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ORIGINAL ARTICLE

USER SATISFACTION WITH PRIMARY HEALTH CARE SERVICES: MEN'S PERCEPTION

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ABSTRACT

Objective: To evaluate the satisfaction of male users with the services offered in primary health care. **Method:** descriptive cross-sectional study conducted in Family Health Strategy units through interviews with 104 men, using a social questionnaire and a validated instrument. The Fisher's exact test was used to analyze the data, considering the significance level of 5%. **Result:** the predominant profile was white, heterosexual, married men aged between 50 and 59 years, with fixed employment, monthly income between one and two minimum wages, and who had not completed elementary school. The highest percentages of satisfaction were found in the aspects of friendliness, clinical examination, and attention given by the doctor/nurse to the complaints presented. Length of time spent in the waiting room, access to consultations, and scheduling of consultations had the lowest percentages of satisfaction. Users with incomplete high school made a more positive assessment of the aspects consultation, friendliness of the professional, and time spent in the waiting room ($p < 0.05$). In turn, the explanations received in consultations generated more dissatisfaction among subjects who use the service in an annual basis. **Conclusion:** the men participating in the study were more dissatisfied with the organization of health services than with the care provided by professionals.

Keywords: Men's Health. Unified Health System. Patient Satisfaction. Family Health Strategy.

INTRODUCTION

The Unified Health System (SUS) has universal access, comprehensive care, and equal health care directed to the individual, family and society as fundamental principles. The principal gateway is the primary health care, developed in Brazil since 1994, with emphasis on the Family Health Strategy (FHS). The development of a set of individual and collective health actions is expected in this level of care, including health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, harm reduction, and maintenance of health. These actions aim at the provision of comprehensive care that impacts the health situation and autonomy of people and the determinants and conditioning factors of the health of communities[1].

Despite the established in laws and ordinances, the health needs of Brazilian men have been neglected, and this is evident in the inexistence of specific preventive actions for this public, while other groups, such as children, women and the elderly have been favored[2].Such choices produced a scenario of low frequency of attendance of men to health units, and consequent high morbidity and mortality and high rates of hospitalization due to ambulatory care-sensitive conditions in males[3-4].

To respond to these demands, the Ministry of Health published in 2009 the National Policy for Comprehensive Care to Men's Health (PNAISH)[5], with its main focus on the male population aged 20 to 59 years. Its actions were operationally aligned at the level of primary health care, highlighting uniqueness of the male sex in its various socio-cultural, political and economic contexts[6]. However, the creation of health policies alone does not guarantee a

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change in the practice of the services. Observations of the health work show that men's health actions still remain incipient in comparison to the magnitude of primary health care in the SUS. Therefore, a collective and continuous effort through evaluative research is needed to identify deficiencies and support improvement strategies.

Among various research approaches, assessing the user's opinion is something that may reveal where exactly improvements are needed to achieve comprehensive and quality care[6]. It is therefore necessary to interview users to know their view of the available health services[7]. Given the above, the present study aimed to evaluate the satisfaction of male users with the services offered in primary health care. The study sought to contribute to the production of evidence for comprehensive health care for men.

METHODOLOGY

Descriptive, quantitative and cross-sectional study conducted in theprimary care of the public health system of a municipality of Minas Gerais.

Records in the Primary Care Information System - SIAB were surveyed in 2012, and 12,800 men aged between 20 and 59 years, registered in urban areas, covered by 14 FHS teams in the municipality of study, were found in the records. The age group was chosen because it is a priority in the PNAISH[5].

The equation for calculation of sample size in small populations, for variables expressed in terms of proportions, resulted in a sample of 95 participants. This sample was proportionally distributed among the FHS teams. A 95% confidence interval and 10% error margin were adopted.

Data collection took place in the second half of 2016, during the opening hours of health facilities, from Monday to Friday. At the reception desk, the researchers checked the daily schedule of medical and nursing consultations to identify male individuals who would attend the facility. In this moment of the survey, it was noted that few people with scheduled consultations met the profile of the survey.

The participants were recruited as they attended the unit, before the scheduled consultation, and after a brief approach to confirm whether they met the inclusion criteria, which were to be aged between 20 and 59 years, and to be enrolled in the unit. The exclusion criteria were: first attendance at that unit, and being affected by health problems that prevented the understanding of the research instrument.

