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The right to health in the territory: service users' perceptions of Primary Health Care

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Abstract *Primary health care is an essential component of effective health systems. The aim of this study aim was to evaluate the quality of primary care in a city in the state of Pernambuco, Brazil. We conducted an exploratory study with 525 service users using structured questionnaires. The quality of primary care was assessed across five dimensions: accessibility, clinical care, professional-user relations, community activities and structure. The findings point to the perpetuation of social vulnerabilities and challenges in achieving equitable universal care. Dissatisfaction rates were highest in the following categories: access to specialist appointments and exams, appointment wait time, and opportunity to make complaints. However, respondents were satisfied with medical and nursing care, particularly in relation to respect, privacy, listening and confidentiality. The findings show that, although health professionals were committed to providing humanized care, fragmentation of care is evident, hampering the provision of adequate and timely follow-up and negatively affecting the quality of care.*

Key words *Primary health care, Health services research, Patient satisfaction*

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Introduction

As the preferred front door to the Brazilian health system, primary health care (PHC) should welcome patients, promoting patient affiliation and co-responsibility for care. However, there are many obstacles to the provision of quality health care and this problem can have a negative effect on the continuity of care, comprehensiveness and health system efficiency[1].

Given the critical role PHC plays within the health system and its impact on the population's health, ongoing evaluation is essential in order to strengthen outcomes and the quality of care[2,3].

Ensuring the quality of care delivered by health care facilities is therefore a technical and social imperative. The pursuit of equity of access to resources, high health care costs and new public concerns have meant that public and private health institutions have directed their efforts to evaluating quality of care and whether it is efficiently provided[4].

Based on the concept of quality developed by Donabedian (1984)[5], the notion of patient satisfaction has become a key element of the assessment of health services. Under this approach, patients are seen to play an active role in the assessment process and their opinions, expectations and everything they consider to be fair and equitable are legitimate elements in the definition and measurement of the quality of care[6].

Within this context, service user satisfaction surveys are an important tool for facilitating patient participation in plans and programs aimed at improving care and supporting the construction of a new aspect of care[7,8].

Moreover, this methodology plays an important role within the Brazilian health care context because it strengthens public participation, insofar as it involves users in health service planning and evaluation processes[9].

The right to health needs to be constantly defended and evaluation is an important tool. Evaluating care based on the experiences of users enables[10] not only the construction of a new perspective of care, but also the monitoring of service availability and strengthening of public participation.

In light of the above, this study analyzed users' perceptions of the quality of primary health care in a municipality located in the Metropolitan Region of Recife in the state of Pernambuco.

Methods

We conducted a quantitative cross-sectional study of family health centers (FHCs) in Jaboatão dos Guararapes in the Metropolitan Region of Recife.

According to the Brazilian Institute of Geography and Statistics[11], in 2018, Jaboatão dos Guararapes was one of the state's five largest cities, with a population of 697,636 inhabitants. According to the Ministry of health, the city had 104 family health teams during the data collection period (July to September 2018), covering 51.43% of the population[12].

The sample size was calculated based on the expected satisfaction rate from studies undertaken by Gouveia (2011)[13] evaluating user satisfaction with health care in the state of Pernambuco.

The number of care centers was selected using proportionate simple random sampling and adopting a 5% sampling error, 20% relative error, 65% satisfaction rate and 95% confidence level, resulting in a sample of 40 centers. A random sample of centers was selected from each health region in a number proportional to the number of health teams in each region when compared to the total number of health teams in the city. The user sample size was calculated using proportionate simple random sampling and adopting a 5% sampling error, design effect of 1.5 and 95% confidence level, resulting in a sample of 525 users.

User inclusion criteria were as follows: users registered at FHCs aged 18 years and over present at the time of interviewing who had had attended at least one appointment in the center in the six months prior to the interview.

The quality of primary care was assessed across the following five dimensions: accessibility, structure, clinical care, professional-user relations and community activities. These dimensions were defined drawing on the Health System Performance Assessment/Proadess[14], quality improvement policies[15], Reid et al. (2002)[16] and Beltran (2006)[17]. The questions relating to satisfaction had five alternative answers: terrible, poor, fair, good and very good.

We administered a 58-item structured questionnaire devised specifically for the study. The data were collected in the care centers' waiting rooms on each day of the week and throughout all appointment scheduling times in order to

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ensure randomness. Service users were selected using a pre-established seating system whereby the interviewer selected the study participants by choosing previously numbered seats at random.

