Primary Health Care Quality: an analysis based on its attributes

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Abstract

This study aims to analyze the dimensions of the Service Quality Scale (SERVQUAL) and its relationship with the essential attributes of Primary Care. This is a qualitative research with elderly people living in eight cities in *'Serra Gaúcha*' region, in Southern Brazil, with Family Health Teams and Primary Care Teams. Semi-structured interviews were conducted and the responses of each dimension were analyzed, relating them to the essential attributes of Primary Health Care. First contact accessible evidenced in the dimensions reliability, responsiveness, assurance, empathy and tangible. Continuity emerged in reliability, responsiveness, assurance and empathy. Comprehensiveness appeared in the dimensions reliability, responsiveness, assurance and empathy. Finally, coordination was reflected in reliability, responsiveness, assurance and empathy. The SERVQUAL scale proved to be a useful instrument for the evaluation of Primary Care.

Keywords: Primary Health Care. Quality Assessment of Health Care. Health of the Elderly.

1. Introduction

Primary health care (PHC), as defined by the World Health Organization, is the level of care with essential care, based on scientifically recognized methods and technologies, universal access to individuals and families in the territory (Ramalho et al., 2019). Primary care can meet a large part of the health needs of a population, have a better response capacity, as they are part of the communities, and respond to the increasing demands of monitoring chronic pathologies (Langlois et al., 2020). Evidences (Starfield et al.,

2005; Macinko et al., 2018, Liao et al., 2021) suggest that health systems organized based on PHC have lower rates of preventable hospitalizations, better performance in reducing social inequalities, lower costs for the management of the health system and more satisfactory population health indicators. In addition, countries that chose to expand primary care coverage recorded a reduction in infant mortality and an increase in the population's life expectancy (Starfield et al., 2005).

The primary level of robust care is essentially characterized by some attributes or characteristics: first contact (accessible), continuity, "comprehensiveness" and coordination care (Starfield, 2002; Starfield et al., 2005; Harzheim et al., 2016; Costa et al., 2018) which demonstrate its degree of orientation and resoluteness. First contact corresponds to the accessibility and search for the service as the first service whenever necessary, that is, it involves structural elements (location, opening hours) and procedural elements (capacity to respond to needs). The continuity of care presupposes the recognition and use of the service by the population over time, maintaining a continuation of care, except in cases where referrals are necessary. Comprehensiveness, on the other hand, implies the care offered to people to solve the reasons for the search for care, either through the team, or in referral to specialized levels, besides having diagnostic, preventive, curative and rehabilitating actions. The coordination attribute involves the sense of integration, that is, the existence of the continuation of care, through the same professional (continuity), or the access to the clinical history in the medical records (science and recognition of the health condition) (Starfield, 2002).

In addition to these attributes, considered essential, two others are considered to be derived or complementary: family and community orientation and, finally, cultural competence. The latter are associated with the capacity of PHC to consider the family and community context and the cultural issues that interfere in the health condition of the subjects in a given location, broadly, which are related to the integrality of care. Thus, resolutive PHC is focused on the existence and performance of these attributes, which implicate in the effectiveness of primary health services in the territories (Starfield, 2002).

Regarding the evaluation of PHC, several instruments have been used in the literature with this objective. One of the best known at the national level is the Primary Care Assessment Tool (PCA-Tool) or Instrument for the Evaluation of Primary Care, adapted and validated in the Brazil (Brasil, 2010). In addition to this, other instruments described in the literature are the Components of Primary Care Index (Index of Components of Primary Care - CPCI) (Flocke, 1997), EUROPEP Questionnaire (Grol et al., 2000), General Practice Survey (Survey of Evaluation of Family Physicians - GPAS) (Ramsay et al., 2000), Primary Care Assessment Survey (Primary Care Evaluation Survey - PCAS) (Taira et al. 2001). Another possibility, applied in the assessment of health services worldwide, is the Service Quality Scale (SERVQUAL), according to Parasuraman et al., (1988). Originally designed to evaluate services in general, the scale has also been used in studies to assess health services, including in PHC (Sousa et al., 2017; Zun et al., 2018; Andrade et al., 2019; Monteiro et al., 2019; Sharifi et al.,2021). Service quality in the SERVQUAL model consists of five dimensions: reliability, responsiveness, assurance, empathy, and tangibles (Pena et al, 2014; Andrade et al., 2019). According to their creators, these dimensions correspond to the criteria of judgment observed by consumers when evaluating a service (Pena et al, 2014).

Reliability is related to the efficiency of the service, in order to transmit confidence to the user.[17,20] At the primary level of care, it is related to the trust in health team professionals and the capacity of linking the

population to the service.

Responsiveness, conforming to Pena et al. (2014); Andrade et al. (2019), refers to the availability of workers to serve the user, in a thoughtful, accurate and agile manner. In PHC, it is associated with the waiting time, the resolution of the care provided and the assistance of the reasons for the search for the health service.