For those willing to participate, the Informed Consent Form was presented and, after signing it, the interviews were held at thereception of the health unit. A socioeconomic questionnaire[4] and the User Satisfaction Assessment Instrument[8] were initially applied. The latter instrument was validated in Brazil and contains 12 questions covering different aspects of the last consultation in the unit, namely: ease of access to consultation; time in the waiting room; cordiality at reception; cordiality of the health professional during the consultation; attention given to complaints; impression about the clinical examination; confidence aroused by the professional; confidence in the prescribed care; explanations about the disease; explanations about the prognosis; way of scheduling; general opinion about the consultation.

To evaluate these items, the instrument has a scale of answers, represented by face pictures with five distinct expressions of satisfaction ("very good - A", "good - B", "fair - C", "bad - D", and "very bad - E"). The association between the answers to each question of the User Satisfaction Assessment Instrument and the socioeconomic questionnaire was investigated through the Fisher's Exact test, considering a significance level of 5%.

The project of the present study was approved by the Research Ethics Committee, registered under Opinion 1.691.145.

RESULTS

A total of 104 men participated in the survey within a total of 90 days, when data was collected, surpassing the 60-day period estimated by the researchers in the research schedule. This happened because of the low attendance of men to the basic health units, especially in the age group established in the study. The socioeconomic profile of the participants is presented in Table 1.

Table 1. Socioeconomic profile of the study population, Minas Gerais, December, 2016 (n = 104)

Researched characteristic	Predominance	%
Age group	50 to 59 years	31.6
Marital status	Married	40.6
Color	White	35.6
Schooling	Complete secondary school	27.7
Occupation	Bricklayer	8.6
Income	1 to 2 minimum wages	43.6
Sexual condition	Heterosexual	80.2
Reason for seeking the FHS	Routine consultation	44.6
Frequency of attendance to health services	Once a month	23.8

Source: Data from the authors.

The user satisfaction with the care provided at the FHS units is shown in Table 2.

Table 2. User satisfaction with the care provided at ESF units, Minas Gerais, December, 2016

Variable	% de Satisfação				
	A	B	C	D	E
Ease of access to consultations	47.5	32.0	12.0	4.0	5.0
Time in the waiting room	26.7	36.6	9.9	7.9	18.8
Cordiality at the reception	63.4	24.8	2.0	3.0	6.9
Cordiality of the health professional	74.3	21.8	2.0	0.0	2.0
Attention to complaints	69.3	23.8	2.0	0.0	5.0
Impression about the clinical examination	58.4	35.6	1.0	1.0	4.0
Confidence aroused by the professional	64.4	27.7	1.0	1.0	5.9
Confidence in the care prescribed	66.3	24.8	0.0	1.0	7.9
Explanations about the disease	69.3	22.8	1.0	1.0	5.9
Explanations about prognosis	60.4	28.7	2.0	2.0	6.9
Way of scheduling consultations	44.6	35.6	6.9	5.0	7.9
General opinion about the consultation	59.4	29.7	2.0	2.0	6.9

Legend: "very good - A", "good - B", "fair - C", "bad - D" and "very bad - E".
Source: Data from the authors.

The highest levels of satisfaction were observed with the friendliness of the professionals, the attention given to complaints, and the explanations about the disease. Dissatisfaction was more evident with the clinical evaluation of the health professional, the ease of access to consultations, the way of scheduling consultations, and the time spent in the waiting room.

The Fisher's exact test was applied to verify the association between the many variables of the study, and the ones which presented a significant association ($p < 0.05$) are presented in Tables 3, 4 and 5.

Tabela 3. User satisfaction with the ease of access to consultations according to monthly income, Minas Gerais, December, 2016 (n = 104)

Variable	N	Time in the waiting room (score)					P-value
		A	B	C	D	E	
Monthly income	104						0,0299
1	15	6	9	0	0	0	
1 to 2	44	18	15	5	3	3	
2 to 3	14	4	7	0	2	1	
More than 3	9	3	4	2	0	0	
Not informed	22	16	2	1	0	3	

Legend: "very good - A", "good - B", "fair - C", "bad - D", and "very bad - E".
Source: Data from the authors.

