Revista Brasileira de Enfermagem
REBEn

THEMATIC ISSUE:
GOOD PRACTICES IN THE CARE PROCESS
AS THE CENTRALITY OF THE NURSING

RESEARCH

Quality of Primary Health Care in Brazil: patients' view

Qualidade do cuidado na Atenção Básica no Brasil: a visão dos usuários

Calidad del cuidado en la Atención Básica en Brasil: la visión de los usuarios

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How to cite this article:
Figueiredo DCMM, Shimizu HE, Ramalho WM, Figueiredo AM, Lucena KDT. Quality of Primary Health Care in Brazil: patients' view. Rev Bras Enferm [Internet]. 2018;71(Suppl 6):2713-9. [Thematic Issue: Good practices in the care process as the centrality of the Nursing] DOI: http://dx.doi.org/10.1590/0034-7167-2017-0656

Submission: 09-27-2017 **Approval:** 05-25-2018

ABSTRACT

Objective: To describe the evaluation of patients that participated in the National Program for Improving the Access and Quality in Primary Health Care (*Programa Nacional de Melhoria do Acesso e da Qualidade na Atenção Básica*) for the comprehensive healthcare, the bond and the coordination of care in the country's macro-regions. **Method:** A descriptive, transversal study, from interviews with 65,391 patients of Primary Health Care, in 3,944 municipalities regarding the use of health services. **Results:** The professionals seek to solve the patients' problems in their unit (73.1%) but focused mainly on the scope of the appointment (65.6%) and offering care away from the population's reality (69.4%). Difficulties in the rescue of clinical history were referred (50.3%) and in the care performed in other health services (29.2%). **Conclusion:** The comprehensive health care, the bond and the coordination of care remain challenges to the Primary Health Care in the country, requiring reflections on the implementation of national policies, especially considering the regional diversities in Brazil.

Descriptors: Primary Health Care; Health Care Quality; Access, and Evaluation; Health Policy; Public Health; Health Services Research.

RESUMO

Objetivo: Descrever a avaliação dos usuários que participaram do Programa Nacional de Melhoria do Acesso e da Qualidade na Atenção Básica quanto à atenção integral, ao vínculo e à coordenação do cuidado nas macrorregiões do país. **Método:** Estudo descritivo, transversal, a partir de entrevista com 65.391 usuários da Atenção Básica, em 3.944 municípios, referente à utilização dos serviços de saúde. **Resultados:** Os profissionais buscam resolver os problemas dos usuários na própria unidade (73,1%), mas com atenção voltada principalmente para o escopo da consulta (65,6%) e oferta de cuidado distante da realidade da população (69,4%). Foram referidas dificuldades no resgate da história clínica (50,3%) e no cuidado realizado em outros serviços de saúde (29,2%). **Conclusão:** A atenção integral, o vínculo e a coordenação do cuidado são ainda desafios para a Atenção Básica no país, exigindo reflexões sobre a implantação de políticas nacionais, sobretudo considerando as diversidades regionais do Brasil.

Descritores: Atenção Primária à Saúde; Avaliação em Saúde; Política de Saúde; Saúde Pública; Serviços de Saúde.

RESUMEN

Objetivo: Describir la evaluación de los usuarios que participaron del *Programa Nacional de Melhoria do Acesso e da Qualidade na Atenção* Básica en cuanto a la atención integral, al vínculo y a la coordinación del cuidado en las macro regiones del país. **Método:** Estudio descriptivo, transversal, a partir de entrevistas con 65.391 usuarios de la Atención Básica, en 3.944 municipios, referente a la utilización de los servicios de salud. **Resultados:** Los profesionales buscan resolver los problemas de los usuarios en la propia unidad (73,1%), pero con atención orientada principalmente al alcance de la consulta (65,6%) y a la oferta de cuidado distante de la realidad de la población (69,4%). Se observaron dificultades en el rescate de la historia clínica (50,3%) y en el cuidado realizado en otros servicios de salud (29,2%). **Conclusión:** La atención integral, el vínculo y la

coordinación del cuidado son aún desafíos para la Atención Básica en el país, exigiendo reflexiones sobre la implantación de políticas nacionales, sobre todo considerando las diversidades regionales de Brasil.
Descriptores: Atención Primaria de Salud; Evaluación en Salud; Política de Salud; Salud Pública; Investigación en Servicios de Salud.

