

Index of Responsiveness of the Urban Family Health Strategy in Urban Areas

Índice de Responsividade da Estratégia Saúde da Família da Zona Urbana

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Keywords

Family health strategy; Health evaluation; Primary health care; Family health; Quality of health care

Descritores

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Abstract

Objective: To evaluate the Family Health Strategy Index of Responsiveness in urban areas of the Federal District.

Methods: This is an exploratory descriptive study. A questionnaire was applied from May 1 to July 31, 2014 approaching 242 users with the following dimensions of responsiveness: a) respect the people: dignity, confidentiality, autonomy, communication; b) orientation to client: facilities, selection of professional, agility in services and social support that were used to calculate the Index of Responsiveness.

Results: The following dimensions have been evaluated as positive: dignity with an index of 0.902 (excellent); confidentiality with 0.838 (very good); communication with 0.833 (very good); social support with 0.814 (very good); and autonomy with an index of 0.746 (good). Facilities and agility were evaluated as regular with indexes of 0.649 and 0.613, respectively. The dimension of selection of professional was evaluated as poor, with an index of 0.169.

Discussion: The best indexes of responsiveness were found in dimensions focused on respect for people, including being treated with dignity, assurance of confidentiality and good communication with professionals. User's autonomy appeared as an attribute to be improved by professionals. The dimensions related to orientation to client performed worst, except for social support. Facilities were considered to be regular, while agility and possibility of selection of professional were unsatisfactory.

Conclusion: The Family Health Strategy (FHS) units should improve the aspect of orientation to client, mainly regarding infrastructure and coordination with the health care network.

Resumo

Objetivo: Avaliar o Índice de Responsividade da Estratégia Saúde da Família das áreas urbanas do Distrito Federal.

Métodos: Estudo descritivo exploratório. Aplicou-se um questionário entre os dias 1 de maio a 31 de julho de 2014 com 242 usuários, que continha as dimensões de responsividade: a) respeito pelas pessoas: dignidade, confidencialidade, autonomia, comunicação; b) orientação para o cliente: instalações, escolha profissional, agilidade no atendimento e apoio social, que foram utilizadas para o cálculo do Índice de Responsividade.

Resultados: Foram avaliados positivamente a dignidade, com o índice de 0,902 (excelente), a confidencialidade, com 0,838 (muito bom), a comunicação, com 0,833 (muito bom), o apoio social, com 0,814 (muito bom) e a autonomia, com o índice de 0,746 (bom). As instalações e agilidade foram avaliadas como regular, com os índices 0,649 e 0,613, respectivamente. A dimensão de escolha do profissional foi avaliada como péssimo com o índice de 0,169.

Discussão: Verificou-se que tiveram os melhores índices de responsividade as dimensões voltadas para o respeito pelas pessoas, que inclui o ser tratado com dignidade, ter a garantia da confidencialidade, e ter boa comunicação com os profissionais. As dimensões atinentes à orientação para o cliente obtiveram os piores índices, exceto o apoio social. Foram consideradas regulares as instalações e insatisfatórias a agilidade e a possibilidade de escolha profissional.

Conclusão: As unidades da ESF devem melhorar no aspecto orientação para o cliente, sobretudo no que se refere à infraestrutura e articulação com a rede de atenção.

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Introduction

Primary Health Care (PHC) was a highlight abroad, opening debates about its expansion to improve the health system performance. In Brazil, the PHC is understood as a strategy to organize the health care system that brings a unique way of appropriating, recombining and reordering all of the system's resources to meet the needs, demands, and representations of the population. This implies placing the PHC as part and coordinator of an Administrative Region.⁽¹⁾ The PHC has expanded through the Family Health Strategy (FHS) thanks to its capacity of minimizing unfairness in the use of services,^(2,3) mainly by expanding access to basic health services.

