http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude
ISSN on-line1984-7513
DOI: 10.4025/cienccuidsaude.v20i0.53086

ORIGINAL ARTICLE

PERFORMANCE OF PRIMARY HEALTH CARE SERVICES: SATISFACTION OF PERSONS WITH HYPERTENSION[1]

Ane Caroline Rodrigues Miranda Lucena*
Anderson da Silva Rêgo**
Patrícia Bossolani Charlo***
Thamires Fernandes Cardoso da Silva Rodrigues****
Maria Aparecida Salci*****
Cremilde Aparecida Trindade Radovanovic******
Lígia Carreira*******

ABSTRACT

Objective: To evaluate the performance of the list of services offered by Primary Health Care (PHC) and to associate with blood pressure control and monitoring of people with arterial hypertension (AH). **Methods**: a cross-sectional study carried out with 417 people with AH, linked to 34 Basic Health Units in a municipality in Paraná. Data were collected between February and June 2016, using an instrument of satisfaction with services provided by PHC, using questions related to the block on List of Services. For data analysis, descriptive and inferential statistics were used. **Results**: people over 70 years old, female, white, and with low educationwere prevalent. The issues related to blood pressure measurement, presence of at least one professional in the unit, and participation in groups of people with AH were better evaluated. People with inadequate follow-up unsatisfactorily assessed blood pressure measurements during consultations and home visits. Those stratified with inadequate blood pressure control unsatisfactorily evaluated health education and information about medicines and their effects. **Conclusion**: The need to improve monitoring and care for patients with AH is highlighted so that the services provided by PHC are satisfactory.

Keywords: Integrality in health. Primary health care. Hypertension. Health services research. Patient satisfaction.

INTRODUCTION

Primary Health Care (PHC) is the first level of access to the health systemfor the patients and must be the coordinator of the other levels of care, through essential attributes, to provide better accessibility and organization of assistance for the population. The PHC's performance has been consolidated through the Family Health Strategy (FHS), which includes actions to promote, protect and rehabilitate health, meeting the needs of individuals, families, and the community, in a decentralized, equitable, and integral way[1-2].

The FHS has an important role as a model of care in developing actions that guarantee adequate and comprehensive monitoring to patients, according to their health needs, for their the treatment and prevention of diseases, such as the Chronic Non-Communicable Diseases (NCD)[3], which are responsible for the highest-burden of morbidity and mortality in the world, and is an important public health problem[4].

Among the NCDs, we highlight Arterial Hypertension (AH) with high prevalence. It is responsible for 63% of a total of 38 million deaths worldwide and with low control rates, and it is one of the main risk factors for cardiovascular diseases[3,5-7]. In this sense, it is chronic morbidity, which has a significant socioeconomic impact at the individual and collective level, overloading health services, especially due to its multifactorial origin, which causes chronic complications[6-7].

The Ministry of Health (MH) emphasizes the importance of the multidisciplinary and

[1]This study has been extracted from the Master thesis entitled "Evaluation of the satisfaction of persons with hypertension with the services provided by Primary Health Care", linked to the State University of Maringá (UEM), 2017.

*Nurse, Master Degree Student from the Graduate Program in Nursing (PSE), State University of Maringá (UEM). Maringá (PR), Brazil. E-mail: anny-kerolin@hotmail.com. ORCID iD: http://orcid.org/0000-0002-2390-1894
**Nurse, Doctoral Student from the PSE/UEM. Maringá (PR), Brazil. E-mail:anderson.dsre@hotmail.com. ORCID iD: http://orcid.org/0000-0002-0988-5728.
***Nurse, Doctoral Student from the PSE/UEM, Teacher from the Department of Medicine and Nursing of the University Center of Maringá (UNICESUMAR). Maringá (PR), Brazil. E-mail: patbcs20@gmail.com. ORCID iD: http://orcid.org/0000-0002-2390-1894.
****Nurse, Doctoral Student from the PSE/UEM. Maringá (PR), Brazil. E-mail: thamy_nutri@yahoo.com.br. ORCID iD: http://orcid.org/0000-0001-7942-4989.
*****Nurse, Doctor of Nursing. Teacher from the PSE/UEM. Maringá (PR), Brazil. E-mail: masalci@uem.br. ORCID iD: http://orcid.org/0000-0002-6386-1962.
******Nurse, Doctor of Health Sciences. Teacher from the PSE/UEM. Maringá (PR), Brazil. E-mail: kikanovic2010@hotmail.com. ORCID iD: http://orcid.org/0000-0001-9825-3062.
*******Nurse, Doctor of Nursing. Teacher from the PSE/UEM. Maringá (PR), Brazil. E-mail: ligiacarreira.uem@gmail.com. ORCID iD: http://orcid.org/0000-0003-3891-4222.

interdisciplinary team in the treatment of AH and the prevention of chronic complications. Among the team's actions, health promotion should be developed through educational strategies with an emphasis on changes in lifestyle and correction of risk factors, which enhance care and allow the self-care action of their health[4,7].