Considering the assumption of independence of observations, level of satisfaction was measured using the following dichotomous variable: dissatisfied (terrible, poor and fair); satisfied (good and very good).

The Friedman test was used to detect statistically significant differences between the different dimensions of satisfaction and their attributes. The results were presented as satisfaction mean rankings, where the greater the mean the higher the level of satisfaction.

It is worth noting that user satisfaction assessments can suffer from "gratitude bias", which is a feeling that can emerge due to the fact that the service is public and the fear of losing guaranteed health care when giving a negative evaluation. This bias was minimized by explaining the study aims and ensuring the confidentiality of the information provided by the participants.

This study was part of a PhD thesis and the research protocol was approved by the research ethics committee at the Aggeu Magalhães Institute, Oswaldo Cruz Foundation, Recife, Pernambuco.

Results

The 525 respondents were predominantly female (87.4%), black/brown (77.0%), aged between 20 and 49 years (61.7%), married or living in stable union (67.0 %), and had a monthly income of up to one minimum wage (64.2%) and children (mean = 2.4 children).

With regard to education, 38.2% had not completed junior high school and 35.3% had completed high school. With regard to occupation, most of the sample were homemakers (27.4%), followed by unemployed (26.9%) and employed/self-employed (24.4%).

The analysis of user satisfaction showed statistically significant differences (p = 0.00) between the dimensions, with *accessibility* and *structure* showing the highest dissatisfaction rates and *professional-user relations* showing the highest satisfaction rates (81.8%) (Table 1).

The category with the highest dissatisfaction rate in the *accessibility* dimension was access to specialist examinations (90.8%), followed by access to specialist appointments (88.8%) and appointment wait time (69.0%), while the category that showed the highest satisfaction rate was distance from home to health center (67.3%), followed by appointment times (65.5%) (Table 2).

Table 2 shows that user dissatisfaction rates were above 60% in most of the categories within the *structure* dimension. The category with the highest user dissatisfaction rate was comfort of chairs (67.9%), followed by number of chairs (65.5%), ventilation and temperature (63%), and health center physical structure (62.9%). The dissatisfaction rate for the categories health center cleanliness and restroom cleanliness were 40.4% and 45.0%, respectively.

Satisfaction rates were above 70% in all categories in the *clinical care* dimension, except treatment provided by community health workers (CHW), where the rate was 68.2%. Likewise, satisfaction rates were above 70% in most categories in the *professional-user relations* dimension. The highest rating category was treated with respect by nurses (95.8%), followed by treated with respect by doctors (93.5%) and confidence in nurses (90.7%), while opportunity to make complaints and promptness of care showed lower satisfaction rates (Table 3).

Table 4 shows that satisfaction rates in the *community activities* dimension were below 70% in all categories except group activities (72.0%). Dissatisfaction rates in the categories directly related to CHWs varied between 44.9% and 55.7%, while 60% of the respondents reported that they were satisfied with doctor and nurse home visits.

Discussion

The evaluation of health care from the perspective of service users is a key tool for identifying aspects and situations that positively influence care delivery and the main factors that generate dissatisfaction. The lens of the service user is the best tool for evaluating care and promoting public participation in the pursuit of quality health systems that provide equal access to universal care tailored to the population's real needs.

Most of the users were young brown or black women (aged between 20 and 39 years) with a low level of education and children. Most of the women were married and homemakers or unemployed, as found in previous studies[18,19].

This may be explained by the fact that women tend to be more concerned about their health and accompany their children and husbands to appointments, while men seem to devote themselves more to work and consequently health becomes a secondary concern.

The findings show that most service users were outside the labor force. Respondents who reported being *unemployed*, *homemakers* or *retired/living on benefits* accounted for more than 70% of the sample. These findings suggest that the economically active population find it more difficult to access services.

The development of health promotion and disease prevention strategies for this group is therefore a major challenge, leading to an increase in cases of late diagnosis. This in turn can result in complications that require complex health care, the majority of which cannot be resolved in PHC.

In this regard, efforts have been made to broaden the provision of public services by extending health center opening times to the evening to facilitate access to health care among workers[20].

The highest rating dimensions were *clinical care* and *professional-user relations*, both of which obtained satisfaction rates above 70%. In contrast, *accessibility*, *physical structure* and *community activities* showed dissatisfaction rates above 40%.

