Cogitare Enfermagem

ORIGINAL ARTICLE

EVALUATION OF ESSENTIAL ATTRIBUTES IN THE FAMILY HEALTH STRATEGY: USERS' PERSPECTIVE

HIGHLIGHTS

1. Marital status and having children were significant for essential score.
2. Having a health problem interferes with satisfaction with the service.
3. Satisfied users rated the presence and extent of attributes more highly.

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ABSTRACT

Objective: to evaluate the presence and extent of the essential attributes of Primary Health Care from the perspective of users of the Family Health Strategy. **Method:** this was a cross-sectional, quantitative study of 256 users of 26 family health units in Santa Catarina, Brazil, carried out between June and December 2021. A characterization questionnaire and the Primary Care Assessment Instrument were used. Descriptive and inferential statistics analysis was carried out. **Results:** users evaluated the units as having a sub-optimal score for the presence and extent of the essential attributes. However, users with health problems rated the essential score (p=0.001), the longitudinality attribute (p=0.024), and the comprehensiveness attribute (p=0.001) positively.). **Conclusion:** periodically evaluating the presence and extent of the attributes makes it possible to guide strengthening strategies and contributes to the continuous improvement of Primary Care, based on indicators for qualified health management, with the difference of considering the views of users.

KEYWORDS: Primary Health Care; Family Health; Health Services Research; Health Management.

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INTRODUTION

Primary Health Care (PHC) is configured as the main gateway to all the population's health needs and problems in the health system, through a set of actions in the areas of health promotion, prevention, and clinical care.

PHC should be structured by its essential attributes: access to first contact, which refers to the accessibility and use of health services for each new problem or a new episode of the same problem; longitudinality, which points to the continued provision of care over time, and should include an interpersonal relationship of mutual trust between users and professionals; comprehensiveness, which is the set of services available and provided to meet the population's health needs comprehensively; and coordination of care, which presupposes PHC's ability to guarantee continuity of care within the Health Care Network (HCN), through coordination between services[1].

The essential attributes of PHC are evaluated in terms of their presence and extent, to guarantee the quality of care and, consequently, improve the articulation of the health system as a whole[2]. This evaluation must take into account the external perception, that is, those who make use of these services (users), who experience and enjoy the benefits or detriments of the presence or absence of these attributes and are therefore a powerful indicator for planning actions[3]. Overall, the attributes aim to broaden the focus of care beyond the disease, leading to more comprehensive, accessible care based on the reality of communities and individuals at different stages of the life cycle.

The Ministry of Health considers the evaluation of the supply of PHC health actions and services concerning the needs of the population to be one of its research priorities[4], which corroborates the Sustainable Development Goals (SDGs), especially SDG 3, which aims to provide a healthy life for all[5]. The application of evaluation models helps in health management by measuring impact, efficiency, effectiveness, and resolution in different contexts of PHC in Brazil, as well as by emphasizing the guarantee of public funding to strengthen PHC as the organizer of the Health Care Network (HCN)[6]. To this end, knowing the users' perspectives provides support for planning effective strategies on the part of managers, to guarantee quality, problem-solving care[7]. In addition, the study is relevant to increasing recognition of PHC and its attributes in the population, inducing spaces for listening to those who use the services and their quality.

From this perspective, questions were asked about how users of the Family Health Strategy assess the presence and extent of the essential attributes of PHC. The aim was therefore to assess the presence and extent of essential PHC attributes from the perspective of Family Health Strategy users.

METHOD

This is a cross-sectional study with a quantitative approach, carried out in 26 Basic Health Units (BHU), with the exclusive presence of family Health Teams (fHT) in a municipality located in the western region of the State of Santa Catarina.

Participants in the study were selected according to the inclusion criteria: adults aged over 18; users of one of the BHU, considering the 12 months before data collection, with a view to the user's knowledge of how the health service works. Those who reported private services as a regular source of health care were excluded.

A sample of participants was calculated based on the municipality's population (estimated at 220,000 inhabitants for 2020) estimated AB population coverage of 100% and FHS population coverage of 89.24%. A margin of error of 5% and a 95% confidence level were declared. The estimated sample size was 247, considering eight to ten participants for each BHU (a total of 26 BHUs), and the order of the units for data collection was randomly selected. The total number of participants in the study was 256 users, due to the fact that the sample number had been reached before all the BHU in the municipality had been collected.

