

ACESSIBILIDADE NA ATENÇÃO PRIMÁRIA: COMO AVALIAM OS PROFISSIONAIS DE SAÚDE?

ACCESSIBILITY IN PRIMARY CARE: HOW DO HEALTH PROFESSIONALS EVALUATE IT?

ACCESIBILIDAD EN LA ATENCIÓN PRIMARIA: ¿CÓMO EVALUAN LOS PROFESIONALES DE LA SALUD?

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RESUMO

Objetivo: avaliar a presença e extensão do atributo acesso de primeiro contato - componente acessibilidade, na perspectiva dos profissionais de atenção primária à saúde. **Método:** estudo transversal realizado em 62 unidades de atenção primária à saúde, por meio da autoaplicação do *Primary Care Assessment Tool* com 546 profissionais (60,3% da população elegível). O banco de dados foi criado no *software Epi-Info* (versão 7), e a digitação realizada por entrada dupla. A análise foi realizada no *software Statistical Package for the Social Sciences* (versão 22). Para as comparações entre os grupos, foi utilizado o teste *U de Mann Whitney* para amostras independentes. **Resultados:** a acessibilidade mostrou-se insatisfatória (média 3,5). Não foi identificada diferença significativa entre os modelos de atenção ($p=0,275$). A área rural (média 3,9) apresentou melhor desempenho quando comparada à área urbana (média 3,5). **Considerações finais:** evidenciou-se necessidade de implementar estratégias relacionadas ao aspecto estrutural do serviço que busquem ampliação ao acesso.

Descritores: Atenção Primária à Saúde; Pesquisa sobre Serviços de Saúde; Acesso aos Serviços de Saúde.

ABSTRACT

Objective: to evaluate the presence and extent of the first contact access attribute - accessibility component, from the perspective of primary health care professionals. **Method:** cross-sectional study carried out in 62 primary health care units, through the self-application of the *Primary Care Assessment Tool* with 546 professionals (60.3% of the eligible population). The database was created using *Epi-Info* software (version 7) and typing was performed by double entry. Analysis performed in the *Statistical Package for the Social Sciences* software (version 22). The *Mann Whitney U* test for independent samples was used for comparisons between groups. **Results:** accessibility was unsatisfactory (average 3.5). No significant difference was identified between the models of care ($p = 0.275$). The rural area (average 3.9) performed better when compared with the urban area (average 3.5). **Final considerations:** there was a need to implement strategies related to the structural aspect of the service that seek to expand access.

Descriptors: Primary Health Care; Health Services Research; Health Services Accessibility.

RESUMEN

Objetivo: evaluar la presencia y el alcance del atributo de acceso del primer contacto: componente de accesibilidad, desde la perspectiva de los profesionales de atención primaria de salud. **Método:** estudio transversal realizado en 62 unidades de atención primaria de salud, mediante la autoaplicación de la Herramienta de Evaluación de Atención Primaria con 546 profesionales (60,3% de la población elegible). La base de datos se creó con el *software Epi-Info* (versión 7) y la escritura se realizó por doble entrada. Análisis realizado en el *Paquete Estadístico* para el *software de Ciencias Sociales* (versión 22). Se usó la prueba *U de Mann Whitney* para muestras independientes para las comparaciones entre grupos. **Resultados:** la accesibilidad fue insatisfactoria (promedio 3.5). No se identificaron diferencias significativas entre los modelos de atención ($p = 0.275$). El área rural (promedio 3.9) se desempeñó mejor en comparación con el área urbana (promedio 3.5). **Consideraciones finales:** era necesario implementar estrategias relacionadas con el aspecto estructural del servicio que buscan expandir el acceso.

Descriptores: Atención Primaria de Salud; Investigación sobre Servicios de Salud; Accesibilidad a los Servicios de Salud.

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INTRODUCTION

The services that make up the Unified Health System (UHS) are articulated and integrated into the Health Care Network (HCN), which has the Primary Health Care Units (PHC) as coordinators and care providers, which assume the role of users' first preferential contact with the system⁽¹⁾.