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INTRODUCTION

The health systems oriented by Primary Health Care (PHC) result in better care quality and more efficiency in therapeutic care projects at lower costs. In addition, such systems produce more opportunities for the population to have access to appropriate care and greater satisfaction with the care received[1-5]. There was also reduction in the potential years of life lost and better health results to the poorest populations, resulted from the early management of health problems and the qualification of referrals to secondary health care or other levels of care[2,5].

In Brazil, the PHC is now designated as Basic Health Care (AB – *Atenção Básica*), in order to highlight the assistance reorientation model based on a universal health system. From the implementation of the Family Health Strategy (ESF – *Estratégia Saúde da Família*), the AB is expanded, with increase in the number of family health teams from 3,062 in 1998 to 26,364 in 2006, and with reduction of the inhabitant/health team ratio from 52,838 to 7,084 in the same period. In 2013, the ESF covered 56.37% of the Brazilian population, with a total of 34,715 teams implanted[6].

With that, studies indicate improvement in some health indicators, such as the reduction in infant mortality (from 53.7 deaths/thousand newborns in 1990 to 13.82 in 2015, according to the United Nations regarding the millennium development goals) and in the rates of Hospitalizations for Primary Care-Sensitive conditions (ICSAP – *Internações por Condições Sensíveis à Atenção Primária*) by 17%[7-8], since the PHC expansion seeks to increase the access of the population to appropriate preventive care and to more efficient and applicable therapeutic projects.

To this end, the PHC must ensure its main attributes: the access to first contact, which addresses the service accessibility and use at each new problem or episode of a same health problem; the coordination of care, which involves the integration between the levels of the health system and the follow-up or continuity of care[9]; the integrality, which refers to the complete offer of services[10]; and the longitudinality, which implies the existence of a regular source of care, maintained over time.

In the last decades, several PHC methods of assessment were developed in Brazil and worldwide, indicating the potential of evaluation strategies as service qualification devices. In order to induce changes in improving the AB access and quality, the Ministry of Health established the National Program for the Improvement of Access and Quality of Basic Health Care (PMAQ-AB – *Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica*)[2,12], aligned to the objectives and challenges of the National Policy of Basic Helath Care (PNAB – *Política Nacional de Atenção* Básica).

The PMAQ-AB is an instrument of evaluation with national scope which analyzed several fundamental aspects to the AB, especially those related to the quality of care and to the patients' participation. The patients' evaluation of the quality of care is considered one of the richest legacies of the program[13]. In this sense, the PMAQ-AB data can show many aspects of the offer of care, especially the way the services/professionals have been connecting with the patients.

This study addresses the primary data of an important sample of the AB patient population in Brazil and may offer subsidies for policy analysis and help the Nursing area to reflect on the way it has been structured to provide care.

OBJECTIVE

To describe the evaluation of patients that participated in the PMAQ-AB in 2012 regarding the comprehensive care, bonds and coordination of care, according to the country's macro-regions.

METHOD

Ethical aspects

This study used secondary data from public domain available from the Ministry of Health website, which does not identify the participants; therefore, the approval of the Ethics Committee was not compulsory.

Study design, location, and period

This study is quantitative, transversal, descriptive, with secondary data from the PMAQ-AB external evaluation stage performed in 2012. A total of 65,391 patients participated, linked to the AB teams, in 70% (n = 3,944) of the Brazilian municipalities.

The study included teams linked to the ESF and traditional AB teams, with the largest participation of ESF teams: 16,643 teams (1,022 in the North Region, 5,346 in the Northeast, 1,060 in the Central-West, 6,355 in the Southeast and 2,860 in the South). The regional distribution of participating patients was: 3,728 in the North Region, 21,556, in the Northeast, 4,337 in the Central-West, 25,406 in the Southeast, and 10,364 int the South.

