REVISTA BRASILEIRA DE MEDICINA DE FAMÍLIA E COMUNIDADE
RBMFC

www.rbmfc.org.br
ISSN 2197-7994

Research Article

Assessment of attributes of primary health care from the perspective of physicians

Avaliação dos atributos da atenção primária à saúde sob a ótica dos profissionais médicos

Evaluación de los atributos de la atención primaria de salud desde el punto de vista del profesional médico

Ana Paula Brandão Costa[1], Maximiliano Ribeiro Guerra[1], Isabel Cristina Gonçalves Leite[1]

[1]Universidade Federal de Juiz de Fora – Juiz de Fora (MG), Brazil.

Abstract

Introduction: The presence and extent of the attributes of Primary Health Care are determining factors in the effectiveness of primary healthcare services. **Objective:** To evaluate the implementation of Primary Health Care attributes from the perspective of physicians working in Health Centers (UBS). **Methods:** This is a cross-sectional study, carried out using the health professionals' version of the Primary Care Assessment Tool (PCATool-Brasil) and a sociodemographic questionnaire to characterize education profile, professional experience, and performance at the Primary Health Care. The study participants were physicians from units of the Family Health Strategy, traditional, and mixed Health Centers, in the city of Juiz de Fora, state of Minas Gerais, Brazil. **Results:** The means in the general, essential, and derivative scores of the attributes of Primary Health Care presented a score deemed satisfactory (≥6.6). However, the professionals evaluated the accessibility attribute as unsatisfactory. Moreover, the continuity and coordination/integration attributes achieved unsatisfactory evaluation among physicians with shorter time of activity in Primary Health Care, whereas the attributes of continuity and family orientation had an unsatisfactory evaluation from physicians who have not attended graduate courses in Family and Community Medicine or related areas. **Conclusions:** The study points to the need for expansion of accessibility to the services of primary health care, for the search for alternatives to appreciate and maintain physicians at Primary Health Care, in addition to promoting the education and training of health professionals, seeking to provide an increase in the problem-solving capacity and quality of services.

Keywords: Primary health care; Health services research; Health personnel.

Corresponding author:
Ana Paula Brandão Costa
E-mail: apbcosta9@gmail.com
Funding:
No external funding.
Ethical approval:
CAAE 06129919.9.0000.5147
Provenance:
Not commissioned.
Peer review:
external.
Received: 05/16/2021.
Approved: 11/17/2021.

How to cite: Costa APB, Guerra MR, Leite ICG. Assessment of attributes of primary health care from the perspective of physicians. Rev Bras Med Fam Comunidade. 2022;17(44):3085. https://doi.org/10.5712/rbmfc17(44)3085

CC BY

Resumo

Introdução: A presença e a extensão dos atributos da Atenção Primária à Saúde são fatores determinantes na efetividade da assistência em serviços de atenção primária. **Objetivo:** Avaliar a aplicação dos atributos da Atenção Primária à Saúde na perspectiva dos profissionais médicos das unidades básicas de saúde. **Métodos:** Trata-se de estudo transversal, realizado por meio da aplicação de questionário *Primary Care Assessment Tool* (PCATool-Brasil), na versão profissionais de saúde, e de questionário sociodemográfico para caracterizar o perfil de formação, experiência profissional e atuação na Atenção Primária à Saúde. Participaram da pesquisa os médicos de unidades da Estratégia Saúde da Família, tradicionais e mistas, do município de Juiz de Fora. **Resultados:** As médias dos escores gerais, essenciais e derivados dos atributos da Atenção Primária à Saúde exibiram pontuação considerada como satisfatória (≥6,6), contudo o atributo de acessibilidade foi avaliado como insatisfatório. Além disso, os atributos de longitudinalidade e coordenação/integração do cuidado obtiveram avaliação insatisfatória entre os médicos com menor tempo de atuação na Atenção Primária à Saúde, enquanto os atributos de longitudinalidade e orientação familiar receberam avaliação insatisfatória dos médicos que não cursaram pós-graduação em medicina de família e comunidade ou áreas afins. **Conclusões:** O estudo aponta para a necessidade de ampliação da acessibilidade aos serviços de atenção primária, da busca de alternativas para a valorização e a fixação do profissional médico na Atenção Primária à Saúde e o estímulo à formação e à qualificação desses profissionais de saúde, com a finalidade de propiciar o aumento da resolutividade e da qualidade dos serviços prestados.

