RESEARCH | PESQUISA

Assessment of Primary Healthcare attributes in one Municipality of Minas Gerais State

Avaliação dos atributos da Atenção Primária à Saúde em um Município Mineiro

Evaluación de los atributos de la Atención Primaria a la Salud en una ciudad en Minas Gerais

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Abstract

Objective: To assess the extent of the Primary Health Care (PHC) attributes from the perspective of nurses of the Family Health Strategy (FHS) and conventional Primary Health Units (PHUs) of the municipality of Passos, MG. **Methods:** This evaluative, quantitative study included 27 nurses, with the data collected using the PCATool-Brazil, professional version, and tabulated in a spreadsheet. **Results:** The FHS nurses provided higher scores in all attributes except for First Contact - Accessibility. Only Community Orientation and Information System showed large differences between the sources. The Care Integration attribute had the lowest difference between the PHU and FHS respondents, while Community Orientation showed the largest difference between the units. **Conclusion:** The FHS achieved better results regarding PHC attributes compared to the PHUs, however, the there is need for improvements in the work process of the teams.

Keywords: Health Services; Primary Health Care; Health Service Evaluation.

Resumo

Objetivo: Avaliar a extensão dos atributos da Atenção Primária à Saúde (APS) na perspectiva dos enfermeiros da Estratégia Saúde da Família (ESF) e Unidades Básicas de Saúde convencionais (UBS) de Passos, MG. **Métodos:** Pesquisa avaliativa, quantitativa, realizada com 27 enfermeiros a partir da coleta de dados levantados pelo PCATool-Brasil, versão profissionais, e tabulados em planilha eletrônica. **Resultados:** A ESF apresentou maiores escores em todos os atributos, com exceção do Acesso de Primeiro Contato. Apenas para Orientação Comunitária e Sistema de Informações são grandes as diferenças entre as fontes. O atributo Integração de Cuidados apresentou a menor diferença entre UBS e ESF, enquanto a Orientação Comunitária recebeu a maior diferença entre as unidades. **Conclusão:** A ESF conseguiu atingir melhores resultados nos atributos da APS em relação as UBS, todavia sugere-se a necessidade de aperfeiçoamentos no processo de trabalho das equipes.

Palavras-chave: Serviços de Saúde; Atenção Primária à Saúde; Avaliação de Serviços de Saúde.

Resumen

Objetivo: Evaluar el alcance de los atributos de la Atención Primaria a la Salud (APS) desde la perspectiva de las enfermeras de la Estrategia Salud de la Familia (ESF) y Unidades Básicas de Salud convencionales (UBS) de Passos, MG. **Métodos:** Investigación de evaluación, cuantitativa. Participaron 27 enfermeros a partir de la colección de los datos recogidos por PCATool-Brasil, versión profesional, y tabulado electrónicamente. **Resultados:** ESF tuvo puntuaciones más altas en todos los atributos, excepto en Acceso de Primer Contacto. Sólo para Orientación Comunitaria y Sistema de Información son grandes las diferencias entre las fuentes. El atributo Integración de Cuidados tenía la menor diferencia entre UBS y ESF, mientras la orientación comunitaria recibió la mayor diferencia entre las unidades. **Conclusión:** ESF ha logrado mejores resultados en los atributos de APS comparado con UBS, todavía se necesita mejoras en el proceso de trabajo de los equipos.

Palabras clave: Servicios de Salud; Atención Primaria a la Salud; Evaluación de Servicios de Salud.

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INTRODUCTION

Primary Health Care (PHC) is the initial level of care within the health system and is characterized by a set of actions involving health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation and health maintenance, which should be within the reach of all individuals and families of the community[1].

In order to operationalize the PHC policies and programs some guiding attributes have been instituted, divided into essential and derivative, which serve as fundamental guiding elements for the development of actions in primary care services[2,3]. The essential attributes are: first contact accessibility; longitudinality; coordination - integration of care; coordination - information system; comprehensiveness - services available; and comprehensiveness - services provided, while the derivative attributes are: family centeredness; and community orientation[2,3].

It is known that PHC in Brazil still faces major difficulties in defining a new care model in the country, with challenges to fully meet the needs of the users and respond to the various proposals of the National Primary Care Policy, presented by the Ministry of Health[4].