Among the forms of PHC organization recognized by the National Primary Care Policy (NPCP), the Family Health Strategy (FHS) is considered a priority for its consolidation in the country⁽²⁾. It is characterized by an attention focused on the health demands of families and communities, considering the socio-cultural context as a factor that influences the health and well-being of individuals⁽³⁻⁴⁾.

The strengthening of health systems through PHC expansion has been recognized, internationally, as the most effective way to improve the health conditions of the population⁽⁵⁾. Therefore, measuring the performance of services is one of the ten research priorities for PHC⁽⁶⁾. In the Brazilian context, which still has PHC services, in the traditional modality, there is a policy, to consolidate this point of the HCN, through the FHS⁽²⁾. The PHC performance assessment process stands out as an important tool capable of identifying the potential and weaknesses of this service⁽⁷⁻⁸⁾.

The traditional approach used for the evaluation of PHC in Brazil and in accordance with the theoretical framework of PHC worldwide⁽³⁾ and the NPCP⁽²⁾, is based on measuring the presence and extent of its attributes⁽⁷⁾ which are defined as essential - first contact access, longitudinality, integrality and coordination and derivatives - family centering, community orientation and cultural competence⁽³⁾.

However, despite the notable advances in access to health services, due to the expansion of the FHS⁽⁹⁾, Brazilian evaluative studies, carried out with PHC professionals, point to access as an attribute that presents greater difficulty in operationalization and consolidation^(4,10-12).

This attribute involves two components: accessibility and use. The accessibility dimension is a structural component of the service and is subject to the availability of the service in view of the users' needs, including the location close to

the community, the opening hours and days and the flexibility to meet spontaneous demand from the units. The utilization dimension - procedural component - is related to the users' perception that the service is accessible and considered a reference⁽³⁾.

Considering that, in order to carry out health actions, services need to implement the structural elements of PHC in their daily work⁽³⁾ and that there is a need to strengthen the current PHC, with regard to the practice of its essential attributes⁽¹⁻²⁾. This study aims to: assess the presence and extent of the first contact access attribute - accessibility component, from the perspective of PHC professionals.

METHOD

This is an evaluative cross-sectional study, approved by the Research Ethics Committee, CAAE 33363314.9.0000.5147, opinion number 3,383,322, in compliance with the provisions of Resolution 466/12 and 510/2016 of the National Health Council, which establishes the regulatory guidelines and standards for research involving human beings.

The research scenario consisted of 62 of the 63 PHC units in the municipality of Juiz de Fora, 47 of which were urban and 15 rural. All medical professionals, nurses, nursing technicians and community health agents (CHA) who worked in the Family Health teams (FHT) and the Primary Care team (PCT) were invited to participate in the research. Professionals who were on statutory vacation, sick leave or on leave were excluded from the study; those who refused to participate in the study and those who were not found after three attempts.

Data collection took place between March 2018 and February 2019, through self-application of the Primary Care Assessment Tool (PCATool), professional version, validated for the Brazilian context⁽⁸⁾ and a questionnaire prepared for the purposes of this research, which collected information on the sociodemographic profile and qualification of professionals.

Participants were informed of the research objectives, procedures, risks and benefits, through the Free and Informed Consent Term (FICT). Professionals, who were not interested in participating, were instructed to return the questionnaire and the blank FICT. All professionals in a PHC unit refused to participate

in the study (reasons were not explained to the main researcher), which justifies the research in 62 PHC units.

The PCATool contains 77 items divided into eight components. In the professional version, PCATool evaluates only the accessibility component of the access attribute, which consists of nine items (A1, A2, A3, A4, A5, A6, A7, A8 and A9). The possible answers, for each item, are based on the Likert scale: "certainly yes" (value = 4); "Probably yes" (value = 3); "Probably not" (value = 2); "Certainly not" (value = 1) and "I don't know / don't remember" (value = 9)⁽⁸⁾.