PHC maximizes its potential by guaranteeing services that are structured based on the needs of the population, offering comprehensive, quality, and equitable health care. For this, it uses technologies, human and organizational resources, which are articulated in the health care network, between the sectors and levels of assistance in a hierarchical and decentralized manner, according to the level of complexity and the set of services demanded by the individuals[8-9].

However, care for people with AH is a challenge for PHC since they are multifactorial conditions[7], with biological and sociocultural determinants. To achieve continuity and improvements in the treatment for AH, several factors must be considered such as access to treatment, strengthening the bond between patients and health professionals, monitoring and adequate multi-professional assistance, and patient satisfactionfor the services offered at this level of care since satisfaction can influence the habits adopted in the health and disease process, positively or negatively[10-11].

In this context, evaluating the services offered to people with AH at this level of care and the satisfaction of people with AH represents an important indicator of results, which can facilitate the assessment of the quality of care provided to the population. However, understanding how patients evaluate care enables the identification of divergences and convergences of indicators, favoring the development of strategies and actions that bring improvements in the organization of work, in the practices of professionals, and the assistance[12-13].

Also, the work organization process in PHC considers the asymmetrical relationship between the population that seeks health services and professionals who work at the levels of care, offering the needs of the population. Therefore, the question is: what is the level of satisfaction of people undergoing treatment for AH regarding the performance of the services offered by PHC? Thus, the study aimed to evaluate the performance of the list of services offered by PHC and to associate it with blood pressure control and monitoring of people with AH.

METHODS

This is a cross-sectional study carried out with people undergoing treatment for AH in a medium-sized municipality, located in the northwest of the state of Paraná, Brazil. The municipality's health care network is decentralized and in the year of data collection had 34 Basic Health Units (*UBS*) and 71 FHS teams, making up the population coverage of 68.01%[14].

The inclusion criterion adopted was the age equal to or above 18 years old; be registered in the SISHIPERDIA program and have been seen at health facilities in the last six months before the beginning of data collection. We excluded people with limited clinical and cognitive conditions, which hindered the ability to answer questions.

The sample calculation was based on a population of 27,741 individuals registered in the program. For the sample selection, we performed the simple random process, considering a 95% confidence interval, with an error estimate of 5% and an additional 15% for eventual losses, totaling 437 participants. Consecutively, the stratified sample of patients registered in each of the 34 UBS included in the survey was carried out, based on a list available by the Municipal Health Secretariat, with the name and registration code in the internal system of the health care network, It was the basis for carrying out a random drawing according to the number of people assisted in each *UBS*. We had some losses and refusals for reasons of not attending meetings; hospitalizations; limited cognitive condition; refusal to participate in the research and; death. Thus, the final sample was composed of 417 people.

We invited the participants for the research during the HYPERDIA meetings. Data collection took place in the *UBS* from February to June 2016, using two instruments, applied by the researchers. The first researcher assessed patients' satisfaction with the services provided by the PHC, based on the Primary Care Assessment Tool (PCAtool) and the assumptions of Barbara Starfield[1]. This instrument includes questions regarding identification, sociodemographic

profile, anthropometric data, presence of concomitant diseases and associated with complications related to AH, and attributes related to PHC: access to diagnosis, accessibility to treatment, adherence/bond, list of services, coordination care, family focus, community orientation and cultural competence[15].

For this study, we used the block of questions referring to the attribute List of Services, which consists of 11 indicators. They are in Table 1. Participants answered the questions corresponding to a Likert scale, with a single answer, assigning values between one and five for the options "1 - never", "2 –hardly ever", "3 - sometimes", "4 - usually" and "5 - always"[13]. The second instrument analyzed and classified the population according to their purchasing power, proposed by ABEP[16], categorized in classes AB, C, and DE.

Blood pressure was measured during the data collection period, with a properly revised and calibrated sphygmomanometer. Values were classified as adequate when systolic (SBP) and diastolic (DBP) blood pressure was ≤ 140 mmHg and ≤ 90 mmHg, respectively, according to the VII Brazilian Guideline on Hypertension[15]. An analysis of the regular monitoring of patients was performed based on the consultation of electronic medical records, considering as appropriate the one who attended the *UBS* at least three times, for consultations with a professional from the multidisciplinary team, in 2015, with pressure values measured and recorded[17].