For this study the variables from module III were selected regarding the interview with patients of the Basic Health Unit (UBS – *Unidade Básica de Saúde*) concerning their experience in using health services. Module III includes variables divided in blocks that go from the patient's identification to questions specific to the life cycles and general questions regarding care, assistance, ambience and satisfaction.

For this study, four variables were selected regarding the socio-demographic and economic characterization of the studied population: gender, age, race/color and income.

In addition, variables were defined and selected regarding the analysis of comprehensive care[14], bond[11,15] and coordination of care[1]:

- *comprehensive care*: ability of the team to try to solve their needs/problems in the health unit; team's approach of other needs apart from the ones that motivated the search for treatment; and team providing solutions of care adequate to reality;
- *bond*: treatment conducted by the same doctor; treatment performed by the same nurse; memory of previous appointments; and ease in talking to health professionals that assisted the patient about doubts, after the appointments;
- *coordination of care*: follow-up of the patient to the AB appointment after assistance in other services and timely access to the tests results that arrive at the UBS.

For the data analysis of this study, the answers "always", "usually", "hardly ever" and "never" were added.

Population, inclusion and exclusion criteria

The study included the universe of patients in the PMAQ-AB database, through convenience sample. The data were collected in all regions of Brazil. Inclusion criteria were: patients of AB services in Brazil, older than 18 years old, who had not gone through appointment or treatment before the interview, who were previously treated in the UBS by the team (the questionnaire was not applied if that was the first moment with the team) and who were treated in the unit at least once in the past twelve months.

Analysis of results and statistics

For analysis of the results, proportional comparisons of the responses of the questionnaire variables were performed, with the five Brazilian regions as a cut-off. The data were stored and organized in a spreadsheet in Microsoft Office Excel 2010 for Windows®. To calculate the confidence intervals of the proportions, a 0.05 significance was used.

RESULTS

The studied population is predominantly female (n = 50,791; 77.7%), with an average age of 49.3 years. Regarding race/color, there was a higher percentage of brown-mixed (n = 29,311; 45.2%). The average household income of the interviewees was 1.93 minimum wage in 2012 (R$ 1,163.1), as shown in Table 1.

The variables that address the comprehensive care, presented in Table 2, show that for the studied population the AB team tries to solve their needs/problems in the health unit itself, a result that appeared similarly in all regions.

Table 1 – Distribution of demographic (gender, age, race/color) and economic (income) characteristics of the studied population, Brazil, 2012

Variable	Brazil n (%)	95%CI
Gender*		
Male	14,600 (22.3)	22 – 22.6
Female	50,791 (77.7)	77.4 – 78
Age (average in years)*	49,3	49.1 – 49.5
Family monthly income (R$)*	1,163.1	1159.4 – 1166.7
Race/color**		
White	25,164 (38.8)	38.5 – 39.2
Black	7,966 (12.3)	12 – 12.5
Yellow	1,735 (2.7)	2.6 – 2.8
Brown/mixed	29,311 (45.2)	44.9 – 45.6
Indigenous	616 (1)	0.9 – 1

*Note: the results express the frequency and percentage of participants. CI95%: 95% confidence interval; * number of interviewed patients = 65,391; ** patients who did not know/did not answer = 599. Patients who answered regarding race/color = 64,792.*

Table 2 – Distribution of responses from Basic Health care patients who participated in the PMAQ-AB regarding the variables related to the Comprehensive Care, Brazil and regions, 2012

