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Artigo Original

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Evaluation of the Primary Care Network in the city of Recife-PE from the perspective of a group of users

Avaliação da rede de atenção primária do município de Recife – PE sob a ótica de um grupo de usuários

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Abstract

Introduction: Primary Health Care has become the main gateway and first contact the user has with the health care networks, being fundamental its accomplishment among cities to improve the Brazilian Health System. In this context, it is necessary to identify the real applicability of the health service model, along with its limitations, considering the perception of users as an important tool for evaluating these services. Objective: To evaluate the attributes of primary health care in Recife-PE from the perspective of users. Materials and Methods: Observational, analytical-descriptive, cross-sectional study. Participants were 80 adult registered users in the Health Units of Recife. The Primary Care Assessment Tool - adult users, reduced version was applied. Results: The components Degree of Affiliation, First Contact Access – Utilization- and Coordination - Integration of care - reached average scores above 6.6, being well evaluated. The dimension First Contact Access - access to care - obtained scores below 6.6, not reaching the desirable established average, not allowing the full reach of the First Contact Access attribute. Regarding the relationship between the assessment of attributes and sociodemographic variables, there was only a correlation between the age group and the first contact access - utilization. Conclusions: Although users have been recognizing the Primary Care Health Centers as the main health care resource and value it as a care coordinator, still remain difficulties in the access to care into the health service, being necessary new strategies that make possible an increase in the access to the health care system.

Keywords: primary health care; health services research; quality of health care

Resumo

Introdução: A Atenção Primária à Saúde tornou-se a principal porta de entrada e o primeiro contato do usuário com as redes de atenção à saúde, sendo de fundamental importância a sua efetivação nos municípios para a melhoria do sistema de saúde do Brasil. Nesse contexto, é imprescindível identificar a real aplicabilidade do modelo de serviço de saúde, juntamente com os seus impasses, tendo a percepção dos usuários como um importante instrumento de avaliação desses serviços. Objetivos/Métodos: Avaliar os atributos da atenção primária à saúde do Recife-PE sob a ótica dos usuários. Materiais e Métodos: Estudo observacional, analítico-descritivo, transversal. Teve como participantes 80 usuários adultos cadastrados nas Unidades de Saúde do Recife. Aplicou-se o instrumento Primary Care Assessment Tool – usuários adultos, versão reduzida. Resultados: Os componentes Grau de Afiliação, Acesso de Primeiro

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Contato –Utilização– e Coordenação –Integração do cuidado– atingiram escores médios superiores a 6,6, sendo bem avaliados. A dimensão Acesso de Primeiro Contato – Acessibilidade– obteve escore inferior a 6,6, não atingindo a média estabelecida como desejável, comprometendo o alcance pleno do atributo Acesso de Primeiro Contato. Quanto à análise de relação entre a avaliação dos atributos e as variáveis sociodemográficas, apenas houve correlação entre a faixa etária e o acesso de primeiro contato –Utilização–. Conclusões: Embora os usuários reconheçam a Unidade de Saúde da Família como principal recurso de atenção à saúde e a valorizam como coordenadora do cuidado, ainda há dificuldades na acessibilidade ao serviço de saúde, necessitando de novas estratégias que direcionem maneiras de ampliação ao acesso.

Palavras-chave: atenção primária à saúde; avaliação de serviços de saúde; qualidade da assistência à saúde

Introduction

Since the Alma-Ata Conference, Primary Health Care (PHC) can be understood as the core of the health systems, which envisage the guarantee of comprehensive, equitable, entire and sustainable admittance to the assisted population.[1]

In Brazil, the Family Health Program (FHP), brought about in 1994, was critical for strengthening PHC nationwide, expanding access to health care, with actions that prioritize health promotion based on the nonstop monitoring of users, reckoning the family and community context, with multi-professional teams working closer to the population and the community. In view of the outstanding results acquired, after little more than a decade of implementation, in 2006, the FHP has been recognized as the main strategy for the reorganization of PHC in Brazil, and now is called the Family Health Strategy (FHS).[2]