Palavras-chave: Atenção primária à saúde; Avaliação de serviços de saúde; Profissionais de saúde.

Resumen

Introducción: La presencia y la extensión de atributos de Atención Primaria a la Salud (APS) son factores determinantes en la efectividad de la asistencia en servicios de atención primaria. **Objetivo:** Este artículo tiene como objetivo evaluar la aplicación de los atributos de la Atención Primaria a la Salud desde la perspectiva de los profesionales médicos situados en las unidades básicas de salud. **Métodos:** Consiste en un estudio transversal, realizado a partir de la aplicación de un cuestionario *Primary Care Assessment Tool* – Brasil, versiones profesionales de salud, y de cuestionario sociodemográfico para caracterizar el perfil de formación, experiencia profesional y actuación en la Atención Primaria a la Salud. Han participado del estudio médicos de unidades de estrategia de salud de la familia, tradicionales y mezcladas, del municipio de Juiz de Fora, Minas Gerais. **Resultados:** Las medias de puntuaciones generales, esenciales y derivadas de los atributos de la Atención Primaria a la Salud han exhibido puntuación considerada satisfactoria (≥6,6), sin embargo, el atributo de accesibilidad ha sido evaluado como insatisfactorio. Además, los atributos de longitudinalidad y coordinación/integración del cuidado han obtenido evaluación insatisfactoria entre los médicos con menos tiempo de actuación en la Atención Primaria a la Salud, mientras los atributos de longitudinalidad y orientación familiar han recibido evaluación insatisfactoria de los médicos que no han cursado posgrado en medicina de familia y comunidad o de áreas relacionadas. **Conclusiones:** El estudio apunta para la necesidad de ampliación de la accesibilidad a los servicios de atención primaria, de búsqueda por alternativas para valorización y establecimiento del profesional médico en la Atención Primaria a la Salud y del estímulo a la formación e calificación de estos profesionales de salud, con fines de proporcionar el aumento de la capacidad de resolución y de la calidad de los servicios ofrecidos.

Palabras clave: Atención primaria de salud; Investigación sobre servicios de salud; Personal de salud.

INTRODUCTION

Since the implementation of the Brazilian Unified Health System (SUS) in 1988, the Brazilian government has been seeking strategies to establish Primary Health Care (PHC) as a regulatory agency of the healthcare network throughout the country,[1] ensuring that citizens have access to health actions at the individual and collective levels that cover the promotion, protection against and prevention of diseases, diagnosis, treatment, rehabilitation, and maintenance of health.[2] Thus, the prioritization of PHC can result in the improvement of results in the health system and the reduction of costs, in addition to promoting equity and contributing to the guarantee of health rights. PHC should be adopted in a relevant and increasing way in health systems, as it presents more effective and resolutive intervention proposals when longitudinally dealing with multimorbidity.[3,4]

The proposals instituted in health with the advent of the SUS and the establishment of the Family Health Strategy (FHS) as a priority model of care for the population in PHC require broad training and qualification from professionals, comprising the knowledge and implementation of the essential and derivative attributes

of PHC, as conceived by Starfield.[1,5] However, these proposals concerning primary health care have still been little considered in the curricula and qualification proposals of PHC professionals.[6]

Contemporary studies show that Brazil currently has more than 43 thousand family health teams (FHT) that serve approximately 63% of the population.[7] However, it is difficult to recruit the staff of FHT, and the absence of physicians is often observed, especially in more distant regions of the country and in the peripheral regions of large cities.[8]

The expansion of the number of physicians in PHC, particularly in the FHS, has contributed to the expansion of the scope of the activities offered to the population and the reduction of social inequities; likewise, investment in training and continuing education has contributed to the improvement of the health indicators of the population served by them.[7]

Santos et al., state that the presence of physicians in the FHT contributes to promoting the increase of the team's intervention capacity by providing different views and actions of prevention, promotion, diagnosis, and treatment in an integrated manner.[9]