The data were entered twice in a Microsoft Excel® 2016 electronic spreadsheet, and we used the Statistical Package for Social Sciences (SPSS) software, version 20.0for the statistical analyzes. Therefore, the Kolmogorov-Smirnov test identified the normality, with Lilliefors correction. For the analysis of variance, we used the Kruskall-Wallis test, obtaining the mean and standard deviation of the domain, which were then classified from the cutoff point of the averages, subdividing into satisfactory (≥ 4), regular (<4 and ≥ 3), and unsatisfactory (<3).

We used the univariate logistic regression analysis with the Forward method, considering the variables that resulted in a p <0.20 between the tests performed, which were later inserted and analyzed by the multiple logistic regression test. The magnitude of the associations was estimated by calculating Odds Ratio (OR), adopting the 95% confidence interval as a measure of precision, establishing a p-value <0.05 as statistical significance.

The study wasfollowing the guidelines of resolution 466/12 of the National Health Council/Ministry of Health, approved by the Permanent Committee for Ethics in Research with Human Beings (COPEP) under opinion number 1,407,687/2016. All participants signed the Informed Consent Form (ICF) in two copies of equal content.

RESULTS

The study had 417 people with AH, accompanied by PHC. The elderly population was predominant, over 70 years old (31.9%), female (67.9%) white (62.4%), with up to elementary school (28.5%), married (58.3%), classified in extract C (43.9%) and most of them were retired/pensioner (55.2%).

According to the assessment of the participants, the provision of information on antihypertensive drugs and their effects (2.99 ± 1.45), AH and its control (3.04 ± 1.45) obtained the lowest averages. The questions related to the measurement of blood pressure (4.32 ± 1.15), presence of at least one professional in the service unit (4.14 ± 1.21), and participation in groups of people with AH, offered in the unit (4.10 ± 1.27) were better evaluated according to Table 1.

Table 1. Performance indicators of the list of Primary Health Care services for people with arterial hypertension. Paraná, Brazil, 2016.

Label	List of Services	Mean	SD	CI 95%
ES1	Offering information about AH and its control	3.04	1.45	2.90 – 3.18
ES2	Offering information about medicines and their effects	2.99	1.45	2.85 – 3.13
ES3	Health education (information on other health topics)	3.07	1.47	2.93 – 3.22
ES4	Checking blood pressure every time you go for an appointment?	4.32	1.15	4.21 – 4.43

To be continued...

Label	List of Services	Mean	SD	CI 95%
ES5	Home visits	3.72	1.39	3.59 – 3.86
ES6	Do you find a professional at the health unit to assist you every working day of the week?	4.14	1.21	4.02 – 4.26
ES7	Participation in groups of people with AH in the health unit?	4.10	1.27	3.98 – 4.22
ES8	Are the opening hours of the health service for care always respected?	3.73	1.33	3.60 – 3.85
ES9	Does the service offer/guarantee exams request by the health professional?	3.85	1.29	3.70 – 3.95
ES10	Does the health unit professional explain the test results?	3.81	1.28	3.69 – 3.93
ES11	Is your return appointment scheduled?	3.78	1.40	3.65 – 3.92

Source: Data from the researchers, 2016.
SD: Standard Deviation; CI95%: Confidence Index.

In the multivariate model, when evaluating the explanation by health professionals about the tests requested, people with inadequate monitoring had a chance of 1.30 (95% CI: 1.10 - 2.83) as unsatisfactory and 1.38 (95% CI: 1.18-2.81) as regular. This same group had a 1.30 (95% CI: 1.12 - 2.74) chance of assessing blood pressure measurements and 1.92 (95% CI: 1.10 - 3.37) of the home visits as unsatisfactory (Table 3).

Table 2. Univariate analysis of Performance Indicators in the list of Primary Health Care services for people with arterial hypertension according to pressure control and adequate monitoring. Paraná, Brazil, 2016

