REME • Rev Min Enferm. 2018;22:e-1134
DOI: 10.5935/1415-2762.20180063

RESEARCH

EVALUATION OF THE QUALITY OF PRIMARY HEALTH CARE: PROFESSIONAL PERSPECTIVE

AVALIAÇÃO DA QUALIDADE DA ATENÇÃO PRIMÁRIA À SAÚDE: PERSPECTIVA DE PROFISSIONAIS

EVALUACIÓN DE LA CALIDAD DE LA ATENCIÓN PRIMARIA DE SALUD DESDE LA PERSPECTIVA DE LOS PROFESIONALES

Rosângela Guerino Masochini [1]
Sheila Nascimento Farias [2]
Ana Inês Sousa [2]

[1] Universidade Federal de Mato Grosso – UFMT. Sinop, MT – Brazil.
[2] Universidade Federal do Rio de Janeiro – UFRJ, Escola de Enfermagem Anna Nery. Rio de Janeiro, RJ – Brazil.

Corresponding author: Rosângela Guerino Masochini. E-mail:rguerino320@hotmail.com
Submitted on: 2017/11/01 Approved on: 2018/08/04

ABSTRACT

Objective: to evaluate the attributes of Primary Health Care by the health professionals. **Method:** it is an evaluative, quantitative study and transversal design. It was performed with 192 health professionals from 15 Basic Health Units, in a city in the State of Mato Grosso. The Primary Care Assessment Tool, professional version, was used for data collection. Participants evaluated attributes in satisfactory, with the exception of First Contact Access. **Results:** data analysis revealed a need to improve service hours and the counter-referral mechanism. **Conclusion:** health professionals evaluated the attributes of Longitudinality, Coordination, and Integrality as satisfactory. The only unsatisfactory attribute was the First Contact Access and this was a barrier to be transposed in the search to meet the patients´ needs.

Keywords: Primary Health Care; Health Personnel; Public Health; Health Services.

RESUMO

Objetivo: *avaliar os atributos da atenção primária à saúde na visão de profissionais de saúde.* ***Método:*** *estudo avaliativo, quantitativa e delineamento transversal. Realizado com 192 profissionais de saúde das 15 unidades básicas de saúde, em uma cidade do estado do Mato Grosso. Para a coleta de dados, foi utilizado o instrumento Primary Care Assessment Tool, versão profissionais. Os participantes avaliaram os atributos em satisfatórios, com exceção ao acesso de primeiro contato.* ***Resultados:*** *a análise dos dados revelou necessidade de aperfeiçoar o horário de atendimento dos serviços e o mecanismo de contrarreferência.* ***Conclusão:*** *os profissionais de saúde avaliaram os atributos longitudinalidade, coordenação e integralidade como satisfatórios. O único atributo insatisfatório foi o acesso de primeiro contato e este constituiu uma barreira a ser transposta na busca de atender às necessidades dos usuários.*

Palavras-chave: *Atenção Primária à Saúde; Pessoal de Saúde; Saúde Pública; Serviços de Saúde.*

RESUMEN

Objetivo: *evaluar los atributos de la atención primaria de salud desde la perspectiva de sus profesionales.* ***Método:*** *estudio evaluativo, cuantitativo, transversal, realizado con 192 profesionales de salud de las 15 unidades primarias de salud de una ciudad del estado de Mato Grosso. Para la recogida de datos se utilizó el instrumento Primary Care Assessment Tool, versión profesionales. Los participantes evaluaron los atributos como satisfactorios, exceptuando Acceso al primer contacto.* ***Resultados:*** *el análisis de datos señaló la necesidad de mejorar el horario de atención de los servicios y el mecanismo de contrarreferencia.* ***Conclusión:*** *los profesionales evaluaron los siguientes atributos como satisfactorios: longitudinalidad, coordinación e integralidad. El único atributo insatisfactorio fue Acceso al primer contacto, una barrera que precisa ser superada si se busca atender las necesidades de los usuarios.*

Palabras clave*: Atención Primaria de Salud; Personal de Salud; Salud Pública; Servicios de Salud.*

How to cite this article:
Masochini RG, Farias SN, Sousa AI. Evaluation of the quality of primary health care: professional perspective. REME – Rev Min Enferm. 2018[cited _____ ___ ___];22:e-1134. Available from: _____ DOI: 10.5935/1415-2762.20180063

INTRODUCTION

Primary health care (PHC) in Brazil is characterized by a set of individual and collective health actions such as health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation and maintenance of health.[1]

The essential attributes are first contact access; longitudinality; integrality – available services and integrality – services provided; coordination – care and coordination – information. There are also the so-called derived attributes, which are: family orientation, community orientation and cultural competence.[2,3]

The essential attributes are called like this since a basic care service, directed to the general population, can only be considered primary care provider when there are four essential attributes, increasing its power of interaction with individuals and the community when presenting also the derived attributes. Identifying these attributes defining if the service is actually based on PHC is important.[3]

The quality of the service provided, the access to the first contact of the patients, the availability of the multi-professional team to provide care, the integration of care and the needs of each patient, orientation to the integrality of care in all spheres available in basic health units (BHU) are, in their totality, the identification of quality referring to all the team inserted in this level of care.

