DOI: 10.4025/cienccuidsaude.v14i3.24050

PRIMARY HEALTH CARE IN THE VIEW OF USERS AND PROFESSIONALS IN A BRAZILIAN CITY

Maria José Sanches Marin*
Milton Marchioli**
José Eduardo Corrente***

ABSTRACT
The purpose of this study is to analyze differences and similarities between the Family Health Strategy (FHS) program and the Traditional Basic Health Unit (TBHU) in the view of users and health professionals, in a municipality of about 220,000 inhabitants. For data collection, questionnaires prepared with Primary Care Assessment Tool (PCAT) components were answered by 142 TBHU and 147 FHS professionals and by 199 TBHU and 197 FHS users. A significance level α equal to 5% ($p \leq 0.05$) was used for analysis, and the Wilcoxon test, for comparison. The FHS was better rated in the majority of the dimensions analyzed, in the view of users and professionals. In the professionals' opinion, the TBHU was better in *access*, whereas the *entrance* domain showed no statistically significant difference when compared with the evaluation done by FHS professionals. Access and services were better evaluated by TBHU users comparatively with FHS users. Nevertheless, both models have important challenges, despite the better results of the FHS.

Keywords: Primary health care. Unified health system. Quality of Health Care.

INTRODUCTION

In the current Brazilian Health Policy, primary care was set as a priority, considering the definition of a health concept that takes into account its determinants and conditioners and the need for paradigmatic changes in the effective model. This direction has been leading to the mobilization of governmental spheres, since changes in the way of acting in and thinking about health care are necessary[1].

With the perspective of developing differentiated forms of health assistance in primary care, the Family Health Strategy (FHS) has been implemented all over the national territory, a modality of care that is gradually replacing the Traditional Basic Health Unit (TBHU) model. However, this implementation has occurred in a diverging manner. Small and medium-sized cities were the ones that showed greater adhesion to the FHS program. Even so, many of them function with both modalities of care[2].

The FHS differs from the TBHU for proposing an interdisciplinary work, adscription of a smaller number of people/families per team, with greater possibilities of expanding bonds and care longitudinally and in health surveillance.

Some studies attribute better results to the FHS. In an evaluation of the FHS in the South and Northeast of Brazil, it was found that its performance was regularly better than that of traditional services, in both regions[3]. In a city located in the south region of the country, the differences in prenatal care between the FHS and the TBHU indicated that, although the procedures performed with pregnant women were below the recommended, those assisted by the FHS were contemplated with a larger number of actions[4].

In an analysis of the implementation of the FHS in the state of Piauí, it was possible to observe the evolution of admissions of patients younger than five years old from 2000 to 2010, with a decrease in the number of hospital admissions. There was, however, a persistence of admissions related to communicable, parasitic and respiratory diseases, which configure diseases liable of control in primary care[5].

In a big city in the state of São Paulo, the evaluation of the implementation of new modalities of primary care and mental health in the performance of basic care revealed the

*Enfermeira. Doutora em Enfermagem. Docente do Curso de Enfermagem da Faculdade de Medicina de Marília. Email: marnadia@terra.com.br.
**Médico. Doutor em Medicina. Docente da Disciplina de Educação em Ciências da Saúde da Faculdade de Medicina de Marília. Email: marchioli@unimedmarilia.com.br
***Professor Adjunto no Departamento de Bioestatística do Instituto de Biociências, UNESP - Botucatu, SP. Email: jecorren@ibb.unesp.br

existence of positive advances[6]. Study based on indicators of children's health to analyze the performance of the FHS revealed reduction in the rate of admissions for diarrhea[7].

On the other hand, with the proposition of verifying the performance of the FHS, the access and continuity of treatment for tuberculosis were analyzed in a Brazilian municipality. It was found that the teams were not taking on the treatment and follow-up of patients comprehensively, with highlight to the difficulty of access to medical consultation[8].

Most of the aspects related to basic care with focus on the FHS and evaluated in different regions of the country have been revealing progresses in their development, although significant changes have not been observed yet, especially regarding access, the physical structure of the units, the qualification of professionals and the organization of healthcare networks[9,10].

