inadequate	OD	IC 95%	P	OD	IC 95%	P
Organizational Accessibility									
Satisfactory	269 (64.5)	179	90	1			1		
Unsatisfactory	29 (7.0)	19	10	1.04	0.46-2.34	0.912	1.08	0.46-2.48	0.856
Regular	119 (28.5)	64	55	1.70	1.10-2.65	0.017*	1.96	1.23-3.10	0.004
Economic Accessibility									
Satisfactory	259 (62.1)	154	105	1					
Unsatisfactory	61 (14.7)	37	24	0.97	0.50-1.89	0.95			
Regular	97 (23.2)	71	26	0.86	0.48-1.54	0.629			

	Total	Monitoring		Univariate Analysis			Multivariate Analysis		
	N (%)	Adequate	Inadequate	OD	IC 95%	P	OD	IC 95%	P
Geographic Accessibility									
Satisfactory	313 (75.1)	195	118	1			1		
Unsatisfactory	43 (10.2)	27	16	0.95	0.53-1.98	0.864	0.97	0.48-1.58	0.656
Regular	61 (14.7)	40	21	1.53	1.32-2.89	0.019*	1.46	1.27-1.78	0.014
Composite Accessibility									
Satisfactory	268 (64.3)	164	104	1					
Unsatisfactory	44 (10.6)	28	16	0.9	0.46-1.74	0.758			
Regular	105 (25.2)	70	35	0.78	0.49-1.26	0.326			
Pressure Control									
Adequate	224 (53.7)	139	85	1					
Inadequate [†]	193 (46.3)	123	70	0.93	0.62-1.38	0.931			

Source: Research data, 2016

OD: Odds Ratio; CI95%: Confidence Index; Classification: satisfactory (≥ 4), regular (< 4 and ≥ 3) and unsatisfactory (< 3); * $p < 0.20$; [†]SBP ≤ 140 mmHg e DBP ≥ 90 mmHg; Composite Accessibility: mean of the questions related to geographic, economic and organizational accessibility

DISCUSSION

The geographical accessibility presented satisfactory results in more than half of the respondents, corroborating a study carried out with people of similar characteristics, resident in a municipality in northeastern Brazil⁽¹³⁾. However, the multivariate analysis has demonstrated that people with inappropriate monitoring have a better chance of evaluating the geographic accessibility as regular.

The need to use transport for locomotion to the BHU was the worst evaluated attribute, followed by the difficulty of displacement of users to the service. These results can be explained by the fact that the majority of the participants are elderly, since the prevalence of chronic diseases tends to rise with ageing, with the need for adoption of public policies by the health system, due to the impact of morbidity and its complications, when related to the difficulty of locomotion and the solution of the treatment⁽¹³⁻¹⁴⁾.

It is reiterated that the satisfactory evaluation on the geographical accessibility, related to the treatment closest to its residence, strengthens the PHC as a priority gateway, certifying the guidelines of the FHS in demarcating the limits of the geographical area for the offer and performance of the healthcare teams to recognize the community and to define the coverage of the population resident in the area of operations of the teams⁽²⁾. This can also explain the satisfactory assessment of the economic accessibility, in which no significant result was found when associated with inappropriate monitoring of the respondents in health services.

The positive result of the economic accessibility indicator also reveals the evolutionary scenario of health services, with actions offered in peripheral regions, far from the

central areas of the city and that points out this decentralization as a facilitator to treatment, with a healthcare team more flexible to the peculiarities of users, according to their social and economic condition, with understanding of their health needs^(2-3,14).

The users' satisfaction with the economic accessibility does not guarantee that the results of the services are effective in the continuity of the treatment and in the pressure control of the population. Despite the adequate classification of most respondents, it is important to consider and analyze the lack of attendance among others, considering the need for continuity of the therapy, with a view to reducing complications of the disease^(5,14).

In the evaluation of the organizational accessibility, the indicator related to the use of medicine for treatment and disease control was the best evaluated and is similar to the result of a study⁽²⁾ carried out in the state of Paraíba, which pointed to the delivery of medications as a priority action, being this indicative recommended by the Ministry of Health⁽⁷⁾.

The frequency of home visits was one of the indicators of the organizational accessibility with worst evaluation, being classified as regular, resembling the study also carried out with people in treatment of HBP in the FHS⁽²⁾. Considering the promotion of health as a focus of the model of health care in Brazil, approaches to change the behavior and incentive to adopt the practices of self-care needs to break the hegemonic model, centered on the disease, for the wider recognition of people's needs^(5,15). However, health professionals can use home visits to understand how people take care of themselves and their families and how this knowledge about care interferes with the process of adherence to the drug treatment⁽⁵⁾.

A study carried out with the health professionals showed the low adherence to the home visits, as well as the absence of a care plan for the family of the person with HBP, with shortage of materials and transport for the displacement of the professionals to the residences being the main factors that prevent the realization of the visits⁽³⁾. This situation could increase the likelihood of exposure of these individuals to social vulnerability and worsening of complications resulting from the chronicity of the disease⁽⁵⁾.

It should be highlighted that the evaluation of accessibility to the treatment that involves the individual and their social network, from a comprehensive perspective, can favor the positive results of the actions carried out by the professionals. In an intervention study⁽¹⁵⁾ conducted with people in treatment of HBP, the authors concluded that following the guidelines of the health professionals promoted autonomy of the people, according to adequate embracement, recognition and discussion of a better care plan for the user.

The regular evaluation referring to the wait for more than 60 minutes to be attended, corroborates other surveys, showing unsatisfactory results concerning the question of the waiting and the fragility of the embracement⁽²⁻⁴⁾. The embracement is a strategy for the solution of the health situation of people, given the reduction of the queues for consultation, according to the planning of the health professionals to meet the demand, of humanized character, with offers of more effective services⁽¹⁶⁾.

