

## User satisfaction with primary health care: an analysis of access and care

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This study aimed to analyze user satisfaction with access and care in Primary Health Care (PHC) based on non-urgent demand for emergency services. 28 non-urgent users of emergency services were intentionally interviewed across five health districts in the city of Ribeirão Preto in São Paulo State. These users had been treated in PHC at least once in the previous six months prior to data collection aimed at evaluating the services. Content analysis was used to analyze the interviews. The results showed there to be satisfaction with care received from health professionals in PHC and dissatisfaction with delays in arranging an appointment and with difficulty to receive care based on spontaneous demand. There was found to be no difference in the levels of satisfaction between the users from different health districts. The article concludes that obstacles to access to PHC services represent a barrier for populations wishing to receive care, with repercussions in terms of user satisfaction and high demand for emergency care.

*Key words:* Primary health care. Patient satisfaction. Health services accessibility

## Introduction

The Constitution of the Federative Republic of Brazil established the Brazilian Unified Health System (SUS), in which health is recognized as a right that must be ensured by the State and is based on organizational principles, among them, universal access to health services at all levels of care.<sup>1</sup>

To ensure universal, equal, and organized access to actions and services at different levels, healthcare networks were created that constitute organizational arrangements of sets of health services coordinated among themselves through common goals and cooperative and interdependent actions that enable the provision of continuous and comprehensive care to the population, coordinated by primary health care (PHC).<sup>2</sup> However, profound changes must be made in order for this form of care organization to overcome a fragmented healthcare system that does not ensure continuity and is centered on acute conditions, through emergency care units (ECUs).<sup>2</sup>

Emergency care units are also defined as points of entry to initial health care by SUS users.<sup>3</sup> However, the guarantees set forth in Brazilian legislation represent one step among many required to construct the SUS. For the right to health to become a reality, changes must occur in the social model, because in practice, access is still selective, focalized, and exclusionary.<sup>4</sup> From this perspective, even though they are considered a point of entry to the system, ECUs treat only the main complaints that led users to the health service.<sup>5</sup>

This frequent search for emergency care demonstrates that the health needs of users are not being met by PHC. When users resort to health services, they are looking for something or some action from health professionals that will resolve, or at least minimize, the problem that led them to seek out that service. Thus, it is understood that if a point of entry fails, necessary care is postponed.<sup>6</sup>

Health needs are related to social production and reproduction, and accessibility to health actions. Additionally, health care must be planned, considering existing demand,

and that health services that must be willing to address these needs, understanding their meanings and the subjects involved in the production and consumption of health.<sup>7</sup>

According to this logic, humanization means taking co-responsibility for subjects' health production; establishing solidary bonds; identifying social health needs; changing healthcare models and work process management, focusing on user needs; and committing to the improvement of work conditions and care provision.<sup>8</sup>

User satisfaction represents a powerful outcome indicator to assess health services. Knowing how users assess the care provided is essential to rethinking professional practices and how services are organized.<sup>9</sup>

User satisfaction is a conceptual polysemic field with little in the way of theorization. Extant studies have pointed to the diversity of theoretical and methodological approaches to investigating user satisfaction in different dimensions.<sup>9-10</sup>

Thus, accessibility can be evaluated through outcome indicators of user experience with the health system, among them, user satisfaction<sup>11</sup>. Embracement is defined as a type of soft technology that professionals employ during care provision, which is also related to user satisfaction.<sup>5</sup> Access refers to the possibility of using services when necessary.<sup>9</sup> Embracement is a practice that exists in care relationships, in the encounter between health workers and users, in the act of welcoming and listening to people. It implies building bonds, in association with attentiveness through trained listening, recognizing user complaints and identifying needs, whether individual or collective, and functioning as a mechanism to facilitate accessibility.<sup>12</sup> Thus, the health care provided to the population must meet the needs of users in their singularity, establishing relationships that take into account emotional, cultural, and social dimensions.