Variable	North n (%) [95%CI]	Northeast n (%) [95%CI]	Southeast n (%) [95%CI]	South n (%) [95%CI]	Central-West n (%) [95%CI]	Brazil n (%) [95%CI]
When you are treated in this health unit, do you think that the team tries to solve your needs/problems in the health unit itself?*						
Yes	2,556 (69.3) [67.8 – 70.8]	15,077 (70.5) [69.9 – 71.1]	18,783 (74.5) [74 – 75.1]	7,914 (77) [76.2 – 77.9]	3,061 (71.2) [69.8 – 72.5]	47,391 (73.1) [72.7 – 73.4]
Yes, sometimes	786 (21.3) [20 – 22.6]	4,947 (23.1) [22.6 – 23.7]	4,714 (18.7) [18.2 – 19.2]	1,945 (18.9) [18.2 – 19.7]	908 (21.1) [19.9 – 22.3]	13,300 (20.5) [20.2 – 20.8]
Never	346 (9.4) [8.4 – 10.3]	1,371 (6.4) [6.1 – 6.7]	1,702 (6.8) [6.4 – 7.1]	414 (4) [3.6 – 4.4]	333 (7.7) [6.9 – 8.5]	4,166 (6.4) [6.2 – 6.6]
Do the health professionals ask questions about other health needs that you have or may have beyond those related to the reason for your appointment?**						
Always/Usually	2,103 (57.6) [56.0 – 59.2]	13,459 (63.4) [62.7 – 64.0]	17,620 (70.3) [69.8 – 70.9]	6,458 (63.3) [62.4 – 64.2]	2,615 (61.6) [60.1 – 63.1]	42,255 (65.6) [65.3 – 66.0]
Hardly ever/ Never	1,546 (42.4) [40.8 – 44.0]	7,770 (36.6) [36.0 – 37.3]	7,433 (29.7) [29.1 – 30.2]	3,744 (36.7) [35.8 – 37.6]	1,630 (38.4) [36.9 – 39.9]	22,123 (34.4) [34.0 – 34.7]

To be continued

Table 2 (concluded)

Variable	North n (%) [95%CI]	Northeast n (%) [95%CI]	Southeast n (%) [95%CI]	South n (%) [95%CI]	Central-West n (%) [95%CI]	Brazil n (%) [95%CI]
In your opinion, during the appointments, do the professionals of this team suggest solutions that are adequate to your reality?***						
Always/Usually	2,119 (60.1) [58.5 – 61.8]	13,892 (66.6) [66.0 – 67.3]	17,778 (72.4) [71.8 – 72.9]	7,328 (73.1) [72.2 – 74.0]	2,691 (64.0) [62.5 – 65.4]	43,808 (69.4) [69.0 – 69.7]
Hardly ever/ Never	1,404 (39.9) [38.2 – 41.5]	6,957 (33.4) [32.7 – 34.0]	6,785 (27.6) [27.1 – 28.2]	2,694 (26.9) [26.0 – 27.8]	1,516 (36.0) [34.6 – 37.5]	19,356 (30.6) [30.3 – 31.0]

*Note: the results express the frequency and the percentage of the participants; 95%CI: 95% confidence interval; *N = 64,857 (99.2% of the interviewed patients); **N = 64,378 (98.5% of the interviewed patients); ***N = 63,164 (96.6% of the interviewed patients).*

Regional differences were observed, regarding the variables that address the other health needs beyond the reason of the appointment and the offer of solutions appropriate to the patients' reality. The Southeast (70.3%) and North (57.3%) Brazilian regions showed extremes in the frequencies for these variables. As for the suggestions of solutions that are adequate to the reality, the South (73.1%) and North (60.1%) regions are notable.

As shown in Table 3, the studied population stated they were always or almost always treated by the same nurse and doctor, although regional differences were observed. However, we noted a significant percentage of patients who claim that the health professional does not remember what happened in the last appointments, especially the interviewees from the North region (41.5%). There is difficulty to access the health team to ask questions after the appointments, also with important regional differences, mainly when comparing the Southeast (48%) and North (38%) regions.

Finally, the variables in Table 4 showed the patients' responses regarding their follow-up after referral to other health services and concerning the access to the results of tests that arrive at the UBS.

