Shimizu et al., Primary Health Care 2012, 2:5
DOI: 10.4172/2167-1079.1000127

Primary Health Care: Open Access

Research Article Open Access

Users' Perceptions of the Performance of the Family Health Strategy in the Greater Brasilia Area, Brazil

Helena Eri Shimizu*, Adriano Drummond and Edgar Merchan-Hamann

Department of Public Health, Brazil

Abstract

In the 1990's, the Family Health Program was created in Brazil, later to be renamed a strategy because it was deemed to be a policy designed to organize and substitute the traditional health care model. The aim of this study was to verify the perceptions of users about the performance of the Family Health Strategy.

This descriptive, exploratory study was undertaken at family health centers in different health districts in the greater Brasilia area: Gama, Santa Maria, Recanto das Emas, Samambaia, Planaltina, Paranoá and Itapoã. A Likert-scale questionnaire ("Primary Care Assessment Tool") which had been previously validated in Brazil was answered by 372 users to assess the services provided.

It was found that the best assessed domain was first contact, which received a mean score of 4.43, followed by longitudinality and quality of professionals, both with 3.84, then comprehensiveness (2.90) and coordination (2.25). The following domains received the lowest assessments: community orientation (mean score of 1.99), accessibility (1.97) and family-centeredness (1.81).

It was concluded that the users of the family health program have relatively easy access to the health system, maybe because they manage to make their first appointments at the centers, which helps the continuity of contact with the service. Also, the quality of the professionals was deemed satisfactory. However, there is a problem with access to services at medium and high-complexity care levels (comprehensiveness) when necessary, which hampers the efficiency of coordination. Finally, it was found that family centeredness and community orientation, both essential to the success of the strategy, were limited.

Keywords: Family health program; Primary health care; Family medicine

Introduction

In Brazil, the Unified Health System (Sistema Único de Saúde, or SUS) must overcome a number of challenges if it is to improve, including the need to invest in Primary Health Care (PHC), given that this is the most effective way for the health system to prevent and treat many diseases, especially chronic generative diseases, which are growing exponentially [1].

According to the World health Organization (WHO) the concept of primary health care encompasses the provision of standardized health care at a low cost to the country and communities, with such services being the primary focus of a country's health care system, constituting the first level of contact for the population to resolve the vast majority of their health needs [2].

This concept, which is contained in the Declaration of Alma-Ata (1978), not only encompasses a commitment to improve health systems, but also embodies a very limited conception of primary health care, seen primarily as nothing more than a "basic basket of health care". As such, especially in developing countries, these services are often no more than a limited program designed to meet the very minimal needs of the very poorest strata of society [3,4].

In Brazil, the PHC approach was initially no different. It was introduced in the 1970's and 80's as a way of getting away from the costly social welfare model in use until then, and was directed primarily towards the most vulnerable members of society.

In the 1990's, especially after the SUS was rolled out, with its commitment to changing the health care model, the importance of primary care as a basis for improving the health system was put back on the discussion agenda. In this process, the traditional concept of PHC as just a way of organizing the first level of care and/or of meeting the health care needs of poor people was abandoned, making way for a vision that saw primary health care as a structural and conceptual philosophy for organizing the whole health system.

In 1994, the Family Health Program was created. Its initial remit was to meet the needs of people with limited access to health services, but it gradually took on a central role and was ultimately renamed the family health strategy as part of a wider review of the social welfare model and the spread of new practices designed to offer users better access to services, to meet their needs fully, and to have a greater orientation towards the family and the local community [5].

The family health strategy translates into the work of family health teams made up of different professionals (general practitioner, nurse, auxiliary nurse and community health agents) who work in a clearly defined area (each team is put in charge of between 600 and 1000 households) and are responsible for recording and attending to all these people's health demands, from their most basic ailments to the most complex cases [5].

Since it was introduced, the family health strategy has been rolled out across the country through specific financial and administrative policies, reaching 94.7% of all Brazilian municipalities by June 2010. There are currently 30,996 family health teams providing services for an estimated 51.66% of the Brazilian population [6].

***Corresponding author:** Helena Eri Shimizu, Associate Professor, University of Brasília, Department of Public Health, Brazil, E-mail: Shimizu@unb.br

Received September 29, 2012; **Accepted** October 23, 2012; **Published** October 25, 2012

Citation: Shimizu HE, Drummond A, Merchan-Hamann E (2012) Users' Perceptions of the Performance of the Family Health Strategy in the Greater Brasilia Area, Brazil. Primary Health Care 2:127. doi:10.4172/2167-1079.1000127

The implementation of the family health strategy has been easier in small municipalities because they previously had little or no health care infrastructure. However, there is a big problem in big cities, where the growth of family health teams is slow because of problems like the high population density, more serious health issues characteristic of big cities, and above all a poorly coordinated and badly distributed supply of social welfare provision [5].