Even though user satisfaction is a complex and multidimensional concept that is difficult to measure, there is consensus that it is based on the expectations of those receiving care and what is important to them, defined as the level of congruence between expectations and user perceptions about the care received.<sup>13</sup>

Furthermore, the diversity of approaches to the concept of accessibility demonstrates the plurality and complexity of the theme, which can be related to different dimensions. To achieve the proposed objectives, the present study focused on the technical and symbolic dimensions of access, given that it addresses network organization and accessibility of health services.<sup>4</sup>

Studies that assess user satisfaction as it relates to accessibility and embracement in PHC conducted with users in ECUs are still scarce in Brazil, indicating a gap in knowledge. Addressing user satisfaction in these dimensions implies considering the opinions of those who characterize the services. In this context, there are no studies of user satisfaction that represent the studied municipality in its totality and that enable the analysis of divergence or convergence between health districts according to user perceptions.

Based on the understanding of the potential of PHC to develop accessibility and embracement actions to meet the needs of users, the aim of the present study was to understand user satisfaction with accessibility and embracement in PHC, conducted with non-emergency users in ECUs in the municipality of Ribeirão Preto, São Paulo, Brazil.

## **Method**

This was a qualitative descriptive study, based on the perspective of health service users. This methodological approach works in the realm of relationships, representations, beliefs, perceptions, and opinions.<sup>14</sup>

Data collection was conducted at the five public ECUs of the five health districts in the municipality of Ribeirão Preto, São Paulo, Brazil, between January and April 2014. The participants were users waiting to receive care at ECUs after being screened by the nursing team and identified as non-emergency or emergency cases. All the participants had received health care at PHC units at least once in the six months prior to data collection and were capable of assessing the service. Cases that required urgent or emergency care

were referred by ECU nursing teams to immediate care, and therefore were not included in the study.

In addition to these inclusion criteria, the sample was intentional. The researchers selected individuals who could be the best informants on the topic of this study. Thus, users were chosen who were open to dialogue and talking about their experiences with care received at PHC units during the data collection period.<sup>15</sup>

Non-emergency users assisted at ECUs reside in the areas covered by the municipality's five health districts, and can seek out ECUs spontaneously or through referrals from PHC services. Thus, focusing on the non-emergency cases at ECU services helps to understand the relationship between users and the services provided in PHC and family health units (FHU).

The number of subjects interviewed was defined by theoretical saturation, which is when information begins to repeat itself and is thus considered sufficient to achieve research aims.<sup>14</sup> Data pre-analysis led to the interruption of interviews at the point when no new themes emerged. In other words, continuing the interview process would supposedly add no new elements to the discussion about the topic of study in relation to the theoretical density already obtained.<sup>16</sup>

Considering the above, 28 subjects were interviewed. The interviews were semi-structured, guided by a script to help develop the conversation, allowing flexibility.<sup>14</sup> Topics relative to accessibility and embracement in PHC, user satisfaction with PHC services, problem-solving capability, reasons for seeking care in ECUs, and comprehensiveness of health care were addressed. The script contained guiding questions such as: How easy was it for you to reach the health unit and receive care? How do you assess the care provided by the health professionals? The interviews were recorded, transcribed, and analyzed using thematic content analysis.<sup>17</sup>

Content analysis was used to analyze the participants' speech because it is a research technique that enables the description and analysis of verbal communication. Through systematic and objective procedures to describe messages, indicators emerge

that allow researchers to infer knowledge relative to the conditions behind the production and reception of messages.<sup>17</sup>

Analysis consisted of three phases: 1) data organization, considering the objectives of the study, conducting a thorough reading of the interviews in search of elements of representativeness, homogeneity and relevance; 2) exploration of empirical material by thoroughly reading the transcriptions, separating the corpus of analysis, and identifying convergences and divergences; and 3) classifying and constructing thematic categories.<sup>14</sup>

Content analysis of the interviews resulted in two thematic categories: 1) “health care in PHC and weak points in obtaining care” and 2) “satisfaction with care as strong points of PHC.” Participants were identified with the letter “U” for user, followed by the number of the interview.