The collection period took place between June and December 2021 and the approach to participants was non-probabilistic, when users showed up at the health units, according to the availability of the population in each scenario on the days of data collection. The presentation of the study and data collection took place while users were waiting to be seen at the health service, with the researchers conducting the questionnaire in a reserved space. There was no loss of completion of the questionnaire.

A questionnaire was used to collect data on sociodemographic characteristics (gender, race and color, schooling, marital status, children, work, and income), clinical characteristics (having a health problem), and the use of services (knowing the nearest service and attending it, being satisfied with it), as well as the Primary Care Assessment Tool – adult reduced version (PCATool-Brasil)[2], consisting of 25 items divided into ten components related to the attributes of PHC, with possible answers on a Likert scale ranging from "certainly not" to "certainly yes". This manuscript presents a cross-section of the eight components (22 items) related to the essential attributes, which are[2]: Affiliation, First contact access - Utilization, First contact access – Accessibility, Longitudinality, Coordination - Integration of care, Coordination - Information systems, Comprehensiveness - Available services, Comprehensiveness - Services provided. Both instruments were collected via *Epi Info Mobile*, available on the cell phones of the members of the research team, who underwent prior training. The average response time was 20 minutes.

The data was organized in a single Excel software spreadsheet (Microsoft®) and then imported into the *Statistical Package for the Social Sciences* (*SPSS*), version 20.0, to carry out the database analysis. Descriptive statistics were used, in which categorical variables were expressed as absolute and relative frequency and quantitative variables as mean and standard deviation or median and interquartile range, according to the symmetry or otherwise of the data, respectively.

The PCATool-Brasil was analyzed according to the guidelines in the Instrument Manual, with the scores (mean of the answers) being transformed into a scale of 0 to 10[2]. The Manual states that scores can be classified as High (score ≥ 6.6) and Low (score < 6.6), with a High score being characterized by the presence and extent of PHC attributes, revealing services that are better oriented towards PHC. The cutoff score of 6.6 reflects responses to the instrument's items with at least the 'probably yes' response category, assigned to code 3 on the original scale, and therefore minimally present in the services[2].

The internal consistency of the essential attributes of the PCATool-Brasil adult version was assessed using *Cronbach*'s Alpha, with a consistency level of 0.876. Pearson's chi-square test or *Fisher*'s exact test was used to analyze the proportions, seeking to identify the variables (sociodemographic, clinical and use of health services) that could be associated with the essential score. The means of the essential PHC attributes were also compared between those with a health problem and those who were satisfied with the BHU. To this end, the normality of the continuous variables was evaluated using the *Kolmogorov-Smirnov* test. All the components of the essential attributes showed a non-normal distribution ($p \leq 0.05$), and the non-parametric Mann-Whitney test was used. The significance level assumed for all tests was 5% ($p < 0.05$).

The study complied with all the ethical precepts recommended by the National Health Council and was approved by the Research Ethics Committee (opinion no. 4.150.955/2020),

with users being informed of the objectives of the research, their right to anonymity and to withdraw from the study at any time, average response time, benefits and risks. In addition, all sanitary measures to deal with Covid-19 were used during data collection.

RESULTS

Of the 256 users who responded to the survey, the majority (n=139/54.3%) classified PHC with a low essential score (<6.6). Table 1 shows the sociodemographic characteristics of the participants according to the high (mean ≥6.6) and low (mean <6.6) essential score, showing the prevalence of females, whites, complete high school education, with a partner, employed and at least one child.

The variables marital status and having children showed a significant difference between the high and low essential score classifications. In the analysis comparing the essential score means with the Mann-Whitney test, although there was no statistically significant difference (p=0.058), those participants with children had an essential score of 6.34 (±1.49), while those without children had an average of 5.86 (±1.62). There was also no significance (Mann-Whitney test p=0.054) when comparing the means of the essential score between those who had a partner 6.40 (±1.51) and those without a partner 5.99 (±1.53) Table 1).

Table 1 - User's Sociodemographic characteristics according to the PHC essential score. Chapecó, SC, Brazil, 2021 (n=256).