The advances and challenges of primary care, especially in the FHS modality, instituted for the attainment of effective changes in the current model of care and diversity of results, considering the distinct formats of its implementation[5,6,8], lead to the need for studies that evidence different realities, aiming its enhancement.

Thus, a question is raised about how the distinct models of primary care are developing, from the perspective of subjects who experience them (users and professionals).

In light of the above and aiming at contributing with data that can evidence gaps in the different modalities and, consequently, contributing with proposals of changes, this study proposes itself to analyze divergences and convergences between the FHS and the Traditional Basic Health Unit (TBHU) in the view of users and health professionals.

MATERIALS AND METHODS

This is a cross-sectional study of quantitative analysis conducted from August to December 2011, whose field is composed of primary health care units of the city of Marília. Located in the Midwest of the state of São Paulo, the municipality has 220,000 inhabitants and counts with 12 TBHU and 28 FHS units, which configure the entrance to the system. In the TBHU, in spite of them having incorporated the Health Community Agents Program (PACS), there was little change in the work process of the professionals. The FHS in general complies with the minimum requirements preconized by the Ministry of Health. FHS units are installed in areas where the population is socio-economically underprivileged, and serves approximately 44% of Marília's population.

Data was collected from a structured questionnaire applied to TBHU and FHS users and from another one applied to health professionals that act in the TBHU and FHS. Such instruments were adapted to the Brazilian reality and validated from components of the Primary Care Assessment Tool (PCAT)[11], formulated to assess critical aspects of primary care in conformity with the framework proposed by Starfield[12].

Said framework comprehends eight dimensions, with their respective specifications contained in the questionnaires for professionals and in those for users, but with a language directed to each of the publics: a) *access:* it refers to the location of the health unit near the population, to the hours and days they operate, to the level of tolerance for non-scheduled consultations and to how much the population perceives the convenience of these aspects; b) *entrance:* it is about the use of the basic care service as the first assistance means to be searched, and about each new problem or new episode of a problem due to which people seek health attention, except in urgent cases; c) *bond or longitudinality:* it presupposes the existence of a regular source of care and its use throughout time, with the establishment of strong interpersonal bonds that reflect a mutual cooperation among people from the community and health professionals; d) *availability of services:* it contemplates the arrangements the unit performs so that the patient receives any kind of healthcare service he or she needs; e) *coordination or integration of services:* it contemplates the facility to access other levels of care and the follow-up assistance in other specialized services; f) *family focus:* it presupposes the consideration of the individual within his or her ordinary environment, since the assessment of health needs should take into

account family context and exposure to health threats of any order, besides the challenge of facing limited family resources; *g) orientation towards the community:* it implies the acknowledgment that all of the community's health needs occur within a determined social context that must be known and considered; and h) *professional training:* it involves the qualification/training that health professionals have to perform their roles in accordance with the dimensions previously mentioned.

From the dimensions cited, assertions are listed, using the Likert scale, based on the occurrence criterion: 1 (never), 2 (rarely), 3 (sometimes), 4 (frequently), 5 (almost always) and 6 (always), in which the participants specific their level of agreement with a statement. The questionnaire intended to professionals counts with a total of 77 assertions distributed into the different dimensions, and that intended to users, 69 assertions in total.

The population sample for data collection was obtained from a simple random sample calculation, which allows for the representativeness of the population, with a possibility of sampling error around 5%. Thus, by using the formula $n = \left(\frac{z_{\alpha/2}\sqrt{p(1-p)}}{\varepsilon}\right)^2$, in which $z_{\alpha/2}$ = 1.95 (corresponding to the quantile 95% of the normal standard distribution), p=0.5 and ε=0.05, a sample of 400 users is obtained [13]. The sampling calculation of health professionals obtained a sample of 150 from the BHU and 164 from the FHS, because 240 and 280 professionals act in them, respectively.