Given the complexity of the management of the Brazilian National Health System (SUS) the evaluation of these services as tools of change is essential, as the assessment of the intrinsic characteristics of the PHC legitimizes its main challenges and demonstrates the best path for the maintenance and/or improvement of care quality. Therefore, it is essential to evaluate the PHC attributes, with a view to improving the quality of the services provided[5]. Thus, to assess whether the use of public funds has resulted in greater access to health services and more integral care, longitudinal monitoring, care coordination by PHC, community orientation, family centeredness and cultural competence have become important issues[6].

In this context, the evaluation tool for primary care - PCATool developed by Starfield and Shi[3] and validated by the Ministry of Health in Brazil[2] is able to measure the incorporation of essential and derivative PHC attributes in the health services, allowing the comparison of the degree of orientation to the PHC of the different services and different primary care models that coexist, the traditional and the FHS model[2]. Furthermore, it aims to expand its response capacity faced with different health situations in an efficient and effective way, that is, it has excellent properties of evaluation regarding the assessment of PHC[7].

Tested and validated internacionaly[8,9], the PCATool has been applied in several countries, such as Spain, the United States, Peru, Colombia, Argentina, England, Canada, New Zealand, South Korea, Hong Kong, Taiwan and Brazil.

The hypothesis that there is a marked heterogeneity in the quality of care provided by the FHS and conventional PHU teams prompts the following question: what is the extent of the essential and derivative PHC attributes from the perspective of professional nurses of the Family Health Units (FHUs) and conventional Primary Health Units PHUs of the municipality of Passos, Minas Gerais (MG)?

The aim of this study was to evaluate, using the PCATool instrument, the extent of the essential and derivative attributes of the PHC from the perspective of nurses of FHUs and conventional PHUs of the municipality of Passos, MG.

METHODS

This was an evaluative study with a quantitative approach.

It was conducted in Passos, MG, between March and August 2015. Passos is a municipality located in the southwest region of Minas Gerais state, which has a land area of 1,338 km^2 and a population to 112,402 inhabitants, corresponding to 79.44 inhabitants/km^2 [10].

The study sample consisted of 28 professional nurses working in 19 FHUs and nine conventional PHUs. The team of an FHU consists of a physician, a nurse, a nursing technician and six community health agents. The conventional PHU has a nurse, a nursing technician, a pediatric physician, a gynecologist and a clinical physician. Both types of team have a registered population, with approximately 3,500 people per team.

The study sought to address all the nurses, however, during the period of data collection one nurse of a PHU was off work due to sick leave with no predicted date of return. Therefore, the sample totaled 27 participants.

It should be noted that the choice of professional nurses as the study participants was made due to the role they perform within the team, because, as well as developing the activities inherent to the profession, the nurse is seen as a reference by the management, by the people and by the team in the structural conformation of these health services in the municipality of Passos, MG.

For the data collection, formal contact was made with the Department of Health and the PHC Coordination in the municipality and, after their agreement, contact was made with the nurses responsible for the units to schedule the meetings for the application of the questionnaire. This was carried out in the work environment of the individuals interviewed, according to their availability.

The aims and procedures of the study were explained and the Informed Consent Form (ICF) was presented to those nurses that agreed to participate in the study. After signing the consent form in duplicate, the participants responded to the data collection instrument, which had an average duration of thirty minutes.

The data collection instrument used was the Portuguese version of the primary care assessment questionnaire - PCATool-Brazil professional version, according to the model validated by the Ministry of Health[2]. This instrument consists of 77 items, divided into eight domains: first contact - accessibility of the individual with the health system; longitudinality; coordination-integration of care; coordination-information system; comprehensiveness-services available; comprehensiveness-services received; family centeredness; and community orientation[2,3]. The responses to the questions were structured on a Likert scale, from which scores were assigned: 4 ("definitely"), 3 ("probably"), 2 ("probably not"), 1 ("definitely not") and "9 (do not know/do not remember")[11].

The responses to the instrument, recorded by one of the researchers, were organized in a database created using the Microsoft Excel software, 2013 version, in order to carry out the statistical analysis of the results.

The degree of orientation of the service in relation to the PHC attributes was given by the mean score for the items in each dimension. In order to enable a more detailed analysis, the 'Essential' score, obtained from the mean of the essential attributes, the 'Derivative' score, obtained from the mean of the derivative attributes, and the 'General' score of the PHC, from the mean value of the essential and derivative attributes combined, were calculated[2]. The scores obtained were then converted to a scale from 0 to 10, using the following formula: [obtained score - 1 (minimum value)] X 10/4 (maximum value) - 1 (minimum value). That is: (Score obtained - 1) X 10/3[2].