The objective of this research was to evaluate the quality of PHC through the essential attributes of PHC: first contact access, longitudinality, coordination and integrality from the perspective of health professionals.

METHODS

This is a descriptive, cross-sectional study with a quantitative approach. The survey was conducted in Sinop, a municipality located 505 km from Cuiabá, capital of the state of Mato Grosso, in the second half of 2016. According to data from the *Instituto Brasileiro de Geografia e Estatística* (IBGE), 2010, the municipality has an estimated population of 135,874 people and their first family health team was implemented in 2001.[4] During the data collection period, there were 15 teams in the urban area and one in the rural area, covering 65% of the population.

Of the 237 BHUs health professionals, 192 professionals accepted to participate in this study. The sample consisted of employees of both genders and public servant. Employees who were absent from the health unit due to health problems, holidays, vacations or those who refused to participate in the survey at the time of collection were excluded.

The data collection was carried out by the researcher and 10 nursing students during the hours of operation of the family health units, through a direct approach to the professionals in the BHU.

The students were trained to conduct the interview, participating in 20-hour training per week. The training facilitator was the lead researcher. The training followed the following proposals: a) presentation of the project; b) presentation of the objectives; c) reading and discussion of questionnaires; instruction on approach and interview; instruction on the informed consent term; instructions for completing the questionnaires; simulation of questionnaire application among interviewers with timing of interview duration; lecture on research ethics.

All participants were invited to participate in the survey. Upon their acceptance, the Free Informed Consent Form (TCLE) was read and the signature was requested. The investigative process was carried out through an interview of 50 minutes for the application of a sociodemographic data protocol, to characterize the interviewees and to assess the attributes of the PHC, the instrument of Primary Care Assesment Tool - PCATool-Brazil professional version.[3]

The Primary Care Assessment Tool (PCATool) has been validated in Brazil and evaluates the level of orientation to PHC through its attributes, and can be applied to professionals or patients of health services and directed to the health actions of adults or children, reflecting the experience of different groups.[5]

The ethical aspects were met according to the favorable opinion of the *Comitê de Ética e Pesquisa* (CEP) under number 1450546. This study is part of the thesis titled "Evaluation of the quality of primary health care in a municipality in the legal Amazon region".

For the data organization, a database was created in the Microsoft Office Excel 2010 program. The results of each interview were compiled and grouped according to the question blocks of the instruments used and the sociodemographic characteristics of the professionals. There was double typing of the database.

For each interview, the score of each essential PHC attribute was calculated according to the guidelines in the Manual of Assessment of Primary Health Care.[3] The final scores were given by the average of the interview answers. For the evaluation of the scores, the values established in the original instrument were used as reference, used in studies carried out with the application of PCATool-Brazil. Scores ≥ 6.6 were considered satisfactory and scores <6.6 were classified as unsatisfactory.[3]

For the execution of the processing and the submission of the analyses, the Excel database was transported to the SPSS software version 19.0, and descriptive statistical analysis was performed, so the categorical variables were described by absolute frequencies, percentages and the quantitative variables by mean and standard deviation.

RESULTS

The professions with the highest number of participants were: community agents (49.9%), nursing technicians (24.0%), nurses (9.9%), doctors (6.3%), dentist technicians 7%) and dentists (4.2%).

Table 1 shows the mean values of the scores given by the health professionals to the attributes of PHC. The health professionals evaluated the longitudinality, coordination and integrality attributes in satisfactory, and the first contact access attribute obtained the classification in unsatisfactory.

The attributes of coordination of information (7.51), integrality - available services (7.76) and integrality - services offered (7.78) presented a high score among the attributes classified as satisfactory, that is, values ≥ 6.6. In the attributes of the perception of health professionals, there is a need for improvement in the harmful use of drugs (lawful and illegal), advice on the non-use of firearms and medical procedures, suturing and placement of splint. Immunization was the item most evaluated by health professionals.

The attributes longitudinality (6.83) and coordination - care (6.87) obtained a "satisfactory" classification. However, close to the cutoff value; and the services that presented a need for improvement are described in Tables 3 and 4. The first contact access attribute was the only one classified as unsatisfactory. In the view of health professionals, the items that obtained negative results are described in Table 2.

Table 2 shows that the low score of the first contact access attribute resulted from the high percentages of negative evaluations on public service hours (A1, A2); care when the health service is not working (A5, A6 and A7); and the waiting time of more than 30 minutes for the doctor and nurse (A9). Positive evaluations are related to when the service is open if it is got in the same day (A3) and quick telephone counseling (A4) and routine scheduling (A8) are available.