None of the categories in the *accessibility* dimension were rated as satisfactory. Dissatisfaction rates were highest in the categories access to

Table 1. Quality dimensions of user satisfaction with primary care in Jaboatão dos Guararapes, Pernambuco, Brazil, 2008.

Dimensions	Mean Ranking	*Answers	Dissatisfied		Satisfied		X^2
			n	%	n	%	
Accessibility	3.39	488	293	60.0	195	40.0	*$X^2 = 483.7$ DF = 4 p < 0.00001*
Clinical care	2.41	483	105	21.7	378	78.3	
Professional-user relations	2.41	463	84	18.2	378	81.8	
Community activities	3.49	321	139	43.3	182	56.7	
Structure	3.30	498	292	58.7	206	41.3	

Source: Fieldwork conducted in Jaboatão dos Guararapes between June and December 2018.

Table 2. User satisfaction with accessibility and structure of primary care in Jaboatão dos Guararapes, Pernambuco, Brazil, 2008.

Accessibility	Mean Ranking	*Answers	Dissatisfied		Satisfied		X^2
			n	%	n	%	
Distance from home to health center	3.38	525	172	32.8	353	67.2	$X^2 = 516.5$ DF = 7 p < 0.00001
Ease of appointment scheduling	4.47	523	314	60.0	209	40.0	
Appointment times	3.47	521	180	34.5	341	65.5	
Appointment wait time	4.79	519	358	69.0	161	31.0	
Access in the case of worsening health conditions	4.28	484	272	56.2	212	43.8	
Availability of medicines	4.45	496	296	59.7	200	40.3	
Access to specialist appointments	5.56	421	374	88.8	47	11.2	
Access to specialist examinations	5.6	413	375	90.8	38	9.2	
Structure							
Health center physical structure	4.12	525	330	62.9	195	37.1	$X^2 = 145.1$ DF = 6 p < 0.00001
Number of chairs	4.27	522	342	65.5	180	34.5	
Comfort of chairs	4.34	523	355	67.9	168	32.1	
Equipment maintenance	4.08	499	309	61.9	190	38.1	
Health center cleanliness	3.42	522	211	40.4	311	59.6	
Restroom cleanliness	3.55	369	166	45.0	203	55.0	
Ventilation and temperature	4.25	524	330	63.0	194	37.0	

Source: Fieldwork conducted in Jaboatão dos Guararapes between June and December 2018.

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Table 3. User satisfaction with clinical care and professional-user relations in primary health care in Jaboatão dos Guararapes, Pernambuco, Brazil, 2008.

Clinical care	Mean Ranking	*Answers	Dissatisfied		Satisfied		X^2
			n	%	n	%	
Treatment provided by doctors	4.3	477	66	13.8	411	86.2	
Treatment provided by nurses	4.06	434	44	10.1	390	89.9	
Treatment provided by nurse technicians	4.15	452	65	14.4	387	85.6	
Treatment provided by community health workers	4.66	494	157	31.8	337	68.2	$X^2 = 96.3$ DF = 7
Performing procedures	4.73	452	132	29.2	320	70.8	p < 0.00001
Clinical examination	4.57	517	107	20.7	410	79.3	
Appointment duration	4.73	522	127	24.3	395	75.7	
Meeting patients' needs	4.8	515	139	27.0	376	73.0	
Professional-user relations							
Treated with respect by doctors	4.82	475	31	6.5	444	93.5	
Treated with respect by nurses	4.45	428	18	4.2	410	95.8	
Professional listening	5.83	518	110	21.2	408	78.8	
Confidence in doctors	5.27	470	65	13.8	405	86.2	$X^2 = 504.7$
Confidence in nurses	4.75	421	39	9.3	382	90.7	DF = 9
Privacy	5.33	514	76	14.8	438	85.2	p < 0.00001
Clarity of information	5.24	525	69	13.1	456	86.9	
Information confidentiality	5.15	505	58	11.5	447	88.5	
Opportunity to make complaints	7.72	294	216	73.5	78	26.5	
Promptness of care	6.44	477	162	34.0	315	66.0	

Source: Fieldwork conducted in Jaboatão dos Guararapes between June and December 2018.

Table 4. User satisfaction with community activities in primary health care in Jaboatão dos Guararapes, Pernambuco, Brazil, 2008.