Despite the strategies of consolidation and reorientation of PHC in the country, there are different ways and instruments to evaluate it among managers, users, and health professionals. This hinders the understanding and strengthening of the healthcare model, especially concerning the expansion of access to the system, which has motivated the performance of this research.[10]

In Brazil, the use of the Primary Care Assessment Tool (PCATool) has enabled to detect arrangements of structure and process of services, aiming at improving the quality in the planning and implementation of PHC.[11] PCATool is used for evaluating PHC in several countries, with the most different arrangements of health systems, and has three versions validated and adapted for Brazil, besides being a self-applicable instrument to those responsible for children, adults, and health professionals.[11] Based on the evaluation of structural aspects, service processes and results, the PCATool aims to obtain evidence on the reality of PHC to increase the effectiveness of actions.[11]

Considering that the knowledge of the structure and work processes allows the adoption of specific strategies to face health issues, this research aimed to evaluate the PHC attributes of the city of Juiz de Fora, state of Minas Gerais, Brazil, from the point of view of physicians of Health Centers (*Unidades Básicas de Saúde* – UBS) of the municipality.

Even considering the expansion of the coverage of the population who use PHC that occurred in Juiz de Fora in recent decades, the municipality still faces a scenario of health units organized in FHS units, mixed, and traditional Health Centers focused on meeting spontaneous demand and curative actions.

Juiz de Fora is the largest of the 94 municipalities in the Southeast Extended Region of Health (*Região Ampliada de Saúde Sudeste*) in the state of Minas Gerais, being a reference in health services of different levels of complexity and technological density in the region.[12] When analyzing the organization in PHC in Juiz de Fora, there is a similarity between the coverage of PHC of the city (74.4%) and the average coverage of Brazilian municipalities with a population between 200 thousand and 600 thousand inhabitants (64.5%), thus justifying the relevance of the study for the analysis of physicians' perception of PHC attributes in this universe.[13]

Analyzing the extent of PHC attributes still depends on organizational, infrastructure, and quality advancements in the provided services. The practices of evaluation of healthcare services and actions in PHC were developed and systematized in Juiz de Fora based on the participation in the National Program for Access and Quality Improvement in Primary Care (*Programa Nacional de Melhoria do Acesso e Qualidade* – PMAQ) in 2012, without total participation of the municipal health teams in any stage.

METHODS

This is a cross-sectional study developed with physicians working in the Health Centers (UBS) of PHC of the municipality of Juiz de Fora from September 2019 to February 2020.

The PHC structure of Juiz de Fora consists of 63 UBS, of which 49 are urban and 14 are rural. The municipality has 43 UBS organized according to the FHS model, 19 in the traditional model, in addition to a mixed one (with one FHT and one team of the traditional model). During the research, in the municipality, there were 94 FHT accredited by the Brazilian Ministry of Health in March 2019.[14]

During the study period, 105 physicians worked in the 63 UBS of the municipality. The following were included in the study: PHC physicians with a workload of 40 hours per week assigned to the urban and rural UBS of the municipality and who worked in the FHS model; professionals linked to the More Doctors Program with a workload of 32 hours per week; and professionals working in traditional UBS with a workload of 20 hours per week and who also worked in the FHS model. The study population corresponded to 89.5% of the physicians who worked in PHC in the municipality during the research period. The other 10.5% were physicians specialized in Internal Medicine, Pediatrics, and Gynecology who worked in traditional Health Centers with emphasis on outpatient care, still outside the FHS model.

Data on PHC attributes were collected by the application of the PCATool-Brasil instrument, in the health professionals' version. A complementary sociodemographic questionnaire was also applied to survey the profile of physicians, their academic background, professional experience, and time of activity in PHC.

This research was approved by the Ethics Committee on Research involving Human Beings of Universidade Federal de Juiz de Fora (UFJF) under opinion No. 3.292.075. The participation of physicians was voluntary. All participants signed the Informed Consent Form and the entire research followed the Resolution No. 466 of December 12, 2012, of the Brazilian Ministry of Health[15], and the criterion of refusal or withdrawal was respected at any time of the research. The questionnaire was handed out by the researcher to the research participants.