Given this reality, the National Policy for Primary Care (NPPC)[3] was published, which in its last updating in 2017, defined Primary Care (PC) as the "set of individual, family and collective health actions comprising promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance, developed through integrated care practices and skilled management, performed through a multidisciplinary team and aimed at the population within a circumscribed territory, over which teams take health responsibility."[3,4]

An exponent in PHC-related studies, Bárbara Starfield[5] systematized an operational definition of PHC widely referenced, even worldwide, also being adopted by the Ministry of Health in Brazil. From this, it is possible to determine the essential attributes to PHC services: the individual´s first contact access with the health system, the longitudinal dimension, comprehensiveness and coordination of care. Moreover, the three derived attributes that qualify the actions of PHC services are: family-centered health care (family orientation), community orientation and cultural competence.[5,6]

A health service having the four essential attributes can be reasoned as a PHC provider, and, if also presenting the derived attributes, its power of interaction with the family and the community is increased, thus enhancing the essential attributes.[5]

There are strong evidences, in several Brazilian regions, of the importance of PHC for maintaining the population health, per several studies that show a strong relationship between the FHS expansion and the reduction of various causes of mortality and morbidity in the country.[7] As evidenced in research conducted in northeastern Brazil, which pointed to a significant impact on the reduction of leprosy cases in line with the

increase in the coverage of FHS services.[8] Another study accomplished in a municipality in the southeastern region, showed an association with the reduction of infant mortality with greater access to family health teams (eSF's).[9]

Despite this, as mentioned by Sousa and Hamann[10], some difficulties for the solidification and expansion of the FHS in the municipalities can be observed, such as difficulty of access, the lack of articulation in the assistance network and under-funding. Besides, few studies are aimed at evaluating the effectiveness and quality of the FHS according to its specialness. In this case, the users' perception is an excellent indicator for the evaluation of health services, since the user's perspective connotes a judgment on the characteristics of the services and furnishes indispensable information to complete and balance the care quality.[11,12]

In a search carried out in the MEDLINE bibliographic databases, through PubMed and SciELO, few studies have been observed aimed at evaluating PHC services according to the view of adult users in northeastern Brazil. This fact can be evidenced through the systematic review performed by Paula et al[13], in which research was included that used the PCATool instrument to assess the PHC attributes in various regions of Brazil and the population of which was the service users. This article showed that 87% of the selected surveys were carried out in municipalities in the south and southeast regions of Brazil, making it clear that studies in the Northeast region represent a small portion. Additionally, the articles citing to the Northeast, generally have a more restrictive sample population, such as Alves' research et al[14], whose objective was to appraise the quality of care in Primary Health Care offered to male users according to their perspective, held in a city in Paraíba.

As a result, this study aims at presenting an evaluation of the presence of the degree of affiliation and of two essential attributes, the first contact access and the care coordination, of the primary care network of the city of Recife in Pernambuco (PE) through the user´s perceptual experience. Such a study becomes relevant, as it covers three aspects that are intertwined, since only a PHC strengthened with good access to the health service and in good affiliation, would be able to impute the complex mission of coordinating a comprehensive health response.

Materials and Methods

Sample and type of study

This is an observational analytical-descriptive cross-sectional study, with a quantitative approach. The socio-demographic context was the municipality of Recife-PE and its PHC network, which has an administrative division in 8 health districts, of which 132 are Family Health Units (FHU) with a registered population and multi-professional teams linked to them. Family health teams cover about 969,500 individuals, which represents 59%[15] of the population. The participants selected for this research belong to the population registered in the health units in Recife.

For the present study, a probabilistic convenience sample was used, therefore, to lessen bias in the selection of individuals, a random drawing of eight health units was accomplished, in which all FHUs were considered. From each selected unit, 10 users were selected and randomly interviewed, forming the research sample with a total of 80 individuals.

The study was approved by the Research Ethics Committee of the Educational Association of Health Sciences (AECISA) of Recife on 08/08/2019, under Opinion No. 3,494,949 (CAAE: 15856319.9.0000.5569).