Assurance refers to workers' knowledge and their ability to transmit guarantee and their ability to convey trust and confidence to users (Pena et al, 2014; Andrade et al., 2019). In PHC, this item implies users' assurance with professionals.

The empathy denotes sensitivity and the ability to understand the needs of users (Pena et al, 2014; Andrade et al., 2019). The embracement and care provided in consultations, procedures and other actions offered to the population are elements of this dimension in primary care.

Finally, according to Pena et al. (2014); Andrade et al. (2019), the tangibles aspects concern the physical structure, ambience, availability of materials and equipment. They are the visible and touchable elements of the service. This item, in primary care, includes the location of the service since it is recommended an accessible place close to the community.

When analyzing the essential attributes of PHC: first contact (access), continuity, comprehensiveness, and coordination care, it is noticed that these characteristics establish similarities to the dimensions of the SERVQUAL scale, which seems to be a relevant evaluative instrument, precisely by this association. This work, therefore, proposes to analyze the dimensions of the SERVQUAL Scale and its relationship with the essential attributes of PHC.

2. Methodology

This is an experimental study of a qualitative and applied approach, anchored in the theoretical basis of Hermeneutic-Dialectic (HD) Method (Rychlak, 1996; Minayo, 2004).

Eighty elderly people participated in the survey, living in eight municipalities in the northeastern region of Rio Grande do Sul (Brazil), that organize PHC services with Family Health Teams (FHT) (four municipalities) and Primary Care Teams (PCT) (four municipalities). The choice of these places was for convenience, since the first registered the highest proportions of elderly people, above 30%, (Rio Grande do Sul, 2018) in the mentioned region and the other four organized primary care with PCT teams.

Participants were chosen from the following inclusion criteria: age equal to or greater than 60 years; both sexes; being registered in the municipal PHC service; living in the participating municipality of the research; having used some PHC service (consultation, procedure, group) or received a home visit from the health team in the last six months.

The definition of the number of participants considered aspects such as: access, availability and representativeness of each location, so that a non-probabilistic, intentional and convenience sample was adopted. The choice of subjects occurred randomly, by drawing lots, from the registers of the recent consultations made by the evaluated teams. The invitation to participate in the study took place in person, when the objectives were clarified, the average duration, as well as other information relevant to the research.

The interviews were conducted between November and December of 2020, applied by one of the researchers, and recorded through filming, with the consent of the participants through a free, prior and informed consent. The length of time of the interviews ranged from 10 minutes to 01 hour and occurred both in the Health Units and in the homes of the elderly, in urban and rural areas, to obtain an enlarged perspective of the elderly living in each municipality.

The instrument used in the semi-structured interviews was the Service Quality Scale (SERVQUAL), idealized by Parasuraman et al. (1988) and adapted for PHC according to studies of Sousa et al. (2017); Andrade et al. (2019). The adaptation proposed in this research maintained the five original dimensions: reliability, responsiveness, assurance, empathy and tangibles, adapting it to open questions (Table 1). After the interviews, the data were analyzed, according to the methodological perspective described (hermeneutic-dialectic), categorized according to the dimensions proposed in the SERVQUAL scale adapted and compared to the essential attributes of PHC. No answers were used as a Likert scale or other form of intensity grading, due to the qualitative approach and the nature of the questions applied (open). The study was approved by the Research Ethics Committee of Higher Education Institution, CAAE nº 29463220.8.0000.5345 and Opinion nº 3.980.972

Table 1: Adapted SERVQUAL Scale: interview script

Dimension	Questions
Reliability	What do you understand by the technical capacity of health professionals and what do you think of them? What do you expect when you go to Health Service for a consultation/examination/procedure (what is it like and how would you like it)? What do you think when referred to other specialists/exams?
Responsiveness	What do you expect when looking for the service (response to demands)? What do you think about the services that the team performs (providing consultations/exams/groups)? How do you find out about them?
Assurance	What do you expect to receive in terms of guidance from the team and what do you think about it (clarity/understanding)? What do you think about the trust/security of the team? How it should be?
Empathy	What do you think of the treatment (reception) of the health service? How it should be? What do you think about the team's interest in your health/problem? How would you like it to be?
Tangible	Regarding the environment and equipment, what do you expect from the health service? How it is? In relation to professionals, what do you expect from the appearance of health professionals? How it is?

Source: prepared by the authors

3. Results

The results from the interviews will be presented below, establishing their relation with the essential attributes of PHC, according to the proposed objectives.

3.1 First contact

The first contact is the first point of care accessible whenever necessary, emerged in the dimensions reliability, responsiveness, empathy and tangible, considering possible barriers of access to the PHC service.

