Esc Anna Nery 2022;26:e20200433

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Assessment of the attributes of Primary Health Care from the perspective of older adults[a]

Avaliação dos atributos da Atenção Primária à Saúde na perspectiva dos idosos

Evaluación de los atributos de la Atención Primaria a la Salud desde la perspectiva de los adultos mayores

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ABSTRACT

Objective: to assess the attributes of Primary Health Care from the perspective of older adults in the municipality of Sinop, Mato Grosso. **Method:** this is an evaluative research study with a cross-sectional design. The data were collected using the Primary Care Assessment Tool for interviews with 345 older adults. After the interviews, with the Primary Care Assessment Tool - Brazil, users' version, the quality level was estimated for the essential and derivative attributes with satisfactory scores ≥ 6.6, and unsatisfactory scores < 6.6. The analysis was performed using the SPSS software, version 19.0. **Results:** the Logitudinality, Coordination and Completeness attributes obtained satisfactory assessments. First Contact Access obtained the worse assessment from the perspective of older adults. **Conclusion:** it is verified that the first contact access constitutes a barrier to be overcome in seeking to meet the older adults' needs.

Keywords: Health Evaluation; Aged; Family Health Strategy; Public Health.

RESUMO

Objetivo: avaliar os atributos da Atenção Primária à Saúde na perspectiva dos idosos, na cidade de Sinop em Mato Grosso. **Método:** pesquisa avaliativa, de abordagem quantitativa e delineamento transversal. Utilizou-se o instrumento *Primary Care Assessment Tool* para entrevista aos 345 idosos. Após entrevista com o instrumento *Primary Care Assessment Tool* - Brasil, versão usuários, estimou-se o nível de qualidade dos atributos essenciais e derivados sendo considerado satisfatório o escore ≥ 6,6 e insatisfatório < 6,6. A análise foi feita no programa SPSS, versão 19.0. **Resultados:** os atributos Longitudinalidade, Coordenação e Integralidade obtiveram avaliações satisfatórias. O Acesso de Primeiro Contato obteve a pior avaliação na perspectiva dos idosos. **Conclusão:** verifica-se que o acesso de primeiro contato constitui uma barreira a ser transposta na busca de atender às necessidades dos idosos.

Palavras-chave: Avaliação em Saúde; Idoso; Estratégia de Saúde da Família; Saúde Pública.

RESUMEN

Objetivo: evaluar los atributos de la Atención Primaria a la Salud desde la perspectiva de los adultos mayores en la ciudad de Sinop en Mato Grosso. **Método:** investigación evaluativa, de enfoque cuantitativo y delineamiento transversal. Se utilizó el instrumento *Primary Care Assessment Tool* en la entrevista a 345 adultos mayores. Después de la entrevista con el instrumento *Primary Care Assessment Tool* - Brasil, versión usuarios, se estimó el nivel de calidad de los atributos esenciales y derivados, y se consideró satisfactorio cuando la puntuación era ≥ 6,6 e insatisfactorio el puntaje < 6,6. El análisis se llevó a cabo en el programa SPSS, versión 19.0. **Resultados:** los atributos Longitudinalidad, Coordinación e Integralidad obtuvieron evaluaciones satisfactorias. El Acceso de Primer Contacto obtuvo la peor evaluación en la perspectiva de los adultos mayores. **Conclusión:** se constató que el acceso de primer contacto constituye una barrera a ser traspuesta en el intento de satisfacer las necesidades de los adultos mayores.

Palabras clave: Atención Primaria de la Salud; Evaluación en Salud; Estrategia de Salud Familiar; Adulto Mayor; Salud Pública.

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Submitted on 10/27/2020.
Accepted on 09/29/2021.

DOI:https://doi.org/10.1590/2177-9465-EAN-2020-0433

INTRODUCTION

Longevity is a worldwide phenomenon and, together with the drop in fertility, causes an aging population on the planet. In other countries, such as Brazil, the impacts arising from the nation's aging are even greater due to the country's rapid senescence process and, consequently, the improvement in the mean life expectancy will lead the current population to reach old age[1].