The "health professionals" version of the PCATool instrument, used in this research, consists of 77 items divided into eight components regarding essential attributes and derivatives of PHC:

a. first-contact access — accessibility;
b. continuity;
c. coordination – integration of care;
d. coordination – information system;
e. integrality – available services;
f. integrality – provided services;
g. family orientation; and
h. community orientation.

The answers were scored according to the Likert scale, with a range of 1–4 for each of the items: "certainly yes" (value=4), "probably yes" (value=3), "probably no" (value=2), "certainly not" (value=1), and "I do not know/do not remember" (value=9).[16]

The scores for each of the attributes or their components were defined using the rescaled values of the responses of the items that compose each attribute or its component in the original scale, of 1–4,

was transferred to the new scale of 0–10 that contains the scores.[16] To evaluate the quality of PHC, the mean essential and derivative scores were calculated, according to the arithmetic mean of each item of the essential and derivative attributes separately, and the mean general score, according to the arithmetic mean of the total scores of the essential and derivative attributes together. For analysis and discussion, the mean scores higher than or equal to 6.6 were considered satisfactory, and the mean scores below this value were considered unsatisfactory.[11] Specializations focused on health care of the segments assisted by the FHS, such as Pediatrics, Gynecology, and Internal Medicine, were considered as FHS-related areas. Standard deviation, median, minimum, and maximum values of the scores (general, essential, and derivative) were also estimated, and the association between the scores and the variables that presented some ordering for their values (i.e., that were at least categorical and ordinal variables) was verified among those investigated through the complementary questionnaire, with Spearman's correlation. In this last stage, originally numerical variables, such as age, did not have their values reclassified into intervals.

The R software version 3.5.3 was used for data entry and analysis.[17]

RESULTS

Regarding sociodemographic data, education, and time working in PHC, 78.7% of the interviewed physicians were under 45 years of age, more than half (58.51%) had up to 15 years of medical education, and 68.11% have been working in PHC for more than 15 years, 90.43% in FHS units and only 9.57% in traditional or mixed Health Centers. In addition, 62.8% held at least one degree in Family and Community Medicine or related areas (Table 1).

According to the evaluation of the interviewees, the general (7.05), essential (6.93), and derivative (7.95) scores of PHC attributes showed means considered satisfactory. Regarding the items that compose the attributes, only the essential attribute of accessibility presented an unsatisfactory mean score (<6.6) and, among the others, the integrality of available services was the one that showed the lowest score (6.74), although still considered satisfactory. The highest scores were attributed to the items of family orientation (8.72) and coordination/information system (8.72) (Table 2).

By correlating the essential and derivative attributes with the time of activity in PHC (Table 3), it was verified that the longer the time of activity in PHC, the higher the mean scores of continuity and coordination/integration of care attributes evaluated by physicians ($p>0.05$).

By correlating the mean scores of the essential and derivative attributes evaluated by physicians with graduate degrees (including specialization, residence, or Master's degree) in the field of Family and Community Medicine or related areas, there were higher mean scores of continuity ($p=0.01$) and family orientation ($p=0.02$) attributes for physicians who hold at least one graduate degree (Table 4) compared with those who did not hold a graduate degree.

DISCUSSION

The evaluation of the implementation of PHC attributes carried out by physicians from the UBS of the municipality of Juiz de Fora demonstrates a satisfactory result in the means of scores of the general (7.05), essential (6.93), and derivative (7.95) attributes, all higher than 6.6, which was also evidenced in similar studies conducted in other Brazilian municipalities.[10,18-20] The high number of professionals who have some

qualification in the field of Family and Community Medicine or related areas (62.76%) probably contributed to this result, as the healthcare model proposed by SUS points to the need for a more critical, reflective, and integral training of human beings.[21]

It is noteworthy that more than half of the physicians who participated in the research had graduated up to 15 years ago, but this did not necessarily give them a better perception of the implementation of PHC attributes. It is worth mentioning that studies point to the fact that the experience of physicians has a favorable implication in their understanding of the service, highlighting the principle of continuity in the importance of health care over time.[21]

Table 1. Sociodemographic characteristics and those related to education and performance in Primary Health Care of physicians of the Health Centers of Juiz de Fora, 2019/2020.