Table 4. Time spent in the waiting room time according to race/skin color, schooling and occupation, Minas Gerais, December, 2016 (n = 104)

Variable	N	Time in the waiting room (score)					Valor-p
		A	B	C	D	E	
Race/skin color	104						0,044
White	38	6	19	6	4	3	
Brown	25	2	10	7	3	3	
Black	17	9	7	1	0	0	
Yellow	1	1	0	0	0	0	
Indigenous	1	0	1	0	0	0	
Not stated	22	9	2	6	1	4	
Schooling	104						0,0104
Illiterate	29	8	13	6	0	2	
Incomplete primary education	19	9	2	4	1	3	
Complete primary education	11	6	2	1	1	1	
Incomplete high school	28	1	15	5	4	3	
Complete high school	10	1	4	3	2	0	
Incomplete higher education	6	1	3	1	0	1	
Complete higher education	1	1	0	0	0	0	
Employment or paid occupation	104						<0,001
Yes	63	14	33	8	4	4	
No	30	10	5	10	4	1	
Not stated	11	3	1	2	0	5	

Legend: "very good - A", "good - B", "fair - C", "bad - D" and "very bad - E".
Source: Data from the authors.

Table 5. Assessment of consultations according to schooling, Minas Gerais, December, 2016 (n = 104)

Variable		Evaluation of consultations (score)					
	N	A	B	C	D	E	P-value
Schooling	104						0,032
Illiterate	29	19	10	0	0	0	
Incomplete primary education	19	12	3	3	1	0	
Complete primary education	11	10	1	0	0	0	
Incomplete high school	28	15	10	2	0	1	
Complete high school	10	5	2	1	1	1	
Incomplete higher education	6	1	4	1	0	0	
Complete higher education	1	0	1	0	0	0	

Most respondents rated the access to the FHS unit's services as "very good" or "good" in all income strata, particularly those with one to two minimum wages.

Time spent in the waiting room showed good satisfaction among white, followed by brown people, as well as among patients with paid occupation. Regarding education, although satisfaction with time was classified as good, mainly by users who did not complete high school or who were not literate, there was a remarkable percentage of dissatisfied users.

DISCUSSION

The social profile of the study participants revealed a higher frequency of older adult users and few young adults seeking care in basic health units. These data converge with studies in which the highest percentage of users are aged between 45 and 54 years[2,10].

Health care in younger men is affected by the routine of daily work and school tasks during a moment of life when they are seeking to achieve financial independence, autonomy, acquire assets and have the possibility to meet family needs or to build and provide to a new family. The organization of working hours of healthcare services coincides with those of the employment and this becomes a barrier to access. Furthermore, men have a resistance to reorganize hours or request the possibility of dismissal from work in order to seek health care, fearing that this will demonstrate weakness to the employer, and put the employment at risk[11].

The predominant marital situation was married, followed by single interviewees. Regarding color, most respondents informed to be white, followed by brown and black skinned. This profile of participants differs from the self-reported color of users in the National Survey on Access, Use and Promotion of Rational Use of Medicines - Services, and from male users interviewed in the state of Rio de Janeiro, who were brown in their majority[12-13]. The historical antecedents of colonization and development lead to different ethnic profiles in the Brazilian regions.

In the study, 80.2% of the participants declared to be heterosexual, while the others did not declare their sexual condition. Different studies conducted with male users of health services also showed a higher prevalence of heterosexual men[2,12].

The characteristics presented by the study participants reinforce the importance of primary care services of the SUS to guarantee the right to health, from a perspective of promoting the principle of equity and reducing social inequality. Thus, men with this profile have characteristics of vulnerability to health, because that they have mostly unfavorable socioeconomic conditions, low purchasing power, unstable working conditions where there is risk of occupational accidents and of health problems related to the profession[14].

Most male users said they went to the FHS unit once a month and sporadically with the purpose of attending routine consultations, unrelated to controlling diseases such as

hypertension and diabetes. In other studies, frequent use of primary care by men is due to chronic conditions and vaccination[15]. This difference in the profile of search for care is conditioned by the availability of services in each unit. During data collection, it was noted that in most units of the FHS there was no vaccination room. Vaccination is done in a centralyzed manner, in the municipality where the research was conducted.