Research Design

Data collection was carried out at the health units between August and October 2019. There were 2 days of visits at each health unit, with intervals between them from 17 to 18 days, in order to address different days of the week, so that they were public interviewees of diversified activities in the unit. This fact aimed to avoid selection bias, ruling out the possibility of selecting a specific user profile, such as single pregnant women or participants in chronic disease control programs.

At the health unit, 5 users were interviewed per day, randomly, in the waiting room of the USF's, while they waited for care. The interview lasted approximately 15 minutes.

Inclusion and Exclusion Criteria

As an inclusion criterion, the interviewees were aged 18 years or over and were registered users in a health unit in Recife who were assisted by the service in the last 12 months.

The following were excluded from this study: people under 18, people who have never been assisted by the primary care service of RMR and people who have received care in the units for more than 12 months.

Procedures

For the evaluation of health services, there are several instruments that can be applied, one of them was created by Starfield[5] at Johns Hopkins Primary Care Policy Center, the PCATool (Primary Care Assessment Tool), a Primary Care Assessment tool, originally presented in self-applicable versions for children (PCATool version Child), adults over 18 (PCATool version Adult) and health professionals. This instrument is based on the health service quality assessment model presented by Donabedian[12], which considers the triad "structure, process and result", as being important information about the care quality.

Even though there are other instruments for PHC assessment, PCATool was considered the most complete and satisfactory to measure the attributes necessary to PHC, since this original version measures the presence and extent of the essential attributes and attributes derived from PHC. This instrument has been widely used in Brazil, including the instrument recommended by the Ministry of Health.[6]

The PCATool, already validated in other countries, was validated in Brazil and received the name of Primary Care Assessment Instrument - PCATool-Brasil, which has consolidated itself as an important instrument for evaluating health services. The validated version of the Adult PCATool contains 87 items, divided into 10 components related to PHC attributes made available through the Primary Health Care Assessment Instrument Manual. [6,16]

However, several authors have already used reduced adaptations of this instrument, including in Brazil. In this study, the instrument was used in a modified version, consisting of eleven questions that assessed the presence and extent of two essential attributes and their respective dimensions: first contact access – use and accessibility; coordination – integration of care. In addition, the degree of affiliation dimension was assessed.

The interviewees were asked to answer the questions (Chart 1), based on their experience of the last consultation in the primary care network in Recife-PE, in the last 12 months prior to the interview. In the questions, the participants had to choose one of the five possible answers organized on a Likert scale: "Certainly, yes" (score = 4); "Probably yes" (score = 3); "Probably not" (score = 2); "Certainly not" (score = 1); and "I don't know or I

don't remember" (score = 0).

Chart 1 - Questionnaire used in the interview, a reduced version of the Primary Care Assessment Tool (PCATool-Brasil) – adult users.

Dimensions evaluated	Questions
Degree of Affiliation	Is there a doctor/nurse or health service that you usually go to when you are sick or need advice on your health?
First contact access - Use	When you have a new health problem, do you come to your health unit before going to another health service?
	When you have to see a specialist, does your doctor/nurse in your health unit have to refer you?
First contact access - Accessibility	Is it easy to make an appointment for a revision appointment (routine check-up) at your health unit?
	When you arrive at your health unit, do you have to wait more than 30 minutes to consult with the doctor or nurse (not counting triage or reception)?
Coordination – Integration of care	Have you been to consult any type of specialist or specialized service during the period that you are being monitored in your health unit?
	Did your doctor/nurse suggest (indicate, refer) that you consult with this specialist or specialized service?
	Did your doctor/nurse discuss different services with you where you could be treated for this health problem?
	Did your doctor/nurse write any information to the specialist regarding the reason for this consultation?
	Does the doctor/nurse know what the results of this consultation were?
	Did your doctor/nurse seem interested in the quality of care you were given (asked if you were well or poorly attended by this specialist or specialized service)?