The questionnaire was applied at two TBHU and four FHS units of each region (North, South, East, West), in a total of eight and sixteen, respectively, by drawing. For data analysis, 142 instruments of professionals from the TBHU and FHS were considered, since some professionals did not answer them and others returned them with many unanswered questions, being disregarded. The users were approached at the unit itself, when arriving for or leaving after assistance, until the sample was defined. The collection was carried out by three dully-trained female nursing graduates, and many of the users had their answers written by the interviewer herself. A total of 199 questionnaires from the TBHU and 197 from the FHS were deemed valid.

Data was typed in Excel 2000 for Windows spreadsheets, followed by statistical analyses performed through the Statistical Package for Social Sciences (SPSS) version 11.0 for Windows. The results of the questionnaires were presented from the calculation of the mean of the answers obtained in each assertion according to the dimension evaluated. Subsequently, inferential analyses were carried out in order to verify differences of evaluation between FHS and TBHU users, as well as between professionals from both modalities. This procedure was done by means of the Wilcoxon Test, which assesses whether there is equality between distribution of data for two samples (in this case, BHU and FHS) [14]. In all of the conclusions obtained by the inferential analyses, a significance level equal to 5% was used ($p \leq 0.005$).

This research had the approval of the Ethics Committee on Research Involving Humans of the College of Medicine of Marília, under protocol No 682/08. All participants signed a free consent form.

RESULTS AND DISCUSSION

Table 1 shows that for most domains the FHS is better evaluated. As for the professionals' evaluation, the TBHU was considered better only in the *access* item, and for the *entrance* domain, there was no statistically significant difference between the opinions of the professionals from the FHS and from the TBHU. FHS users gave *access* lower scores, and when those scores were compared with the mean of the scores given by TBHU users, statistically significant differences were observed, which also happened with *availability of services*.

In a more detailed analysis, taking into consideration the assertions that compose the access dimension, some aspects stand out. In the view of TBHU professionals, the supply of equipment, the possibility of being able to make a non-urgent medical appointment within 24 hours, and the unit work hours were the best evaluated assertions, with statistically significant differences (p=0.0241; <0.0001; <0.0001, respectively). For TBHU users, the facility to

make an appointment at the unit, the waiting time for assistance, the supply of medicines and of other equipment were significantly better evaluated if compared with the evaluation by FHS users p<0.0001; <0.0001; <0.0001 and <0.0001, respectively).

Table 1. Distribution of the means obtained in the evaluation done by users and professionals concerning the assistance modalities (TBHU and FHS), in accordance with the quality of assistance domains proposed by Starfield. Marília, 2013.

DOMAINS	PROFESSIONAL			USER		
	TBHU Mean	FHS Mean	p-value	TBHU Mean	FHS Mean	p-value
1. Access	4.0	3.6	<0.0001	3.0	2.8	0.0933
2. Entrance	4.7	4.9	0.3506	5.1	5.5	0.0005
3. Bond	4.3	4.6	<0.0001	4.4	4.7	0.00037
4. Availability of services	4.7	5.2	<0.0001	4.2	3.7	0.2488
5. Coordination	4.6	4.9	0.0058	3.1	3.7	<0.0001
6. Family focus	3.1	4.9	<0.0001	2.8	3.9	<0.0001
8. Orientation towards the community	3.1	3.6	0.0007	3.2	3.8	0.0048
9. Professional training	3.2	3.9	<0.0001	4.3	4.8	0.0582

In face of the comprehension of *access* as the way users come and are approached at the entrance door, as well as the possibilities they have to use all different technologies available and necessary for the resolution of their health problem[15], it is understood that, especially for users of both modalities of care, such dimension still lacks investments that can promote a more effective attention to the needs. Similar data was found in a study that analyzed the undertaking of actions for the strengthening of basic healthcare in four urban centers, since the possibility to make a medical appointment without previous scheduling was negatively evaluated by users[16]. Even so, the same study considered to be important the percentage of families that seek for fewer hospital, specialized and urgent services after the implementation of the FHS.