The reliability dimension emerged points of first contact concerning to negative experiences in the PHC service, bond with a specific team professional (usually the physician) and search for PHC services even with complementary health insurance, especially medications and, possibly, consultations.

In some reports, episodes were reported in which health services were not solved, either by diagnostic failure or by the delay in forwarding specialized care. In these cases, the services offered the first contact weakened, impacting the credibility for future care and favoring the break of the bond in complex situations, since it was perceived the loss of trust in the service. It was also identified the existence of a bond with a specific professional (doctor) and the evident relationship of trust established between this and the elderly. Thus, on occasions of absence of this professional, the PHC service at first contact showed weakness since some elderly mentioned seeking other places of care in nearby cities or emergency services in the absence of such professional.

The responsiveness brought to light some peculiarities of this attribute: preference and relevance of consultation with the medical professional, together with access to prescribed medications; appreciation of home care, especially of doctors and nurses and, in the FHT teams, the secondary role of the community health worker in relation to other team members.

The reports of the participants showed the importance given to the medical professional and how this factor stands out in health care, in the view of the elderly person. In situations of absence of this professional, or in the absence of a greater bond, the recognition of the service as the first point of health care was weakened, negatively affecting its resolvability. In addition to medical care, access to medications also stood out as an item related to care, as it is a monthly practice (going to the health service to take medication), reported by most of the participants. Complaints related to eventual drug shortages were reported by several elderly in the PHC teams. It is observed, therefore, that the elderly prioritize medicalization as a form of care and maintain the culture of care centered on the medical figure and the remedy as a "solution" to health problems. Therefore, these items are seen as priorities in primary care.

Another point observed in this dimension was related to the community health worker, associated, in several reports, to receiving information from the service, that is, a secondary role of informant, distinct from other team components with inherent care functions.

The empathy dimension, related to this attribute, was shown in the facilitated scheduling, through telephone contact or in person. In addition, reports of impossibility of access were rare, since PHC involves the demand of the evaluated sites (small cities).

The tangible aspects, a dimension that established a relationship with the accessibility of the service

(physical and organizational barriers), presented positive reports in most of the evaluated locations. A municipality participant with PCT, however, negatively mentioned the closure of the service at noon. In another location with geographic barriers (service located in a steep hill), most of the interviewees criticized the location, especially for users with some mobility restriction, such as the elderly.

3.2 Continuity

Continuity, in the sense of long-term care and the frequent return to the same place over time, reflecting the link of users to the PHC service, appeared in the dimensions reliability, responsiveness, assurance and empathy.

This attribute was related to the reliability of PHC. The negative experiences with the health service weaken the continuity of care, a context already observed in the search for PHC at first contact. Therefore, an episode of frustration in the care received has repercussions, both in the search for the service whenever necessary (continuity), and in its access as a first point of care.

Complementary to trust, the link to a professional preferred by the elderly was also presented in this dimension. Only in one municipality did this relationship not become explicit, since in the other places the participants mentioned the name of the doctor who sought care and sought to maintain continuity in care. In addition, in the service where it was identified frailty in the link with the elderly population, the labor relationship of the professionals was established through contract, with occasional changes of the doctor, interfering in the link to users. It is observed, therefore, that turnover harms not only the reliability of the health service, but also the longitudinal care of the population.

Responsiveness emerged in the positive reports referring to home care, which, although occurring more frequently in FHT teams, were also described in places with PCT. Therefore, regardless of the configuration of the team, the perspective of longitudinal care over time can occur at the level of PHC that meets the needs of users.

In addition to reliability, the assurance dimension also appeared in the reports of this attribute, because the breach of trust in a given professional directly influenced the feeling of security associated with it, so that participants would again turn to such a professional only in urgent cases or seek care in nearby municipalities.

3.3 Comprehensiveness

The comprehensiveness attribute, understood as the offer of complete care to people, through care in PHC or forwarding in the necessary cases, maintaining the link with users, could be identified especially in the responsiveness dimension, but was also present in reports associated with reliability, assurance and empathy.

The reliability of PHC related to the comprehensiveness of care appeared mainly in the link between the team (usually the doctor) and the elderly person. At this point, the relationship of trust of the user with the health service favors the resolution of care and, in the absence of this link, there is a greater tendency to seek other places of care or, still, a greater number of consultations in search of the solution of health problems.

The responsiveness of PHC, associated with the comprehensiveness, was presented in the access to

pharmaceutical services, a relevant item from the perspective of the participants. Therefore, any lack of medications of continuous use was evaluated negatively in the reports, even if they assumed to be a temporary situation. Even in cases where the elderly had supplementary health insurance, they removed medications in the municipal pharmacy. Complementary to medication, availability of appointments and facilitated scheduling were components that contributed to the provision of comprehensiveness care.