Studies have been carried out to understand whether any significant change has taken place since the family health strategy has been introduced to the health system, but few have taken sufficient account of users' perceptions. This is because this parameter is deemed subjective and often reflects isolated cases of dissatisfaction. However, as Kloetzel et al. [7] rightly noted in a similar study [8], it is not specifically about setting strict quality criteria for a service, but about apprehending conclusions that can be used to predict a patient's future behavior and their attitudes towards the health service, which are fundamental for helping improve the quality of its services.

The objective of this study was to identify the perceptions of users about the performance of the family health strategy in the greater Brasilia area.

Method

This was an exploratory, descriptive study undertaken with family health teams in the greater Brasilia area. This area has 16 health districts with complete PHC teams, meaning they had one general practitioner, one nurse, one auxiliary nurse and five community health agents. Those health districts covering the greatest numbers of users were included in the study, which were identified from data from August 2009 (Department of Health), summing a total of 227,294 users [9]. However, the health districts covering less than 4% of the entirety of users were not included. This left ten health districts from satellite towns, but three of these refused to take part in the study. As such, seven health districts were studied, as shown in table 1.

The sample was calculated using a 90% confidence interval and a 5% error margin, using 40% as the maximum general satisfaction index, resulting in 372 users being interviewed, distributed proportionally amongst the health districts as shown in table 1.

A questionnaire called the Primary Care Assessment Tool was used to gather the data to assess the quality of the PHC services. It was originally designed at Johns Hopkins University and has been used before in Brazil [10]. The tool assesses the eight domains of primary care (accessibility, first contact, continuity of care or longitudinality, comprehensiveness or range of services, coordination, family-centeredness, community orientation and professional qualification) in a total of 107 items. It is structured as a Likert scale with scores of 0 to 5 that designate how often an event takes place, namely: never=0; hardly ever=1; sometimes=2; often=3; almost always=4; and always=5). The mean of the scores obtained for each block of questions represents the aggregate score of each domain of primary health care, and the mean of the eight aggregate scores represents the total aggregate score for primary health care [11].

The questionnaires also provide another option, "I don't know", which in the analysis was coded as an answer left blank. When 20% or more of the responses were answered thus, the question was excluded.

Satellite town	Total users	% of questionnaires	Total number of questionnaires
Gama	7,222	5.648	21
Santa Maria	20,748	16.226	60
Recanto das Emas	10,209	7.984	30
Samambaia	51,912	40.59	151
Planaltina	21,879	17.11	64
Paranoá	10,279	8.039	30
Itapoã	5,581	4.365	16
Total	12,7863	100%	372

Table1: Proportional distribution of the questionnaires amongst the health districts in the greater Brasilia area, 2011.

Selection of interviewees

The people who answered the questionnaire were regular users of family health services, i.e. people who had been users of the services for more than six months. The users were approached at the family health centers. People who were using some service (appointment, exam) at the center on the day the interviewer was at the centre were invited to respond to the survey. The following were not allowed to take part: people with a mental illness or disturbance that may affect the way they interpret the real conditions of the service or the survey questions; people under 18 years of age; and people who were illiterate.

Ethical considerations

The research project was approved by the Research Ethics Committee of the education and research section of the greater Brasilia health department. Everyone who took part in the survey signed an informed consent form.

Results

The results obtained from the Primary Care Assessment Tool are shown in tables 2-6. Table 2 shows the PHC score for each of the satellite towns in the greater Brasilia area. Table 3 shows the aggregate scores, made up of the weighted mean of the PHC domains obtained for each satellite town. Tables 4-6 shows the more in-depth analyses of the domains given the lowest scores with a view to understanding better what the main problem areas were, in this case: accessibility (Table 4), family-centeredness (Table 5) and community orientation (Table 6).

Turning to the socio-demographic profile of the people who took part in the survey, the respondents were primarily women (67%), with only 42% of the interviewees having completed eight years of formal education. The percentage of respondents with access to electricity was 98%, while 85% had homes with piped water. In other words, most of the interviewees had access to what would be considered almost satisfactory basic infrastructure and public services.

Table 2 shows the PHC scores obtained for each of the satellite towns. Paranoá had the highest aggregate score (3.47), followed by Samambaia (3.34) and Itapoã (3.11). The towns with the worst scores were Planaltina (2.81), Recanto das Emas (2.77), Santa Maria (2.73) and Gama (2.53), which shows there is a disparity in the performance of the family health strategy in the greater Brasilia area.