However, studies show that the consolidation of PHC in large urban centers is a huge challenge, mainly regarding the FHS in cities with more than 100 thousand inhabitants that embrace the sharpest inequalities in relation to possibilities of improving the population's quality of life.⁽³⁾ Thus, health disparities refer to differences in health levels between different socio-economic or regional groups. Some aspects determine these differentiated standards: unequal investment of resources in health; and lack of investment in social policies. Therefore, health inequalities can be worsened by demographic and environmental determinants, and determinants of access to health goods and services and social policies.⁽⁴⁾

In addition, the recent globalization process has changed the dynamic of big cities, bringing about many contradictions and, above all, increasing social inequalities. The heterogeneity of poverty is expanded, among other aspects, by different conditions of access to essential goods and services, including health services. In this context, the HFS faces more difficulties in developing intersectoral actions to effectively reduce unfairness.⁽⁵⁾

The Federal District bears traits similar to those of big metropolises and, in this way, faces many problems related to uncontrolled urbanization processes, increases in population density, and social inequalities that hinder the FHS work.

In the Federal District, the HFS was implemented in 1997, starting with the remotest and poorest regions. The HFS units have been gradually expanded, but mainly characterized by low coverage, which has recently increased to 13.24%. The basic care network is composed of 68 health units, 3 mixed units, 39 urban and rural health units, 39 Family Health teams, 17 oral health teams, and 4 Centers of Support to Family Health.⁽⁶⁾ Another limitation to the effective implementation of basic health care is the coexistence of large numbers of traditional health centers, which hampers moving away from the hegemonic medical model toward the sanitary model.

Moreover, in the Federal District the access to basic health services is very troublesome because of the characteristics of care and the organization and geographic barriers that contribute to making hospital emergency services the main entry door for users. As such, access is considered to be one of the essential attributes to achieving quality in health services, as well as accessibility, which is the core element to providing care at the first contact, because it enables people to have access to services.⁽⁷⁾ This aspect should be improved in the Federal District.

Most recently, some FHS units in the Federal District have adhered to the National Program on Improvement of Basic Care Access and Quality (PMAQ AB) in order to strengthen the process of changing care, placing the PHC as care coordinator. It is another effort to improve the PHC, specifically in the FHS; however, it has yet to be evaluated, mainly in the light of users that are directly affected by the results of services.⁽⁸⁾

Responsiveness should be evaluated regarding to which extent the health system meets the legitimate expectations of users in relation to non-medical aspects of care, that is, elements that are not directly related to health status. Moreover, the study proposes to identify how users were served rather than how they feel about the service, involving the ethical dimension of care. These aspects are under-evaluated because greater emphasis has been attached to studies on users' satisfaction.⁽⁹⁾

It is worth mentioning that users are rarely asked to evaluate the services they use, because it is understood as a task exclusive to managers. In this way, the need for in-depth studies on their expectations in relation to care received in health services is justified.

Therefore, the objective of this study was to evaluate, in the users' light, the responsiveness of the Family Health Strategy participating in the PMAQ located in urban areas of the Brazilian Federal District.

Methods

It is a quantitative, cross-sectional, descriptive, and exploratory study that describes the facts of reality to increase familiarity with the problem. It was performed in the Federal District, capital of Brazil, which has 31 Administrative Regions (ARs) and 15 Regional Health Directorates (RHD). The population calculated by the 2010 IBGE census was 2,570,160 inhabitants. Population is relatively young because of the migration in recent past. According to IBGE's estimates for 2030, the Federal District and the Metropolitan Vicinities of Brasilia (MVB) will house five million inhabitants.

To define the sample size, the study considered the total number of users of the FHS Units in the Federal District that have adhered to the National Program on Improvement of Access to and Quality of Basic Health Care (PMAQ-AB), which was 55,681 considering urban and rural health units. The sample error was 5% and the confidence level was 95%, resulting in a sample of 382 users in urban and rural areas.

As the proportional inclusion of users of each health unit is considered to be important, the study made a simple stratified sample in 16 health units at the urban area distributed in the following Administrative Regions: one health unit in Ceilandia (13 users); one health unit in Estrutural (16 users); eight health units in Gama (128 users); one health unit in Itapuã (6 users); one health unit in Paranoá (17 users); one health unit in Recanto das Emas (16 users); one health unit in Samambaia (10 users);

one health unit in Sobradinho II (17 users); and, one health unit in Taguatinga (17 users). In the urban area the sample totaled 242 users, excluding the sample of a health unit that was deactivated and of layers that referred to the same unit.

As the proportional inclusion of users of each Administrative Region is considered to be important, the study made a simple stratified sample, as shown in table 1.