The data collected underwent a review of the questionnaires to verify the readability and quality of the information collected. After that, the questionnaires were grouped according to the health units in each region and district. For data entry, Microsoft Excel® 2019 software was used and double entry was made, at different times and by different people, who later compared the two databases and corrected any errors or inconsistencies. Only after comparing the databases did the definitive database be used for statistical analysis, using the Statistical Package for the Social Sciences (SPSS) software, version 21, in which both the descriptive analysis of the variables and the chi-square test were performed Pearson's test to corroborate the association between qualitative variables. The degree of significance adopted for the tests was 5% and the confidence interval was 95%.

The calculation of the PHC performance score followed the manual of the PCATool-Brasil[6] of the Ministry of Health. Therefore, it was necessary, first, to observe that, in the original scale of the instrument, the responses of the likert type, each alternative has a value, as table below:

Chart 2 - Values of the answers to the questions 2,3,4,7,8,9,10 and 11* † ‡

Possible answers	Certainly, yes	Probably, yes	Probably, no	Certainly, no	I don't know / I don't remember
Corresponding Value	4	3	2	1	9

* Questionnaire number 1 had a value of 1 when the answer was NO and a value of 4 when the answer was YES.

† Questionnaire number 5 was formulated in such a way that the higher the value (answer) assigned, the lower the orientation for PHC. Therefore, these items had their values reversed to: (value 4 = 1), (value 3 = 2), (value 2 = 3), (value 1 = 4). ‡Questionnaire number 6 had no evaluative value. It was used only to follow up on other issues.

The PHC score was calculated for each of the dimensions analyzed. Each component was evaluated by the arithmetic mean of the corresponding questionnaires, that is:

1. Degree of Affiliation (question 1):

It was evaluated only by question number 1, so it was not necessary to calculate the arithmetic mean. In this case, the possible scores were 1 or 4 for this attribute.

2. First contact access - use (questions 2 and 3):

The score for this component was calculated by adding the value of the items divided by 2, that is, the score = Q2+Q3/2.

3. First contact access - accessibility (questions 4 and 5*):

* Question 5 has an inverted value, so this component was calculated after converting to the corresponding value.
The score for this component was calculated by adding the value of the items divided by 2, that is, the score = Q4+Q5/2.

4. Coordination - integration of care (questions * 7, 8, 9, 10 and 11):

* Question 6 was not included in the score calculation because it is a descriptive item.
The score for this component was calculated by adding the items' value divided by 5, that is, Score = Q7 + Q8 + Q9 + Q10 + Q11/5.

Later, all scores, for each of the attributes, were subsequently transformed on a scale ranging from 0 (zero) to 10 (ten) points, according to the PCATool-Brasil validation instrument in its version for adults. The standardization for the 0-10 scale was made as follows: Standardized score = [(Score obtained – 1) x 10]/3.

For the scale conversion, the following two situations were observed:

1. If for an interviewee, the sum of blank answers with "9" answers ("I don't know/I don't remember") reached 50% or more of the total items of an analyzed attribute, the score of this component for this component was not calculated. interviewed. The score of this component for this interviewee was left blank in the database.
2. If, for an interviewee, the sum of blank answers with "9" answers ("I don't know/I don't remember") was less than 50% of the total items of an analyzed attribute, the transformation of the value "9" was carried out to the value "2" ("probably not"). This transformation was indispensable to negatively point out some characteristics of the health service that are not known by the interviewee.

For the score analysis, values equal to or greater than 6,6 were considered high scores, as they correspond to answers for options 3 (probably, yes) or 4 (certainly, yes) on the original scale of the instrument. The results were presented through descriptions of the relative and absolute frequencies.

Results

80 users were interviewed, linked to 8 USF's in Recife, Pernambuco. Regarding the profile of the interviewees, it was noted that the majority were female (82.50%), adults between 25 and 59 years old (52.50%), with a family income of up to 1 minimum wage (63.75%) and with a family composition of 4 people or more (42.50%). 68.75% declared themselves black or dark-skinned and 57.50% had 10

years of schooling or more. (Table 1).

Table 1 - Sociodemographic profile of primary care users in Recife, PE, Brazil, 2019.