Aging of the Brazilian population brings about several challenges, especially in the health services, which carry out monitoring activities for chronic diseases, in particular, Primary Health Care (PHC), which aims at promoting, preventing, treating and rehabilitating health[2] by currently integrating an area of global interest due to its strategic position in disease prevention and promotion of the population's health[3].

Starfield[4] established qualities specific to PHC, called essential and derivative attributes. These attributes qualify actions in Primary Health Care, increasing its power to interact with individuals and the community. And, to assess these attributes, she developed the instrument called Primary Care Assessment Tool, which originally presents versions aimed at children, adults, health professionals and managers[2,5].

The essential attributes are so called because the primary care service, aimed at the general population, can only be considered a primary care provider when it is present. They qualify actions in primary health care, increasing its power to interact with individuals and the community. There are four essential attributes: First Contact Access, Longitudinality, Coordination and Completeness. The derivatives are: family orientation, community orientation and cultural competence. These attributes can be analyzed individually, although they are related during the clinical practice[4,5,6].

Identification of these attributes is important to define whether the health service is really based on Primary Health Care[4,5].

Assessing the quality of the service offered, access to the users' first contact, availability of the multi-professional team to provide care, integration of care and the needs of each client and orientation to comprehensive care in all spheres available in the health services allows, in its entirety, the identification of quality referring to the entire team inserted in this care level[1].

The structure and organization of the services interfere in the assistance offered to the users and, especially, to older adults.

The ability to face these challenges applies both to the patients and to the users, for the promotion of users' well-being and quality of life[6].

The objective of this research was to evaluate the essential and derivative attributes of Primary Health Care from the perspective of older adults.

METHOD

This is an evaluative, descriptive and cross-sectional research study with a quantitative approach and derives from the research entitled "*Assessment of the quality of Primary Health Care in a municipality of the Legal Amazon region*", approved by the "Humanities" Ethics Committee of *Universidade Federal do Mato Grosso* (UFMT) under number 1450546.

It was conducted in the municipality of Sinop, state of Mato Grosso, which has a population of 132,934 inhabitants[7] and 20 Family Health Strategy teams.

For the study, a "finite" sample of 3,349 aged users registered in the 15 Family Health Units in the municipality was considered. Using the finite sample formula, a total sample of 345 was estimated. In order to select the older adults proportionally in each health unit, a stratified sample was used. In each sample stratum, the older adults were randomly selected using the Family Registration Form.

The instrument used was the Primary Care Assessment Tool, users' version, and totals 87 items divided into 10 components related to the PHC attributes. The "Degree of Affiliation" used to calculate the scores is not considered an attribute.

To calculate the scores of the PHC attributes, a simple arithmetic mean was used and the following formula (Score obtained - 1) x 10/3 was resorted to in order to transform the values of the answers into a scale from 0 to 10[2,4].

In accordance with the aforementioned norms, in order to facilitate interpretation of the magnitude of the values, the values established in the original instrument were taken as reference, which were used in studies carried out with application of the PCATool-Brazil, users' version, described as follows: Scores ≥ 6.6 and attributes equal to a value of three or more on the Likert scale were considered satisfactory; and Scores < 6.6 and attributes corresponding to values below 3 on the Likert scale were classified as unsatisfactory[5,6].

For data analysis, a database was created in the Microsoft Office Excel 2010 program, in which the data were compiled and grouped according to the question blocks of the instruments used in data collection and to the sociodemographic characteristics of the older adults. Subsequently, the data collected were transcribed to the SPSS program, version 19.0 for Windows, for processing and analysis submission. Descriptive statistical analysis was performed so that the categorical variables were described by means of absolute frequencies, percentages and quantitative variables, through mean values, standard deviations and Mann-Whitney test.