Table 3 – Distribution of responses of AB patients who participated in the PMAQ-AB regarding the variables related to bonds, Brazil and regions, 2012

Variable	North n (%) [95%CI]	Northeast n (%) [95%CI]	Southeast n (%) [95%CI]	South n (%) [95%CI]	Central-West n (%) [95%CI]	Brazil n (%) [95%CI]
In this unit, are you treated by the same doctor?*						
Always/Usually	2,707 (73.0) [71.6 – 74.4]	17,656 (83.6) [83.1 – 84.1]	21,373 (84.7) [84.3 – 85.2]	8,387 (81.4) [80.6 – 82.1]	3,635 (84.5) [83.4 – 85.5.]	53,758 (83.1) [82.9 – 83.4]
Hardly ever/Never	1,000 (27.0) [25.6- 28.4]	3,460 (16.4) [15.9 – 16.9]	3,855 (15.3) [14.8 – 15.7]	1,917 (18.6) [17.9 – 19.4]	668 (15.5) [14.5 – 16.6]	10,900 (16.9) [16.6 – 17.1]
In this unit, are you assisted by the same nurse?**						
Always/Usually	2,765 (76.2) [74.8 – 77.6]	17,640 (87.8) [87.3 – 88.3]	18,450 (77.2) [76.6 – 77.7]	7,047 (71.4) [70.5 – 72.3]	3,327 (82.4) [81.2 – 83.5]	49,229 (80.0) [79.7 – 80.3]
Hardly ever/Never	862 (23.8) [22.4 – 25.2]	2,449 (12.2) [11.7 – 12.7]	5,455 (22.8) [22.3 – 23.4]	2,826 (28.6) [27.7 -29.5]	711 (17.6) [16.5 – 18.8]	12,303 (20.0) [19.7 – 20.3]
Do the professionals remember what happened in your last appointments?						
Yes	1,600 (44.2) [42.6 – 45.8]	9,781 (47.5) [46.8 – 48.2]	13,200 (54.3) [53.7 – 54.9]	4,949 (50.2) [49.2 – 51.2]	1,918 (46.4) [44.9 – 47.9]	31,448 (50.3) [49.9 – 50.7]
Yes, sometimes	518 (14.3) [13.2 – 15.5]	3,535 (17.2) [16.7 – 17.7]	3,869 (15.9) [15.5 – 16.4]	1,836 (18.6) [17.9 – 19.4]	596 (14.4) [13.3 – 15.5]	10,354 (16.6) [16.3 – 16.9]
No	1,501 (41.5) [39.9 – 43.1]	7,270 (35.3) [34.7 – 36]	7,230 (29.8) [29.2 – 30.3]	3,073 (31.2) [30.3 – 32.1]	1,622 (39.2) [37.7 – 40.7]	20,696 (33.1) [32.7 – 33.5]
When you need to ask questions after the appointment, is it easy to talk to the professionals that assisted you?****						
Always/Usually	1,395 (38) [36.4 – 39.5]	9,939 (46.4) [45.8 – 47.1]	12,115 (48) [47.4 – 48.6]	4,790 (46.5) [45.5 – 47.5]	1,673 (38.9) [37.4 – 40.4]	29,912 (46.1) [45.7 – 46.5]
Never	461 (12.5) [11.5 – 13.6]	1,973 (9.2) [8.8 – 9.6]	2,270 (9) [8.6 – 9.4]	956 (9.3) [8.7 – 9.8]	388 (9) [8.2 – 9.9]	6,048 (9.3) [9.1 – 9.5]
Did not have to ask questions	1,044 (28.4) [27 – 29.9]	5,828 (27.2) [26.6 – 27.8]	6,557 (26) [25.5 – 26.5]	2,659 (25.8) [25 – 26.7]	1,540 (35.8) [34.4 – 37.2]	17,628 (27.2) [26.8 – 27.5]

*Note: the results express frequency and percentage of participants; 95%CI: 95% confidence interval; *N = 64,658 (98.9% of the interviewed patients); **N = 61,532 (94.1% of the interviewed patients); ***N = 62,498 (95.6% of the interviewed patients); ****N = 64,895 (99.2% of the interviewed patients).*

Table 4 – Distribution of responses of AB patients who participated in the PMAQ-AB regarding the variables related to the coordination of care, Brazil and regions, 2012