Variables	High essential score (n=117)	Low essential score (n=139)	p value
Gender n (%)			0.224*
Female	75 (64.1)	99 (71.2)	
Male	42 (35.9)	40 (28.8)	
Color n (%)			0.117*
White	78 (66.7)	81 (58.3)	
Yellow	0 (0)	7 (5)	
Indigenous	1 (0.5)	1 (0.7)	
Brown	32 (27.4)	39 (28.1)	
Black	6 (5.1)	11 (7.9)	
Education n (%)			-
Not literate	4 (3.4)	1 (0.7)	
Elementary school	59 (50.4)	40 (28.8)	
High school	42 (35.9)	64 (46.0)	
Higher education	12 (10.3)	34 (24.5)	
Marital statusn (%)			**0.048***
With partner	79 (67.5)	77 (55.4)	
Without partner	38 (32.5)	62 (44.6)	
Children n (%)			**0.008***
No	16 (13.7)	38 (27.3)	
Yes	101 (86)	101 (72.7)	

Works n (%)			0.880*
No	44 (37.6)	51 (36.7)	
Yes	73 (62.4)	88 (63.3)	
Income (R$) – median (interquartile range)	2,150 (1,400-3,000)	2,500 (1,600-4,500)	0.365ƒ

* Chi-square test. ƒ Mann Whitney test

Source: The authors (2022).

Table 2 shows users' clinical characteristics (whether or not they had a health problem) and their use of services. Among the health problems, the three most prevalent were: Systemic Arterial Hypertension (SAH), Diabetes Mellitus (DM), and Depression. There was statistical significance between high and low scores for the variables highlighted - having a health problem and being satisfied with the BHU.

Table 2 - Users' clinical characteristics and use of health services according to the essential PHC score. Chapecó, SC, Brazil, 2021 (n=256) .

Variables	High essential score (n=117)	Low essential score (n=139)	p
Have any health problems n (%)			**<0.001***
No	45 (38.5)	86 (61.9)	
Yes	72 (61.5)	53 (38.1)	
Sabe qual a BHU **mais próxima n (%)**			-
No	0 (0)	0 (0)	
Yes	117 (100)	139 (100)	
Attends the nearest BHU **n (%)**			0.064ƒ
No	0 (0)	4 (2.9)	
Yes	117 (100)	135 (97.1)	
If the person is satisfied with the nearest BHU **n (%)**			**<0.001ƒ**
No	2 (1.7)	28 (20.1)	
Yes	115 (98.3)	111 (79.9)	

*Chi square test. ƒFisher's Exact Test

Source: The authors (2022).

Table 3 shows a comparison of the means of the components of the essential attributes according to the clinical variable of having or not having a health problem. Except for accessibility in first contact access, all the components were better evaluated by the population with a health problem. There was a significant difference between the means of the essential score, affiliation, and comprehensiveness – services provided, showing that those who have a health problem rated them with higher means than those who don't.

Table 3 - Comparison of the components' means of the essential attributes of PHC among those who reported having or not having a health problem. Chapecó, SC, Brazil, 2021 (n=256).

Variables	Have a health problem (n=125) Mean (SD)	No health problems (n=131) Mean (SD)	*p*
Essential score	6.55 (±1.45)	5.94 (±1.54)	**0.001**
Affiliation	**7.57 (±2.88)**	**6.79 (±2.87)**	**0.024**
First contact access – Usage	**8.74 (±2.41)**	**8.11 (±3.06)**	0.117
First contact access – Accessibility	6.49 (±3.11)	**6.71 (±2.71)**	0.800
Longitudinality	**7.33 (±1.86)**	**7.04 (±2.08)**	0.298
Comprehensiveness – Services available	5.38 (±2.60)	4.85 (±2.73)	0.113
Comprehensiveness – Services provided	**6.92 (±2.47)**	5.70 (±2.87)	**0.001**
Coordination of care – Integration of care	5.61 (±3.13)	4.82 (±2.55)	0.071
Coordination of care – Information systems	6.10 (±2.86)	5.80 (±2.85)	0.384

SD= standard deviation (±)/ p= Mann Whitney Test

Source: Authors' database (2022).

Table 4 shows a comparison of the components of the essential attributes' means according to satisfaction with the BHU, with satisfied users rating the presence and extent of the attributes more highly. There was a significant difference in the essential score, in the accessibility component of the first contact access attribute, in longitudinality and comprehensiveness.