Variables		PHC Users (N = 80*)			
		n	%	IC 95%†	
Sex	Female	66	82,50%	73,10%	89,60%
	Male	14	17,50%	10,40%	26,90%
Age	Between 18 and 24 years	16	20,00%	12,39%	29,74%
	Between 25 and 59 years	42	52,50%	41,63%	63,19%
	60 years or older	22	27,50%	18,64%	37,96%
Color / Race	Whites	15	18,75%	11,39%	28,33%
	Blacks and Dark-skinned	55	68,75%	58,07%	78,10%
	Others	10	12,50%	6,61%	21,04%
Family Income	Up to 1 minimum wage ‡	51	63,75%	52,88%	73,65%
	From 1 to 2 minimum wages	25	31,25%	21,90%	41,93%
	More than 2 minimum wages	4	5,00%	1,71%	11,45%
Family Composition	Up to 2 people	22	27,50%	18,64%	37,96%
	3 people	24	30,00%	20,80%	40,62%
	4 people or more	34	42,50%	32,09%	53,44%
Education	No schooling	5	6,25%	2,42%	13,15%
	Up to 9 years of study	29	36,25%	26,35%	47,12%
	10 years of study or more	46	57,50%	46,56%	67,91%

Key: PHC – Primary health care; *N = 80 corresponds to the total population of the sample; †IC 95% - 95% confidence interval; ‡ Minimum wage in effect during the survey period was R$ 998.00.

Table 2 shows the general scores average and the respective percentages of the high and low scores for each dimension: degree of affiliation, first contact access – utilization, first contact access – accessibility and coordination – care integration. It was found that the Degree of Affiliation, first contact access – use and coordination – integration of care reached an average score greater than 6.6, thus being well evaluated. The first contact access component – accessibility obtained a score below 6.6.

Table 2 - Average values of the dimensions and the respective percentage of high and low score for each dimension assessed.

Dimensions	Average value* (0-10)	High score (≥ 6,6)	Low Score (< 6,6)	Not Rated
	Average (IC 95%†)	n (%)	n (%)	n (%)

Degree of Affiliation	8,9 (8,2- 9,6)	71 (88,75%)	9 (11,25%)	-
First contact access - Use	7,7 (7,2- 8,2)	63 (78,75%)	17 (21,25%)	-
First contact access - Accessibility	3,3 (2,7- 3,9)	11 (13,75%)	69 (86,25%)	-
Coordination - Integration of care	6,8 (6,2- 7,3)	36 (45,00%)	24 (30,00%)	20 (25,00%)

Key: * Corresponds to the arithmetic mean of the PHC scores assessed according to each of the dimensions, on a scale of 0-10; † 95% CI: 95% confidence interval

Tables 3, 4, 5 and 6 detail the variability in the assessment of dimensions in relation to the sociodemographic factors considered in this study. When analyzing each dimension separately, it was identified that only one component of the attribute "first contact access" (dimension "use") was related to one of the factors considered. In percentage values, the evaluation of users aged 60 or over was associated with better "first contact access – utilization", with a statistically significant difference (p = 0.036). (table 4)

The other dimensions (degree of affiliation, first contact access – accessibility and coordination – integration of care), according to tables 3, 5 and 6, were evaluated in a homogeneous way in relation to the considered variables (p> 0.05).

Table 3 - Association of the Degree of Affiliation component with the sociodemographic variables.

Variables	**Degree of Affiliation (N = 80)**			
	Low score (0)	**High score (10)**	**Total**	**Value of p***
	n (%)	n (%)	n (%)	
Sex				
Female	8 (12,12%)	58 (87,88%)	66 (100,00%)	1,00
Male	1 (7,14%)	13 (92,86%)	14 (100,00%)	
Age				
Between 18 and 24 years	0 (0,00%)	16 (100,00%)	16 (100,00%)	
Between 25 and 59 years	7 (16,67%)	35 (83,33%)	42 (100,00%)	0,249
60 years or older	2 (9,09%)	20 (90,91%)	22 (100,00%)	
Color / Race				
Whites	1 (6,67%)	14 (93,33%)	15 (100,00%)	
Blacks and Dark-skinned	6 (10,91%)	49 (89,09%)	55 (100,00%)	0,646
Others	2 (20,00%)	8 (80,00%)	10 (100,00%)	
Family income				
Up to 1 minimum wage	4 (7,84%)	47 (92,16%)	51 (100,00%)	