Table 1. Distribution of users' sample by Administrative Region, according to users registered at the basic health care units

Administrative Region	Number of users
Ceilândia	13
Estrutural	16
Gama	128
Itapuã	6
Paranoá	17
Recanto das Emas	16
Samambaia	10
Sobradinho II	19
Taguatinga	17
Total	242

The following were the inclusion criteria: users aged 19 years or more and using the service regularly for more than three months. It excluded users that did not use the service regularly and those with physical and mental impairments to answer the questionnaire. The most important aspect related to the use of service was the user's attachment to the family health team. In this way, the target audience was composed of users who had been served by the team at least once.

Data were collected from May to July 2014 on different days and shifts (morning/afternoon). Users were approached in the waiting room for a medical visit, to get medicines, to schedule a medical visit, and to undergo exams. The questionnaire application took 15 minutes on average.

It employed the methodology developed and validated by Andrade, Vaitsman, and Farias (2010), applied on high-complexity unit, but did not exclude the adaptation and use of the Index of Service Responsiveness (ISR) in other kinds of health care services.⁽⁹⁾ The ISR is structured to evaluate two dimensions: 1) respect for people comprising ethical aspects involved in the interaction between

people and the health system, namely dignity, confidentiality, autonomy and communication; and 2) orientation to client, which included components that influence the patient's satisfaction, but are not directly related to health care, namely agility, social support, facilities and selection of professional. Following are the content pertinent to the dimensions evaluated.⁽⁹⁾

Altogether, 28 closed Likert-type questions (always, almost always, rarely, and never) and dichotomous questions (yes and no) were asked. The first part of the questionnaire asked questions about the user's profile characterization, while the second one approached the service responsiveness. To build the index, different weights were assigned to the responses: for Likert-type questions, 10 to always, 7 to almost always, 3 to rarely, and 0 to never. For dichotomous questions the answer "no" weighed 10, while "yes" weighed 0. Then, the weights of answers were multiplied by the frequency of selection of each question. By the end, the results of multiplications were summed and then divided by 1,000. The value achieved was named the "question score," where 1 was the maximum value related to the service dimension. The scale for building the index question scores was as follows: excellent (0.901 and 1); very good (0.801 to 0.900); good (0.701 to 0.800); regular (0.601 to 0.700); poor (0.401 to 0.600); very poor (0.201 to 0.400); and horrible (0.000 to 0.200). The Stata SE software, version 4.0, was used to analyze data. The study development complied with the national and international rules of ethics in research involving human beings, and was approved by the SES/DF Research Ethics Committee, report 569/2011.

Results

Most of the research participants were women (77%) of age ranging from 19 to 59 years (81%) and an average age of 44 years. Most frequent education levels were complete secondary education (34%) and incomplete fundamental education (22%). The prevailing occupation was waged formal worker (29%) followed by non-remunerated

family worker-"housewife" (25%). Monthly family income was one minimum wage (45%) and two to four minimum wages (42%). The time length that users attend the health unit was longer than 10 years (41%).

The dimensions related to respect for people (dignity, confidentiality, autonomy, and communication) scored better (0.850) when compared with the dimensions of orientation to client (0.608) (agility, social support, selection of professional, and facilities), as shown in table 2.

In the dimension of respect for people (Table 2), dignity was considered excellent (0.902). This referred to the respectful and thoughtful treatment received at the FHS units, free of harassment or mistreatment. In addition, it concerned being treated with privacy and the right to safeguard information about their diseases. In this sense, it is worth mentioning that confidentiality was evaluated as very good (0.838). This involved confidentiality of the information provided by patients, and keeping medical files as confidential (except if the information was required by other health professionals).

The study also found that the communication dimension was evaluated as very good (0.833) (Table 2). This referred to the careful way that health professionals should listen to patients. Moreover, health professionals should explain in a way understandable to users, with time enough to clarify all of their doubts.

Respect to autonomy was evaluated as good (0.749) (Table 2), involving dialogue between the professional and the user about the options and alternatives of therapy. Moreover, health professionals were advised to get the patients' consent before starting any therapy or test.

Social support was the only dimension of orientation to client with a positive value, evaluated as very good (0.814) (Table 2). This was about allowing the participation of relatives, friends, and important community members in the care delivered. Services should also include other relevant social resources existing in the community that might contribute to increase health care quality.