		n	%
Sex	Woman	47	50
	Man	47	50
Age	<35	36	38.3
	35–55	38	40.4
	>55	20	21.3
Marital status	Single	36	38.3
	Separated/Divorced	9	9.6
	Married/Common-law marriage	45	47.9
	Other	4	4.3
Graduate degree	Family Health or related areas*	59	62.7
	Other areas**	02	2.1
	None	33	35.1
Years since graduation	<5	29	30.8
	5–15	26	27.6
	>15	39	41.5
Training in PHC	No	15	25.7
	Yes	79	74.3
Working time at PHC	<5	30	31.9
	5–15	34	36.2
	>15	30	31.9
UBS model in which the physicians work	Traditional	9	9.6
	FHS	85	90.4
Workload	20h	2	2.1
	32h	23	24.5
Employment relationship	40h	69	73.4
	Selection process/CLT regulations	28	9
	Statutory	4323	45.7
	More Doctors Program		24.5

UBS: Health Center (*Unidade Básica de Saúde*); FHS: Family Health Strategy; CLT: Brazilian Labor Laws Consolidation.
*Internal Medicine, Gynecology, Cardiology, Pediatrics, Nephrology. **Aesthetic Medicine, Anatomy, and Pathology
Source: Prepared by the authors (2020).

Table 2. Scores of the attributes of Primary Health Care according to the evaluation of physicians of the Health Centers of Juiz de Fora, 2019/2020.

Attributes	Mean	SD	Median	Min.	Max.
Accessibility	4.02	3.99	3.33	0	10
Continuity	7.12	2.62	6.66	0	10
Coordination/Integration of care	7.22	3.08	6.66	0	10
Coordination/Information System	8.72	1.96	10.00	0	10
Integrality/Available services	6.74	3.77	6.66	0	10
Integrality/Provided services	8.31	4.25	10.00	0	10
Family orientation	8.72	1.76	10	3.33	10
Community orientation	7.57	3.00	10	0	10
General	7.05	3.40	6.66	0	10
Essential	6.93	3.47	6.66	0	10
Derivative	7.95	2.70	10	10	10

SD: standard deviation

Source: Prepared by the authors (2020).

Table 3. Correlation between the time of activity in Primary Health Care and the mean of the scores according to essential and derivative attributes.

Attributes	n	Spearman's correlation	p-value*
A. Accessibility	94	-0.0743	0.4764
B. Continuity	94	0.4069	<0.0001
C. Coordination/ Integration of care	94	0.2104	0.0418
D. Coordination/Information System	93	0.1724	0.0984
E. Integrality/Available services	94	0.0159	0.8787
F. Integrality/Provided services	94	0.0665	0.5243
G. Family orientation	94	0.1858	0.0730
H. Community orientation	94	-0.0252	0.8093

*Spearman's significance test.

Source: Prepared by the authors (2020).

Table 4. Correlation between medical education and individual mean scores according to attribute and type of score.

Attributes	n	Some Training in the area*	No training in the area**	Spearman's correlation	p-value***
A. Accessibility	94	58	36	-0.0564	0.5893
B. Continuity	94	58	36	0.3636	0.0004
C. Coordination/Integration of Care	94	58	36	0.1815	0.0799
D. Coordination/Information System	93	58	35	0.0056	0.9573
E. Integrality/Available services	94	58	36	0.0379	0.7165
F. Integrality/Provided services	94	58	36	0.0990	0.3424
G. Family orientation	94	58	36	0.2407	0.0194
H. Community orientation	94	58	36	0.0353	0.7355

*Specialization and/or residency and/or Master's degree in Family and Community Medicine and clinical specialties (Gynecology and Obstetrics, Pediatrics, Geriatrics, Internal Medicine, Nephrology, and Cardiology). **Anatomy/Pathology and Aesthetic Medicine. ***Spearman's significance test.

Source: Prepared by the authors (2020).