Fom 1 to 2 minimum wages	5 (20,00%)	20 (80,00%)	25 (100,00%)	0,288
More than 2 minimum wages	0 (0,00%)	4 (100,00%)	4 (100,00%)	
Education				
No schooling	0 (0,00%)	5 (100,00%)	5 (100,00%)	
Up to 9 years of study	4 (13,79%)	25 (86,21%)	29 (100,00%)	0,852
10 years of study or more	5 (10,87%)	41 (89,13%)	46 (100,00%)	

Key : * Pearson's chi-square test

Table 4 - Association of the First Contact Access component - Use with sociodemographic variables.

	First Contact Access - Use (N = 80)			
Variables	**Low score (< 6,6)**	**High score (≥ 6,6)**	**Total**	**Value of p***
	n (%)	n (%)	n (%)	
Sex				
Female	12 (18,18%)	54 (81,82%)	66 (100,00%)	0,162
Male	5 (35,71%)	9 (64,29%	14 (100,00%)	
Age				
Between 18 and 24 years	6 (37,50%)	10 (62,50%)	16 (100,00%)	
Between 25 and 59 years	10 (23,81%)	32 (76,19%)	42 (100,00%)	0,036†
60 years or older	1 (4,55%)	21 (95,45%)	22 (100,00%)	
Color / Race				
Whites	3 (20,00%)	12 (80,00%)	15 (100,00%)	
Blacks and Dark-skinned	12 (21,82%)	43 (78,18%)	55 (100,00%)	1,000
Others	2 (20,00%)	8 (80,00%)	10 (100,00%)	
Family income				
Up to 1 minimum wage	11 (21,57%)	40 (78,43%)	51 (100,00%)	
From 1 to 2 minimum wages	6 (24,00%)	19 (76,00%)	25 (100,00%)	0,811
More than 2 minimum wages	0 (0,00%)	4 (100,00%)	4 (100,00%)	
Education				
No schooling	0 (0,00%)	5 (100,00%)	5 (100,00%)	
Up to 9 years of study	7 (24,14%)	22 (75,86%)	29 (100,00%)	0,742
10 years of study or more	10 (21,74%)	36 (78,26%)	46 (100,00%)	

Key : * Pearson's chi-square test; †Value of p < 0,05

Table 5 - Association of the First Contact Access component - Accessibility with sociodemographic

variables.

Variables	First Contact Access - Accessibility (N = 80)			
	Low score (< 6,6)	**High score(≥ 6,6)**	**Total**	**Value of p***
	n (%)	n (%)	n (%)	
Sex				
Female	59 (89,39%)	7 (10,61%)	66 (100,00%)	0,095
Male	10 (71,43%)	4 (28,57%)	14 (100,00%)	
Age				
Between 18 and 24 years	15 (93,75%)	1 (6,25%)	16 (100,00%)	
Between 25 and 59 years	37 (88,10%)	5 (11,90%)	42 (100,00%)	0,423
60 years or older	17 (77,27%)	5 (22,73%)	22 (100,00%)	
Color / Race				
Whites	13 (86,67%)	2 (13,33%)	15 (100,00%)	
Blacks and Dark-skinned	37 (67,27%)	18 (32,73%)	55 (100,00%)	1,000
Others	8 (80,00%)	2 (20,00%)	10 (100,00%)	
Family income				
Up to 1 minimum wage	46 (90,20%)	5 (9,80%)	51 (100,00%)	
From 1 to 2 minimum wages	20 (80,00%)	5 (20,00%)	25 (100,00%)	0,280
More than 2 minimum wages	3 (75,00%)	1 (25,00%)	4 (100,00%)	
Education				
No schooling	4 (80,00%)	1 (20,00%)	5 (100,00%)	
Up to 9 years of study	24 (82,76%)	5 (17,24%)	29 (100,00%)	0,482
10 years of study or more	41 (89,13%)	5 (10,87%)	46 (100,00%)	

Key : * Pearson's chi-square test

Table 6 - Association of the Coordination component - Integration of Care with sociodemographic variables.