Variable	North n (%) [95%CI]	Northeast n (%) [95%CI]	Southeast n (%) [95%CI]	South n (%) [95%CI]	Central-West n (%) [95%CI]	Brazil n (%) [95%CI]
After you were treated by other professionals outside this health unit, did the team talked to you about this treatment?*						
Yes	796 (21.4) [20.1 – 22.7]	5,560 (25.9) [25.3 – 26.4]	8,341 (32.9) [32.3 – 33.5]	3,375 (32.7) [31.8 – 33.6]	1,006 (23.3) [22 – 24.5]	19,078 (29.2) [28.9 – 29.6]
Yes, sometimes	310 (8.3) [7.4 – 9.2]	1,983 (9.2) [8.8 – 9.6]	2,380 (9.4) [9 – 9.7]	1,208 (11.7) [11.1 – 12.3]	318 (7.4) [6.6 – 8.1]	6,199 (9.5) [9.3 – 9.7]
Never	1,309 (35.2) [33.6 – 36.7]	7,202 (33.5) [32.9 – 34.1]	8,645 (34.1) [33.5 – 34.7]	3,578 (34.6) [33.7 – 35.5]	1,432 (33.1) [31.7 – 34.5]	22,166 (34) [33.6 – 34.3]
Do you think it is easy to access your test results that arrive at this health unit?**						
Yes	2,200 (59.1) [57.5 – 60.7]	12,399 (57.7) [57 – 58.3]	18,095 (71.4) [70.8 – 71.9]	7,393 (71.5) [70.7 – 72.4]	2,852 (66) [64.5 – 67.4]	42,939 (65.8) [65.5 – 66.2]
Yes, sometimes	576 (15.5) [14.3 – 16.6]	3,988 (18.6) [18 – 19.1]	3,400 (13.4) [13 – 13.8]	1,449 (14) [13.4 – 14.7]	643 (14.9) [13.8 – 15.9]	10,056 (15.4) [15.1 – 15.7]
Never	946 (25.4) [24 – 26.8]	5,111 (23.8) [23.2 – 24.3]	3,857 (15.2) [14.8 – 15.7]	1,491 (14.4) [13.8 – 15.1]	829 (19.2) [18 – 20.3]	12,234 (18.8) [18.5 – 19.1]

*Note: the results express frequency and percentage or participants; 95%CI: 95% confidence interval; *N = 47,443 (72.6% of the interviewed patients) Does not know/Did not answer = 17,792 (27.2% of the interviewed patients); **N = 65,229 (99.8% of the interviewed patients).*

Of the total participants, 29.2% claim that, after the assistance outside the AB, the team talked about the assistance in another service. As for the ease in accessing test results, 65.8% of the respondents answered affirmatively to the question; South and Southeast were the regions with more positive answers, while Northeast and North were the regions with less frequent positive answers.

DISCUSSION

The predominant population in the study is female and brown in race/color, with average age of 49.3 years, a profile also observed in other studies that showed the more expressive search for health services by women; however, white women are more likely to use health services when compared to non-white[2,16-17]. A justification for the profile of search for AB services is often the service schedules focused on programmatic offerings to the detriment of spontaneous demands[2].

The average income declared by the patients was R$ 1,163.10, compatible with the average income in Brazil. According to a previous study on the use of health services in the country[17], people employed in the formal economy sector, housewives and retired people use the services more when compared to those in the informal labor market, unemployed, or students[2].

Regarding the comprehensive care, the study results revealed that, for most patients, the health team tries to solve the patients' needs/problems in the unit, which is satisfactory, since the AB proposes to answer more than 80% of a population's health needs and to be the preferred entrance door of the health system[2].

However, a significant number of patients claimed that approaching the issues that led them to seek the health service is restricted, that is, questions that are not the subject of the appointment are not analyzed, discussed or perceived[2].

These results suggest the practices of health professionals can be centered on the complaint-behavior. It is the influence of the hegemonic medical model, with potential to make the care more medicalizing, costly, and limited from the point of view of patient autonomy[18] and of the focus on psychosocial needs[19]. Comprehensive care, essential to health care, requires the ability to understand as much as possible the health needs of the population by listening to and dialoguing with the subjects (health professionals and patients)[2,10].