The accessibility/first-contact access attribute was the one that received unsatisfactory mean scores in general, corroborating the results of other studies.[10,19,20] If, on the one hand, one of the objectives of SUS concerns the decentralization of services and the establishment of PHC as the gateway to the healthcare network, on the other hand, there is still a lack of availability of services during lunchtime, night shift, and weekends, both in Juiz de Fora and in other municipalities investigated in other studies.[10,16,18,19] This contributes to the search for emergency units and hinders the adoption of continued and longitudinal care proposed by the National Primary Care Policy. A research on PHC attributes conducted in Passos (state of Minas Gerais, Brazil) points to the need to improve the organizational structure of healthcare services to expand access and consequently the quality of care.[21] When discussing the unsatisfactory results regarding the accessibility attribute, a research conducted in the state of Goiás (Brazil) highlights the need for more financial investment in the qualification of access, by overcoming legal limitations that prevent the organization of the work performed at UBS outside business hours and on weekends.[20]

It is emphasized that the limitation in the service hours and the mechanisms of communication with users impairs the access to healthcare services of part of the population, especially of individuals who work on the morning shift. This situation is mainly based on men, considered as the part of the population that least seek healthcare services.[23] This is a debate that should often be promoted in health care and governmental spheres, in budgetary terms, aiming at the greater inclusion of people little contemplated in the programmatic lines of PHC so far.

Despite the creation of the Health on Time Program (*Programa Saúde na Hora*) in the country by the Brazilian Ministry of Health in 2020, Juiz de Fora did not confirm its participation in the program; only 12 UBS were pre-enrolled to participate in it[24] and did not advance its implementation in the municipality. However, this is an agenda that should be debated among the people responsible for the city's health policy, in the search for viable alternatives to expand access. It is also worth mentioning the importance of the advance in the implementation of the logical healthcare network for the effectiveness of PHC and the effective expansion of access.

Regarding the continuity attribute, professionals with more years of activity in PHC have a better perception of the scope of this attribute in their practice. Authors state that the guarantee of continuity provides the development of the bond between users and health professionals, allowing greater knowledge of the problems and the development of the subject's health history by the health team, besides enabling greater confidence and, consequently, greater potential for resolution.[25] Although the professionals with longer time of activity in PHC of Juiz de Fora have positively evaluated the continuity attribute, it is noteworthy that 54.26% of the interviewed physicians do not have an effective employment relationship with the municipality, which leads to the impairment of longitudinal follow-up of the healthcare service. Professionals who have temporary employment have to periodically undergo selection processes of the municipality for the revalidation of their contracts, which increases the turnover of assignments and impairs the professional's relationship with both users and health teams.

As well as continuity, the attribute of family orientation was also better evaluated by professionals with training related to the field of Family and Community Medicine, as verified in studies conducted in Goiânia (state of Goiás, Brazil)[20] and Lajeado (state of Rio Grande do Sul, Brazil).[19] Starfield[5] draws attention to the fact that professionals who focus on biological aspects and not on the socio-environmental context, who work in traditional primary care Health Centers, tend to have difficulty understanding the impact related to environmental, social, and behavioral factors on the etiology and progression of the disease, as they are often unfamiliar with the environment in which patients live and work.[5]

Family orientation is satisfactory as it denotes the ability of professionals to interact with families, respecting their uniqueness and recognizing their problems and needs in the context in which they are inserted.

The attribute coordination/integration of care also obtained worse performance among professionals with a shorter time working in PHC (p-value=0.0418). In the municipality of Juiz de Fora, as well as in others – such as Sobral (state of Ceará, Brazil)[10] and Lajeado (state of Rio Grande do Sul, Brazil) –,[19] difficulties were found in the communication of physicians with other units of the healthcare network and weaknesses in the reference and counter-reference system and access to specialized services. Coordination, in its variants of integration of care and available services, is related to the relevance of continuity of the services. Thus, it is worth highlighting the importance of the effectiveness of the counter-reference of secondary and tertiary services as a fundamental instrument for the continuity of user's follow-up by the health team, favoring the continuity of the therapeutic process and the resolution of care. Mendes (2010) highlights the demographic and epidemiological transition in Brazil, which triggers the increase in chronic conditions, and the fact that the health system in the country is still focused on providing assistance to acute conditions. At the same time, the author points to the importance of investments aiming at consolidating Health Care Networks for greater users' satisfaction and improved quality of services.[26] Starfield (2002) states that the qualification of the coordination of health care is closely linked to how much PHC physicians know about the process of disseminating information, which probably seems to be more difficult among those with shorter time working in PHC, justifying the results found in this research.[5]

As this is a cross-sectional study, there are some limitations of causality perception. In addition, the collected data are self-reported, which may influence the assessed information. Conversely, the good representativeness of the investigated population regarding PHC physicians in the municipality and the use of a collection instrument recommended for the evaluation of PHC in the country reinforce the applicability of the performed research.