Variables	Coordination - Integration of care (N = 80)				
	Low score (< 6,6)	**High score (≥ 6,6)**	**Not rated**	**Total**	**Value of p***
	n (%)	n (%)	n (%)	n (%)	
Sex					
Female	19 (28,79%)	33 (50,00%)	14 (21,21%)	66 (100,00%)	0,106
Male	5 (35,71%)	3 (21,43%)	6 (42,86%)	14 (100,00%)	
Age					
Between 18 and 24 years	7 (43,75%)	5 (31,25%)	4 (25,00%)	16 (100,00%)	

Between 25 and 59 years	12 (28,57%)	18 (42,86%)	12 (28,57%)	42 (100,00%)	0,476
60 years or older	5 (22,73%)	13 (59,09%)	4 (18,18%)	22 (100,00%)	
Color / Race					
Whites	5 (33,33%)	7 (46,67%)	3 (20,00%)	15 (100,00%)	
Blacks and Dark-skinned	16 (29,09%)	25 (45,46%)	14 (25,45%)	55 (100,00%)	0,983
Others	3 (30,00%)	4 (40,00%)	3 (30,00%)	10 (100,00%)	
Family income					
Up to 1 minimum wage	14 (27,45%)	26 (50,98%)	11 (21,57%)	51 (100,00%)	
1 to 2 minimum wages	8 (32,00%)	9 (36,00%)	8 (32,00%)	25 (100,00%)	0,575
More than 2 minimum wages	2 (50,00%)	1 (25,00%)	1 (25,00%)	4 (100,00%)	
Education					
No schooling	1 (20,00%)	4 (80,00%)	0 (0,00%)	5 (100,00%)	
Up to 9 years of study	7 (24,14%)	14 (48,28%)	8 (27,59%)	29 (100,00%)	0,501
10 years of study or more	16 (34,78%)	18 (39,13%)	12 (26,09%)	46 (100,00%)	

Key : * Pearson's chi-square test

Discussion

The incorporation of the user's opinion in the evaluation of health services has been valued and related to the improvement in adherence to treatment and to a greater link between the health service and the user. In the last decades, several studies, national[11,17,18] and international[19,20], have included the users' viewpoint in the evaluation processes, having a significant importance in the contribution to PHC studies, since it allows more satisfactory interventions to resolve problems present in the daily services, providing advances in the scope of care and management health services.

When compared the international[21,22] setting, Brazil still has a deficiency of studies that evaluate health services from the perspective of its users. Yet, it is clear that the current challenge is to make health assessment from the perspective of users an institutionalized practice in order to regard it as a reorganization and an integral part of the daily operations of health management.

In terms of the dimensions evaluated, the degree of affiliation aims at identifying the service that serves as a reference for the user, functioning as a regular source of attention to their health. This study results showed that this dimension obtained the highest score (8.9) among all the components evaluated. This result is analogous to that found by Duarte et al[23] who evaluated the opinion of users attended at UBS's in a city in the central-west region of Minas Gerais and observed that the degree of affiliation was one of the dimensions best evaluated in the study. The positive evaluation of this dimension reflects the value of the family health team for users who, many times, only have the health care framework in PHC, ratifying what is advocated in the organizational

bases of the NPPC[3], as to the ability to link and hold the care on the part of the eSF's, being primal to the effectiveness of primary care as the first contact of the health care network.

With regard to each of the PHC attributes, the guarantee of first contact access, in its dimensions of use and accessibility, is incidental to the use of PHC as the open and preferred gateway to the care network, being the source of care for each new health problem, with the exception of real medical emergencies and emergencies. This attribute comprises the utilization dimension that refers to the processes established in the service to users and the accessibility which refers to the available structure.