Access is highly valued by SUS users. Especially in situations of greater socioeconomic vulnerability, they do not have other alternatives to receive care for their health problems, which is in line with the result found in the study regarding user satisfaction score with ease of access to consultations[16].

In the units where the research was developed, there is a predominance of scheduled consultations, madiated by Community Health Agents (CHA), and according to the user's needs. About 20% of the total daily medical consultations are intended to meet spontaneous demand. However, before this outcome, users without scheduled consultations go through reception with risk classification, made by the nursing staff.

There is a low familiarity of men with health institutions, either due to the difficulties of embracement, or difficulties related to the preparation of professionals to deal with the health demands of this public. In the case of primary care services, besides being directed primarily to women, children and elderly people, health services are not organized to receive and meet the needs of the male public[11].

Although most users were satisfied with the time spent in the waiting room, this was also the attribute in which there was more dissatisfaction, especially among users with incomplete higher education, and who did not declare color and paid activity. Waiting room time is a reference of accessibility and quality of health care; when this time exceeds 30 minutes, this delay negatively affects the user's assessment of the service[17]. In this sense, it is clear that there is little investment in the planning of health actions from a gender perspective, and this contributes to a difficul interaction between the male population and health services[11].

The attitudes at the reception of the basic health unit to which the users are linked are a generator of satisfaction in the research participants. Embracemente involves much more than the administrative reception in the unit. It includes the attentive behaviors and attitudes on the part of the professionals, and involves the accountability for the care and the resolution of problems, or the necessary referrals. It is recognized in the literature as an important factor for the satisfaction of users with the care provided[18].

Among the items evaluated, the cordiality of health professionals in consultations was responsible for the highest scores of satisfaction. In the association with the variable “sex”, transsexuals exposed greater dissatisfaction; however, with respect with the level of education, users from all strata were satisfied with the cordiality of the service provided to them. As established in the PNAISH, comprehensive care should be promoted for transsexuals, as well as for different social groups, in a humanized and inclusive manner[5]. Users attach great importance to medical appointments and, when they manage to have their consultations, they expect good care and attention during these moments[19].

Users said to be satisfied with the attention given to their complaints. These results contribute to the establishment of a care relationship between patients and health professionals. Attention to complaints is the key to understanding the meaning of the disease brought by users and their translation into the scientific language of health professionals. It is exactly in the space of “retranslation” that attentive listening and embracement are consolidated, combining the “being” and “doing” of the professional, which is directly related to user satisfaction during care[20].

The clinical examination, the confidence aroused by the professional during the consultation, the explanations given by the professionals about the disease, and the reason for seeking the consultation were satisfactorily evaluated by the interviewed users. In the association between explanations received and frequency of seeking service, dissatisfaction was more related to subjects who attended the FHS unit on an annual basis. Feeling comfortable with the doctor, the explanations about

examinations given by the professional, and the information about the symptoms of the disease and the physical examination performed by the professional are relevant for satisfactory evaluation of the care provided[21]. Non-realization of physical examination is perceived as a fragility in the care of PHC services[22].

Most of the men interviewed were satisfied with the way the consultations are scheduled, with homosexuals and transsexuals being the most dissatisfied among the interviewees. Dissatisfaction with this item was higher when compared to the others. A study conducted with primary care users of both sexes indicated the access as bureaucratic and time consuming, considering the time elapsed between the scheduling and the day of the consultation, as well as the process of care provision in the facility itself (whether scheduled or not)[19].

Although scheduling seems simple and mechanical to professionals, it has another connotation from the perspective of users. Commitment and the establishment of bonds can be understood as attentive care. This bond is created through objective strategies, such as leaving the return consultation scheduled and always ensuring at least one reference professional in these consultations[23].

Most of the users surveyed were satisfied with the confidence in care measures prescribed. Such perception promotes treatment adherence and quality of life[21]. Satisfaction can be seen as a dynamic process in which several dimensions of care are interconnected[21], such as those evaluated in the present study and synthesized in the high level of satisfaction with the consultation as a whole, regardless of educational level. It is noteworthy that there was a concentration of dissatisfied users among those who received one to two and two to three minimum wages.