In the *entrance* dimension, referring to the search for preventive actions such as vaccines, blood pressure checking and routine exams, FHS users evaluated it in a more positive way; the TBHU, in turn, was better evaluated when the search for it refers to a health problem (p=0.0046). It is worth highlighting, however, that in this dimension the assertions of the instrument are intended to the recognition of the existence of a hierarchization of health actions and not to their qualification. In this way, the average scoring obtained from the answers of professionals and users corresponds to the normative of the organization of assistance from the municipality, since the regulation system defines that the assistance, at medium and high-complexity levels of care, depends on the referral of basic healthcare. Users, then, only have the possibility of seeking directly emergency services during the hours when basic health units are not operating.

It can be questioned, therefore, whether the search for basic care as the entrance door to the system is an option or a requirement, considering that a study conducted in other locations reveals that this is not the option of users when they need health care [15]. This question is reinforced when the scores given in the access dimension, especially by users, are observed, because problems related to the guarantee of access remain.

As for bond, the assertions that the FHS professionals evaluated in a more positive way in relation to TBHU users were the adscription of the population by the unit, the possibility of clarifying doubts with the professional who provided the assistance by phone, the time available for the user to explain his or her complaints, and the knowledge about the user's conditions to get medicines (p= 0.0002, 0.0071; <0.0001 and <0.0001, respectively). For FHS users, the best evaluated assertions refer mainly

to being examined by one same professional, the information that professionals have about the medicines used and the condition to get them, comparatively with the opinions given by TBHU users (p< 0.0001; <0.0001; <0.0001, respectively).

In the attributes proposed by Starfield[12], bond is a core characteristic of basic care. To the author, in this dimension there is an implicit relationship of responsibility and trust, which leads to more accurate diagnoses and more efficient treatments. In face of that, it is possible to consider that the FHS has been seeking to provide services that are more similar to the proposal of the Brazilian Health Unified System (SUS). Although several difficulties and challenges stand before the FHS, it is necessary to acknowledge that the team has the chance to know people within their social, emotional, family and financial context. This is a unique privilege in comparison with other health attention scenarios in which learning information about the conditions of life and health of users depends on extensive anamneses with all the implications that this represents regarding the time spent and the subject's conditions and willingness to provide information necessary to a plan that contemplates his or her health needs.

The *availability of services* dimension was evaluated by FHS professionals in a more positive manner, and the assertions with higher scores were those related to educative actions. As for other items, such as vaccination, assistance to different age groups and specific conditions – chronic-degenerative diseases, endemic and epidemic diseases – there were no statistically significant differences. For FHS users, although they have given a score lower than that given by TBHU users to the dimension as a whole, the assertions regarded as more positive, just as the scores given by professionals, were those referring to health education. TBHU users had a more positive evaluation of the assistance to patients with chronic diseases, mainly.

About the *coordination* dimension, for FHS professionals, the assertions that received a higher scoring, comparatively with TBHU professionals, refer to the frequency of use of reference and counter-reference norms, to the orientation provided to users in case of referral to other services, to the fact that exams done in other services are referred to the unit, that follow-up consultations for exam results are directly held at the unit, and that users are informed or consulted about the scheduling (p=0.0199; 0.0009, 0.0192; <0.0001 and <0.0001, respectively). In the answers of users regarding the coordination dimension, the FHS was better evaluated in all assertions, and comparatively with the TBHU, the difference was significant.

The *coordination* dimension has as fundamental requisite the operation of the reference and counter-reference system, since in a hierarchized system the quality of care and the use of necessary resources in an effective and efficient way demand the organization of assistance flows. It is logical, then, that every referral offered to users counts with referencing. In this dimension, it is also evaluated whether there is a closer and careful follow-up for users when they need another service, and it is pointed out that the FHS is more positively complying with such procedures.

FHS professionals rate as very good the assertions that include the *family focus* dimension, that is, the organization of medical records by family, the possibility professionals have to talk to a family about the health of a user, and the fact that data with social focus and about living conditions is collected during anamnesis. Such items, when compared with the opinion of TBHU professionals, were statistically more significant (p<0.0001; <0.0001; <0.0001, respectively). As for users, the FHS was better evaluated when they were questioned about whether the professionals ask about the living conditions of theirs and of their families, whether the health professionals know family and user well, and whether they ask the opinion of the user prior to conducting a treatment. Comparatively with the TBHU, there were statistically significant differences (p<0.0001; <0.0001; <0.0001, respectively).