The utilization component obtained a high score (7.7), similar to the study by Araújo et al[24] which assessed the perspective of quality of care in PHC in elderly people and used it as the best dimension evaluated among all attributes. This result demonstrates that the teams' work process in relation to the first contact is very well evaluated, showing the presence of an interrelation between the PHC service and the care receiver.

Taking into consideration the accessibility dimension, the score was below the desired degree (3.3). Different researches already carried out showed that it is the worst dimension evaluated[17,25], corroborating with the results of the present study. Users perceive access to the PHC service as bureaucratic and time-consuming, which means that the FHS is not valued as a locus capable of solving the population's health problems. Hence, users tend to look for other ways to meet demands that could be solved in PHC, thus overloading other services and compromising the full reach of PHC's first contact access attribute. [15]

The coordination component – integration of care is considered a mainstay of the structuring and complex conception of PHC, in which it assumes some sort of continuity of care, either through monitoring by the same professional and/or through medical records, or through the recognition of the problems approached in other services.[6] This dimension also received a positive evaluation in the users' perception (6.8). The result is in line with the research by Araújo et al[25] which was carried out at UBS's in a municipality in Paraná and identified a high score for the coordination dimension – integration of care from the view of caregivers of children under 12 years old. In turn, the positive evaluation of this attribute points to the presence of articulation between the different degrees of care. Yet, despite being considered well evaluated, the result 6.8 is close to the cutoff point considered for the low score (<6.6), this shows that there is a weakening of the coordination and continuity of care processes throughout the network health care.

In the assessment of the PHC dimensions when analyzed comparatively in relation to the different sociodemographic factors, there was no statistically significant difference, except for the first contact access component – use in relation to the age group. It was detected that, in percentage values, the positive evaluation of the item use it was higher among the elderly with a statistically significant difference ($p < 0.05$), which reveals a better assessment of this attribute by the elderly. Alves et al[14] found similar results when evaluating male users in a municipality in Paraíba. This result may be related to the greater use of users by the health service due to age, a fact that can be explained by chronic diseases resulting from aging, requiring long-term monitoring.

In this research, there was a female predominance in the profile of users, in which there is a compatibility with various studies carried out both nationally[13,26,27] and internationally[19]. This refers to a social situation in which women assume a central role in the family in relation to health care, accessing health

services more frequently, compared to men. Although men have higher rates of morbidity and mortality, they are more resistant to seeking health care, making it difficult to assess male perception for health services in general.

Although the sample of this work is delineated by users from the eight health districts of Recife-PE, the representativeness regarding the number of USF's and, accordingly, the sample should be considered as a limitation, thus having a more exploratory character since it encompasses 8 of the 132 USF's of the city of Recife. Notwithstanding, despite the indicated limitation, the importance of PHC for users was evident, since they satisfactorily recognize essential components such as the degree of affliction, first contact access – use and coordination – integration of care. Furthermore, it was identified that there are still numerous barriers to be faced in relation to health, yet one of the most crucial to be overcome is that of access. Therefore, it is also suggested that studies be carried out that aim at subsidizing knowledge in order to promote better access to primary care, particularly with a view to guaranteeing accessibility on a structural basis.

Conclusion

The scores evidenced by the PCATool-Brasil assessment instrument demonstrated that PHC users in the city of Recife – PE consider the FHU as a continuous source of attention to their health needs throughout life. Nonetheless, it was clear that users find it difficult to access the health service. Thus, although PHC is the preferred gateway to the health system, there was a need for changes in order to render the service less bureaucratic.

It was also found that the position of the FHU as a coordinating center of care at other degrees of care is recognized. However, the evaluation indicates that this attribute still needs improvement. In addition, it was observed that the older age group presents better evaluations regarding the use of first contact access with the FHU, which is a positive point since numerous elderly people need long-term follow-up due to chronic diseases resulting from age.

It is hoped that the results of this research will support the reformulation and performance of advance actions within the scope of the municipal and national health policy, as well as the strengthening of health assessment in the FHS from the user's perspective.

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