Table 3 shows the aggregate scores for each PHC domain. The domains that received the best scores were first contact (4.57), which investigates a unit's capacity to respond to new or recurring demands; health professionals (4.24), which covers the direct relationship with

Satellite Town	Primary Care Score
Gama	2.53
Itapoã	3.11
Paranoá	3.47
Recanto das Emas	2.77
Planaltina	2.81
Samambaia	3.34
Santa Maria	2.73
TOTAL AGGREGATE SCORE	3.06

Table 2: PHC scores in the health districts of the greater Brasília area, 2011.

users and their companions with health professionals; longitudinality (4.15), which concerns whether the unit is a regular source of care; and comprehensiveness (3.2), relating to the breadth of services supplied by the family health center (20). The domains with the lowest scores were: coordination (2.65), which covers the continuous supply of health care, either by the same professional as in the first appointment or through the use of medical records; family-centeredness (1.73), which relates to the professionals' involvement with the users' families and home life; community orientation (1.94), which relates to the interest of the services in the collective problems of the community they serve; and accessibility (1.97), which assesses the strategies used by the service to help users have access to medical care or information whenever they need it.

Table 4 shows the data on accessibility, which received an aggregate score of 1.97. The aspects that received the lowest scores were: whether the health centers are open on weekends (0.72); waiting time of less than 30 minutes for appointments (0.90); access to the telephone number when the center is closed (1.23); access to medicines (1.33); access to equipment needed (1.73); and how easy it is to get an appointment in 24 hours (1.78) or at a later date (1.89). The highest scores were given for the fact that the service was free (4.67) and the possibility of contacting the center by phone when it is open, to obtain information (3.22).

Table 5 focuses on the items related to the family-centeredness domain, showing that the professionals demonstrate little interest in taking account of issues relating to the patient's family (1.51) and know little about the users' families (1.83). The other aspects that scored low were whether the professionals talk to the users' families about their health problems (0.64) and whether they take into account the patients' opinions and ideas when defining their treatment (1.43). The item that received the best assessment was about whether the professionals asked about the diseases the other members of the users' families suffered from (3.25).

In the table 6, which deals with community orientation, the items that received the best scores were whether there were health services in schools (2.63), how often the professionals from the center made home visits (2.21), and whether there was any group work being done to improve the living conditions in the community (2.61). Meanwhile, the items given the lowest scores were: whether the services met the community's health needs (0.77), whether the professionals knew about the most prevalent health problems in the community (1.88), and whether the managers asked community representatives to take part in the running of the center or the local health board.

Discussion

This study has a few limitations, one of which being the fact that it is transversal. Additionally, when it comes to the health professionals' performance, the tool does not sufficiently address the activities undertaken by the community health agents, who are key members of the family health teams. Finally, the users who were interviewed were the people who were at the center and were waiting for a long time, which could have a negative impact on the overall impression of the quality of the services rendered [7].

In the analysis of the profile of the population covered by the family health teams, it was found that the women sought out health services more than the men, and that a high proportion had little formal schooling. A similar profile has been identified in other studies [8] as one of the reasons why men do not contact the health services. A public policy has recently been developed in Brazil precisely to address men's health issues.

The aggregate score obtained for the family health teams working in the greater Brasilia area was low (3.06), especially if compared with the results of similar studies undertaken in other states [12]. One of the factors that might be behind this result is the very low coverage of family health teams in the area (11.5%) [13], which is lower than in other parts of the country.

The users of the family health services in the greater Brasilia area have sought them out as a point of entry, meaning that they have contacted them to resolve their immediate health problems, but they have great difficulty being seen because of the shortage of appointments, which translates into long waiting times. Another serious problem is that there is nobody to man the center during three shifts (morning, afternoon and night) and at weekends, which restricts the working population's access to primary care. Also, there is no telephone service for users to clarify any queries they may have. This difficulty of access to the family health teams has triggered a recurring problem in the health system, which is that users with problems that are not serious go to the emergency services, overloading them with non-emergency cases [14,15].

The quality of the professionals received a positive assessment from the users, possibly because they are willing to provide continuity of care (longitudinality), a factor that was given a satisfactory assessment [16].

However, for family health teams to be truly accessible to the population, the financial, geographical, temporal and cultural barriers must be overcome. The geographical barriers have been resolved in part by having teams deployed near to where the target populations live, in line with the criterion of territorialization, but this process has been hampered by the lack of adequate coverage by the family health teams in many health districts. Any shortfalls in cultural competence are intended to be overcome by the involvement of community agents, who provide a bridge between the community and the health service because they actually live in the community the family health center is supposed to be serving and therefore generally come from the same social group as the users [17]. The time-related hurdles are considerable, with the main obstacles being related to the inefficiency of the appointments system, telephone contact for making appointments, and the system of referrals to other services.