The continuity of access favors cost reduction and unnecessary care in emergency services, since the possibility of creating the bond of users with the professionals strengthens the adherence to treatment. The fragmentation of the services carried out at the BHUs can lead to disorganization in the attention to the demand, especially when there is delay in attendance, unavailability of consultations and service schedules not favorable to the usual dynamics of the user⁽⁴⁾.

A study conducted in the United States verified the effectiveness of the interventions with the professionals to improve the access of the users to the provided services, with reduction of queues and resolute results to people's needs. The study concluded that the allocation of users with scheduled consultations in the early hours of the work shift makes it possible to serve the community that composes the demand for services⁽¹⁷⁾.

As for nursing consultations, an observational study carried out with 27 BHUs, from 10 Brazilian states, revealed that the time spent by health professionals in patient care consultations is in accordance with the advocated by the Ministry of Health, however, the need to solve bureaucratic problems and time dedicated to filling reports and

documents, results in less availability for the care provision. The study concludes that there is a need for resizing the health services provided and public policies for the human resources area⁽¹⁸⁾.

A large number of individuals with inadequacy of pressure values and regular monitoring by the FHS teams were identified. This is troubling, because it reiterates that the pressure maintenance and the good state of health of the individual with HBP, who can present many complications according to their chronicity, cannot be conducted only by the distribution of medicines⁽¹¹⁾, which was one of the indicators with better evaluation in this study.

Nevertheless, the adequacy of the service offering also establishes the scheduling of the return of these users to the BHU to encourage the continuous access to the treatment, a subject that also presented regular evaluation in this research. In a study conducted with health professionals in the state of Paraná⁽³⁾, it was identified that the control and active search of absentees users in group meetings of HIPERDIA were not carried out, neither a periodic scheduling of return consultations was performed. Therefore, it is possible to understand that the difficulty in the adequacy of services is mainly related to the organization of the professionals, since it is not a common problem of all the BHUs in which the research was developed.

Results of a meta-analysis study⁽¹⁹⁾, in which most individuals were Asians, revealed that the primary HBP, with therapeutic measure based on changes in life habits, was significantly associated with mortality when compared to people who presented blood pressure values above normal levels. The study also stated that the health professionals responsible for primary care should be aware of the correct diagnosis, better therapeutic choice and the monitoring of people with HBP⁽¹⁹⁾.

A study conducted with health professionals revealed that the nursing consultation was not carried out by more than 68% of the respondents and the decision for the therapeutic scheme had no participation of almost 94% of the individuals investigated⁽³⁾. According to the Ministry of Health, consultations with HBP patients can be performed by the nurse and subsequently by the doctor⁽⁷⁾, what is also recommended by the Brazilian Society of Cardiology (SBC – *Sociedade Brasileira de Cardiologia*)⁽¹¹⁾, as a timely method for better control and prevention of aggravations caused by the chronicity of the disease. These data can justify the regular evaluation by the respondents classified with inadequate monitoring regarding the organizational accessibility to the treatment of morbidity.

In this way, it is necessary to make sure that the professional training is an instrument of improvement of the ser-

vices provided to the population, from a health care team prepared to meet the needs related to health in an equitable and resolute way, with a work process according to the demand for services. It should also be highlighted that professional training is a recommendation from the Ministry of Health⁽⁷⁾.

The inadequate or ineffective attendance may be a contributing factor for non-resolutive treatment, with low adherence to drug therapy, not only of HBP, but of several diseases, mainly the chronic and degenerative ones. Regarding skilled, motivated professionals, the use of the services provided by the PHC can be decision-making measures to improve the quality of community health care⁽¹⁸⁻²⁰⁾.

In this context, this study portrays an important issue for SUS, highlighting problems that can be solved when it is given real value to the satisfaction of those who are attended. The study also signals important advances in the care provided to people with HBP, enhancing the understanding of health professionals, especially the nurse, on the need to monitor these people and of ease to the treatment, promoting adhesion and bonding to the therapy of choice.

■ CONCLUSION

According to the results of the analysis of the satisfaction of people with high blood pressure on accessibility to treatment and associated with the monitoring carried out by the teams of the Family Health Strategy, it was observed that most people with HBP, registered in the HIPERDIA program and accompanied by the FHS, evaluated satisfactorily the services related to the attribute.

Regarding the geographical and economic accessibility, the majority of respondents evaluated satisfactorily, differentiating themselves from the organizational accessibility, in which the lack of home visits was one of the indicators with regular evaluation by the interviewed. These results can encourage further discussions between the FHS teams and managers to create new services offering strategies to meet the demand, aiming at reducing the waiting queues.

The study is limited to the variables related to electronic records, in which it was difficult to identify the attendance records, since many teams still use the printed chart model, enhancing the need for professional training, considering the technological innovations that arise to help in the care provision.

Regarding the implications of teaching, the study points out to the need for a better preparation of future professionals for comprehensive and resolute care, in a fair way, with knowledge of the reality of each individual and the community in which it is inserted. As for the contri-

butions to the care provision, the findings of this study may contribute to the organization of the work process of the nursing team, providing the revision and management of health care actions, which are implemented to people with arterial hypertension, for a resolute care and contributing to the quality of life of the population.

It is emphasized the importance of new studies to identify, in an evaluative way, the working process among the teams, to understand how the discussions and case study are carried out, mainly of the users with HBP and to identify ways to reduce the inequities of the care, promoting a better working condition for professionals and quality care for the population, within to the services of the PHC.

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