The values of item A9 were inverted, since it was formulated so that the higher the value assigned, the lower the orientation for PHC. The attribute score was calculated by the simple arithmetic mean of the response values for each question and subsequently transformed into a continuous scale from 0 to 10, using the formula $[(\text{score obtained} - 1) \times 10] / 3$. For the analysis of the result of the attribute score, the same methodology of the PCATool manual was used, which determines that values equal to or greater than 6.6 represent high orientation for PHC⁽⁸⁾. The dependent variable was the accessibility attributes score, and the independent variables were composed of sex, age, profession, qualification and professional experience.

The database was created using the Epi-Info software (version 7) and typing was performed by double entry.

Then, the consistency of the data was evaluated by the data compare function, in order to eliminate typing errors. Data tabulation was performed

using Microsoft Excel software (2013), and statistical analysis using Statistical Package for the Social Sciences for Windows (SPSS) - version 22.

Qualitative variables were described as absolute and relative frequencies, and quantitative variables, according to the data analysis method recommended by PCATool⁽⁸⁾, as average and standard deviation.

For analytical statistics, the normality of the quantitative variable was tested using the Kolmogorov-Sminorv test. With the normality of the data discarded, Mann Whitney's nonparametric U test was used to compare scores between groups. For all tests, a significance level of $p < 0.05$ was adopted.

RESULTS AND DISCUSSION

546 professionals participated in the study, allocated in 62 PHC units (47 urban and 15 rural). It is noteworthy that all professionals in a PHC unit refused to participate in the study (reasons were not explained to the main researcher) 27 professionals were excluded who were on statutory vacation, ten due to sick leave or leave and 321 who refused to participate in the study and / or were not found after three attempts. The profile of the study participants is shown in Table 1.

Table 1 - Participant profile stratified by type of service, Juiz de Fora, 2019.

Qualitative variables	Pct* (n=57)		Fht† (n=489)	
	Nº	%	Nº	%
Sex				
Female	47	82	431	88
Male	9	16	47	10
Not informed	1	2	11	2
Professional				
Doctor	11	19	41	8
Nurse	16	28	74	15
Nursing technician	30	53	63	13
CHA			311	64
Training§ to work in PHC‡				
Yes	26	46	321	66
No	20	35	64	13
Not informed	11	19	104	21
Employment bond in another service				
Yes	14	25	32	7
No	29	51	354	72
Not informed	14	25	103	21

Source: Research data (2019).

Notes: *Primary Care team. †Family Health team. ‡Primary Health Care. § Training of professionals to work in PHC by the Municipal Health Secretariat.

Regarding the qualification of professionals, it was identified that nine (9.7%) nursing technicians and 45 (14.5%) CHA have higher education; 27 (51.9%) doctors and 49 (54.4%) nurses specialize in family health; seven (13.5%) doctors and three (3.3%) nurses (7.0%) have residency in family health.

The average age of the professionals was 47.54 years (standard deviation \pm 10.2). The

greatest age was 70 years and the lowest 25 years.

The analysis of the items that constitutes the accessibility attribute indicated low service orientation for the attribute from the perspective of professionals (average 3.5; standard deviation: \pm 1.1), as well as in other studies that used the same instrument^(4,10-11-12-13-14). The description of each item of the accessibility component is shown in Table 2.

Table 2 – Assessment of the presence and extension of the access attribute - accessibility component - and its respective items from the perspective of PHC professionals, Juiz de Fora, MG, Brazil, 2019.