This aspect represents a fortress for care, since in our society family constitutes the main form of backup and support to people. Health practices, therefore, should work from the comprehension of the complexity, of the interactivity and of the dynamicity of existing relations between their members[17].

In the *orientation towards the community* dimension, the assertions that the professionals of the FHS team evaluated more positively refer to the application of polls to the community in order to know whether the services provided meet the needs of the population, and to identify the problems of the community, in addition to the fact that the offer of household visits and the offer of services are based on identified needs of the community. By comparing this evaluation with that of TBHU professionals, the analysis pointed p=0.0143; 0.0021; 0.0003; <0.0001, respectively. FHS users evaluated more positively, in comparison with TBHU users, assertions referring to the presence of community representatives in meetings held by the unit's direction board, to the offer of health services in schools, and to the development of works with other groups in order to improve the living conditions of the community.

It is worth stressing that for TBHU professionals orientation towards the community is a dimension that most of the times is not regarded, because the assistance values essentially medical consultations turned to an individualized care. A study that assessed the perception of patients, professionals and managers who develop control actions against tuberculosis has concluded that the orientation towards the community was considered unsatisfactory[18]. In the perception of nurses, the innovation of the FHS is in the emphasis given to the collectiveness, having as center the approximation with families and their systematic follow-up[19].

Referring to the *professional training* dimension, in the view of FHS professionals, only the assertion about specific training to act in basic healthcare was statistically significant when compared with the evaluation of TBHU professionals (p=0.0048). Comparing the answers of FHS and TBHU users to the assertion "You would recommend this unit to a friend", the FHS was considered better, with a statistically significant result (p=0.0145). In this dimension, it is important to consider that the TBHU develops its activities with a great focus on the logics of specialty. As for the FHS, though better evaluated in this dimension by professionals and users, its insufficiency stands out, which reinforces the need for training and qualification for professionals to act in face of the new logics of care proposed.

From this perspective, it is possible to observe some governmental initiatives to institute Permanent Education processes in basic healthcare services, incentives to curricular changes in undergraduate courses in the health area, such as "Pró Saúde" and "Pet Saúde", in their different modalities, as well as subsidizes for the development of residencies and multidisciplinary specializations in family and community health, which represents an important advance for the construction of a new health attention logics.

Concerning the limitations of the study, it is worth pointing out that it was conducted in one single municipality, which certainly differs from the others in relation to structure and organization of the work process, hindering the generalization of findings. In addition, it is necessary to recognize its limitation as a study that uses an instrument with an excessive detailing that, in spite of having gone through evaluations and validations, turned out exhaustive to some of the participants.

CONCLUSION

The present study unveils some primary care aspects of a medium-sized municipality in the state of São Paulo and complements national studies conducted in other places, aiming at contributing with data for a better understanding of the current organization of the national health system. When comparing the view of professionals and users, a more comprehensive knowledge of the quality of care is sought, since users and professionals are protagonists in the basic care system.

Even so, considering its potentialities and limitations, it was possible to come to some reflections about convergences and divergences between the modalities of primary care in the view of professionals and users with respect to the dimensions of basic healthcare evaluation proposed by Starfield.

The fact that the FHS received a more positive evaluation than that of the TBHU, from the perspective of users and professionals, in aspects related to bond; availability of services, with highlight to educative actions; coordination;

family focus; orientation towards the community; and professional training aimed at basic care, indicates that this modality of assistance is walking a way of professional/user approximation and accountability, in a more expanded format, for directing the attention to families and communities as well.

On the other hand, even though the analysis was conducted according to a statistical significance perspective, it is not possible to state that such results are satisfactory before the investments, uncontestably greater, that governmental initiatives have been undertaking in FHS. Its fragility referring to access should be considered too, especially in the view of FHS users, who evaluated it unfavorably.