Indicator	Classification	Adequate Monitoring		Univariate Analysis			Adequate Pressure Control		Univariate Analysis		
		Yes	No	OD	CI 95%	*p*	Yes	No	OD	CI 95%	*p*
ES1	Satisfied	96	60	1			91	65	1		
	Dissatisfied	105	59	0.89	0.57-1.41	0.646	78	86	1.54	0.99-2.40	0.054†
	Regular	61	36	0.94	0.56-1.59	0.830	55	42	1.06	0.64-1.78	0.798
ES2	Satisfied	94	57	1			92	59	1		
	Dissatisfied	113	59	0.86	0.54-1.35	0.520	82	90	1.71	1.09-2.66	0.017†
	Regular	55	39	1.16	0.69-1.97	0.560	50	44	1.37	0.81-2.30	0.234
ES3	Satisfied	109	55	1			102	62	1		
	Dissatisfied	96	59	1.38	0.85-2.23	0.191†	73	82	1.84	1.18-2.88	0.007†
	Regular	57	41	1.70	0.99-2.91	0.051†	49	49	1.64	0.99-2.73	0.054†
ES4	Satisfied	208	126	1			184	150	1		
	Dissatisfied	29	16	1.35	1.15-2.82	0.015†	25	20	0.98	0.52-1.83	0.953
	Regular	25	16	1.18	0.92-1.46	0.335	15	23	1.88	0.94-3.73	0.071†
ES5	Satisfied	164	73	1			125	112	1		
	Dissatisfied	51	41	1.70	1.02-2.82	0.019†	50	42	0.93	0.57-1.52	0.793
	Regular	47	41	1.36	0.81-2.31	0.119†	49	39	0.88	0.54-1.45	0.637
ES6	Satisfied	196	102	1			163	135	1		
	Dissatisfied	35	27	1.48	0.85-2.58	0.165†	40	22	0.66	0.37-1.17	0.158†
	Regular	31	26	1.61	0.90-2.86	0.161†	21	36	2.07	1.15-3.71	0.015†
ES7	Satisfied	190	98	1			158	130	1		
	Dissatisfied	39	32	1.59	0.93-2.69	0.084†	39	32	0.99	0.59-1.68	0.992
	Regular	33	25	1.46	0.82-2.60	0.189†	27	31	1.39	0.79-2.45	0.248
ES8	Satisfied	146	85	1			134	97	1		
	Dissatisfied	61	37	1.04	0.63-1.69	0.869	48	50	1.43	0.89-2.31	0.133†
	Regular	55	33	1.03	0.62-1.71	0.907	42	46	1.51	0.92-2.47	0.100†
ES9	Satisfied	157	90	1			141	106	1		
	Dissatisfied	56	33	0.64	0.37-1.12	0.123†	45	44	1.30	0.80-2.11	0.289
	Regular	49	32	0.93	0.54-1.59	0.803	38	46	1.50	0.90-2.49	0.112†
ES10	Satisfied	147	94	1			137	104	1		
	Dissatisfied	60	28	1.47	1.26-2.83	0.010†	46	42	1.20	0.73-1.96	0.460
	Regular	55	33	0.84	0.85-2.10	0.069†	41	47	1.51	0.92-2.46	0.099†

†Included in the multivariate analysis; OD: Odds Ratio; 95% CI: Confidence Index.

Regarding the offer of health education, there are 1.87 (95% CI: 1.03 - 3.39) chances of the same group to evaluate how to regulate information on different health topics. The respective variable was adjusted by the attribute ES9, which is the supply of tests requested by health professionals. For this reason, it is present in the table, even though it does not show statistical significance (Table 3).

In the variables referring to people with inadequate blood pressure control, there were 1.77 (95% CI: 1.12-2.77) chances of assessing

health professionals' information about medicines and their effects as unsatisfactory, and 1.89 (95% CI: 1.20-2.97) chances of unsatisfactorily evaluating health education. However, the variable referring to the presence of at least one professional from the unit to provide care on all working days of the week had 2.03 (95% CI: 1.11-3.69) chances of being assessed as regular by the participants with inadequate pressure control (Table 3).

Table 3. Multivariate analysis of Performance Indicators in the list of Primary Health Care services for people with arterial hypertension according to pressure control and adequate monitoring. Paraná, Brazil, 2016

Indicator	Classification	Adequate Monitoring		Multivariate Analysis		
		Yes	No	OD	CI 95%	*p*
ES10	Satisfied	147	94	1		
	Dissatisfied	60	28	1.30	1.10-2.83	0.021*
	Regular	55	33	1.38	1.18-2.81	0.013*
ES4	Satisfied	208	126	1		
	Dissatisfied	29	16	1.30	1.12-2.74	0.009*
	Regular	25	16	0.52	0.21-1.27	0.153
ES5	Satisfied	164	73	1		
	Dissatisfied	51	41	1.92	1.10-3.37	0.022*
	Regular	47	41	1.50	0.85-2.62	0.156
ES3	Satisfied	109	55	1		
	Dissatisfied	96	59	1.48	0.87-2.53	0.145
	Regular	57	41	1.87	1.03-3.39	0.039*β
ES9	Satisfied	157	90	1		
	Dissatisfied	56	33	1.68	0.61-4.56	0.308
	Regular	49	32	1.85	0.86-3.99	0.114
Indicator	**Classification**	**Adequate Pressure Control**		**Multivariate Analysis**		
		Yes	**No**	**OD**	**CI 95%**	***p***
ES2	Satisfied	92	59	1		
	Dissatisfied	82	90	1.77	1.12-2.77	0.013*
	Regular	50	44	1.32	0.78-2.26	0.294
ES3	Satisfied	102	62	1		
	Dissatisfied	73	82	1.89	1.20-2.97	0.006*
	Regular	49	49	1.30	0.90-2.54	0.116
ES6	Satisfied	163	135	1		
	Dissatisfied	40	22	0.63	0.36-1.13	0.126
	Regular	21	36	2.03	1.11-3.69	0.020*