Negatively, however, the waiting time for consultations and specialized procedures emerged in the reports, which occur in the reference services of nearby cities. Situations of delay in access to secondary and tertiary care services affect, even indirectly, the responsiveness and, consequently, the comprehensiveness offered in PHC.

On the other hand, the availability of health transport for reference services in other municipalities received praise from the participants, being offered to all residents, even for consultations and procedures in the private system. Thus, the transportation guarantee is seen as an adjuvant factor in the entire service.

Home care, related to the care and continuity of PHC, also help in the comprehensiveness of the service. Therefore, as mentioned above, the possibility of home care enhances the care and the resolution of primary care.

As for empathy, it identified its relationship with comprehensiveness in the moments of embracement, that is, listening to complaints, in a sensitive and qualified way, allowing the user to feel really welcomed and their demands assume legitimacy for those who receive them. On the other hand, moments of lack of concern to the elderly, signaled by some participants, fragment comprehensiveness care, as well as generate dissatisfaction that affects the other attributes of PHC.

Empathy emerged, in addition, in the reports associated with health transport, some referring to management and the others to drivers, recognized by sensitivity and patience in guiding on the location of reference services, food points, withdrawal of examinations and, still, in cases where passengers presented indispositions during the journey, arising from the treatments performed or from the fragile state of health. Health transportation, in addition to being associated with empathy, provides a sense of assurance to the interviewees.

3.4 Coordination of care

Coordination of care, an attribute that presupposes integration of care, through the same professional, the science of medical registers or contact with other points of the care network connected to PHC. This characteristic was mainly pointed out in the responsiveness and empathy dimensions, as well as reports related to reliability and assurance.

The responsiveness of PHC, relative to the coordination of care, was shown in the reports on referrals, from diagnostic imaging exams to even consultations with specialists. In these situations, it was noted the recognition of the limitation of the primary level in complex conditions, which require specialized monitoring. Thus, the referrals were not associated with unsatisfactory resolution, but rather with the restrictions of PHC in ensuring the integrality of care at the local level.

Reliability, another dimension related to coordination, was evidenced in the statements related to the link between doctor and elderly, like other attributes. This professional-user tune takes prominence in PHC, since it allows the team greater knowledge of the predominant pathologies in the population, facilitating

its management and avoiding unnecessary interventions.

Finally, a dimension assurance also associated with coordination, was noticeable in the relationship with the professionals of the team, since the elderly reported confidence in a specific professional. Therefore, again it emerged in PHC the importance of the bond as a condition for the continuation of care.

4. Discussion

The dimensions of the SERVQUAL Scale, reliability, responsiveness, assurance, empathy and tangible were present in all essential attributes of PHC, that is, first contact, continuity, comprehensiveness and coordination of care. Therefore, it should be noted that this instrument presented positive performance and met the proposed objective of evaluating the quality of PHC.

The prioritization of consultation and access to pharmaceutical services, evidenced in the dimensions responsiveness, reliability, assurance and empathy, were the demands of greatest concern of the participants, corroborated by other authors (Meier et al., 2020; Oliveira et al., 2021; Perillo et al., 2021). Medication is the most frequent health care practice for the elderly, which strengthens the biomedical model and the curative logic of the work process, according to Furlanetto et al. (2020); Ceccon et al. (2021). Therefore, the quality in the offer of essential attributes (first contact, continuity, comprehensiveness and coordination) favors the resolution of primary care, since, in smaller locations, this is the only existing health care point, a factor that makes it easier for the team to monitor the conditions present in the territory.

First contact showed better performance in FHT teams. This is because, according to the normative in force in the country (Brasil, 2017), all professionals of these teams must perform the 40 hours weekly workload, while the FHT teams can act 20 hours or 30 hours a week. This difference can negatively affect the service's response and, consequently, the continuity and completeness of care, since it presupposes limited hours of team operation. Older studies (Leite et al., 2016; Tesser et al., 2018), prior to the accreditation of the current PCT, indicate greater access to care in FHT teams, compared to other configurations of PHC teams. However, robust and recent evidences of this possible fragility in the access to the PCT teams were not found in the scientific literature.

Despite the different workload of PCT professionals, there was no lack of access in the evaluated locations. Except in a municipality where there was no doctor in one shift, in the other services there was a sufficient supply of consultations and procedures, since the demand in areas with a smaller population is included by the capacity of PHC care. This reality, however, is different in larger cities, where teams serve a larger population, in which part of the elderly population reports difficulties in accessing spontaneous demand consultations and, in some cases, it prefers to access emergency services, considering them more resolutive, reliable and agile in the service, as claimed by Ferreira et al. (2020); Camargo et al. (2021).