To measure each attribute the arithmetic mean of the responses was compared to the reference value of 6.66, the boundary between a high and low score adopted in the PCATool[12].

All the recommendations and/or regulations of the National Research Ethics Commission were followed, according to National Health Council Resolution No. 466/2012, and the data were collected only after authorization from the Research Ethics Committee of the Higher Education Foundation of Passos, Process 986.154, 5 March 2015.

RESULTS

The mean values and respective standard deviations of the PHC attributes, Essential score and General score conferred by the participating nurses are presented in Table 1.

The mean scores of the PHC attributes demonstrate that the best and worst assessed attributes match according to both the PHU and FHU nurses, these being Family centeredness, with 8.61 and 9.18, respectively, and First Contact - Accessibility with 4.44 and 4.21.

The low score for the First contact - accessibility attribute is the result of the high percentage of negative ratings for items related to hours of service for users, especially the item "professionals of the unit attend sick patients at night" (PHUs 1.25 and FHUs 0.18), and how the population communicates with the service or with some form of care when it is not in operation, especially the item "there is a phone number for information when the unit is closed" (PHUs 2.08 and FHUs 1.93).

With reference to the standard deviation, which is used to measure the variability of the results, the highest values were observed in the Coordination - information system and Community orientation attributes, in both health services. The lowest values observed in the PHUs were for the Coordination - integration of care and Comprehensiveness - services available attributes, while in the FHUs these were Comprehensiveness - services available and the General score. In general, the assessment carried out in the PHUs had higher standard deviation values compared to the FHU assessments, with the exception of Coordination - integration of care, suggesting that the responses of the FHU nurses had less variation from the mean when compared to the responses of conventional PHU nurses.

The difference in the PHC attributes, Essential score and General score, conferred by the participating nurses are presented in Table 2.

The Coordination - Care Integration attribute presented the least difference between the PHUs and FHUs (0.09), this shows that there was no disparity regarding the ability to ensure continuity of care through the health teams, with the analyzed services recognizing the problems that require regular monitoring. However, the analysis of the needs of families with regard to the physical, economic, social and cultural context in which they live was the greatest challenge faced by the PHUs in comparison to the FHUs, as the biggest difference between the units, of 1.60, was found in the Community Orientation attribute, as can be seen in Table 2.

Regarding the care integration, the lack of counter-referral of the services for which patients were referred is an item that should be mentioned, as it was the worst item evaluated by the FHUs and the PHUs, with 2.46 and 1.25 respectively. This factor reduces the knowledge and monitoring of the unit regarding the health of the users.

Figure 1 shows graphically the summary of the scores of the conventional PHUs and FHUs. Considering the eight attributes evaluated, it was confirmed that there was a greater presence of these in the FHUs than in the PHUs, especially with regard to Longitudinality, Coordination - information system, Comprehensiveness - services available, Family centeredness and Community orientation. Thus, the FHS presented higher scores in all attributes except the First contact - accessibility, which was better assessed by the nurses of the conventional PHUs, with a difference of 0.23.

Table 3 reflects the proportion of professional nurses that attributed low and high Essential and General scores, by unit type.

The table cited above shows that the FHUs presented a high degree of PHC orientation when compared to the PHUs. A similar division in the opinions of the PHU professionals can be observed regarding the allocation of low and high scores related to the PHC essential attributes, and opinions with greater divergence in the general score, when the derivative attributes were also introduced. This shows that Community orientation and Family centeredness were the attributes that decisively influenced this disparity.

DISCUSSION

Considering the results presented, it can be seen that, with the exception of the Accessibility attribute, the FHUs had higher scores in all attributes when compared to the PHUs. However, the study did not include statistical tests to determine significant differences.