In addition, the training of health professionals should contemplate the approach and care of collective needs, considering psychical, emotional, historical and cultural factors of human illnesses. The practice of health professionals should be flexible and sensitive to the daily challenges and the experience of workers, patients and families, as well as permeated by interpersonal relations.

The health system should also produce and facilitate connections between the several network services, with assistance centered on the patients, answering to their needs, contemplating biological, psychological and social aspects and acting on several levels of determination of the health-illness process[20].

The study also showed that, for the expressive number of respondents, the health team professionals did not offer solutions of care that are adequate to their realities, which occurs mainly in the North region[2]. When the offers of care are not consistent or are distant from the context of the person seeking care, a negative impact is observed in the resoluteness of care[21]. There are also difficulties to bring the practice closer to reality both in the training and in the permanent education of professionals.

Regarding the strategies of AB services to promote longitudinality, which assumes the bonding between the professionals and patients through the sequence of therapeutic clinic and established care contracts[2,22], it was found that a significant number of respondents claimed to be accompanied by the same doctor and nurses, although they said these health professionals commonly do not remember what occurred in the last appointments.

It is evident that services need to link patients and health professionals more closely, making it possible to jointly manage and

monitor the evolution of the clinical picture, as well as allowing conduct adjustments when necessary, avoiding the loss of references and minimizing the risks of iatrogenesis resulting from lack of knowledge of life stories and the coordination of care[2,22].

Several factors are considered obstacles to the link between professionals and patients, such as the problem of fixing health professionals in municipalities[2,23], the high turnover rate caused by internal[2,24] (wage policy, benefits policy, physical-environmental conditions, among others) or external factors[2,24] (job opportunities in the labor market, more attractive career plans, better working conditions).

Regarding the coordination of care, a significant number of interviewed patients claimed to have difficulty talking with the AB professionals after being referred to professionals outside the health unit. Being the AB responsible for coordinating care, aiming to ensure the continuity of treatment, it is fundamental that it allows the patients' access after referral to another point of the network and the results of their tests. However, a barrier is established to the patient's medical follow-up in the UBS, especially from the teams' work organization, which contributes to compromising the therapeutic plan sequence[2].

This time, there are several challenges for the coordination of care to be consolidated. Among them, we highlight the need for institutional recognition of the AB as coordinator and organizer of the Health Care Network (RAS – *Rede de Atenção à Saúde*), the urgent need to change the teams' work organization, to ensure the legitimacy of society and public administrators, and innovation of practices[2].

We also recognize the relevance of the PMAQ-AB results[25] in the orientation and induction of health practices aimed to improve the AB access and quality, especially when Brazil is compared to other Latin American countries[26], which also have problems in the AB strengthening process[27-28].

Study limitations

Among the limitations of this study, we can mention the study design, cross-sectional, and the convenience sampling. However, this study has a national scope, including samples of AB patients.

Contributions to the fields of nursing, health or public policy

The results of this study contribute to the field or nursing because it rethinks the teamwork process in order to focus on the patients' needs and the service and system organization, so the AB can assume the coordination of care and the health care network, formulating public policies closer to the health needs of the population.

CONCLUSION

The comprehensive care, bond and coordination of care remain important challenges to the PHC in Brazil, which should be politically and institutionally recognized as a point in the care network capable of answering the population's needs and demands, being the locus of comprehensive care and center of the health system. The regional inequalities identified in this study are substantial and require reflection on the need to understand and prioritize the implementation of national policies in order to ensure more effectiveness and reduce inequities. Thus, regional studies are fundamental, seeking to better understand these events and their justifications, thereby allowing appropriate interventions to be formulated to respond to these problems. Even with these difficulties, the AB continues a priority in Brazil, strengthened by several programs and strategies to its improvement, such as the PMAQ-AB.

ACKNOWLEDGMENTS

To everyone who contributed to this study, although they did not sign it as authors.

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