Community activities	Mean Ranking	*Answers	Dissatisfied		Satisfied		X^2
			n	%	n	%	
Lectures	3.79	303	95	31.4	208	68.6	
Group activities	3.6	192	52	27.1	140	72.9	
CHW home visits	4.17	492	274	55.7	218	44.3	$X^2 = 10.4$
Guidance provided by CHWs	4.05	492	221	44.9	271	55.1	DF = 6
Monitoring of health status	4,05	488	232	47,5	256	52,5	p = 0.111
by CHWs	4.05	488	232	47.5	256	52.5	
Doctor home visits*	4.24	136	47	34.6	89	65.4	
Nurse home visits)*	4.11	142	51	35.9	91	64.1	

*Home visits are directed at specific groups (bed-ridden patients, postpartum women, patients with disabilities, etc.) and therefore the results represent users who had experience of this type of care.

Source: Fieldwork conducted in Jaboatão dos Guararapes between June and December 2018.

specialist appointments and access to specialist examinations, illustrating weaknesses in access to specialist care. This is mainly due to a lack of capacity and shortage of professionals in specialist care facilities to meet the demands and needs of the population, resulting in long appointment wait times and compromising the provision of adequate and timely care and case resolvability.

Although satisfaction rates for the categories distance from home to health center and

appointment times were around 60%, dissatisfaction rates were high in the categories ease of appointment scheduling, access in the case of worsening health conditions, appointment wait time and availability of medicines.

Distance from home to health center is a key element of user satisfaction. Our findings show that more than 30% of respondents were dissatisfied with this aspect. The location of FHCs should be planned considering the specific geographic characteristics of each territory in order to facilitate access. In practice, this question is often neglected by health managers, and health centers are built in hard-to-reach places. It is also common to find the same center housing various health teams, leading to large distances between services and certain areas, thus making it difficult for some patients, many of whom rely on public transport, to get to the facility.

A study conducted in Brazil[21] showed that living a fair distance or far from the health center reduced the chance of user satisfaction by 32% and 16%, respectively. According to Santos et al.[8], easy geographic access is an important factor in health care seeking behavior, influencing appointment seeking, follow-up and treatment.

Dissatisfaction rates were above 50% in the categories ease of appointment scheduling, access in the case of worsening health conditions and appointment wait time. Considering that FHCs deliver services to the population within a specific territory under the responsibility of a single health team, it is necessary to rethink the planning of the actions and services necessary to meet the specific demands and needs of the population within that territory.

A study conducted in a teaching clinic[22] highlighted that difficulty scheduling initial appointments was the main complaint mentioned by patients, while Protassio et al.[23] reported that not receiving health care without an appointment decreased the chance of being satisfied by 42%.

Appointment wait time has also been widely associated with user dissatisfaction[18,23-25]. The current study showed that mean wait times varied across health centers, with most patients having to wait up to seven days to get an appointment. However, it is worth noting that 17% of respondents got an appointment on the same day, revealing that some teams are sensitive to the need to provide adequate and timely appointments in order to identify cases that need priority treatment.

Around 60% of users were dissatisfied with availability of medicines. This may be related to deficiencies in the medication planning and distribution process, resulting in medicine shortages and affecting treatment in cases of acute and chronic conditions. This finding is particularly important given that the majority of the service users in our study are from vulnerable families.

Our findings are corroborated by a study conducted by Gabe et al.[22], who found a high level of user dissatisfaction with access to medications in a teaching clinic. In contrast, Soeiro et al.[26] reported that 58.4% of users were satisfied with these services.

Our results show a high rate of dissatisfaction with *physical structure*, corroborating the findings of previous studies[8,19,27]. Dissatisfaction rates were around 60% in all categories except those related to center cleanliness.

User dissatisfaction with physical structure can have a negative effect on processes of welcoming and meeting community demands. According to Lucena et al.[19], a quality care setting encourages reflection on practices and modes of operation, creating facilities that deliver effective health care in a functional, welcoming and comfortable environment.

Spaces should be adapted to the context in which they are located, taking into account the specific characteristics and health needs of the local population, number of expected users and services provided in order ensure the delivery of humanized and welcoming care.

Satisfaction rates in the *clinical care* dimension were above 70% in all categories, except treatment provided by community health workers.

The highest rating categories in this dimension were treatment provided by doctors, nurses and nurse technicians. The categories clinical examination, appointment duration, performing procedures and meeting patients' needs were rated highly by the respondents. These findings point to service delivery that focuses on humanized care and favors patient affiliation with the care provider, resulting in better chances of success of health promotion and disease prevention actions and treatment.

Studies in Brazil and Spain showed that satisfaction rates for care provided by health teams in primary care centers were above 80%[7,28].