The low score of the First contact - accessibility attribute depicts the reality, as in the municipality of Passos-MG, with the FHS units and PHUs functioning during business hours on weekdays. The same impediment was reported in a study conducted in the city Alfenas-MG[8]. This unavailability of staff to

Table 1. Mean values and standard deviations of the Primary Health Care (PHC) attributes, Essential Score and General Score, conferred by nurses in the assessment of the primary care network, Municipality of Passos - MG, 2015

PHC Attributes	Conventional PHUs (N = 8)				FHS (N = 19)			
	Min.	Max.	Mean	SD	Min.	Max.	Mean	SD
First Contact Access - Accessibility	2.96	5.93	4.44	0.97	3.33	6.67	4.21	0.86
Longitudinality	5.90	9.49	7.37	1.20	5.64	9.74	7.88	1.17
Coordination - Integration of Care	6.11	8.89	7.57	0.84	5.56	9.44	7.66	1.18
Coordination - Information System	4.44	10.00	7.36	2.65	4.44	10.00	8.71	1.82
Comprehensiveness - Services Available	3.79	6.52	5.42	0.96	5.30	7.27	6.13	0.54
Comprehensiveness - Services Provided	5.11	9.33	7.69	1.69	4.89	9.33	7.92	1.18
Family Centeredness	6.67	10.00	8.61	1.42	5.56	10.00	9.18	1.16
Community Orientation	1.11	10.00	5.83	2.94	3.89	10.00	7.43	1.34
Essential Score	5.03	7.80	6.65	1.06	5.67	7.97	7.09	0.68
General Score	5.03	8.00	6.80	1.16	6.00	8.37	7.40	0.64

Source: Personal development. Min.: Minimum; Max.: Maximum; SD: Standard Deviation.

Table 2. Difference in the Mean values of the Primary Health Care (PHC) attributes, Essential Score and General Score between the Family Health Strategy Units and the conventional Primary Health Units, Municipality of Passos - MG, 2015.

PHC Attributes	No. items	Conv. PHU	FHS	Difference
First Contact Access - Accessibility	09	4.44	4.21	0.23
Longitudinality	13	7.37	7.88	0.51
Coordination - Integration of Care	06	7.57	7.66	0.09
Coordination - Information System	03	7.36	8.71	1.35
Comprehensiveness - Services Available	22	5.42	6.13	0.71
Comprehensiveness - Services Provided	15	7.69	7.92	0.23
Family Centeredness	03	8.61	9.18	0.57
Community Orientation	06	5.83	7.43	1.60
Essential Score	68	6.65	7.09	0.44
General Score	77	6.80	7.40	0.60

Source: Personal development.

attend users at times such as at night and weekends reduces the contact between the patients and the unit[8].

In a study in the PHU of Chapecó-SC the Accessibility attribute obtained a mean score of 3.6. The authors stated that this result was consistent with the structural deficiencies as well as the organizational structure of health services[6].

The items: "units are open during the weekend and after 8:00pm", and "the absence of a phone number for information when the unit is closed", make access to the FHUs and PHUs difficult for the users. These data corroborate the findings of a study conducted in Piracicaba-SP with 69 health professionals from the FHUs and PHUs[13]. According to the study data, the insertion of the FHS does not necessarily lead to improved access[13].

In the present study, the FHUs score for Accessibility, with 4.21, and the General score, with 7.40, were the same as those of a study that assessed the presence and extent of the primary care attributes in Curitiba-PR[12]. The limitations in the Accessibility attribute contribute to users seeking emergency services to receive care.

The PHC General score estimated using the PCATool-Brazil for the Longitudinality attribute resulted in 7.37 in the conventional PHUs and 7.88 in the FHUs of Passos-MG. In Chapecó-SC the mean score of the PHUs was 6.0 (5.83-6.34 confidence interval), a significantly lower value than that of the present study, demonstrating a process considered fragile and unsatisfactory[6].

Figure 1. Difference in the Primary Health Care (PHC) attributes between the Family Health Strategy Units and the conventional Primary Health Units, Municipality of Passos - MG, 2015.