Twenty-eight users were interviewed: 6 users were selected in 3 health districts, and 5 in 2 health districts. Of these, 22 were women and 6 were men. The mean age of the sample was 41 years, with a median of 39, minimum of 22 and maximum of 79. Regarding education level, 11 users had completed secondary education, 8 had completed elementary education, and 2 had a university education.

The study protocol abided by the norms of the Research Ethics Committee of EERP-USP, approved under protocol 12678013.9.0000.5393. After participants agreed to voluntarily participate, they were asked to sign a free and informed consent form, as established in Resolution 466/12 of the Brazilian National Health Council.

## **Results and Discussion**

The results are presented according to an initial rhetoric, contextualizing the participants, and are then submitted to an in-depth analysis in the discussion, using the theoretical framework of embracement and accessibility to health services at the various SUS levels. Throughout this process, excerpts that converge with the framework and inferences are presented discursively to structure a comprehensive trajectory of analysis.

## Health care in PHC and weak points in obtaining care

The category “weak points in obtaining care” reflects a set of perceptions reported by users that converge into the comprehensiveness of practices and different services. Comprehensiveness results in users being embraced and able to access services at all levels of complexity. Thus, the quality of points of entry is an important part of quality management.<sup>18</sup> The present study discusses how quality is associated with various issues, such as long wait times in units and when scheduling appointments, refusal to receive spontaneous demands, and low care technology.

Waiting for care is a routine part of users seeking health care in Brazil. Long wait times for appointments in PHC was frequently reported by users as a reason for dissatisfaction. Having to wait to be seen by a professional, in addition to dissatisfaction, led to users feeling deprived of their right to access health.<sup>19</sup>

You have an appointment with a doctor, for example, Dr. Z; he’s a good doctor, except that the appointment is scheduled for 3:30 and you get done at 6:00...he’s a great doctor, but he needs to be quicker with his appointments [...]  
(U14)

First, care needs to be improved; wait time is too long, we wait a long time for an appointment [...] sometimes it takes so long because there are many people in line. [...] Sometimes it takes three, four hours or more for our turn (U18).

Another factor perceived by users was long wait times to schedule appointments at the PHC. Users showed understanding of the micro-politics of schedule management in their units; they were aware of the slowness of the process and ended up seeking other services. The perceptions of the participants about patient flow and wait times for outpatient care in the public system has also been documented by the literature.<sup>19</sup> As the

coordinating entity of the healthcare network, PHC needs to overcome the situations reported in the interviews.

[...] It's a good unit, but the appointments are no good, because you can't schedule one. Now they share appointments with the primary health care unit, but if we try to schedule an appointment there, it takes months [...] So if we have to die, we die, because before we can find an opening we've died already, because there are too many people and not enough resources. (U5)

It takes three months for you to get an appointment with a doctor. And sometimes you don't. They tell you "scheduling will begin on such and such day," so you call them on that day and there are no more openings. Then you have to wait another three months to get an appointment (U10).

The users also reported situations in which care is not provided for spontaneous demands and PHC professionals instruct them to seek out ECUs. Not providing care to users who seek out PHC goes against SUS principles, which establish embracement at the primary level as an important strategy for reorganizing the healthcare model.<sup>20</sup> This leaves users with a negative impression of PHC and points to the need to improve service management and invest in professional training and access to appointments. Users should receive clarification about how emergency care is based on risk classification before being referred to those services. Risk classification is one form of managing municipal patient flow that must begin at the PHC level.<sup>21</sup>

When I go there (PHC), I have to wait for an opening, so I prefer to come to the ECU. Here they make a chart for you and it's ready right away, then you go in the room and tell them what's wrong and then you wait an hour; what's an hour or two? I'd rather come here than to the PHC unit (U6).



They tell us that the doctors are not in and send us here (ECU) [...] When we actually get appointments with them (PHC professionals), the service is good. But they have a rule about not surpassing a given number of patients per day. But when they do see us, the service is good (U22).

I needed a same-day appointment because I was feeling very sick and she (PHC professional) said that she couldn't make room for me after 1:00. So I had to come to the ECU (U27).