DISCUSSION

In this study, there was a predominance of the elderly population, female, white, and with low education. The sample was similar to other studies[6,18]. The fact that the female gender is prevalent in this study may be because women are more perceptive about their health condition, looking more for health services, and adhering better to the treatment for AH[18]. Also, the importance of the active search for people with AH is emphasized but that they do not seek health services and, consequently, do not have proper monitoring.

The results of this study allowed us to verify that people with AH with inadequate monitoring, evaluate as regular and unsatisfactory the questions related to the explanation of health professionals about requested exams. Their results showed a point to be improved, both in monitoring and in the communication and guidance of people with AH, so that there is equitable and resolute assistance. Monitoring is enhanced with the creation of protocols that allow the identification of conditions that directly or indirectly contribute to the maintenance of blood pressure levels, guaranteeing personalized service for the real needs of each individual[19].

Corroborating these findings, a study conducted in Ceará with people with AH and FHS professionals detected weakened communication in medical and nursing consultations, being a challenge for PHC. We emphasized the need for efficient communication between health professionals and patients, and communication is a fundamental tool for the provision of comprehensive care that enables the strengthening of interpersonal relationships and health-promoting actions[20].

Participants stratified as inadequate monitoring rated blood pressure measurement as unsatisfactory in all SISHIPERDIA

consultations and home visits. through actions and methods to organize the work process, the FHS must perform the monitoring through monthly consultations, promoting the monitoring of morbidity based on guidelines and appropriate treatment, and assessing the evolutionary process of the instituted therapy[19-21].

As measuring blood pressure, home visits (HV) are a tool used by FHS teams for getting to know the context of the life of the assisted population, enabling the creation of bonds between professionals and patients, and longitudinal monitoring[21-22]. This practice has an important meaning in the context of PHC, as it allows the identification of the needs of the population in their own home, prompting the development of care practices consistent with reality[3]. In this sense, aiming at health promotion, we need to better recognize people with AH in its entirety, considering their limitations and needs and breaking the model of care centered on the disease, since the measurement of blood pressure and HV are strategies that can assist in the proper monitoring of these people.

Health education is another important indicator that was assessed as unsatisfactory by groups with inadequate monitoring and blood pressure control. Health education is an important tool that, when effective, can generate major improvements in the lives of people with AH, such as disease prevention and health promotion[8]. Thus, health professionals need to rethink their health education strategies and activities, aiming at a better reception for the enrolled population and allowing knowledge to reach these people, helping in their health conditions[8].

However, the results of this study showed that the participation in groups for people with AHin the health unit obtained a satisfactory evaluation by most participants. They revealed the importance of educational groups as a tool that can help health professionals in the diagnosis treatment, control, and therapeutic regimen of AH. A study carried out in northeastern Brazil showed that the participation of people with morbidity in therapeutic groups such as SISHIPERDIA presented better results in those individuals being monitored. Thus, the actions developed in groups can offer good results in the management and control of AH[6].

Regarding the provision of information on medications and their effects, an unsatisfactory and significant evaluation was obtained by the group with inadequate blood pressure control, and the vast majority of participants were elderly people with up to elementary school. A study carried out in Belo Horizonte, which assessed the level of understanding about pharmacotherapy among elderly patients of PHC found that more than half of the participants had an insufficient level of understanding of the guidelines provided by health professionals[23].

However, when asked about the guidelines received, the same individuals reported understanding a lot or everything about such guidelines and they did not need additional information about the use and effects of medications. The results demonstrated the lack of perception of people with AH, about their knowledge regarding the use of medications[23], which makes effective monitoring and health guidance difficult for these individuals.

Thus, linked to the results of this study in which the supply of information about AH and its control had a significantly low average, showing that the lack of knowledge about the disease is a challenge for adequate monitoring and pressure control, we assume that health professionals can develop strategies for better absorption of health guidelines, mainly related to chronic morbidity under treatment. Active participation and the population's understanding of AH are of great importance for changing lifestyle habits, as well as better health control[4].