CONCLUSION

The results obtained from this research enabled a reflection on the organization of PHC services in the municipality of Juiz de Fora and, although verifying a satisfactory evaluation of PHC attributes in general, the need for improvement of services in the areas of accessibility, continuity, coordination of care, and family orientation was identified, seeking the improvement of care quality and local management.

Although recognizing the relevance of incorporating other and diverse perspectives when it comes to addressing health policies, this research sought to emphasize the view of physicians who work in primary care, taking into account the historical importance existing in the collective consciousness of the role performed by this professional in health care as well as the relevance of their work in FHT.

Conversely, when considering the role of PHC as a regulatory agency of the healthcare network, it is paramount to emphasize that discussions on the coordination of care should be held by all health professionals, considering their fundamental importance in the process of comprehensive care and the investment in training, continuing education, and collaborative practices in PHC.

This is a topic of discussion of universal scope, in which there are still many gaps of knowledge in the literature to be explored. Nevertheless, as it refers to the reality of a medium-sized municipality with a relatively structured network of PHC services, the achieved results may offer important elements for the expansion and deepening of the topic in the national context.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

APBC: Conceptualization, Data curation, Formal analysis, Writing – original draft, Writing – review & editing. MRG: Conceptualization, Data Curation, Formal analysis, Writing – review & editing. ICGL: Formal analysis, Writing – review & editing.