The family health strategy was conceived to expand access to

Satellite towns	Accessibility	First Contact	Longitudinality	Comprehensiveness	Coordination	Community Orientation	Family-Centeredness	Health professionals
Gama	1.72	4.2	3.93	3.12	1.7	1.2	1.26	3.1
Itapoã	2.75	4.57	3.7	2.51	2.6	2.47	2.52	3.76
Paranoá	2.22	4.43	3.95	2.99	3.57	2.87	3.42	4.32
Recanto das Emas	1.98	4.89	3.86	2.62	2.16	2.12	1.2	3.32
Planaltina	1.83	4.55	3.73	2.87	1.91	1.66	1.57	4.33
Samambaia	1.94	4.75	4.68	3.78	3.32	1.94	1.61	4.7
Santa Maria	1.97	4.22	3.74	2.71	1.9	1.82	1.56	3.93
AGGREGATE SCORE	1.97	4.57	4.15	3.20	2.65	1.94	1.73	4.24

Table 3: Aggregate scores of the domains for each satellite town in the greater Brasilia area, 2011.

ACCESSIBILITY	Score
How easy it is to get an appointment	1.89
How easy it is to get an appointment in 24 hours	1.78
Whether the health center is open on weekends	0.72
Whether the health center is open after 6pm at least once a week	2.28
Phone number for making appointments or obtaining information is available at the center when it is open	3.22
Phone number for making appointments or obtaining information is available when the center is closed.	1.23
Maximum waiting time for appointments of 30 minutes	0.90
Access to all the medicines needed at the center	1.33
Access to all the equipment needed at the center	1.73
Whether service is free (no payment for procedures)	4.67
AGGREGATE SCORE	**1.97**

Table 4: Mean scores given for the items used to assess the Accessibility domain, greater Brasilia area, 2011.

FAMILY-CENTEREDNESS	Scores
Whether professional asks about patient's family's living conditions	1.51
Whether professional asks about diseases of family members	3.25
Whether professionals know the patient's family well	1.83
Whether professionals would talk to user's family about their health problems (if they allowed it)	0.64
Whether professionals ask for the patient's opinion about the treatment	1.43
AGGREGATE SCORE	**1.73**

Table 5: Mean scores obtained for the items used to assess the Family Centeredness domain, greater Brasilia area, 2011.

COMMUNITY ORIENTATION	Scores
Users are asked whether the services offered meet their health needs	0.77
The professionals at the health centre know about the community's health needs	1.88
The managers ask community representatives to take part in running the center or taking part in the local board.	1.55
Health services are provided in schools	2.63
How often the professionals from the health center make home visits	2.21
Whether group activities are undertaken at the center to improve the living conditions of the community.	2.61
AGGREGATE SCORE	**1.94**

Table 6: Mean scores obtained for the items used to assess the Community Orientation domain, greater Brasilia area, 2011.

primary care and to coordinate integration with the different health services available: specialized outpatient services, secondary and tertiary hospital services, rapid response and emergency services, and other services [12]. When assessed, this dimension of coordination proved unsatisfactory in the greater Brasilia area, especially because of the non-availability of a comprehensive set of services enabling users to be referred to other levels of care when necessary. This is one of the most serious problems in the greater Brasilia area, which is related to the inefficiency of the referral and counter-referral system. This competency needs the interdependency of the administrators of the different services of the organizations that make up the system to be recognized. Also, effort must be put into developing the kinds of cooperation and coordination mechanisms needed for the efficient, accountable management of collective resources with the capacity to respond to local and regional service needs.

When it comes to the low scores obtained for family-centeredness and community orientation in the greater Brasilia area, although other studies show that family health teams are received more positively than traditional primary care services [12], they continue to fall far short of expectations. The factors that contribute to the poor performance of family-centeredness are the inadequate qualification of the professionals and the limited investments in capacity building. The professionals also demonstrate little interest in finding out about the users' living conditions or their opinions about the treatment they propose, showing that a mechanistic approach is still prevalent amongst health professionals.

The low score obtained for community orientation could be explained by the fact that the professionals are not sufficiently integrated with the community. A few community projects have been undertaken, especially in schools, but there is no strategy to work in closer collaboration with the communities to resolve their needs and demands. The administrators also seem not to be prepared to actively seek out the community's participation, and the specific health complaints of the local people seem to be of minimal interest. The community is not effectively involved in co-administrating the family health teams, despite their crucial importance in meeting their demands and needs [18].