The group with inadequate blood pressure control assessed how to regulate satisfaction related to the presence of at least one health professional in the *UBS*, demonstrating the dissatisfaction of these people, regarding the support and care provided. To offer comprehensive, quality, and equitable health care, PHC must guarantee continued care based on the needs of the population, including the monitoring of the multidisciplinary and interdisciplinary team in the treatment of AH[4,8,9].

Research carried out in the state of São Paulo showed that the lack of doctors is one of the factors that hinder treatment adherence. This is due to the fragility in creating a bond with the health team, an essential element for establishing favorable conditions aiming at the patient's

involvement with his health problem[24].

However, a study on adherence and bonding between FHS health professionals and people with AH had barriers regarding the attendance by the same professional in the consultations held periodically in the evaluated *UBS*. We evidence the importance of longitudinally and continuity of care provided to the studied population due to the encouragement of the patient participation in the treatment of morbidity, as the protagonist of the therapeutic process and who has the right to listen, question, and give opinions[18].

In this context, understanding patient satisfaction regarding the services offered by PHC wecan identify the strengths and weaknesses in services, demonstrating more and more the need to strengthen PHC, and directing public policies to this level of attention, being a way to seek solutions to the problems presented. Such findings can contribute to the practice of health professionals, especially for nursing professionals, enabling the identification of needs presented by the population, and providing comprehensive care to patient service.

The limitations of the study were due to bein only one municipality, being an obstacle for the comparison and generalization of the results, in which we suggest being careful when comparing the findings of this research with different care contexts, and other morbidities. The study is also limited to changes in the results of some associations due to the reverse casualty bias, which is inherent in exploratory, cross-sectional studies.

The contributions of this study are based on the importance of the multi-professional health team and its integral assistance on the activities that are carried out in the units, with multidimensional planning and care actions, allowing innovative educational practices, focused on the promotion and health education, enabling patient interaction in the care of their health, promoting self-care practices and a critical view of their role as a bearer of chronic morbidity, responsible for the activities inherent to their health condition.

CONCLUSION

We conclude that most of the participants satisfactorily evaluated the performance indicators related to pressure measurement, presence of at least one professional in the unit to attend and participate in SISHIPERDIA. The evaluations with low averages were for the provision of information on AH, medications and side effects, and health education practices. Regular average assessments were specified for home visits, opening hours of the units, scheduling of return, and conducting clinical examinations.

The assessment of people with AH in the list of services offered by PHC allows the identification of positive points to be improved for equitable and resolutive assistance. Based on the services offered, there was a limitation in the communication process between health professionals and the community, highlighting the need to improve the monitoring and care of patients with AH by the FHS to raise the population's satisfaction with the services provided byPHC and producing better health indicators.

DESEMPENHO DOS SERVIÇOS DA ATENÇÃO PRIMÁRIA À SAÚDE: SATISFAÇÃO DAS PESSOAS COM HIPERTENSÃO

RESUMO

Objetivo: avaliar o desempenho do elenco de serviços ofertados pela Atenção Primária à Saúde (APS) e associar ao controle pressórico e ao acompanhamento de pessoas com hipertensão arterial (HA). **Métodos:** estudo transversal, realizadocom 417 pessoas com HA, vinculadas a 34 Unidades Básicas de Saúde de um município do Paraná. Os dados foram coletados entre fevereiro e junho de 2016, utilizando instrumento de satisfação com serviços prestados pela APS, empregando questões referentes ao bloco sobre Elenco de Serviços. Para análise dos dados, utilizou-se estatística descritiva e inferencial. **Resultados:** observou-se prevalência de pessoas com idade superior a 70 anos, do sexo feminino, brancas e com baixa escolaridade. Obteve-se melhor avaliação nas questões relacionadas à aferição da pressão arterial, presença de no mínimo um profissional na unidade e participação em grupos de pessoas com HA. Pessoas com acompanhamento inadequado avaliaram insatisfatoriamente a aferição da pressão arterial nas consultas e visitas domiciliares. Os estratificados com controle pressórico inadequado avaliaram insatisfatoriamente a educação em saúde e informações sobre medicamentos e seus efeitos. **Conclusão:** destaca-se a necessidade de aperfeiçoar o acompanhamento e atendimento aos pacientes com HA, de modo que os serviços dispensados pela APS sejam satisfatórios.

Palavras-chave: Integralidade em Saúde; Atenção Primária à Saúde. Hipertensão.Pesquisa sobre Serviços de Saúde. Satisfação do Paciente.