Facilities were evaluated as regular (0.649) (Table 2). This referred to the unit's organization and

Table 2. Index of Service Responsiveness according to dimensions

Dimension	Urban (95% CI)
Respect for people	0.850(0.843-0.858)
Dignity	0.902(0.893-0.911)
Confidentiality	0.838(0.792-0.885)
Autonomy	0.749(0.729-0.768)
Communication	0.833(0.820-0.846)
Orientation to client	0.608(0.595-0.621)
Agility	0.613(0.585-0.641)
Social Support	0.814(0.775-0.854)
Selection of professional	0.169(0.131-0.208)
Facilities	0.649(0.636-0.661)
Responsiveness	0.788(0.781-0.795)

hygiene. Finally, the possibility of selecting the professional was considered to be horrible (0.169) (Table 2). This concerned the possibility of selecting the professional that will delivery care to the patient.

Analysis of results by administrative regions showed that the Taguatinga received better ISR values, while Itapoá and Estrutural were among the ARs with the lowest indexes (Table 3). With regard to the index difference, the dimensions with sharper variations were social support (from 0.550-poor, to 0.907-excellent); confidentiality (from 0.666-poor, to 1-excellent), autonomy (from 0.552-poor, to 0.816-good); and selection of professional (from 0-horrible, to 0.264- very poor).

Discussion

The results of this study showed that dimensions related to respect for people, which included being treated with dignity, have confidentiality ensured, and good communication with professionals, except for providing autonomy, were better evaluated by the FHS users than the dimensions related to orientation to client: that is, agility and selection of professional, and facilities, except for social support. Data suggest that the FHS units' teams have improved ethical and humanistic competences to relate with users. However, the service infrastructure should be improved: ambience should be cozier, count on more professionals to ensure agility to services and enable the selection of professional. In addition, the FHS units should better coordinate with other care network services.

A study carried out in Nigeria about the National Health Service's responsiveness showed that users considered the dimensions of increased communication, dignity, and quality of facilities as the most important ones. However, the domains of autonomy, communication, and prompt care were identified as priority areas of action to improve the system's capacity of response.⁽¹⁰⁾

Regarding the users' profiles, it was found that health services, notably the FHS, were more sought

Table 3. Index of Service Responsiveness (ISR) according to dimensions and administrative regions

Administrative regions	Respect for people				Orientation to client				Total
	Dignity	Confidentiality	Autonomy	Communication	Agility	Social Support	Selection of professional	Facilities	
Estrutural	0.861 (0.821-0.901)	0.812 (0.597-1)	0.666 (0.580-0.752)	0.785 (0.726-0.845)	0.568 (0.464-0.673)	0.650 (0.437-0.862)	0.081 (0-0.184)	0.568 (0.529-0.608)	0.721 (0.693-0.748)
Itapoá	0.854 (0.782-0.926)	0.666 (0.124-1)	0.552 (0.388-0.717)	0.735 (0.619-0.851)	0.554 (0.368-0.740)	0.550 (0.020-1)	0 (0-0.351)	0.721 (0.653-0.789)	0.709 (0.659-0.758)
Paranoá	0.892 (0.856-0.927)	0.823 (0.621-1)	0.589 (0.506-0.671)	0.711 (0.646-0.775)	0.632 (0.530-0.734)	0.788 (0.626-0.949)	0.217 (0.043-0.392)	0.693 (0.642-0.744)	0.741 (0.714-0.769)
Sobradinho	0.901 (0.867-0.935)	0.894 (0.742-1)	0.762 (0.694-0.829)	0.901 (0.864-0.939)	0.632 (0.533-0.732)	0.742 (0.545-0.939)	0.105 (0-0.257)	0.583 (0.523-0.642)	0.794 (0.769-0.818)
Samambaia	0.909 (0.863-0.954)	0.800 (0.498-1)	0.585 (0.469-0.700)	0.741 (0.665-0.817)	0.520 (0.373-0.666)	0.600 (0.302-0.897)	0.140 (0-0.351)	0.613 (0.547-0.680)	0.722 (0.685-0.759)
Gama	0.912 (0.900-0.924)	0.835 (0.770-0.900)	0.790 (0.765-0.814)	0.850 (0.833-0.867)	0.627 (0.589-0.664)	0.867 (0.822-0.912)	0.238 (0.178-0.297)	0.651 (0.632-0.669)	0.806 (0.798-0.815)
Ceilândia	0.910 (0.873-0.948)	1	0.805 (0.728-0.881)	0.855 (0.802-0.909)	0.657 (0.511-0.802)	0.907 (0.820-0.994)	0.046 (0-0.114)	0.687 (0.670-0.704)	0.820 (0.794-0.847)
Taguatinga	0.907 (0.874-0.939)	0.823 (0.621-1)	0.816 (0.757-0.875)	0.888 (0.851-0.925)	0.673 (0.529-0.817)	0.829 (0.705-0.953)	0.035 (0-0.086)	0.688 (0.651-0.725)	0.821 (0.798-0.844)
Recanto das Emas	0.877 (0.840-0.913)	0.812 (0.597-1)	0.715 (0.644-0.786)	0.815 (0.763-0.867)	0.520 (0.400-0.639)	0.818 (0.637-1)	0.062 (0-0.195)	0.684 (0.643-0.725)	0.771 (0.745-0.796)