Therefore, there need to be advances, especially when it comes to the structuration of the health system as a whole, taking into account that the two modalities analyzed constitute the entrance door to the system and have the same responsibility for and the same commitment with the community assisted.

ATENÇÃO PRIMÁRIA À SAÚDE DE UMA CIDADE BRASILEIRA SOB A ÓTICA DOS USUÁRIOS E PROFISSIONAIS

RESUMO

O presente estudo analisa as divergências e as convergências entre a Estratégia Saúde da Família (ESF) e a Unidade Básica de Saúde Tradicional (UBST) pela ótica dos usuários e profissionais da saúde em um município brasileiro com população aproximada de 220.000 habitantes. Na coleta de dados, os questionários, formulados a partir dos componentes do *Primary Care Assessment Tool (PCAT*), foram respondidos por 142 profissionais da UBST e 147 da ESF e, ainda, por 199 usuários da UBST e 197 da ESF. Na análise foi utilizado o nível de significância α igual a 5% ($p \leq 0,05$) e, para as comparações, o teste de Wilcoxon. Constatou-se que, na maioria das dimensões analisadas, tanto do ponto de vista dos usuários como dos profissionais, a ESF recebeu melhor avaliação. Quanto à feita pelos profissionais, a UBST foi considerada melhor apenas no item *acesso* e, para o domínio *porta de entrada*, não houve diferença estatisticamente significante comparando-se com a avaliação dos profissionais da ESF. Para os usuários da UBST, o acesso e o elenco de serviços foram considerados melhores em comparação com a dos usuários da ESF. Mesmo frente aos melhores resultados da ESF, existem desafios importantes para as duas modalidades.

Palavras-chave: Atenção primária à saúde. Sistema único de saúde. Qualidade da Assistência à Saúde.

ATENCIÓN PRIMARIA A LA SALUD DE UNA CIUDAD BRASILEÑA BAJO LA VISIÓN DE LOS USUARIOS Y PROFESIONALES

RESUMEN

El presente estudio analiza las diferencias y las similitudes entre la Estrategia Salud de la Familia (ESF) y la Unidad Básica de Salud Tradicional (UBST) bajo la visión de los usuarios y profesionales de salud en un municipio brasileño con población aproximada de 220.000 habitantes. En la recogida de datos, los cuestionarios realizados a partir de los componentes del *Primary Care Assessment Tool (PCAT*) fueron contestados por 142 profesionales de UBST y 147 de ESF y, aun, por 199 usuarios de UBST y 197 de ESF. En el análisis fue utilizado el nivel de significancia α igual al 5% ($p \leq 0,05$) y para las comparaciones, la prueba de Wilcoxon. Se constató que, en la mayoría de las dimensiones analizadas, tanto bajo la visión de los usuarios como de los profesionales, ESF ha sido mejor evaluada. En la evaluación de los profesionales, UBST ha sido mejor considerada en el ítem *acceso* y, para el campo *puerta de entrada*, no hubo diferencias estadísticamente significativas comparándose con la evaluación de los profesionales de ESF. Para los usuarios de UBST, el acceso y las opciones de servicios fueron considerados mejores en comparación con los usuarios de ESF. A pesar de los mejores resultados de ESF, hay importantes desafíos para las dos modalidades.

Palabras clave: Atención primaria de salud. Sistema único de salud. Calidad de la Atención de Salud.

REFERENCES

1. Brasil. Constituição da República Federativa do Brasil de 1988 [on-line]. Brasília (DF): Senado Federal; 1988. [citado em 15 abr 2012]. Disponível em:URL http://www.planalto.gov.br/ccivil_03/Constituicao/Constituicao.htm

2. Brasil. Ministério da Saúde. Departamento de Atenção Básica. Atenção básica e saúde da família [on-line]. Brasília, DF: Ministério da Saúde; [2011] [citado em: 15 jun 2012]. Disponível em: URL http://dab.saude.gov.br/atencaobasica.php

3. Facchini LA, Piccini RX, Tomasi E, Thumé E, Silveira DS, Siqueira FV et al. Desempenho do PSF no Sul e no Nordeste do Brasil: avaliação institucional e epidemiológica da Atenção Básica à Saúde. Cienc Saúde Colet. 2006; 11(3):669-81.