With regard to meeting patients' needs, the findings suggest that PHC professionals are committed to seeking effective responses to users' health problems. Comprehensiveness of care is directly related to the health team's capacity to resolve health problems. A national study in Brazil[21] showed that the fact that users are able to

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resolve their health problems in the health center was a key factor in patient satisfaction.

Most of the categories in the *professional-user relations* dimension showed high satisfaction rates, notably treated with respect by doctors and nurses, privacy, and information confidentiality. Treatment with respect, trust, privacy and confidentiality facilitates the development of a bond between the professional and patient, which in turn facilitates user affiliation, positively affecting follow-up.

Rodrigues et al.[29] showed that more than 80% of PHC service users were satisfied in relation to trust in professionals, while studies with pregnant women and older persons[25,27] also showed high user satisfaction rates in relation to respectful treatment by health professionals.

Corroborating the findings of the current study, other authors[25,30,31] have shown high satisfaction rates for privacy and confidentiality. In contrast, other studies reported that privacy during consultations was one of the main shortcomings in care delivery identified by service users[27].

It is worth mentioning that studies show that listening and clarity of information during consultations, aspects related to effective communication, were highly rated[19,25,29]. Effective communication is an important element of quality care, especially dialogue with patients, which should promote effective listening and a clear explanation of the health condition and/or treatment.

Satisfaction rates were low in the category opportunity to make complaints, which is a reality that has been widely discussed in both the national and international literature[21,27-29]. The lack of opportunity for patients to show their dissatisfaction and the fact that complaints that are made often go unaddressed is a concern and can lead to negative perceptions of care. This fact suggests a lack of ethical commitment on the part of professionals, illustrated by a lack of interest in resolving complaints and addressing patient demands.

With regard to *community activities*, the only category rated as satisfactory was group activities. More than 40% of the respondents were dissatisfied with the work of CHWs (home visits, guidance and monitoring of health status).

CHWs are recognized as playing an important role in the development of actions in the community. They experience similar situations to service users, meaning they are able to build a close relationship with the community and understand the local reality[32,33].

However, our findings show that this bond alone is not enough to achieve user satisfaction. Although home visits encompass listening and welcoming, the frequency of visits and guidance provided fall short of expectations.

Most of the respondents were satisfied with home visits made by doctors and nurses; however, 30% were dissatisfied with this activity. These findings also illustrate a weakness in relation to access to health services by people who have mobility problems. In this regard, it is important to rethink work processes in order to ensure universal access to services.

Home visits are an important tool for understanding the social determinants of health. Home visits allow professionals to evaluate the patient's life context, social and environmental aspects, housing conditions, etc. This information facilitates the planning and implementation of care strategies tailored to the specific reality of each case.

Investment and the development of community activities are needed to promote a shift from care models focused on disease to health promotion. To this end, activities need to be promoted that involve the whole health team, prioritizing community engagement, the inclusion of routine home visits in work processes and the development of educational activities that promote self-care and strengthen user autonomy.

Final considerations

Considering the place of speech of subjects involved in health care is fundamental to ensuring a right that has been severely threatened. This space is even more important when it depicts the vulnerability that characterizes our society. Our findings show that most users were young black or brown women with children and a low level of income and education.

With regard to inequality, important aspects of health care were characterized by dissatisfaction. The lowest-rated dimensions were accessibility, community activities and physical structure. These dimensions are essential to the welcoming process, strengthening community affiliation, and the delivery of quality comprehensive care.

On the other hand, users were satisfied with clinical care and professional-user relations, demonstrating the commitment of health professionals to promoting quality humanized care focused on affiliation, respect and confidence,

despite structural problems and difficulties accessing medications and specialist consultations and examinations.

Further research investigating and reflecting upon the provision of health services and actions is essential in order to safeguard the right to health. Investment in PHC as a pivotal component of health care is essential. To this end, understanding the perspectives of service users provides important inputs to help health managers plan effective strategies aimed at defending respect for subjectivities and dignity and guaranteeing the provision of quality comprehensiveness care.

Collaborations

DS Melo contributed to study conception and design, data analysis and interpretation and writing the article. ALA Silva contributed to data analysis and interpretation. PJL Martelli and TM Lyra contributed to the critical revision of the article. GMD Miranda contributed to data analysis and interpretation and writing the article. ACG Mendes contributed to study design and data analysis and interpretation, and approved the final version to be published.

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