On the lesser relevance of the community agent in the FHS, emerging in this study, one of the possible explanations for the fact is the need to plan the visit, so that this action is solvable, and not just an assignment performed mechanically or in compliance with bureaucratic rules and determinations. The planning of the actions of this professional, together with the other members of the team, seeks to optimize the actions of the agent in the approach of families (Nunes et al., 2018).

Study conducted by Nunes et al. (2018), that researched the planning of home visits pointed out that, in some localities, such as the southern region of the country, there is a low proportion of teams that perform joint programming of home visits, context that denotes the fragmentation in the work process of some FHS teams. Other researches (Amorim et al. 2020; Garcia et al., 2020; Brasil et al., 2021), however, contrast the results of present survey, by stating greater satisfaction of the elderly with the community health worker, since it acts closer to the territory and presents a condition facilitated for strengthening bonds, in addition to knowing the problems prevalent in the territory (Brasil et al., 2021).

On the other hand, it observed the importance and value of home care provided by PHC professionals, primarily physicians and nursing staff. However, this action is influenced by the organization of the teams' agenda and by professional profiles, as distinctions were noted in the locations evaluated. The satisfaction of the elderly regarding the possibility of home care is corroborated by authors (Schenker et al., 2019; Garcia et al., 2020, Sacco et al., 2020) because it broadens the scope of actions offered in PHC, strengthens the link between users and the health service, as well as providing access to people with mobility restrictions. This responsiveness of the service meets the attributes of PHC, especially the continuity and comprehensive of care.

Waiting for specialized care, another emerging point in this study, affects the responsiveness of the PHC service and, consequently, its attributes. Such frailty impacts, in particular, the comprehensiveness of care and facilitates the feeling of anguish and dissatisfaction of the elderly population (Schenker et al., 2019), in addition to aggravating previously existing chronic conditions (Sacco et al., 2020).

The relevance of the link between the elderly and the trusted professional was evidenced in the dimensions responsiveness, reliability, safety and empathy, a condition associated with all the essential attributes of PHC, with emphasis on continuity and coordination of care. The user embracement linking and accountability of the team in the care of users stimulate the recognition of PHC as the main access point to the care network (Queiroz et al., 2020).

When primary care does not assume the role of coordinator of care, compromising one of its attributes, it hinders the formation of the link to the health service, since it is influenced by the subjectivity inherent to the care offered (Sacco et al., 2019; Almeida et al., 2021). This leads to the search for other points of care, conforming to Almeida et al. (2021)[41] which can be identified by the scale used in this study (responsiveness). In addition, continuity and the link to the PHC service are formed from a relationship of trust that is fragmented when there is turnover of professionals in the teams (Lima Junior et al, 2020). In this sense, it is possible to understand why PHC services become unresolved, affecting the frequent demand for appointments and referrals, which, in addition to the negative effects on the population's health, cause economic losses for management, as claimed by Meier et al. (2020). The PHC, when solved, it enables the provision of actions based on health promotion and prevention of health problems, as well as reducing referral to specialized levels of care (Lima Junior et al., 2020).

Regarding embracement, present in the empathy dimension, this is recommended by the Ministry of Health as a posture of qualified listening and able to respond to the needs of users who seek the service. Therefore, this is not an isolated practice, but rather an action practiced by all professionals, from arrival to departure from the service (Brasil, 2010; Ferreira et al., 2018) In this study, reception was related to the way in which the elderly were received in the health service, as well as to the obtaining of medications,

consultations/procedures, similar to the findings of Ferreira et al. (2018) who cite the concept of "welcoming" understood as the fact of being received cordially at reception, obtaining medicines, or, still, achieving the demand sought in the service. The elderly population prefers, therefore, a respectful and humanized care, sensitive to its conditions that require continued care, differentiated from other users of the service (Ferreira et al., 2018).

Still referring to empathy, which affects the attributes of first contact, comprehensive and coordination, the transportation offered by the municipal health departments proved to be a promoter of access to health care in secondary and tertiary care points. It should be noted, therefore, the relevance that the guaranteed displacement represents in these places, a characteristic that involves, in addition to the above-mentioned empathy, the perception of safety with the health service.

As well as the embracement and sanitary transport, the trust established through the bond plays a prominent role in satisfaction with the care received. This is because patients tend to positively evaluate professionals when they receive care and are guided about their chronic conditions/diseases. Thus, one of the main complaints of patients would be the lack of regard and conversation during the consultations. Factors such as qualified regard and listening, dialogue and physical examination would be more significant than simply the resolution/cure of diseases (Souza et al, 2020).

Finally, the tangible aspects identified in this study, mainly related to the care given to first contact, tend to come under the governance of management, while the other dimensions evaluated are more linked to the work of the professionals and the organization of the service. Thus, even if teams develop qualified care geared to users' needs, issues related to organizational and geographical barriers, among others, can restrict access for the elderly population. In addition, conforming to Amorim et al. (2020), factors associated with structure, location and extended hours are predictors of greater user satisfaction with the health service.