That said, the findings here provide advances in the understanding that the connection between men and health represents a challenge to promote a humanized, accessible care that addresses male singularities and may make the search for care a daily practice without suffering or pressure[24].

As a limitation of the present study, the sample covered a single municipality, and the basic health units linked to the FHS operate in restricted shifts and hours.

FINAL CONSIDERATIONS

The study participants reported high level of satisfaction in the items evaluated. The analysis of the results allowed us to infer that they showed an important degree of dissatisfaction with the organization of the health services. In contrast, the level of satisfaction in the professional-patient relationship was high. It appears that it is necessary to improve the clinical evaluation of health professionals, reorganize the work process in order to facilitate the access to consultations, improve the way of scheduling, and reduce the time spent in the waiting room.

It is not intended to generalize the data regarding social and demographic characteristics of men using the FHS because of the extent of the research. But it is necessary to consider the profile presented here when it comes to planning the form and content of the actions organized at this level of health care, so as to improve the satisfaction of the population studied with the services.

SATISFAÇÃO DO USUÁRIO COM OS SERVIÇOS DE SAÚDE DE ATENÇÃO BÁSICA: PERCEPÇÃO MASCULINA

RESUMO

Objetivo: avaliar a satisfação do usuário do sexo masculino com os serviços oferecidos na atenção primária à saúde. **Método**: estudo descritivo, transversal, realizado em unidades da Estratégia de Saúde da Família por meio de entrevista com 104 homens, utilizando questionário social e instrumento validado. Na análise, utilizou-se o teste Exato de Fisher, considerando a significância de 5%. **Resultado**: o perfil predominante foi de homens brancos, heterossexuais, casados, com idade entre 50 e 59 anos, com emprego fixo, renda mensal entre um e dois salários mínimos e que não concluíram o ensino fundamental. Os maiores percentuais de satisfação foram com a cordialidade, o exame clínico e a atenção dada às queixas pelo médico/enfermeiro. O tempo em sala de espera, o acesso e o agendamento da consulta apresentaram os menores percentuais de satisfação. Usuários com ensino médio incompleto apresentaram avaliação mais positiva em relação à consulta, cordialidade do profissional e o tempo na sala de espera ($p<0,05$). Por sua vez, as explicações recebidas em consulta geraram mais insatisfação entre sujeitos que utilizam o

serviço anualmente. **Conclusão**: os homens participantes do estudo estão mais insatisfeitos com a organização dos serviços de saúde do que com o atendimento dos profissionais.

Palavras-chave: Saúde do Homem. Sistema Único de Saúde. Satisfação do Paciente. Estratégia Saúde da Família.

SATISFACCIÓN DEL USUARIO CON LOS SERVICIOS DE SALUD EN LA ATENCIÓN PRIMARIA: PERCEPCIÓN MASCULINA

RESUMEN

Objetivo: evaluar la satisfacción del usuario del género masculino con los servicios ofertados en la atención primaria de salud. **Método:** estudio descriptivo, transversal, conducido en unidades de la Estrategia de Salud de la Familia, mediante entrevistas con 104 hombres, utilizando cuestionario social e instrumento validado. En el análisis, se utilizó la prueba Exacta de Fisher, considerando la significación del 5%. **Resultado:** el perfil predominante consistió en hombres blancos, heterosexuales, casados, con edades entre 50 y 59 años, con empleo fijo, ingreso mensual entre uno y dos salarios mínimos y que no terminaron la escuela primaria. Los porcentajes más altos de satisfacción fueron con la cordialidad , el examen clínico y la atención prestada a las quejas por parte del médico/enfermero. El tiempo en la sala de espera, el acceso y la programación de consultas tuvieron los porcentajes más bajos de satisfacción. Los usuarios con escuela secundaria incompleta presentaron una evaluación más positiva con respecto a la consulta, la cordialidad del profesional y el tiempo en la sala de espera ($p<0,05$). A su vez, las explicaciones recibidas en las consultas generaron más insatisfacción entre los sujetos que usan el servicio anualmente. **Conclusión:** los hombres que participan en el estudio están más insatisfechos con la organización de los servicios de salud que con la atención brindada por los profesionales.

Palabras clave: Salud del Hombre. Sistema Único de Salud. Satisfacción del Paciente. Estrategia de Salud de la Familiar.

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