Accessibility	Average Score/Standard Deviation	CI 95%	% High score (>6.6)
A1- The service is open Saturday or Sunday	0.6 (\pm 1.5)	0.5 - 0.7	2.1
A2- It is open at least a few days until 8 pm	1.2 (\pm 2.7)	0.9 - 1.4	9.4
A3- If the Health Service is open and the user becomes ill, someone will see it on the same day	8.0 (\pm 2.3)	7.8 - 8.2	93.6
A4- Patients get quick advice over the phone when the Health Service is open	6.8 (\pm 3.0)	6.6 - 7.1	79.9
A5- Is there a phone number that patients can call when the Health Service is closed	2.2 (\pm 3.4)	1.9 - 2.5	19.2
A6- When the Health Service is closed, on weekends, and the patient becomes ill, someone from the Health Service will see you on the same day	0.8 (\pm 1.9)	0.6 - 0.9	4.4
A7- When the Health Service is closed at night, and the patient becomes ill, someone from the Health Service will see you that night	0.6 (\pm 1.7)	0.5 - 0.8	3.5
A8- It is easy for patients to make an appointment for a health review	7.6 (\pm 2.5)	7.4 - 7.8	90.6
A9- On average, patients have to wait more than 30 minutes to be seen by the doctor or nurse	3.8 (\pm 2.7)	3.6 - 4.1	26.9

Source: Research data (2019).

Accessibility is an essential characteristic of PHC and is responsible for allowing the user to enter the health system, ensuring that their needs and family are met. It is associated with factors such as: availability of service, location of the establishment and communication barriers between teams and users⁽³⁾.

A literature review, carried out by authors who validated the PCATool, for the Brazilian context, suggests the need to update the instrument's accessibility item, including or adapting items, such as, new means of communication between professional and user, such as e-mail and applications⁽¹⁵⁾. When analyzing the original instrument proposed by Starfield, to analyze the American PHC service⁽¹⁶⁾, it is clear that the Brazilian authors have faithfully adapted the instrument, without making a cultural adaptation to the organizational characteristics of Brazilian PHC.

In this sense, the instrument validated for Brazil⁽⁸⁾ evaluates characteristics of PHC services

that are not realities, in the vast territory of the country, such as services on Saturdays and Sundays; opening hours until 8 pm; phone number users can call when the service is closed. Such characteristics were responsible for the low qualification of the attribute, since they are not considered in the reality of the municipality under study.

It is important to point out that, usually, people work during the conventional service hours of the units, which makes it common for other HCN services - such as emergency care units (ECU) - to end up working as a gateway, due to inflexibility in unit programming^(12,14). In addition, the dynamics of PHC teams, in general, prioritize routine care, and the communication of users with the service generally requires physical presence⁽⁴⁾. The service is only considered accessible, when the population perceives the convenience of the aspects that involve the days and hours of service and the tolerance for unscheduled activities⁽³⁾.

NPCP recommends that the opening hours of the units facilitate the population's access to the service, a situation assessed in items A1, A2, A6 and A7. The aforementioned ordinance proposes a minimum workload of 40 hours per week (at least five days a week) and allows for the agreement of alternative hours according to the demands of the population. The responsibility for analyzing territorial demands lies with the municipal management. Each FHT professional must comply with the aforementioned minimum workload. PCTs, on the other hand, have greater flexibility: minimum workload per professional of 10 hours and minimum per category of 40 hours. Thus, PCT can be composed of up to three professionals in each category⁽²⁾.

It is noticed that the NPCP proposal allows several arrangements to the PCT. The flexibility of the professionals' working hours puts at risk the continuity of care, the establishment of bonds between users and the team and strengthens the individual curative model⁽¹⁷⁾. Therefore, when in its text it states that: "opening hours and days must be organized in such a way as to guarantee amply access, the link between people and professionals, continuity, coordination and longitudinality of care"^(2, p. 14), in terms, it contradicts itself.

Another fact that deserves to be highlighted, as it can intimately compromise the population's access to PHC, is the lack of definition in the number of CHAs per team, as it is a territory worker, who knows the dynamics of the community and, as a consequence, is a facilitator of the approximation between the service and the community⁽¹⁷⁾.