Confidence Interval: 95%

after by women, showing their concern about taking care of their health. Other reasons for increased adherence to and use of health services by women can be explained by the physiology and life cycles of women, which demand regular care. In addition, the PHC services and activities have been historically driven to the maternal infantile group and, in this way, it systematically attempts to meet the needs of women and children.⁽¹¹⁾

The FHS was more used by the population with lower socio-economic level, as evidenced by the 87% of users with monthly family income of up to four minimum wages, and by the higher percentage of individuals with incomplete elementary education. Studies show that individuals with more favorable socio-economic conditions make more and better use of health services. The FHS has changed this scenario by reducing inequalities in the process of health services use, that is., favoring the disadvantage people's access to health services, strengthening fairness.⁽¹²⁾

Regarding dimensions related to respect for people, the dignity-based treatment of users was a highlight. Similar result was found by studies performed in Africa. Understanding, respect, kindness, non-discrimination and clearness are core aspects to services quality.⁽¹⁰⁾

The FHS professionals' capacity to ensure confidentiality was positively assessed. Confidentiality refers to respect to privacy, and is a basic moral precept of health-related professions, implying the duty of safekeeping and preserving third parties' data/information. It is a crucial aspect in the professional-user relation that fosters questioning about therapy and the disease.⁽¹⁰⁾

Communication between professionals and users has also been satisfactorily evaluated in this study. Communication should break the barrier of information asymmetry, building new possibilities of understanding and solving the problems perceived. Many times, the lay knowledge of users is downgraded; however, health professionals should be capable of establishing inter-subjectivity relations to co-build health care, getting closer to the world of patients' lives.⁽⁷⁾

However, this study noticed that FHS professionals have difficulties to respect the user's autonomy, Autonomy refers to the capacity of agreeing

or refusing in a free, voluntary, and informed way, that is., with proper information about procedures for diagnoses or therapies to be performed. It also incorporates the concept of empowerment, where users are not only entitled to information, but also to make informed decisions. In other words, professionals should engage the patient and family members in the decision-making processes. In this way, the autonomy described herein involves participatory relations that contribute to the development of critical and demanding capacity among the social actors concerned.^(10,13)

Autonomy also depends on conditions external to the subject, even when s/he participates in the creation of such circumstances. Autonomy in the health field could be understood as self-care, defined as representations and practices used by populations to prevent, diagnose, explain, and heal processes that affect health without the direct intervention of professionals, although these last are the reference to self-care activities. It stands for the recognition of habits, conditions, and customs of patients that influence the decision of self-prescription and of the form of autonomy to undergo the therapy.⁽¹⁴⁾

In fact, the FHS team should incorporate supported self-care into their practices. Here, supported self-care is defined as systematic delivery of educational care and supporting interventions to increase the confidence and skills of health care systems users to manage their problems. This involves monitoring health conditions, defining a care plan with goals to be achieved, in addition to the support to solve these problems. In this logic, supported self-care is grounded on the following aspects: information and education about self-care; elaboration and monitoring of a self-care schedule; and material support for self-care. The purpose of supported self-care is to generate knowledge and skills, so that patients with chronic conditions become acquainted with their health condition so that they can decide and select their therapies, and also adopt, change, and maintain behaviors favorable to their health.⁽¹⁾