Table 4 - Comparison of the components of the essential attributes' means of PHC according to satisfaction with the BHU. Chapecó, SC, Brazil, 2021 (n=256)

Variables	Satisfied with the BHU (n=226) Mean (SD)	Dissatisfied with the BHU (n=30) Mean (SD)	*p*
Essential score	6.44 (±1.44)	4.76 (±1.35)	**0.000**
Affiliation	**7.15 (±2.93)**	**7.33 (±2.68)**	0.836
First contact access – Usage	**8.53 (±2.62)**	**7.55 (±3.70)**	0.243
First contact access – Accessibility	**7.00 (±2.69)**	3.61 (±2.83)	**0.000**
Longitudinality	**7.45 (±1.74)**	5.16 (±2.46)	**0.000**
Comprehensiveness – Services available	5.29 (±2.63)	3.74 (±2.69)	**0.003**
Comprehensiveness – Services provided	6.52 (±2.67)	4.63 (±2.79)	**0.001**
Coordination of care – Integration of care	5.32 (±2.93)	4.36 (±2.19)	0.130
Coordination of care – Information systems	6.04 (±2.75)	5.22 (±3.46)	0.208

SD= standard deviation (±)/ p= Mann Whitney Test

Source: Authors' database (2022).

DISCUSSION

The results of the study show that the majority of users rated PHC with a low essential score, suggesting that the municipality is below expectations in terms of the presence and extent of these attributes. In general, the essential score is evaluated negatively (below the cut-off point) in user surveys in Brazil, such as in Fortaleza[8], Mato Grosso[9], and internationally, such as in China[10], South Korea[11] and Chile[12], as opposed to good performance in the studies in Florianópolis[13], São Paulo[14] and Spain[15].

A low essential score demonstrates the structural weaknesses of a PHC and, in the case of this study, shows important flaws in the integrality of care and as a coordinator of care. Ensuring accessibility and welcome are fundamental, services must be organized to be able to receive the demands of the assigned population and respond positively, with the ability to link the user to the service and consequently be able to resolve health issues[16].

A study shows that having children encourages families, especially women, to seek health services[7]. This may interfere with a more positive evaluation of the essential attributes, due to the focus on women's/pregnant women's and children's health among PHC's programmatic actions and the possibility of resolving health needs. It should be pointed out that women generally use health services more, which is a limitation of dealing with men, as well as analyzing the differences in perception between the two groups.

The fact that users with a partner rated PHC more highly may represent a shortcoming in sexual and reproductive health education actions and programs that are also able to include users who do not have a partner. Although this study did not assess the sexual orientation of users, it points to the ratification of policies to care for the LGBTTQIA+ population (lesbians, gays, bisexuals, transsexuals, transvestites, queers, intersexuals, asexuals, and all other possibilities of sexual orientation), which have been theoretically formulated since 2011; however, their implementation in practice is permeated by deficiencies and gaps in training, organization, and care[17].

The fact that users with a health problem rated the essential attributes more positively points to a certain degree of satisfaction among users about their links with the BHU, even though the essential score was rated as less than ideal by both groups (with and without a health problem). This result demonstrates PHC's focus on programmatic action aimed at planning and developing actions and models of care for individuals with chronic health problems, which require a user-professional therapeutic relationship.

A study found a positive correlation between the degree of affiliation and the essential score, demonstrating the importance of bonding, increased access, and comprehensive care for the health needs of these individuals for a positive view of the quality of PHC services[18-19] and as an integral part of the challenge to strengthen PHC[19].

It is noteworthy that even users who said they were satisfied with the PHC referral service had a low essential score. Research has shown that the evaluations made by users are not capable of providing a consistent theoretical model that can deal with the complexity of PHC, due to a lack of knowledge of the real attributions of this service or low expectations of it[10]. Added to this is the fact that PHC still works with a focus on a biomedical model, based on the complaint conduct and the medical figure.

In terms of first-contact access, the divergence in evaluations of the 'accessibility' component between satisfied users and those with health problems suggests shortcomings in care, especially among the chronically ill, who use the services the most.

On the other hand, the 'Utilization' component was rated satisfactorily, showing that the participants have the BHU as their first choice service. A study corroborates this, showing that

the utilization component generally performs better than accessibility[3]. Among the factors that interfere with the user's first contact with PHC are: schooling, opening hours, having a nurse on site, communication difficulties, home care, trust, availability of information, and gratuity[20].