DESEMPEÑO DE LOS SERVICIOS DE ATENCIÓN PRIMARIA DE SALUD: SATISFACCIÓN DE PERSONAS CON HIPERTENSIÓN

RESUMEN

Objetivo: evaluar el desempeño del elenco de servicios ofrecidos por la Atención Primaria a la Salud (APS) y asociar al control de la presión arterial y al acompañamiento de personas con hipertensión arterial (HA). **Métodos:** estudio transversal, realizado con 417 personas con HA, vinculadas a 34 Unidades Básicas de Salud de un municipio de Paraná-Brasil. Los datos fueronrecolectados entre febreroy junio de 2016, utilizando instrumento de satisfacción con servicios ofrecidos por la APS, usandocuestiones referentes altemasobre Elenco de Servicios. Para el análisis de los datos, se utilizó estadística descriptiva e inferencial. **Resultados:** se observóel predominio de personas conedad superior a 70 años, del sexo femenino, blancas y con baja escolaridad. Se obtuvouna mejor evaluaciónen las cuestiones relacionadas a la toma de la presión arterial, presencia de al menos un profesional en la unidad y participación en grupos de personas con HA. Individuos con acompañamiento inadecuado evaluaron insatisfactoriamente la toma de la presión arterial en las consultas y visitas domiciliarias. Los con la toma de presión arterial inadecuadaevaluaron insatisfactoriamente la educación en salud e informaciones sobre medicamentos ysus efectos. **Conclusión:** se destaca la necesidad de perfeccionar el acompañamiento yla atención a los pacientes con HA, de modo que los servicios suministrados por la APS sean satisfactorios.

Palabras clave: Integralidad en salud. Atención primaria de salud. Hipertensión. Investigación sobre servicios de salud. Satisfacción del paciente.

REFERENCES

1. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: Unesco, Ministério da Saúde; 2002.

2. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica. Brasília; 2017.

3. Becker RM, Heidemann ITSB, Meirelles BHS, Costa MFBNA, Antonini FO, Durand MK. Nursing care practices for people with Chronic Noncommunicable Diseases. Rev Bras Enferm 2018; 71:2643–9. https://doi.org/10.1590/0034-7167-2017-0799.

4. Gomes LOS, Azevedo AMG de B, Silva DO da. Health education as a tool in the patient knowledge with arterial hypertension. Journal of Nursing UFPE on Line 2017; 11:3279–89. https://doi.org/10.5205/1981-8963-v11i8a110194p3279-3289-2017.

5. World Health Organization. A global brief on hypertension: silent killer, global public health crisis: World Health Day 2013. Geneva: WHO; 2013 [cited 2019 Oct 8] Available from: http://apps.who.int/iris/bitstream/10665/79059/1/WHO_DCO_WHD_2013.2_eng.pdf.

6. Turra L, Restelatto MT da R, Dallacosta FM. Adherenceto treatment and life style of patients with hypertension. Revista de Pesquisa: Cuidado é Fundamental Online 2019; 11:113–7. https://doi.org/10.9789/2175-5361.rpcfo.v11.6490.

7. Barreto M da S, Mendonça R de D, Pimenta AM, Garcia-Vivar C, Marcon SS. Não utilização de consultas de rotina na Atenção Básica por pessoas com hipertensão arterial. Ciênc Saúde Coletiva 2018; 23:795–804. https://doi.org/10.1590/1413-81232018233.12132016.

8. Cecilio HPM, Figueiredo RM, Marcon SS. Coordenação e elenco de serviços no controle da tuberculose: percepção de enfermeiros e médicos. Cad Saúde Colet 2018; 26:439–45. https://doi.org/10.1590/1414-462x201800040410.

9. Gomide MFS, Pinto IC, Bulgarelli AF, Santos ALP, Gallardo MPS. A satisfação do usuário com a atenção primária à saúde: uma análise do acesso e acolhimento. Interface (Botucatu) 2017; 22:387–98. https://doi.org/10.1590/1807-57622016.0633.

10. Malachias M, Souza W, Plavnik F, Rodrigues C, Brandão A, Neves M, et al. 7ª Diretriz Brasileira de Hipertensão Arterial. Arq. Bras. Cardiol. [internet]. 2016 [acesso em 2018 set 16]; 107(3):1-104. Disponível em: http://www.scielo.br/pdf/abc/v107n3s3/0066-782X-abc-107-03-s3-0067.pdf.

11. Morais, JD, Ribeiro KSQS, Paes NA. Apoio social e satisfação de hipertensos com a atenção básica: construção de um índice sintético. Saúde em Debate [online]. v. 43, n. 121 [Acesso em 5 Novembro 2020], pp. 477-488. Disponível em: https://doi.org/10.1590/0103-1104201912115>. ISSN 2358-2898. https://doi.org/10.1590/0103-1104201912115.