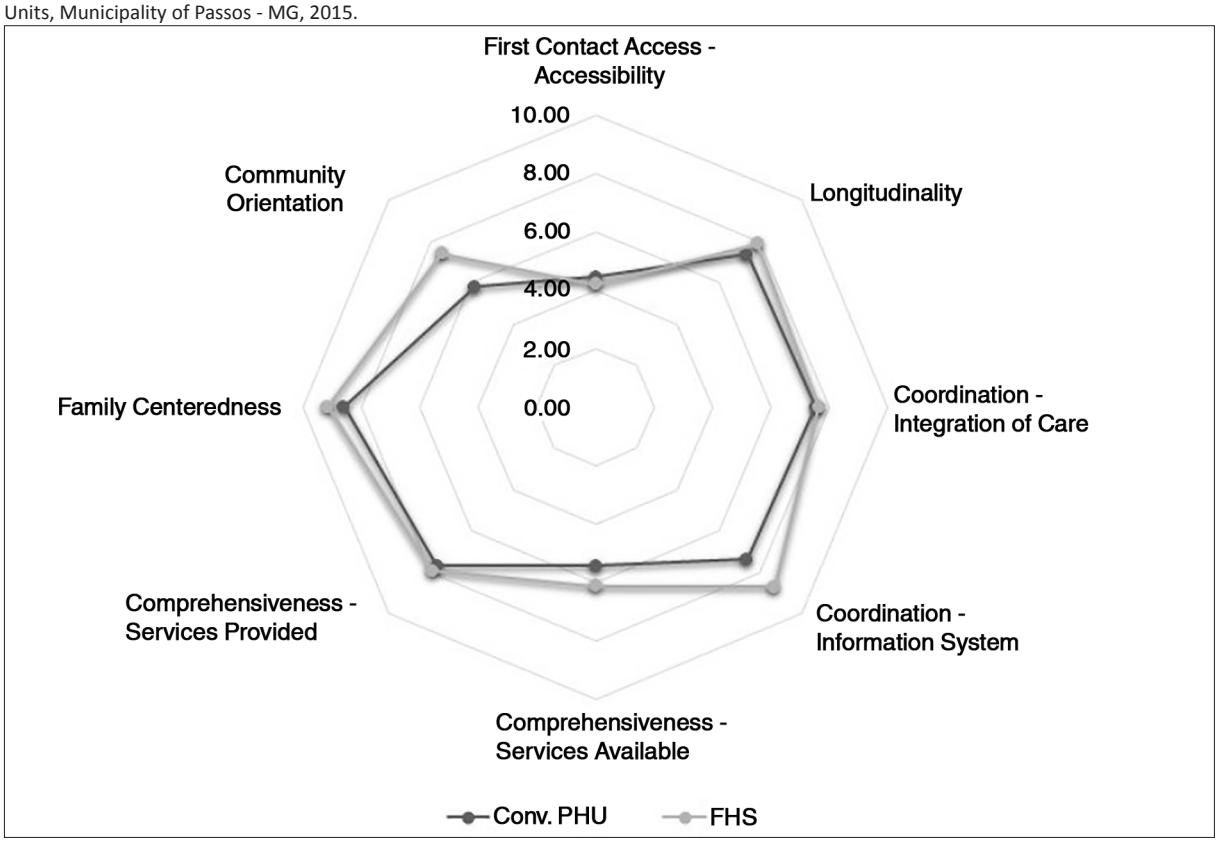

Table 3. Proportion of professional nurses that attributed low and high Essential Scores and General Scores, according to type of Primary Health Care service of Passos - MG, 2015*

Unit type	PHC essential score				PHC general score			
	Low		High		Low		High	
	n	%	n	%	n	%	n	%
Conv. PHU	04	50.00	04	50.00	03	37.50	05	62.50
FHS	03	15.79	16	84.21	03	15.79	16	84.21

Source: Personal development. * The PHC score of ≥ 6.6, on a scale of 0 to 10, is considered a high score.

Comparing the PHUs and FHUs of Piracicaba-SP, in the following items the FHUs presented a higher score than the PHUs: "users are most often examined by the same professional", "there is more than sufficient time for the consultation" and "the professionals are more knowledgeable about the medications used by patients"[13]. This last item differs from the present study, in which the PHUs presented a higher score than the FHUs[13].

The items that had low scores from the perception of nurses of both care models in a study performed in Porto Alegre-RS were: "if patients have a question, they can call and talk to the doctor who knows them best", "you know who lives with each of your patients", "you know the complete medical history of each of your patients", "you know the work or job of each of your patients" and "you know about all the medications your patients are taking"[14]. The item "you understand what problems are the most important for the patients you attend" obtained a notably higher mean score in the FHUs, of 8.26, than in the PHUs, of 6.91. This discrepancy was also observed in the item "you know whether your patients failed to obtain the prescribed medications or had difficulties paying for them", where the mean score was 8.26 in the FHUs and 6.79 in the PHUs[14].

One of the great challenges for the SUS is to qualify PHC to exercise the coordination of care and to organize integrated, intercommunicating, specialized care points that are able to ensure that the integral care line is fully articulated with PHC and provide the users of the SUS with responses appropriate for their needs[15].