RESULTS

The participants were 345 older adults linked to 20 health teams, all of which are organized in a Family Health Strategy and have a complete health professional team (physician, nurse, nursing assistant or technician, community health agent, dentist, assistant or oral health technician)[8] as recommended by Ordinance No. 2,488 of October 2011[9].

In relation to gender, 88.4% was female and the mean age was 72.4 years old, varying between 60 and 90 years old, 46.1% are married, 51.3% had an income of up to 1 minimum wage, 53.3% were retired, and 84.1% of the older adults stated being financially independent. Regarding health problems, the main disease mentioned was Systemic Arterial Hypertension (59.7%).

In relation to the degree of affiliation, 302 older adults answered yes to the three questions: Is there a health professional or service where you usually go when you get sick or need advice about your health? Is there a health professional or service that knows you better as a person? Is there a health professional or service that is more responsible for your health care? The degree of affiliation of the older adults is centered on the medical professional[1].

Table 1 represents the attributes of PHC. Among the derivative attributes, "family orientation" stands out (8.86) followed by "community orientation" (6.73). And, among the essential attributes, there was "access-use" (9.69), "longitudinality" (8.04), "care coordination" (8.42), "information coordination" (8.17), "services provided" (8.30) and "available services" (7.66). These attributes presented a prominent position from the perspective of the older adults, as they presented a mean value ≥ 6.6, being classified as satisfactory.

The only attribute classified as unsatisfactory was "access-accessibility", which obtain a score of 2.57.

In Table 2, it it is verified that, among the 10 attributes of PHC, 9 obtained satisfactory results and all presented a statistically significant difference (p<0.001). However, even among the older adults who evaluated PHC with a high overall score, the accessibility conditions were below the required since, of the 345 older adults, only 1 (0.3%) classified access as satisfactory and 344 (99.7%) classified it as unsatisfactory.

Table 1. Scores assigned by the older adults to the PHC attributes. SINOP, 2016.

ATTRIBUTES	Mean	Lower		Upper	Median
Degree of affiliation	3.81	3.77	3.88	4.00	0.50
Access-use	9.69	9.60	9.78	10.00	0.82
Access-accessibility	2.57	2.49	2.64	2.50	0.69
Longitudinality	8.04	7.98	8.10	8.10	0.54
Care coordination	8.42	8.24	8.59	8.33	1.66
Information coordination	8.17	8.05	8.28	7.78	1.08
Available services	7.66	7.62	7.70	7.58	0.41
Services provided	8.30	8.26	8.35	8.46	0.42
Family orientation	8.84	8.64	8.83	8.89	0.96
Community orientation	6.73	6.64	6.83	6.67	0.87
Essential	6.43	6.39	6.47	6.49	0.40
General	6.70	6.65	6.74	6.76	0.40

Note: CI - 95% Confidence Interval; SD - Standard Deviation.

Table 2. Analysis of the classification of the PHC attribute scores from the perspective of the older adults. SINOP, 2016.

ATTRIBUTES	n	%	n	%	p
Degree of affiliation	6	1.7	339	98.3	0.0001*
Access-use	1	0.3	344	99.7	0.0001*
Access-accessibility	344	99.7	1	0.3	0.0001*
Longitudinality	3	0.9	342	99.1	0.0001*
Care coordination	9	2.6	336	97.4	0.0001*
Information coordination	9	2.6	336	97.4	0.0001*
Completeness of available services	0	0.0	345	100	-
Completeness of services provided	1	0.3	344	99.7	0.0001*
Family orientation	2	0.6	343	99.4	0.0001*
Community orientation	75	21.7	270	78.1	0.0001*
Essential score	231	67.0	114	33.0	0.0001*
Overall score	87	25.2	258	74.8	0.0001*

Note: * p≤0.05: statistically significant difference in the proportion distribution by the Mann-Whitney test. Values < 6.6 were classified as "Unsatisfactory" and values ≥ 6.6, as "Satisfactory".