12. Rêgo AS, Haddad MCFL, Salci MA, Radovanovic CAT. Acessibilidade ao tratamento da hipertensão arterial na estratégia saúde da família. Rev Gaúcha Enferm. 2018;39:e20180037. doi: https://doi .org/10.1590/1983- 1447.2018.20180037.

13. Zuo H-J, Ma J-X, Wang J-W, Chen X-R, Hou L. The impact of routine follow-up with health care teams on blood pressure control among patients with hypertension. JournalofHumanHypertension 2019; 33:466–74. https://doi.org/10.1038/s41371-018-0158-7.

14. Instituto Paranaense de Desenvolvimento Econômico e Social. Caderno Estatístico Município de Maringá [Internet]. Curitiba: IPARDES; 2016 [cited 2016 Sep 16]. Available from: http://www.ipardes.gov.br/cadernos/MontaCadPdf1.php?Municipio=87000&btOk=ok

15. Paes NA, Silva CS, Figueiredo TMRM, Cardoso MAA, Lima JO. Satisfação dos usuários hipertensos com os serviços da rede de atenção primária no Brasil: um estudo de validação. Rev PanamSaludPublica [Internet]. 2014 [cited 2016 Jun 25];36(2):87-93. Available from: http://www.scielosp.org/pdf/rpsp/v36n2/03.pdf

16. Associação Brasileira de Empresas de Pesquisas. Critério de classificação econômica Brasil. São Paulo: ABEP, 2016 [citado 2019 jul 22]. Disponível em: http://www.abep.org/Servicos/Download.aspx?id=09.

17. Brasil. Ministério da Saúde. Secretaria de Políticas de Saúde. Plano de Reorganização da Atenção à Hipertensão Arterial e ao Diabetes Mellitus no Brasil. Brasília, DF: 2001.

18. Rêgo AS, Radovanovic CAT. Adherence of hypertension patients in the Brazil's Family Health Strategy. Rev Bras Enferm [Internet]. 2018;71(3):1030-7. DOI: http://dx.doi.org/10.1590/0034-7167-2017-0297

19. Dantas RC de O, Roncalli AG, Dantas RC de O, Roncalli AG. Protocolo para indivíduos hipertensos assistidos na Atenção

Básica em Saúde. Ciência e Saúde Coletiva 2019; 24:295–306. https://doi.org/10.1590/1413-81232018241.35362016.

20. Torres GMC, Figueiredo IDT, Cândido JAB, Pinto AAG, Morais APP, Araújo MFM, e9t al. Comunicação terapêutica na interação profissional de saúde e hipertenso na estratégia saúde da família. Rev Gaúcha Enferm. 2017;38(4):e2016-0066. doi: http://dx.doi.org/10.1590/1983-1447.2017.04.2016-0066.

21. Rocha RG, Velasco HJL, Rêgo AS, Paiano M, Radovanovic CAT, Salci MA. Action of community health agents for persons depending on care as a result of chronic disease. CiencCuidSaúde 2018;17. https://doi.org/10.4025/cienccuidsaude.v17i3.44723.

22. Siqueira LD, Reticena K de O, Nascimento LH do, Abreu FCP de, Fracolli LA. Estratégias de avaliação da visita domiciliar: uma revisão de escopo. Acta Paul Enferm 2019; 32:584–91. https://doi.org/10.1590/1982-0194201900081.

23. Park E, Kim D, Choi S. The impact of differential cost sharing of prescription drugs on the use of primary care clinics among patients with hypertension or diabetes. Public Health 2019; 173:105–11. https://doi.org/10.1016/j.puhe.2019.05.005.

24. Pierin AMG, Silva SSBE da, Colósimo FC, Toma G de A, Serafim T de S, Meneghin P. Chronic and asymptomatic diseases influence the control of hypertension treatment in primary care. Rev Esc Enferm USP 2016; 50:763–70. https://doi.org/10.1590/s0080-623420160000600008.

Corresponding author: Anderson da Silva Rêgo. Programa de Pós-graduação em Enfermagem da Universidade Estadual de Maringá, Avenida Colombo, 5.790 - Campus Universitário - Bloco 001. CEP: 87020-900 - Maringá – Paraná – Brasil. Telefone: 44 99990-3924, E-mail: anderson.dsre@hotmail.com; andersondsre@gmail.com

Submitted: 21/05/2020
Accepted: 11/01/2021

FINACIAL SUPPORT

Coordination for the Improvement of Higher Education Personnel (CAPES), Social Demanda Scholarship, process number 001.