A study with 98 FHS professionals of Sobral-CE showed that 50% answered "probably not" in relation to receiving a counter-referral from the specialist[16]. The results of case studies on the implementation of the Family Health Strategy in Large Urban Centers highlight that the counter-referral is not commonly practiced[17]. Unlike the scores in this study, a study performed in Piracicaba-SP identified that the professionals of the PHUs received more counter-referrals than those of the FHUs, however, in both services it was reported that they receive less than half of the inter-consultation results[13].

The items of this attribute that received low scores from the professionals of both the FHUs and the PHUs in a study performed in Porto Alegre-RS were: "you know about all of the consultations that users have with specialists or specialized services", "when your patients need a referral, you discuss the different services where they could be attended with them" and "you receive useful information about the referred patient from the specialist or specialized service"[14].

In the state of Paraná, some municipalities have addressed the counter-referral problem through the implementation of an integrated electronic medical record system, which provides access to the results of examinations and clinical reports issued by other care levels[9].

In the present study, the majority of the professional of both the PHUs and the FHUs said they discussed the care places with the users when they were referred to other services. In a study carried out in Sobral-CE, 60.2% of the 98 FHS professionals interviewed answered "definitely" to this item[16]. However, 64.8% of 607 users interviewed answered "definitely not" stating that the nurses and medical professionals did not discuss the different services in which they could be attended for a particular health problem[16].

Furthermore, according to the Sobral-CE study, to ensure the integrality of the care, providing the resources capable of responding to the needs of the users, it is essential to know and to stimulate discussion about the services available in the healthcare network[16].

In a study that included a small (Engenheiro Paulo de Frontin), a medium-sized (Itaboraí) and a large municipality (Rio de Janeiro) the disarticulation of the network or the lack of available support services compromised the effectiveness of the primary health care[18]. According to another study performed in the Federal District, seeking a PHC system that exercised its role of coordinator of the health system also presented challenges to be overcome[19].

Among the 98 FHS professionals that were the participants of a study performed in Sobral-CE, 60.2% answered "definitely" to allowing users to analyze their medical records[16]. In this study, the majority of users gave positive responses regarding access to medical records, however, the large number of users who were unaware of their right to access their own medical records was highlighted[16]. It was emphasized that the act of users examining their medical records can help in the understanding of their health-disease process, observing its evolution and the participation of different professionals in the care[16].

The Comprehensiveness attribute obtained a higher score in the FHUs than in the PHUs, this result coincides with that observed in a study performed in Piracicaba-SP[13]. In Alfenas-MG, the negative assessment of the Comprehensiveness attribute revealed that the professionals, in many cases, limited themselves to complying with only what is demarcated by the Government Programs and do not develop their actions through analysis of the health situation and the local reality[8].

It was noticed that items such as: "oral evaluation", "dental treatment", "sewing up a cut that requires stitches", "splinting", "removal of warts" and "care for as ingrown toenail", received an extremely low or even zero evaluation. According to the Ministry of Health[20], procedures can be performed in the PHU, however, often are not. The implementation of these measures in PHC would reduce the user demand for urgent and emergency service, as well as increase user satisfaction.

In Porto Alegre-RS the items that received the lowest scores by the nurses of both PHC models were: "dental check-up", "treatment by a dentist", "counseling for mental health problems", "identification (some type of evaluation) of visual problems", "identification (some type of evaluation) of hearing problems", "sewing up a cut that needs stitches", "splinting", "removal of warts" and "care for ingrown toenail"[14], consistent with what was found in the present study. Two other results found were also similar to the study, which were: "counseling or treatment for harmful drug use" and "inclusion in supplemental feeding programs" in which the FHUs received a significantly higher score than the PHUs[14].

The data found in Porto Alegre-RS demonstrated that the mean scores of the FHS nurses were greater than those of the PHU nurses[14]. The items: "you ask about whether the user has a gun, its storage or its security" and "advice on seat belt use or child safety seats and preventing children from having high falls" received low scores from the professional of both care models[14]. It is believed that this result may be related to the difficulty that professionals have in discussing these issues with users due to the socio-cultural and vulnerability conditions to which both users and professionals are exposed[14]. Furthermore, even if these are common for the community, they are topics that are not included in the quotidian of the professionals[14].