Despite these obstacles and in order to expand this offer to primary services, some specific initiatives have been developed in the country. In Recife, a model called "*Upinhas 24 horas*" has been implemented since 2013 to reduce disparities in access to FHT. As a differential, this service offers extended opening hours for consultations and urgent situations in PHC units. The model guarantees, in most cases, a service by the health professional, but it comes up against the question of continuity of care, as it is unlikely that, after conventional hours, the user will be attended by this team⁽¹⁸⁾.

By Ordinance GM no. 930, of May 15, 2019, the Ministry of Health instituted the "*Programa Saúde na Hora*" (Health on the Spot

Program), with the aim of expanding the coverage of FHT and care, in addition to reducing low-risk care in hospitals and emergency care units. The proposal is that the weekly workload should be at least 60 hours, including five hours on Saturdays or Sundays. It applies to medical professionals, nurses and dental surgeons and also provides financial incentives from the federal government to units that join the program⁽¹⁹⁾.

As the current secretary of Primary Health Care in the Ministry of Health is the principal investigator of the validation studies of the PCATool, for the Brazilian context, it can be inferred that the *Programa Saúde na Hora* was created, based on the results of the Brazilian researches that used the PCATool, since all showed low orientation of the access attribute, indicating weaknesses in the PHC operating period.

Another important initiative in order to promote access is the implementation of welcoming in the units, recommended as a guideline of the National Humanization Policy. Its institutionalization occurs by qualified listening to unscheduled demands from users in order to ensure adequate access to each need⁽²⁰⁾.

The time that users wait to receive care was another factor that contributed to the low qualification of the attribute. It is noticed that the ease and agility of access to the service are still organizational challenges to be overcome⁽²¹⁾.

In Juiz de Fora, there is no flexibility in the days and hours of service of the units, which occasionally operate, during the week, from Monday to Friday, from 7 am to 11 am and from 1 pm to 5 pm, with the exception of Thursdays, where the service works until 3 pm, for team meeting. At weekends and at night, the population's access to public health services is conditioned to hospitals and emergency care units (ECU), which operate 24 hours a day. The population's communication with the service is restricted to this organizational arrangement.

The units' service flowchart basically happens as follows: users with scheduled demand arrive at the beginning of the working hours and wait for the service; spontaneous demand is sent to reception; and procedures and other assistance are performed on a first-come, first-served basis, respecting the priorities. This organization of the service may be associated with the long waiting time for the service,

especially in terms of the management of scheduled demand, which could be minimized by scheduling appointments by time.

An integrative review analyzed 42 studies that used PCATool between 2001 and 2016 and presented the behavior of each PHC attribute in the national and international context. Of these studies, 40.5% were carried out in Brazil. It is noteworthy that only in Columbia - South Carolina, Seoul - South Korea, Changsha - China and in the Catalonia Region - Spain, accessibility reached a strong orientation for PHC⁽¹⁵⁾,

therefore, it appears that the operationalization of the attribute is still incipient in Brazil and in the world.

Regarding the comparison of the performance of the accessibility attribute between the models of care, the present study did not show any statistically significant difference ($p = 0.275$). The PCT had a mean score of 3.6 (standard deviation ± 1.0) and the FHT had a mean score of 3.5 (standard deviation ± 1.1). It is worth noting that PCT had a significantly higher score in relation to item A4, as shown in Table 3.

Table 3 - Comparison of the access attribute - accessibility component - and its respective items, from the perspective of professionals, between the FHT and PCT, Juiz de Fora, MG, Brazil, 2019.