In addition to more technical issues related to patient flow management and access to services, the present study revealed user perceptions that placed emphasis on the importance of providing humanized care. Lack of humanized care is harmful to user embracement and the creation of bonds with professionals and health units. Some users reported that physicians did not conduct physical exams during appointments, which was also perceived as a weak point of PHC services.

The first doctor I saw didn't touch me, he didn't look me in the face [...] in reception they don't seem like human people, they seem robotic... (U2)

The doctor who used to work there (PHC) left, and everyone cried. She was an excellent doctor. [...] We need another doctor like her, not these rude doctors who swear at us when we come in (U5).

The doctor who works in the morning talks to patients, helps them feel at ease. The doctor who comes in after him goes in and out of the room, examines you quickly, you sit down and leave, and they don't really know what's wrong with you (U16).

Another weak point of PHC services indicated by the participants was the low technological density of care; although this is not a principle of PHC<sup>2</sup> in many models of

user care, it was a reason for dissatisfaction in this study. This may be an indication, not only of users' lack of knowledge about this modality of care, but also of professionals who are unprepared to practice embracement.

The doctors don't request the tests you want, they don't refer you to the service you actually need. So lately I've been using the private system paying for appointments [...] I think that they (PHC) should provide more tests, everything should be done there instead of referring us somewhere else (U9).

I know it's not easy, there are so many people, but sometimes, I don't know, sometimes it reaches the point that you get an appointment, but then they don't have an answer or a solution because they don't analyze the situation, or conduct a proper examination. They just ask you one question and then give you a prescription. So, care provision needs to improve in many aspects (U18).

The weak points discussed indicate that users felt lost in the studied care network, and were not given solutions regarding needed care. Solutions could be provided by the professionals themselves or more decisively resolved by municipal administration.

### **Satisfaction with care as a strong point of PHC**

In contrast with the weak points of PHC, some respondents expressed satisfaction with the care and embracement received throughout their stay at the health unit. They experienced professionals who were open to dialogue and attentive to their needs, an impression found in other studies<sup>22, 23</sup>, which reinforces the association between professional-user relationships and quality of care.

When I arrive at the health unit, the nurses and doctors are attentive, polite [...]When we arrive they pay attention to us, they are kind, not rude, this fact

alone is something good...and they give us good guidance about what we need to do (U3).

Ah, the nurses talk with us, the doctors too. They're not those kinds of doctors who just look at you when you enter the room. Dialogue is good (U19).

(Care) is great, every day I am more surprised [...] because they make you feel comfortable to talk about what's the matter, how you're feeling, if you feel like crying around them you can cry, they talk a lot with patients (U7).

According to many users, ECUs provide immediate care and do not present problem-solving capability.

Here (ECU) they're not very kind, they barely touch us and then write up our prescription and send us on your way. There (PHC), they examine us, they check out what you've got properly, I think it's better to go there than here [...] Over there (PHC) appointments are scheduled, they run complete check-ups, examine us. Here (ECU) they don't, they just give us medicine, don't ask for any test, you leave feeling just as sick as you came (U1).

At the ECU they don't look at you. It's like I said, they don't examine you, they don't try to figure out what the patient has got, do they? I try not to come here when I have an emergency, but what I've observed with other people is that the service is terrible [...] It's too quick and they don't go into detail. (U12)

The emergency care doctor deals only with emergencies. He'll solve your immediate problem. If you need anything beyond that, then it's a problem. (U24).

The image of physicians and their attentiveness in complying with their work hours at the health unit were also related to user satisfaction, since this results in agility in

appointment scheduling. Consequently, their absence is understood as a significant barrier to satisfaction, as presented in another study.<sup>18</sup>

There's a shortage of clinicians at the health unit. I went there to change Dr. X's prescription but she doesn't work there (FHU) any more, and they still haven't sent another physician to us, so that's missing. I came to the ECU to see a clinician, let's see how it goes. [...] If there were more doctors there for us it would be better, because there are so many people and we need more doctors (U5).