In this study the dimension oriented to client was the worst evaluated. Facilities got regular indexes, showing that investments scheduled to infra-

structure and ambience in the PHC are not enough to keep the physical environment where care is provided with clean facilities, proper furniture, sufficient ventilation, clean water, among other requirements, to welcome users in a satisfactory way. These data show that the Federal District Health Secretariat has not properly used the provisions of Decree GM no. 341 of March 4, 2013 about funding to refurbish basic health units.⁽¹⁵⁾

Agility was also unsatisfactorily evaluated in this study. There are long first-come, first-served queues in units. Another factor that drastically contributed to this result was the long waiting time for medical visits and therapies, mainly when specialized services are required. It is a weak point in the care network and represents a huge challenge to make Basic Care the entry door to health services and to ensure comprehensive care. That is so because Basic Care is not capable of taking on the role of coordinating care and, therefore, users have sought urgency and emergency services in public hospitals as the first contact and regular source of care. A regulatory system with well-defined reference and counter-reference mechanisms should be established.⁽¹¹⁾

The low value of the ISR for selection of professional is worth of notice. That is so because each family health team is responsible for no more than 4,000 individuals in the territory. In this way, users are served only by professionals belonging to the team corresponding to their area of residence. The multi-professional team is composed of at least a physician, nurse, nursing assistant or technician, and community health agent. As such, users are not entitled to select the professional and are limited to the accompaniment by that team in basic care. Eventually, users are served by professionals from different fields of knowledge in the Center of Support to Family Health that work in an integrated way, supporting the professionals of the family health teams.

The possibility of selecting professionals, although not yet an option in the Brazilian PHC, is an important dimension that increases the system's capacity of response, because it allows a closer relationship between professionals and users when delivering health care. This study found differences in the ISR for each Administrative Region, evidencing the importance of

analyzing the situation of each location. Moreover, these results suggest the need for investment in the FHS teams' working processes to keep competences related to dimensions focused on respect for people, and of enhancing the health care network to improve local health system conditions, which affect the dimensions oriented to clients, mainly agility in services and possibility of selecting the professional.⁽¹⁶⁻¹⁸⁾

Thus the PHC in the Federal District should progress in the light of the PHC's social building. Because the structure of supply is very limited, as suggested by the results of this study, it probably responds only partially to the demands resulting from acute conditions and worsened chronic conditions and to the demands for preventive care, administrative demands and, sometimes, demand for home care. Typically, the model based on restricted supply is not capable of responding to the demands by non-worsened chronic conditions that have considerably increased in the latest years due to general and unspecific problems and diseases, and demands for supported self-care.⁽¹⁾

In addition, the FHS should advance in the light of cooperation between sectors, because the solution to complex health problems in the urban population requires approaches that go beyond the traditional model of developing policies. The systemic approaches of urban management that foster the capacity of generating co-benefits are useful mainly to improve the population's health.^(16,17)

A limitation of the study is the potential bias of prevalence typical to cross-sectoral studies. Another potential limitation is the gratitude bias that could have been omitted in this evaluation, mainly because it approaches public services. The gratitude bias can come about because of the affinity built between users and professionals. Another bias is that of acquiescence that reflects the influence of the order of scales, and concerns the user's tendency to agreeing on the first item of the scale, regardless of its content.⁽⁹⁾

Conclusion

The best indexes of responsiveness in the urban Family Health Strategy in the Federal District

were found in dimensions focused on respect for people, including being treated with dignity, assurance of confidentiality, and good communication with professionals. User's autonomy appeared as an attribute to be improved by professionals. The dimensions related to orientation to clients performed worst, except for social support. Facilities were considered to be regular, while agility and possibility of selection of professional were unsatisfactory. In this way, heavier investments in the FHS are required, as well as better coordination with the care network of the Urban PHC system to provide timely access for users.

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Collaborations

Shimizu HE states to have contributed to the study conception, analysis, data interpretation, article elaboration, relevant critical review of the intellectual content and final approval of the version to be published. Dutra EB, Trindade JS, Mesquita MS, and Ramos MC state to have contributed with the elaboration of the article and critical review and final approval of the version to be published.

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