Accessibility	Average score (Standard deviation)		Value of p^{\ddagger}
	FHT* (n=489)	PCT† (n=57)	
A1- The service is open Saturday or Sunday	0.6 (± 1.6)	0.5 (± 1.2)	0.926
A2- It is open at least a few days until 8 pm	1.2 (± 2.8)	0.7 (± 1.9)	0.280
A3- If the Health Service is open and the user becomes ill, someone will see it on the same day	8.0 (± 2.3)	7.9 (± 2.2)	0.526
A4- Patients get quick advice over the phone when the Health Service is open	6.7 (± 3.0)	7.9 (± 2.5)	0.003
A5- Is there a phone number that patients can call when the Health Service is closed	2.0 (± 3.4)	1.9 (± 3.6)	0.255
A6- When the Health Service is closed on weekends and the patient becomes ill, someone from the Health Service will see them on the same day	0.8 (± 2.0)	0.8 (± 1.7)	0.442
A7- When the Health Service is closed at night, and the patient becomes ill, someone from the Health Service sees them that night	0.6 (± 1.8)	0.6 (± 1.6)	0.773
A8- It is easy for patients to make an appointment for a health review	7.6 (± 2.6)	8.0 (± 2.4)	0.205
A9- On average, patients have to wait more than 30 minutes to be seen by the doctor or nurse	3.8 (± 2.7)	4.4 (± 3.1)	0.145

Source: Research data (2019).

Notes: * Primary Care team. † Family Health team. ‡ Mann-Whitney U test of independent samples.

A comparative study between the care models, carried out in Piracicaba, in the state of São Paulo, showed better accessibility performance in the PCT, signaling that the access did not improve with the implantation of the FHT⁽¹³⁾, corroborating the results of this study.

It is noteworthy that, in the municipality in question, both models of care have the same management and, basically, are organized by the same principles, a fact that perhaps contributed to the result.

However, despite showing these difficulties, in both models, studies indicate family health as a strategy capable of producing better results in primary services^(14,22). However, it does not match the text of the new NPCP, which expresses the "deconstruction of a commitment to the expansion of family health

and the public system"^(17, p.14), because, at the same time, in which it considers strategy as a priority for the consolidation of PHC in the country, it recognizes and encourages other types of organization⁽²⁾, putting the UHS and its principles at risk⁽¹⁷⁾.

In addition, the NPCP does not provide for differentiated valuation between the teams⁽¹⁷⁾, which compromises the transition from PCT to FHT, in the Brazilian territory, as recommended by the policy. It is a fact that the simultaneous existence of both PHC models is an obstacle to the reversion of the curative and individual care model⁽⁴⁾.

The result of this study reinforces that, despite the expansion of access, due to the expansion of the FHT, there is a clear need for advances and overcoming the barriers that

prevent its realization, whether geographic or organizational⁽¹¹⁾.

Accessibility was higher in the rural area (mean score of 3.9; and standard deviation ± 1.2) than in the urban area (mean score of 3.5 and

standard deviation ± 1.1), with no significant difference ($p = 0.073$). The description of the scores for each item of the accessibility component and their comparisons is shown in Table 4.

Table 4 - Comparison of the access attribute - accessibility component - and its respective items, from the perspective of professionals, between urban and rural areas, Juiz de Fora, MG, Brazil, 2019

Accessibility	Average (SD)		Value of p^*
	Urban (n=507)	Rural (n=39)	
A1- The service is open Saturday or Sunday	0.6 (± 1.6)	0.3 (± 1.0)	0.332
A2- It is open at least a few days until 8 pm	1.2 (± 2.8)	0.6 (± 2.0)	0.173
A3- If the Health Service is open and the user becomes ill, someone will see it on the same day	8.0 (± 2.3)	8.6 (± 1.7)	0.119
A4- Patients get quick advice over the phone when the Health Service is open	6.7 (± 3.0)	8.6 (± 2.2)	<0.001
A5- Is there a phone number that patients can call when the Health Service is closed	2.1 (± 3.3)	2.4 (± 4.1)	0.786
A6- When the Health Service is closed on weekends and the patient becomes ill, someone from the Health Service will see them on the same day	0.8 (± 1.1)	0.9 (± 1.1)	0.761
A7- When the Health Service is closed at night, and the patient becomes ill, someone from the Health Service sees them that night	0.6 (± 1.8)	0.8 (± 1.9)	0.735
A8- It is easy for patients to make an appointment for a health review	7.6 (± 2.6)	8.9 (± 2.1)	<0.001
A9- On average, patients have to wait more than 30 minutes to be seen by the doctor or nurse	3.9 (± 2.7)	3.9 (± 3.2)	0.909

Source: Research data (2019).