4. Mendoza-Sassi RA, Cesar JA, Teixeira TP, Ravache C, Araújo GD, Silva TC. Diferenças no processo de atenção ao

pré-natal entre unidades da Estratégia Saúde da Família e unidades tradicionais em um município da Região Sul do Brasil. Cad Saúde Pública. 2011; 27(4):787-96.

5. Barreto JOM, Nery IS, Costa MSC. Estratégia Saúde da Família e internações hospitalares em menores de 5 anos no Piauí, Brasil. Cad Saúde Pública. 2012; 28(3):515-26.

6. Onocko-Campos RT, Campos GWS, Ferrer AL, Corrêa CRS, Madureira PR, Gama CAP et al. Avaliação de estratégias inovadoras na organização da Atenção Primária à Saúde. Rev Saúde Pública. 2012; 46(1):43-50.

7. Roncalli AG, Lima KC. Impacto do Programa Saúde da Família sobre indicadores de saúde da criança em municípios de grande porte da região Nordeste do Brasil. Cienc Saude Colet. 2006; 11(3):713-24.

8. Figueiredo TMRM, Villa TCS, Scatena LM, Gonzales RIC, Ruffino-Netto A, Nogueira JA et al. Desempenho da atenção básica no controle da tuberculose. Rev Saúde Pública. 2009; 43(5):825-31.

9. Conill EM. Ensaio histórico-conceitual sobre a Atenção Primária á Saúde: desafios para a organização de serviços básicos e da Estratégia Saúde da Família em centros urbanos no Brasil. Cad Saúde Pública. 2008; 24(Supl 1):S7-S16.

10. Campos GWS. Debate sobre o artigo de Conill. Cad Saude Pública. 2008; 24(Supl 1):S17-9.

11. Almeida C, Macinko J. Validação de uma metodologia de avaliação rápida das características organizacionais e do desempenho dos serviços de atenção básica do Sistema de Saúde (SUS) em nível local. Brasília (DF): Organização Pan-Americana de Saúde; 2006.

12. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília (DF): Ministério da Saúde; 2002.

13. Oliveira EFT, Grácio MCC. Análise a respeito do tamanho de amostras aleatórias simples: uma aplicação na área de Ciência da Informação. Data Grama Zero[on-line]. 2005 jun [citado em: 3 nov 2008];6(3):1-9]. Disponível em: URL http://www.dgz.org.br/ago05/Art_01.htm.

14. Vieira S. Bioestatística: tópicos avançados. 3ª ed. Rio de Janeiro: Elsevier; 2010.

15. Frenk Mora J. El concepto y la medición de accesibilidad. Salud Publica Mex. 1985; 27(5):438-53.

16. Almeida PF, Fausto MCR, Giovanella L. Fortalecimento da atenção primária à saúde: estratégia para potencializar a coordenação dos cuidados. Rev Panam Salud Publica. 2011; 29(2);84-95.

17. Nunes ECDA, Silva LWS. A subjetividade de enfermeiros expressando em arte o significado do cuidado à família. Texto & Contexto Enferm. 2011; 20(3):253-60.

18. Curto M. Atenção individual, enfoque familiar e orientação à comunidade nas ações de controle da tuberculose na percepção de diferentes atores - Ribeirão Preto, SP (2007). 2009. [dissertação]. Ribeirão Preto (SP). Escola de Enfermagem de Ribeirão Preto-USP; 2009.

19. Souza GS, Mandú ENT. Percepções de enfermeiros sobre a Estratégia Saúde de Família. Cienc Cuid Saúde. 2010; 9(4): 643-50.

Corresponding author: Av. Brigadeiro Eduardo Gomes, 1886. CEP: 17514000. Marília, SP - Brasil. Email: marnadia@terra.com.br.

Submitted: 18/06/2014
Accepted: 09/03/2015