DISCUSSION

The older adults interviewed assessed the assistance received in primary care as partially satisfactory, with a need for improvement, especially in relation to the Essential (6.4) and Overall (6.7) scores. This corroborates the results of a single previous study, carried out with 100 aged individuals in Macaíba, Rio Grande do Norte[10], which presented the following Overall (5.7) and Essential (6.0) scores, far from the maximum possible rating (10.0). In relation to the studies carried out in other age groups, there is one conducted in municipalities from southern Minas Gerais[11], with 527 adults aged over 18 years old, which presented an Adult Essential score of 5.96 and Overall score of 5.92[10]. As the populations are comparable, the results indicate that there is no prioritization of care for the older adults in the municipality studied, a fact that does not agree with the National Policy for Older Adults, which ensures preferential care in the health services. The first attribute that comprises the Primary Care Assessment Tool instrument, users' version, is "access-use" and "access-accessibility"[2]. In this study, it is verified that "access-accessibility" obtained the only unsatisfactory rating. "Accessibility" represents absence of organizational and physical barriers to obtaining health care, such as the restriction of days and hours of operation.

The health units in the municipality of Sinop are only open on weekdays and during limited hours, from 7:00 am to 11:00 am and from 1:00 pm to 5:00 pm. These service hours represent a serious limitation, as there is a daily break for the provision of services to the older adults and, consequently, this could overload the service in the only Emergency Care Unit (*Unidade de Pronto Atendimento*, UPA). The change in hours, with service offer at night and during the weekends, could contribute to improving this attribute. In order to implement these changes, financial investment is required to hire professionals and open new units. With these changes, in addition to expanding access for the older adults, the health service may improve the assistance provided, mainly at reception, which enables autonomy, citizenship and co-responsibility in the production of health care[8].

In relation to the "longitudinality" attribute, a satisfactory result was obtained. A satisfactory result in this attribute indicates that there is care continuity in relation to the older adults and the health service, with construction of a bond. Positive results were found in other studies, in the age groups above 18 years old and above 60 years old[9,10]. The "coordination" attribute is divided into care coordination and information coordination. They were rated as satisfactory, with results of 8.34 for care coordination and 8.17 for information coordination. The worst-rated items were "counter-referral" and "lack of care continuity", that is, the professionals refer the older adults to the reference service, but they do not receive in writing which course of action was followed, which makes it impossible to continue the care provided to the older adults[12]. In relation to the availability of the medical records, the older adults are not aware that they can consult it. The need for guidance to the older adults is inferred, as the medical records belong to the patients and they have the right to access a copy, according to the Consumer Defense Code, article 72, and to the Code of Medical Ethics in Resolution No. 1,246/88 of the Federal Council of Medicine[12,13].

In general, the older adults interviewed evaluated the assistance received in primary care as partially satisfactory, with a need for improvement, especially in relation to the Essential (6.4) and Overall (6.7) scores. This corroborates the results of a single previous study, carried out with 100 aged individuals in Macaíba (RN), which presented the following Overall and Essential scores (5.7 and 6.0), far from the maximum possible rating (10.0) [9]. In relation to the studies carried out in other age groups, there is one conducted in municipalities from southern Minas Gerais, with 527 adults aged over 18 years old and which presented an Essential Adult score of 5.96 and Overall score of 5.92[10]. As the populations are comparable, the results indicate that there is no prioritization of care for the older adults in the municipality studied, a fact that does not agree with the National Policy for Older Adults, which ensures preferential care in the health services[9].

The first attribute that comprises the Primary Care Assessment Tool instrument, users' version, is "access-use" and "access-accessibility". In this study, it is verified that the "access-accessibility" attribute obtained the only unsatisfactory classification.

"Accessibility" represents absence of organizational and physical barriers to obtaining health care[8], such as restricted days and hours of operation. The health units in the municipality of SINOP are open from Monday to Friday, from 7:00 am to 11:00 am, and from 1:00 pm to 5:00 pm. The organizational structures are factors that prevent nurses from doing a good job of promoting health in primary care, which corroborates the study carried out in Sweden[14].