REFERENCES

1. Girardi SN, Stralen ACSV, Cella JN, Maas LWD, Carvalho CL, Faria EO. Impacto do Programa Mais Médicos na redução da escassez de médicos em Atenção Primária à Saúde. Ciênc Saude Colet. 2016;21(9):2675-84, 2016. https://doi.org/10.1590/1413-81232015219.16032016
2. Brasil. Ministério da Saúde. Portaria n. 399, de 22 de fevereiro de 2006. Divulga o Pacto pela Saúde 2006 – Consolidação do SUS e aprova as Diretrizes Operacionais do Referido Pacto. Brasília: Diário Oficial da União; 2006.
3. Starfield B. The hidden inequity in health care. Int J Equity Health. 2011;10(1):15. https://doi.org/10.1186/1475-9276-10-15
4. Kemper ES, Tasca R, Harzheim E, Jiménez JMS, Hadad J, Sousa MF. Cobertura universal em saúde e o Programa Mais Médicos no Brasil. Rev Panam Salud Publica. 2018;42(1):1-5. https://doi.org/10.26633/RPSP.2018.1
5. Starfield B. Atenção primária: equilíbrio entre necessidade de saúde, serviços e tecnologia. Brasília: Unesco, Ministério da Saúde; 2002.
6. Vieira SP, Pierantoni CR, Magnago C, Ney MS, Miranda RG. A graduação em medicina no Brasil ante os desafios da formação para a Atenção Primária à Saúde. Saude Debate. 2018;42(1):189-207. https://doi.org/10.1590/0103-11042018s113
7. Facchini LA, Tomasi E, Dilélio AS. Qualidade da Atenção Primária à Saúde no Brasil: avanços, desafios e perspectivas. Saude Debate. 2018;42(1):208-23. https://doi.org/10.1590/0103-11042018s114
8. Sousa MF, Prado EAJ, Leles FAG, Andrade NF, Marzola RF, Barros FPC, et al. Potencialidades da Atenção Básica à Saúde na consolidação dos sistemas universais. Saude Debate. 2019;43(spe5):82-93. https://doi.org/10.1590/0103-11042019S507.
9. Santos LMP, Costa AM, Girardi SN. Programa Mais Médicos: uma ação efetiva para reduzir iniquidades em saúde. Ciênc Saude Colet. 2015;20(11):3547-52. https://doi.org/10.1590/1413-812320152011.07252015
10. Batista KBC, Gonçalves OSJ. Formação dos profissionais de saúde para o SUS: significado e cuidado. Saude Soc. 2011;20(4):884-99. https://doi.org/10.1590/S0104-12902011000400007
11. Brasil. Ministério da Saúde. Secretaria de Atenção Primária à Saúde. Departamento de Saúde da Família. Manual do Instrumento de Avaliação da Atenção Primária à Saúde: PCATool-Brasil – 2020. Brasília: Ministério da Saúde; 2020.
12. Juiz de Fora. Prefeitura de Juiz de Fora. Secretaria Municipal de Saúde. Plano de Saúde 2018-2021. Juiz de Fora: PJF; 2018.
13. Instituto Brasileiro de Geografia e Estatística. Estimativas da população residente para os municípios e para as unidades da federação brasileiros com data de referência em 1° de julho de 2020: tabelas. Rio de Janeiro: IBGE; 2020. [cited on Aug. 08, 2020]. Available at: https://ftp.ibge.gov.br/Estimativas_de_População/Estimativas_2020/POP2020_20201030.pdf
14. Brasil. Ministério da Saúde. e-Gestor AB. Informação e gestão da Atenção Básica. Cobertura da Atenção Básica. Todos os municípios – MG. Brasília: Ministério da Saúde; 2019.
15. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução no 466, de 12 de dezembro de 2012. Aprova as seguintes diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Brasília: Diário Oficial da União; 2013.
16. Ferreira VD, Oliveira JM, Maia MAC, Santos JS, Andrade RD, Machado GAB. Avaliação dos atributos da Atenção Primária à Saúde em um Município Mineiro. Esc Anna Nery. 2016;20(4):1-8. https://doi.org/10.5935/1414-8145.20160104
17. R Core Team. R: A language and environment for statistical computing. Vienna; 2019. [cited on Aug. 10, 2020]. Available at: https://www.R-project.org/
18. Gomes MFP, Fracolli LA. Avaliação da estratégia saúde da família sob a ótica dos profissionais. Rev Bras Promoç Saude. 2018;31(3):1-13. https://doi.org/10.5020/18061230.2018.7108
19. Penso MJ, Périco E, Oliveira MMC, Strohschoen AAG, Carreno I, Rempel C. Avaliação da Atenção Primária à Saúde utilizando o instrumento PCATool-Brasil. Rev Bras Med Fam Comunidade. 2017;12(39):1-9. https://doi.org/10.5712/rbmfc12(39)1212
20. Santos NA, Lima DR, Gontijo MKB, Martins MA, Leite GR, Silva LA, et al. Avaliação dos atributos da atenção primária por profissionais de saúde. Rev APS. 2017;20(3):339-48. https://doi.org/10.34019/1809-8363.2017.v20.15964
21. Oliveira MPR, Menezes IHCF, Sousa LM, Peixoto MRG. Formação e qualificação de profissionais de saúde: Fatores associados à qualidade da Atenção Primária. Rev Bras Educ Méd. 2016;40(4):547-59. https://doi.org/10.1590/1981-52712015v40n4e02492014

22. Rodrigues RB, Silva NC, Rocha TAH. Atração e retenção do profissional médico e os desafios para a Estratégia de Saúde da Família. Rio de Janeiro: XXXIV Encontro da ANPAD; 2010. [cited on Aug. 02, 2000]. Available at: http://www.andas.org.br/admin/pdf/for/2161.pdf
23. Guibu IA, Moraes JC, Guerra Junior AA, Costa EA, Acurcio FA, Costa KS, et al. Características principais dos usuários dos serviços de atenção primária à saúde no Brasil. Rev Saude Publica. 2017;51(Supl 2):1s-13. https://doi.org/10.11606/S1518-8787.2017051007070
24. Brasil. Ministério da Saúde. Secretaria de Atenção em Saúde. Departamento de Atenção Básica. Manual do instrumento de avaliação da atenção primária à saúde: primary care assessment tool, PCATool-Brasil. Brasília: Ministério da Saúde; 2010.
25. Brasil. Ministério da Saúde. Portaria n. 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Brasília: Diário Oficial da União; 2017.
26. Mendes EV. As redes de atenção à saúde. Cien Saude Colet. 2010;15(5):2297-305. https://doi.org/10.1590/S1413-81232010000500005.