It should be noted that first contact access helps to reduce morbidity and mortality, hospital admissions, the time it takes to resolve health problems and unnecessary referrals, making it essential for formulating public policies and ensuring better PHC performance[16,20].

The longitudinality attribute is evaluated together with the affiliation component (knowing which BHU is closest to your home and attending it)[1-2], both of which were evaluated satisfactorily in the study, demonstrating the maintenance of bonds and trust with BHU professionals for comprehensive care. It should be borne in mind that this attribute was best evaluated by users who reported having a health problem and was critically evaluated by those who were dissatisfied with the service. Research shows that users with chronic diseases who access the service more, get to know the unit and the team better, develop a greater bond and, therefore, result in a better evaluation of the longitudinality attribute[21]. On the other hand, dissatisfaction with the service may be due to this lack of bonding.

The comprehensiveness attribute was evaluated with a low score, especially in the available services component, and it was possible to identify the lack of health counseling for users. A review study pointed out that the majority of studies have a low score for this attribute[3,22]. This demonstrates users' lack of knowledge about the services that the unit can offer and provide to the population, due to the model of care based on complaints and lack of health promotion and disease prevention aspects[8].

The coordination of care attribute was rated unsatisfactorily in both components: integration of care (related to networking with specialized services, user referral) and information systems (related to user consultation of BHU medical records)[1-2]. This is in contrast to studies in Rio Grande do Sul[23] and Santa Catarina[13] which gave positive evaluations of the different models of care (FHS and BHU), showing a lack of responsibility and continuity of care in the HCN in the municipality of Chapecó. Coordination of care is a form of continuity and articulation between the various points of the HCN, which depends on effective communication between managers, professionals and users[4].

The evaluation of essential attributes contributes to health management by recognizing the realities and models of health care, which helps to develop and validate methodologies and instruments capable of subsidizing the effectiveness of PHC and supporting decision-making in the SUS[6]. Evaluation and monitoring are dynamic processes that are constantly being improved in the search for quality, recognizing the complexity and diversity of the actions that make up the set of PHC responsibilities[24-25].

It should be noted that this study was carried out during the Covid-19 pandemic, which brought new demands for PHC beyond the prevention, detection, and treatment of cases of the disease, such as: the reduction of programmatic actions, and the interruption of group activities, meetings and actions of local health councils; the lack of equipment for telecare; emotional overload; the aggravation of existing situations of vulnerability, among others; which will still have medium and long-term impacts on the presence and extent of essential attributes[26].

The limitations of this study refer to the collection of data during the pandemic period, which may have influenced the evaluation of users due to the reorganization of care and the lack of evaluation of the structural characteristics of the units and qualitative information that corroborated the understanding of the evaluation by users.

CONCLUSION

The results of the survey show that, from the users' perspective, the municipality is below the ideal index in terms of the presence and extent of the essential attributes of PHC. Having a health problem and being satisfied with the referral unit were associated with better averages of the essential attributes. These results can serve as a basis for guiding health professionals and managers in their search for strategies to strengthen and continuously improve PHC.

In this sense, some strategies can be implemented to improve both the quality of care and user satisfaction, including the evaluation of communication alternatives used by professionals; the development of internal measures for the systematic evaluation of services; the expansion of information and communication technology in the HCN; and extended hours and expansion of care models, such as advanced access.

The above suggestions constitute elements that can qualify PHC in Brazil, in addition to the evaluation of professionals under the attributes, the strengthening of lines of care in the HCN considering the local/regional reality of the population and the structure of health services. There is also a need for ongoing research to monitor the quality of services at this level of care in different Brazilian municipalities.

For these measures to improve the presence and extent of PHC's essential attributes to become a reality, qualified health management is needed, based on sufficient public funding of the system and the establishment of teaching-service-community integration to invest in and qualify health training, both undergraduate and postgraduate, multi-professional and interprofessional, aimed at the Family Health Strategy and strengthening PHC.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **Borin ER, Silva CB da, Trindade L de L, Reinehr KR, Ascari RA.** Drafting the work or revising it critically for important intellectual content - **Borin ER, Silva CB da, Trindade L de L, Reinehr KR, Barimacker SV.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **Silva CB da, Trindade L de**. All authors approved the final version of the text.

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