This represents a serious limitation, since there is a daily break for providing service to the older adults, in addition to the possibility of overloading the service in the only Emergency Care Unit (*Unidade de Pronto Atendimento*, UPA). It is necessary to strengthen the "gateway" at the basic care level, demarcating the care flows organized based on epidemiological, health and social demands[5,10].

To implement these changes, financial investment is necessary to hire professionals and open new units. With these changes, the health service, in addition to expanding access for the older adults, will contribute benefits, especially at the reception, which enables autonomy, citizenship and co-responsibility in the production of health care[4].

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referral" and "lack of care continuity", that is, the professionals refer the older adults to the reference service, but they do not receive in writing which course of action was followed, which makes it impossible to continue the care provided[16].

In relation to "availability of the medical records", the older adults are not aware that they can consult it. The need for guidance to the older adults is inferred, as the medical records belong to the patients and they have the right to access a copy, according to the Consumer Defense Code, and to the Code of Medical Ethics[12,13].

The "completeness" attribute was elaborated in Available Services and Services Provided. They obtained a score above 7.0 and were classified as satisfactory. "Completeness" is constituted in the daily work through the interactions that take place between the user and the service[17]. The older adults attributed insufficient evaluations to the actions of legal and illegal drugs (available services) and domestic accidents and those related to firearms and intoxicating substances, as well as prevention of burns (services provided).

The negative results of the completeness attribute items indicate that the health professionals do not perform the actions based on the analysis of the health situation and of the local reality, a result that was found in other studies[10,18].

Thus, it is acceptable for the health management to consider carrying out specific training of the teams for these issues, as improvement of these inefficient points requires low-complexity investment, which may mean cost/benefit as a public health action since, in this way, the possibility of more costly harms to the health system is ruled out[19,20].

CONCLUSION

From the perspective of the older adults, the attributes of PHC were classified as satisfactory, with "First Contact Access" being a barrier to be overcome so that they can meet the needs of aged individuals. In this sense, developing actions that benefit older adults, with a view to favoring access through qualified listening to meet the real needs of the aged population, is of great relevance.

As a member of the health team, the nurse can significantly contribute to this process. This study points to the need to advance towards offering effective access to strengthen the bond between the health team and the older adults.

For this, *reception*, *attentive listening*, *dialog* and *knowledge of the reality* in which the user is inserted are **essential** for accessing health actions, meeting the families' needs and involvement in solving problems and promoting health[21].

As a limitation of this study, it is stated that the assessment took place in a single municipality, which does not allow generalizations to other contexts.

AUTHOR'S CONTRIBUTIONS

Study design. Rosângela Guerino Masochini. Sheila Nascimento Pereira de Farias.

Data collection or production. Rosângela Guerino Masochini.

Data analysis. Rosângela Guerino Masochini. Sheila Nascimento Pereira de Farias. Ana Inês Sousa.

Interpretation of the results. Rosângela Guerino Masochini. Sheila Nascimento Pereira de Farias. Ana Inês Sousa.

Writing and critical review of the manuscript. Rosângela Guerino Masochini. Sheila Nascimento Pereira de Farias. Ana Inês Sousa.

Approval of the final version of the article. Rosângela Guerino Masochini. Sheila Nascimento Pereira de Farias. Ana Inês Sousa.

Responsibility for all aspects of the content and integrity of the published article. Rosângela Guerino Masochini. Sheila Nascimento Pereira de Farias. Ana Inês Sousa.

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[a] Extracted from the PhD thesis entitled "*Quality of primary health care in a municipality of the Legal Amazon region from the perspective of professionals and older adults*", by Rosângela Guerino Masochini, under supervision of Sheila Nascimento Pereira de Farias and co-supervision of Ana Inês Sousa. Graduate Program in Nursing, Anna Nery School of Nursing, *Universidade Federal do Rio de Janeiro*, 2017.