They're always late and they leave early, they're always on vacation and see a low number of patients, I know this because I hear the comments, and that burdens the other doctors who actually come to work [...] Then we have to leave PHC and come here (ECU) (U16).

When asked about the meaning of satisfaction with health care provided, many users associated it with problem-solving capability. Thus, problem-solving capability was understood as synonymous with satisfaction with PHC services.

I think they have to solve my problems, I think they have to provide the care that people deserve, if you need blood work done, they should draw the blood already, they should examine you, they need to solve our problems (U8).

(Satisfaction) is knowing the solution for my pain (laughs). I've been experiencing this pain for almost a month now and I haven't been able to see the person I need to see and get an opening so I can leave (U23).

(Satisfaction) is having your problem solved. Whether its testing or referrals. I think that people leave dissatisfied not because of long wait times, because anywhere you go there's a line. I think it depends on solving your problem (U24).

Long wait times for appointments and when waiting for care in PHC was present in all the interviews. This problem has been researched in different countries and is a current reality in primary healthcare services.<sup>5, 24</sup>

Not meeting spontaneous demands was another factor that generated dissatisfaction among PHC users. Furthermore, the participants reported missing the days in which appointments could be scheduled, making it even more difficult to obtain medical care. Furthermore, the difference between actual supply and demand for care was identified by participants as a barrier to user access in search of health care.<sup>22</sup>

The movement to humanize health care has influenced quality of care and was highlighted in the interviews. When users did not feel welcomed and listened to, the services were rated poorly. This demonstrates the importance of solidary care, which influences satisfaction with the services. This type of care must be developed in PHC services.<sup>8</sup>

In this direction, attentiveness and valuing the listening process when providing care are elements that result in user satisfaction, representing positive differences in health actions.<sup>12</sup> Additionally, lack of physical examinations during appointments negatively impact the professional–user relationship.

These weak points are highly relevant in determining the frequent search for emergency care by the population of Ribeirão Preto. Despite the weak points perceived by users, the municipality strives to implement its five health regions by making PHC services adequate points of entry, in accordance with the principles set forth in Decree 7.508 of 2011.<sup>3</sup> Thus, the municipality acts with the understanding that PHC and emergency points of entry need to be improved and qualified to improve user accessibility and embracement.

Even though ECU services were described as overcrowded, impersonal and focused on the main complaint, they provide a variety of resources such as consultations,

medication, nursing procedures, laboratory tests, and hospital admissions, which make it easier for users to access health care and find a solution to their problems.<sup>3,5</sup>

Scientific development and technological advances have emerged with the purpose of improving care, resulting in the instrumentalization and medicalization of health.<sup>25</sup> Thus, users have better assessments of professionals who work within the logic of health medicalization, whether through the use of devices in examinations and diagnostics, or through drug prescriptions.

In previous decades, a significant part of health actions was performed with more difficulty because of low technical and technological development of science. However, compared with the present, it can be said that technological and scientific advances have resulted in more distant relationships between professionals and users.<sup>25</sup>

In contrast, in terms of the strong points of PHC, the participants reported some examples of satisfaction with the care received. Primary health care professionals were positively assessed, even though users frequently experienced long wait times both to schedule appointments and on the day of appointment, in addition to other barriers to health care.

The success of therapeutic encounters is in the purview of the dialogical dimension, i.e., showing an interest in listening.<sup>26</sup> Professionals must be trained to practice quality listening, and in every encounter in which listening is possible, provide users with embracement and encourage dialogue. Thus, being open to listening and to conversation positively and directly impacts user satisfaction with care.

The image of physicians, according to users, was still understood as being a facilitating factor to access PHC services. Thus, some users suggested hiring more physicians.

These data illustrate the importance of this professional category within health services. When physicians are unavailable, no other team members were identified by users as capable of giving them the answers they needed, as observed in a previous study.<sup>9</sup>

Users seek out care that is strongly based on the biomedical model, which up to the 1980s was recognized by health services to promote pain relief and treat various illnesses. However, nowadays it is considered a limited model of care, because it emphasizes curative actions, medicalization, and hospital care with high technological density. The model places little emphasis on analyzing the determinants of the health-illness process and distances itself from the experience of subjects and their multidimensional aspects.<sup>27</sup>

Based on these interpretations, non-medical professionals attempt to meet the demands of users by referring them to ECUs when physicians are not available.