Notes: * Mann-Whitney U test of independent samples.

A study carried out in Diamantina, Minas Gerais, with professionals and users, showed a significantly higher evaluation for the attribute in the rural area compared to the urban area⁽²³⁾.

Considering that users in the rural region constantly face difficulties of access (the distance between the population and the source of care, scarce means of transport, turnover and shortage of professionals), without considering, in most cases, that they are extremely vulnerable areas⁽²⁴⁾, it is believed that, in this study, the qualification of the professionals has been positively associated with the result, since 70% (n=24) of the professionals who work in these teams received training to work in PHC, and all professionals with higher education have specialization in family health.

It should be noted that training focused on Family Health is among the factors that are most associated with the good performance of PHC and should be encouraged and valued⁽²⁵⁾, therefore, models of care geared to the contexts of communities, considering their traditional practices and knowledge, are indispensable to meet health needs⁽³⁾.

In addition, both supply and demand for the primary service can occur in different circumstances. In the urban area, the population has a greater variety of services, in contrast, in the rural area; PHC may be the only source of care for that community. Geographical dispersion itself reduces the demand for other services as a regular source of attention⁽²³⁾.

The rural and urban PHC services in the municipality, although organized by the same principles and management, differ in terms of population allocation. The rural units are responsible for a smaller number of users, so it is believed that the ease of receiving advice over the phone and making an appointment have shown significance in this area.

As a limitation of the study, it is expected that self-application may have contributed to the high number of refusals, since the results shown are 28.1% of doctors eligible for the study; 69.2% of nurses; 58.9% of nursing technicians and 72.1% of CHA. However, this methodology was chosen, seeking to guarantee the coverage of the study, in all units, considering the physical and financial resources available and the time necessary for its execution.

As contributions to the advancement of knowledge, the study demonstrated that evaluation is an instrument capable of directing and supporting decision making, in search of greater effectiveness of care, by pointing out the characteristics of the service that hinder accessibility.

Brazil is a developing country, with PHC not fully consolidated, but it has been constantly seeking to overcome the challenges and advance in the implementation of UHS principles and guidelines⁽⁴⁾.

FINAL CONSIDERATIONS

The research showed that, according to the experience of medical professionals, nurses, nursing technicians and CHA, the accessibility component of the first contact access attribute is present in PHC services in the city of Juiz de Fora, however with an unsatisfactory performance (score less than 6.6). Both models of care showed low orientation for the attribute. The rural area showed greater orientation when compared to the urban area, however no statistically significant difference was identified.

Only three items showed high orientation for PHC (scores above 6.6), the one referring to care, on the same day, when the user becomes ill during the hours of operation of the health service (item A3); the possibility of quick telephone advice when the unit is open (item A4) and the facility to make an appointment for the health review (item A8).

Considering that the accessibility item of PCATool does not consider the reality of the PHC services in Juiz de Fora and that this has contributed to the low orientation of these services, it is believed that simply seeking new adaptations and validations is not the best strategy to assess the performance of the access attribute. The weaknesses measured in PCATool deserve to be discussed and evaluated by local managers in order to outline strategies that reduce these disparities and give visibility to PHC as a gateway.

It is suggested to adapt the days and hours of operation of the services to the needs of the community. In addition, adherence to the Health on the spot is seen as an important step in the search for this expansion.

It also emphasizes the importance of investments in training and qualification of all professionals who are part of the PHC teams.

Future comparative studies with the perception of service users are suggested, since the primary objective of health care is to improve their living and health conditions.

It is concluded that the study made it possible to identify the presence and extent of accessibility in the local PHC service, from the perspective of professionals, pointing out contributions to the improvement of the service. These notes have an influence on improving the health conditions of the community and reducing disparities in access and use of the service, as well as assisting decision making and the development of interventions for this purpose.

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