5. Conclusions

The dimensions of the adapted SERVQUAL scale established a relationship with the four essential attributes of PHC. First contact was evidenced in the dimension’s reliability, responsiveness, assurance and tangible. Continuity emerged in the following items: reliability, responsiveness, assurance, and empathy. Comprehensiveness, on the other hand, was reflected in the dimension reliability, responsiveness, assurance, and empathy. Finally, the coordination was noticeable in the item’s reliability, responsiveness, assurance and empathy.

The Service Quality Assessment Scale (SERVQUAL), adapted to PHC, proved to be a useful, practical, and adaptable assessment tool to the context of PHC, enabling us to analyze the quality of the services evaluated.

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References

Ramalho, A.; Castro, P.; Gonçalves-Pinho, M.; Teixeira, J.; Santos, J. V.; Viana, J.; Lobo, M.; Santos, P.; Freitas, A. Primary health care quality indicators: An umbrella review. *PloS one*, 14 (8), 2018, e0220888. https://doi.org/10.1371/journal.pone.0220888

Langlois, E. V.; McKenzie, A.; Schneider, H., Mecaskey, J. W. Measures to strengthen primary health-care systems in low- and middle-income countries. *Bulletin of the World Health Organization*, 98 (11), 2020, 781–791. https://doi.org/10.2471/BLT.20.252742

Starfield, B.; Shi, L.; Macinko, J. Contribution of primary care to health systems and health. *The Milbank quarterly*, 83 (3), 2005, 457–502. https://doi.org/10.1111/j.1468-0009.2005.00409.x

Macinko, J.; Mendonça, C. Estratégia Saúde da Família, um forte modelo de Atenção Primária à Saúde que traz resultados. *Saúde em Debate,* 42 (supl.1), 2018, 18-37. https://doi.org/10.1590/0103-11042018s102.

Liao, R.; Liu, Y.; Peng, S.; Feng, X. L. (). Factors affecting health care users' first contact with primary health care facilities in north eastern China, 2008-2018. *BMJ global health*, *6* (2), 2021, e003907. https://doi.org/10.1136/bmjgh-2020-003907

Starfield, B. *Atenção primária: Equilíbrio entre necessidades de saúde, serviços e tecnologia.* Brasília: Unesco, Ministério da Saúde (MS), 2002.

Harzheim, E.; Pinto, L. F.; Hauser, L.; Soranz, D. Assessment of child and adult users of the degree of orientation of Primary Healthcare in the city of Rio de Janeiro, Brazil. *Ciencia & saude coletiva*, 21 (5), 2016, 1399–1408. https://doi.org/10.1590/1413-81232015215.26672015

Costa, L. B.; Mota, M. V.; Porto, M.; Fernandes, C.; Santos, E. T.; Oliveira, J.; Mota, T. C.; Porto, A.; Alencar, M. Assessment of the quality of Primary Health Care in Fortaleza, Brazil, from the perspective of adult service users in 2019. *Ciencia & saude coletiva*, *26* (6), 2021, 2083–2096. https://doi.org/10.1590/1413-81232021266.39722020

Brasil. Ministério da Saúde. Secretaria de Atenção em Saúde. Departamento de Atenção Básica. *Manual do instrumento de avaliação da atenção primária à saúde: primary care assessment tool PCA-Tool - Brasil.* Brasília: Ministério da Saúde, 2010.

Flocke, S. A. Measuring attributes of primary care: development of a new instrument. *The Journal of family practice*, *45*(1), 1997, 64–74.

Grol, R.; Wensing, M.; Mainz, J.; Jung, H. P.; Ferreira, P.; Hearnshaw, H.; Hjortdahl, P.; Olesen, F.; Reis, S.;

Ribacke, M.; Szecsenyi, J. European Task Force on Patient Evaluations of General Practice Care (EUROPEP). Patients in Europe evaluate general practice care: an international comparison. *The British journal of general practice: the journal of the Royal College of General Practitioners*, 50 (460), 2000, 882–887.

Ramsay, J.; Campbell, J. L.; Schroter, S.; Green, J.; Roland, M. The General Practice Assessment Survey (GPAS): tests of data quality and measurement properties. *Family practice*, *17*(5), 2000, 372–379. https://doi.org/10.1093/fampra/17.5.372

Taira, D. A.; Safran, D. G.; Seto, T. B.; Rogers, W. H.; Inui, T. S.; Montgomery, J.; Tarlov, A. R. Do patient assessments of primary care differ by patient ethnicity? *Health services research*, 36 (6 Pt 1), 2001, 1059–1071.

Parasuraman, A.; Zeithaml, V.; Berry, L. SERVQUAL: A Multiple-item Scale for Measuring Consumer Perceptions of Service Quality. *Journal of Retailing,* 64, 1988, 12-40.