Conclusion

We found that the score obtained for family health care in the greater Brasilia area is still low. The domains with the best assessments were first contact, followed by continuity of care (longitudinality), quality of the professionals, and comprehensiveness. The lowest scores were obtained for family-centeredness, followed by community orientation, accessibility and coordination. We found that the users seek out family health teams as a point of entry to the system, but have difficulty obtaining access to the services they need. However, the service is capable of helping to form longitudinality (continuity of care) and the professionals themselves received positive appraisals. Despite this, the family health teams have not managed to satisfactorily reach out to families and communities, and there is a shortfall in the continuity of the care provided.

Overall, the family health teams are perceived by the local communities as providing an important service, but their capacity to meet their demands and needs is limited, which hampers the target populations' access to comprehensive health care.

References

1. Bodstein R (2002) Atenção básica na agenda da saúde. Rio de Janeiro Cienc Saúde Coletiva 7: 401-412.
2. World Health Organization (2008) The world health report 2008: primary health care now more than ever.
3. Gil CRR (2006) Atenção primária, atenção básica e saúde da família: sinergias e singularidades do contexto brasileiro. Rio de Janeiro Cad Saúde Pública 22.
4. Starfield B, Shi L, Macinko J (2005) Contribution of primary care to health systems and health. Milbank Q 83: 457-502.
5. Escorel S, Giovanella L, Mendonça MHM, Senna MCM (2007) O Programa de Saúde da Família e a construção de um novo modelo para a atenção básica no Brasil. Washington Rev Panam Salud Publica 21.
6. Brasil. Ministério da Saúde (2006) Pacto pela Saúde Política Nacional de Atenção Básica.
7. Kloetzel K, Bertoni AM, Irazoqui MC, Campos VPG, Santos RN (1998) Controle de qualidade em atenção primária à saúde. I – A satisfação do usuário. Rio de Janeiro Cad Saúde Pública 14: 623-628.
8. Gomes R, Schraiber LB, Couto MT, Valença OAA, Silva GSN, et al. (2011) O atendimento à saúde de homens: estudo qualitativo em quatro estados Brasileiros. Rio de Janeiro Physis 21.
9. Distrito Federal (2009) Secretaria de assistência a saúde / DPHC – Datasus. Consolidado das famílias cadastradas do ano de 2009 da zona geral.
10. Almeida CM, Macinko J, Oliveira ES, Sá PK (2004) Validação de uma metodologia de avaliação rápida das características organizacionais e do desempenho de serviços de atenção básica do SUS em nível local. Relatório Final, Rio de Janeiro: ENSP/Fiocruz.
11. Ibñez N, Rocha JSY, Castro PC, Ribeiro MCSA, Foster AC, et al. (2006)

Avaliação do desempenho da atenção básica no Estado de São Paulo. Rio de Janeiro Ciênc Saúde Coletiva 11.

12. Stralen CJ, Belisário SA, Stralen TBS, Lima AMD, Massote AW, et al (2008) Percepção dos usuários e profissionais de saúde sobre atenção básica: comparação entre unidades com e sem saúde da família na Região Centro-Oeste do Brasil. Rio de Janeiro Cad. Saúde Pública 24:S148-S158.
13. Brasil. Ministério da Saúde (2010) Números da Saúde da Família – Resultados alcançados (2003-2009) – Saúde da Família, Saúde Bucal e Agentes Comunitários de Saúde.
14. Elias PE, Ferreira CW, Alves MCG, Cohn A, Kishima V, et al. (2006) Atenção Básica em Saúde: comparação entre PSF e UBS por estrato de exclusão social no município de São Paulo. Rio de Janeiro Cienc Saúde Coletiva 11: 633-641.
15. Castanheira ERL, Dalben I, Almeida MAS, Puttini RF, Patrício KP, et al. (2009) Avaliação da qualidade da atenção básica em 37 municípios do centro-oeste paulista: características da organização da assistência. Saúde e Sociedade 18: 84-88 18.
16. Starfield B (1980) Continuous confusion? Am J Public Health 70: 117-119.
17. Travassos C, Martins M (2004) Uma revisão sobre os conceitos de acesso e utilização de serviços de saúde. Rio de Janeiro Cad Saúde Pública 20: 190-198.
18. Shimizu HE, Dytz JL, Lima Mda G, Pereira MF (2009) Local health governance in central Brazil. J Ambul Care Manage 32: 132-140.
19. World Health Organization (1978) Declaration of Alma-Ata.