In the Porto Alegre-RS study, the item "ways to handle family conflicts that arise from time to time" received higher mean scores by the FHS professionals, with a value of 9.33, while the professionals of the PHUs attributed a score of 8.15[14]. The item "possible exposures to hazardous substances (e.g. ant/mouse poison, bleach), at home, at work, or in the neighborhood of the user" received a score of 8.80 from the FHS nurses and 7.53 from those of the PHUs[14]. "Care for common problems related to menstruation or menopause" also obtained a higher score, of 9.86, in the FHUs, with 8.64 in the PHUs[14]. With regard to "how to prevent falls" there was also a significant difference between the

services, with the FHUs obtaining a score of 9.46 and the PHUs 8.27[14]. The mean score of the item "ways to deal with children's behavior problems" was higher among FHU nurses, with a mean of 9.73, compared to those of the PHUs, with 8.39[14].

The Family centeredness and Community orientation attributes were found to be more present in the FHUs. This result is similar to that found in the Central-West Region of Brazil from the perspective of professionals[21]. The attributes Family centeredness and Community orientation in the FHUs of São Paulo-SP received high scores from managers and professionals and lower scores from users[22]. It is assumed that these attributes are emphasized in the Family Health Program and therefore it is unlikely that they would be poorly evaluated by managers and professionals, considering that they are in charge of implementing them in the services[22].

In the present study, it was assumed that the low scores by the nurses of the PHUs in relation to Community orientation were due to the absence of Community Health Agents (CHAs) in these units. These professionals represent a link between the community in which they live and the health system and are only present in the FHUs, comprising part of the minimum team of this service[1].

It is believed that the absence of Local Health Councils in the municipality of Passos - MG hinders the participation of users in the planning, implementation and evaluation of health actions in PHC. The results of an evaluative study on innovative arrangements and strategies in the organization of primary care in a large city of São Paulo state found that counselor users reported that, even with the adoption of resource such as letters, invitations and prior appointments, it was very difficult to get the population to attend the meetings of the Local Health Council[23].

However, according to the study cited above, the counselors believed that they could represent the needs of the community, although, other non-counselor users claimed to not feel represented by their counselor peers. Many did not know who the people were that occupied this position, stating that when they needed to make a complaint they sought the service coordinator or ombudsman of the municipality, as they considered the council slow and bureaucratic[23]. Furthermore, they did not feel that their problems were listened to, arguing that: "when we complain, they [coordinators] can do whatever they want with us" (narrative of users)[23].

It was found here that the General score of the FHUs was higher than that of the PHUs, with the values found being similar to those of a study performed in Porto Alegre-RS, in which the FHUs received a mean score of 7.43 and the PHUs 6.84, with standard deviation of 5.58 in the FHUs and 5.83 in the PHUs[14]. Regarding the Essential score, the same study found a score of 7.17 for the FHUs and 6.67 for the PHUs, with standard deviation of 0.46 for the FHUs and 0.61 for the PHUs[14].

In view of the above, it is important to note that PHC does not meet all the health needs of the population in this level of care in the municipality studied, with its technical character constantly needing improvement. The primary healthcare units must operate in accordance with the needs of users, in partnership with the communities, to reduce access barriers and improve the utilization of the services. Therefore, the professional teams studied, together with other participants, such as managers and the community, should provide the means and conditions to analyze and understand the local health situation and propose changes in the work process of the teams when difficulties are detected.

FINAL CONSIDERATIONS

The results presented here show better performance regarding the PHC attributes in the FHUs. However, it is important to emphasize that, from the perspective of the professionals of both the FHUs and the PHUs, some attributes need to be improved, especially the Accessibility attribute, which received the lowest scores in both services, indicating that this should be a priority for the qualification of PHC in the municipality. The need for improvements in the work process of the teams is also suggested.

The findings of this study highlight what should be changed in the health service to improve its impact. For the teams involved in the study and the municipal management, the challenge remains of being able to positively impact the assessment of the PHC attributes.

It is believed that this study contributes by indicating which PHC attributes need to improve for the achievement of quality care. Based on these findings, efforts to ensure that policies are put in place and realized are also necessary. Due to the relevance of the theme, studies are suggested applying the versions of the PCATool for adult users and children, which can add and confront other evaluative perspectives of the PHC services.

The limitations of this study relate to the absence of associations, through statistical tests, between the FHU and PHU scores. Furthermore, there was no data collection related to the demographic and socioeconomic characteristics of the study population, which made it impossible to make correlation between these variables and the results found. It is important to note that the results encountered refer to the reality of the municipality studied.

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