Sousa, L.; Mesquita, R.; Matos, F. R.; Moura, L.; Moura, M. Dimensões da satisfação dos usuários da Estratégia Saúde da Família. *Revista Portuguesa de Investigação Comportamental e Social,* 3, 2017, 2-9. https://doi.org/10.7342/ismt.rpics.2017.3.2.50.

Zun, A. B.; Ibrahim, M. I.; Hamid, A. A. Level of Satisfaction on Service Quality Dimensions Based on SERVQUAL Model Among Patients Attending 1 Malaysia Clinic in Kota Bharu, Malaysia. *Oman Med J,* 33 (5), 2018 sep, 416-422.

Andrade, L.; Salazar, P.; Leopoldino, K.; Montenegro, C. B. Primary health care quality assessment according to the level of satisfaction of elderly users. Avaliação da qualidade da atenção primária à saúde segundo o nível de satisfação dos idosos. *Revista gaucha de enfermagem*, 40, 2019, e20180389. https://doi.org/10.1590/1983-1447.2019.20180389

Monteiro, N.; Amorim, L.; Nogueira, L. M.; Rodrigues, I.; André, S. Avaliação do serviço de coleta para exame colpocitológico pela escala SERVQUAL. *Revista Brasileira de Enfermagem,* 72, 2019, 118-124. https://doi.org/10.1590/0034-7167-2018-0331.

Sharifi, T.; Hosseini, S.; Mohammadpour, S.; Javan-Noughabi, J.; Ebrahimipour, H.; Hooshmand, E. Quality assessment of services provided by health centers in Mashhad, Iran: SERVQUAL versus HEALTHQUAL scales. *BMC Health Services Research,* 21, 2021. https://doi.org/10.1186/s12913-021-06405-4.

Pena, M. M.; Silva, E. M. S.; Tronchin, D. M. R.; Melleiro, M. M. The use of the quality model of Parasuraman, Zeithaml and Berry in health services. *Rev Esc Enferm USP*. 47 (5), 2013, 1227-32.

Minayo, M. *O desafio do conhecimento. Pesquisa qualitativa em saúde.* 12ª ed. São Paulo: Hubitec, 2010.

Rychlak, J.F. An enquiry into the hermeneutic-dialectic method of inquiry. *J Soc Distress Homeless,* 5, 1996, 305–317. https://doi.org/10.1007/BF02091655

Rio Grande do Sul. Fundação de Economia e Estatística. Estimativas Populacionais (Revisão 2020), ano 2018. Porto Alegre, 2018. Available on: < https://dee.rs.gov.br/populacao/>.

Meier, J. G.; Cabral, L. P. A.; Zanesco, C.; Garden, C. R. B.; Fadel, C. B.; Bordin, D. Factors associated with the frequency of medical consultations by older adults: a national study. *Rev Esc Enferm USP,* 27 (54), 2020 mar, 1-8.

Oliveira, P. C.; Silveira, M. R.; Ceccato, M. D. G. B.; Reis, A. M. M.; Pinto, I. V. L.; Reis, E A. Prevalência e Fatores Associados à Polifarmácia em Idosos Atendidos na Atenção Primária à Saúde em Belo Horizonte-MG, Brasil. *Cien Saude Colet,* 26(4), 2021 abr, 1553-1564.

Perillo, R. D.; Poças, K. C.; Bernal, R. T. I.; Duarte, E. C.; Malta, D. C. Factors associated with the evaluation of Primary Health Care from the user's perspective: results of the telephone survey Vigitel, 2015. *Cien Saude Colet*, 26 (3), 2021 mar, 961-974.

Furlanetto, D. L. C.; Lima, A. A.; Pedrosa, C. M.; Paranaguá, T. T. B.; Xavier, M. F.; Silva, A. K. P. D.; Rodrigues, V. B.; Santos, L. M. P. Satisfação do usuário da Atenção Primária no Distrito Federal: a importância do acesso oportuno e da visita domiciliar. *Cien Saude Colet*, 25 (5), 2020 mai, 1851-1863.

Ceccon, R. F.; Soares, K. G.; Vieira, L. J. E. S.; Garcia Júnior, C. A. S.; Matos, C. C. S. A.; Pascoal, M. D. H. A. Primary Health Care in caring for dependent older adults and their caregivers. *Cien Saude Colet*, 26 (1), 2021 jan, 99-108.

Brasil. Ministério da Saúde. *Portaria nº 2.436 de 21 de setembro de 2017.* Diário Oficial da União. Brasília, 2017. Available on: https://www.in.gov.br/materia/-/asset_publisher/Kujrw0TZC2Mb/content/id/19308123/do1-2017-09-22-portaria-n-2-436-de-21-de-setembro-de-2017-19308031

Leite, R. S.; Santos, A. M.; Ribeiro, C. L.; Brito, M. F. Estratégia Saúde da Família versus centro de saúde: modalidades de serviços na percepção do usuário. *Cadernos Saúde Coletiva*, 24 (3), 2016, 323-329.