The dissatisfaction expressed by users when they are not able to meet with physicians indicates that medical services are still the most important predictor of satisfaction with health units, as shown in another study.<sup>23</sup>

According to this logic, the social division of labor still corresponds to the technical separation of activities, in which tasks and responsibilities are divided.<sup>28</sup> Thus, health care is not shared and co-responsible, resulting in fragmentation. It seems that only medical professionals are responsible for users who seek healthcare services. The rest of the team, despite being health professionals, do not share in the collective responsibility for health work.

User satisfaction with PHC was correlated with problem-solving capacity regarding health issues, in agreement with another study.<sup>29</sup> Thus, when users perceive that their needs are not met, the service is rated poorly. On the other hand, users showed awareness that ECUs provide specific care that does not usually solve their problems. In this sense, they recognize the value of PHC, considering that users recognized that when they are able to see a professional, they receive high-quality care.<sup>30</sup>

In contrast with this result, barriers to access to regular sources of care in PHC were directly associated with high demand for emergency care, corroborating the findings of another study.<sup>23</sup>

Despite the various weak points of PHC units highlighted by users, they were still satisfied with the care provided at these services. Their answers expressed a certain level of conformity by the population, because despite the weak points indicated, users frequently expressed satisfaction with PHC services.

In this direction, is important to emphasize the definition of user satisfaction as the relationship between expectations and perceptions of those who receive care and what is important to users.<sup>5, 9-11</sup> Thus, the lower the expectations about health provision, the less likely there will be frustration. In contrast, the higher the expectations about services, the more likely they will not meet expectations.

Even though the health districts had different levels of family health coverage, there were no differences among the opinions of users, which were seemingly homogenous among the five different regions in the studied municipality.

Some limitations of the present study must be considered. The findings indicating high satisfaction may have been expressed out of the misplaced fear of losing the right to PHC care if assessments were negative.<sup>10</sup> Additionally, the low education levels of the participants may have influenced the content and clarity of their answers.

Furthermore, this study considered an in-depth assessment of users of PHC services provided in only one municipality, representing a methodological limitation. Thus, the results cannot be generalized to all Brazilian municipalities.

### **Final Considerations**

Long wait times, both to schedule appointments and on the day of the appointment for PHC, in addition to not meeting spontaneous demands, constituted the main factors behind user dissatisfaction with PHC. Humanization of care also impacted quality of health care. When users did not feel welcomed and listened to, let alone submitted to physical examinations, the health service was poorly rated by them.



In contrast, some users were satisfied with the service, since embracement, attentiveness, and dialogue with PHC professionals were well-rated, even considering the barriers to obtaining health care.

For users, the image of physicians is still a strong point that determines the agility of scheduling appointments for PHC. Additionally, user satisfaction and problem-solving capacity were positively correlated, because when users perceived that their needs were not met, the service was rated poorly. Furthermore, users were aware that ECUs do not resolve health issues.

The findings indicate progress in PHC provision, because the participants recognized the importance of this level of care in ensuring continuity and comprehensiveness of health care. However, organization of appointment scheduling must be improved, and professionals must take greater co-responsibility in facilitating accessibility and embracement of all who seek care in PHC, giving priority to users who seek out emergency services in non-urgent situations.

### **Collaborators**

Mariana Figueiredo Souza Gomide participated in the construction of the research project, data collection, interpretation, analysis and writing of manuscript. Ione Carvalho Pinto participated in the construction of the research project, interpretation and analysis of data and writing of the manuscript. Alexandre Fávero Bulgarelli participated in the interpretation and analysis of data and writing of manuscript. Alba Lúcia Pinheiro dos Santos and Maria del Pilar Serrano Gallardo participated in the construction of the research project, interpretation and analysis of data and writing of manuscript.

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