Tesser, C. D.; Norman, A. H.; Vidal, T. B. Acesso ao cuidado na Atenção Primária à Saúde brasileira: situação, problemas e estratégias de superação. *Saúde em Debate*, 42 (supl. 1), 2018, 361-378

Ferreira, L. S.; Moreira, L. R.; Paludo, S. D. S.; Meucci, R. D. Access to Primary Health Care by older adults from rural areas in Southern Brazil. *Rev Saude Publica,* 54 (149), 2020 dec 16, 1-11.

Camargo, P. N. N.; Tenani, C. F.; Bulgareli, J. V.; Guerra, L. M.; Silva, R. P.; Batista, M. J. Estudo qualitativo da percepção de usuários hipertensos e diabéticos sobre saúde na Atenção Primária. *Rev Ciênc Med*, 30, 2021, 1-11.

Nunes, C. A.; Aquino, R.; Medina, M. G.; Vilasbôas, A. L. Q.; Pinto Júnior, E. P.; Luz, L. A. Visitas domiciliares no Brasil: características da atividade basilar dos Agentes Comunitários de Saúde. *Saúde Debate,* 42 (supl. 2), 2018, 127-144.

Amorim, J. S. C.; Teixeira, L. B.; Ferla, A. A. Satisfação com a organização do cuidado em idosos usuários dos serviços avaliados pelo PMAQ. *Cien Saude Colet*, 25 (9), 2020 set, 3625-3634.

Garcia, L.; Nardelli, G.; Oliveira, A.; Casaburi, L.; Camargo, F.; Santos, A. Satisfaction of octogenarians with Primary Health Care services. *Revista Brasileira de Geriatria e Gerontologia*, 23 (1), 2020, 1-11.

Brasil, C. C. P.;; Silva, R. M. D.; Bezerra, I. C.; Vieira, L. J. E. S.; Figueiredo, M. D. L. F.; Castro, F. R. V. F.; Queiroz, F. F. S. N.; Capelo, M. R. T. F. Community health workers caring for dependent elderly people. *Cien Saude Colet,* 26 (1), 2021 jan, 109-118.

Schenker, M.; Costa, D. H. D. Advances and challenges of health care of the elderly population with chronic diseases in Primary Health Care. *Cien Saude Colet*, 24 (4), 2019 apr, 1369-1380.

Sacco, R. C. C. S.; Assis, M. G.; Magalhães, R. G.; Guimarães, S. M. F.; Escalda, P. M. F. Trajetórias assistenciais de idosos em uma região de saúde do Distrito Federal, Brasil. *Saúde em Debate,* 44 (126), 2020, 829-844.

Queiroz, R. F.; Alvarez, A. M.; Morais, L. J.; Silva, R. A. R. D. Perception of nursing workers on the care of hypertension in older adult. *Rev Bras Enferm*, 72 (supl. 2), 2019 nov, 3-13.

Sacco, R. C. C. S.; Cardoso, P. R. D. R.; Escalda, P. M. F.; Assis, M. G.; Guimarães, S. M. F. Evaluation of micro-level management of older person care in primary health centers in a health region in the Federal District of Brazil. *Cien Saude Colet,* 24 (6), 2019 jun 27, 2173-2183.

Almeida, H. B.; Vanderlei, L. C. M.; Mendes, M. F. M.; Frias, P. G. As relações comunicacionais entre os profissionais de saúde e sua influência na coordenação da atenção. *Cadernos de Saúde Pública,* 37 (2), 2021, 1-13.

Lima Júnior, A. L.; Barreto, I. C. H. C.; Maranhão, R. R.; Nuto, S. A. S.; Benevides, B. S.; Saintrain, M. V. L.; Vieira-Meyer, A. P. G. F. Medical hiring formats in the Family Health Strategy and the performance of their core attributes. *Cien Saude Colet,*26 (5), 2021 may, 1657-1668.

Brasil. Ministério da Saúde. *Acolhimento nas práticas de produção de saúde*, Brasília (DF), 2010.

Ferreira, B. R.; Silva, F. P.; Rocha, F. C. V.; Oliveira, A.; Amorim, F. Elderly Welcoming in Primary Health Care: The User Perspective. Rev Fund Care Online, 10 (3), 2018, 669-674.

Souza, Y. V.; Gomes, R. S.; Sá, B. V. S.; Mattos, R. M. P. R.; Pimentel, D. M. M. Percepção de pacientes sobre sua relação com médicos. *Revista Bioética,* 28 (2), 2020, 332-343.