Table 3 shows the percentage of the answers of the items that make up the longitudinality attribute. Interviewees report that the same health professional is always responsible for the follow-up of patient care (B1), who understands the questions of their patients (B2), that patients understand what the healthcare professional tells them (B3), who gives them enough time to talk (B5) and that the patients feel comfortable to report their problems and concerns (B6). The professionals believe that they know their patients well (B7) and what are the most important problems for them (B9). The quality is also demonstrated in item B10, in which most of the professionals report that they know well the history of health, the medications in use (B13) and that they would know if there was difficulty in getting some medicine (B12).

However, they do not consider that patients could clarify their doubts by a telephone call to the health unit, if necessary (B4). Regarding the knowledge of the health professionals about the economic and family conditions of the patients, there is an important gap between health professionals and patients, as health professionals answered that they had little information about the family members and the employment of the patients assisted at the BHU (B8, B11).

Table 1 - PHC attributed scores were checked by the professionals interviewed in the basic health units, Sinop-MT, 2016 (n=192)

Attributes	Mean	Inferior	Superior	Median	SD
Access of the first contact	3.49	3.34	3.65	3.33	1.11
Longitudinality	6.83	6.60	7.05	6.92	1.55
Coordination – care	6.87	6.61	7.14	6.67	1.84
Coordination – information	7.51	7.15	7.86	7.78	2.49
Integrality – available services	7.76	7.46	8.06	8.03	2.12
Integrality - services offered	7.78	7.41	8.15	7.89	2.60

Table 2 - Percentage of the health professionals answers regarding the components of the attribute of first contact access, Sinop-MT, 2016 (n=192)

Evaluation	A1	A2	A3	A4	A5	A6	A7	A8	A9
	%	%	%	%	%	%	%	%	%
Absolutely, no/I do not know/I do not remember	100	89	6.2	13	85.4	90.6	93.7	2	15.6
Probably, no	0	3.6	3.1	14	11.4	7.8	4.6	4.6	28.6
Probably, yes	0	3.6	31.2	41.1	2	0.5	1	34.3	45.3
Absolutely, yes	0	3.6	59.3	31.7	1	1	0.5	58.8	10.4
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Note: A1 - Is your health service open Saturdays and Sundays? A2 - Is your health service open at least a few days a week until 8 pm? A3 - When your health service is open and a patient becomes ill, does someone at your service assist you on the same day? A4 - When your health service is open, can patients get prompt advice over the phone when they feel it is necessary? A5 - When your health care service is closed, is there a phone number that patients can call when they get sick? A6 - When your health service is closed, on Saturdays and Sundays, and some of your patients become ill, does someone from your service assist you on the same day? A7 - When your health service is closed at night and some patient becomes ill, does someone at your service assist you that night? A8 - Is it easy for a patient to be able to set a time for a health checkup (routine visit, check-up) at your health service? A9 - On average, do patients have to wait more than 30 minutes to be assisted by the doctor or nurse (not counting the screening or the hosting)?

Table 3 - Percentage of professionals´ answers regarding the items of the longitudinality attribute, Sinop-MT, 2016 (n=192)

Evaluation	B1	B2	B3	B4	B5	B6	B7	B8	B9	B10	B11	B12	B13
	%	%	%	%	%	%	%	%	%	%	%	%	%
Absolutely, no/I do not know/I do not remember	2.6	1.0	0.5	48.4	3.1	0.5	6.7	25.0	4.6	17.1	25.5	7.2	20.3
Probably, no	2.6	0.5	3.6	16.1	3.1	5.7	7.2	29.1	7.2	27.6	35.4	16.1	29.1
Probably, yes	34.9	40.6	59.3	25.5	13.0	33.8	39.5	13.5	43.2	44.7	29.6	40.6	38.5
Absolutely, yes	59.9	57.8	36.4	9.9	80.7	59.9	46.3	32.2	44.7	10.4	9.38	35.9	11.9
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Note: B1 - In your health service, are the patients always assisted by the same doctor/nurse? B2 - Can you understand the questions your patients ask you? B3 - Do your patients understand what you say or ask them? B4 - If patients have a question, can they call and speak with the doctor or nurse who knows them best? B5 - Do you give patients enough time to talk about their concerns or problems? B6 - Do you think your patients feel comfortable telling you their concerns or problems? B7 - Do you know your patients as a person more than just someone with a health problem? B8 - Do you know who lives with each of your patients? B9 - Do you understand what problems are most important to the patients you assist? B10 - Do you know the full health history of each patient? B11 - Do you know the job of each patient? B12 - Would you have known if your patients could not get the prescribed medications or had difficulty paying for them? B13 - Do you know all the medicines your patients are taking?

Table 4 describes the evaluation of health professionals regarding the coordination of care attribute. Questions C2, C3, C4, and C6 obtained positive answers, indicating that the professionals do a writing referral and the patients receive help for the scheduling. However, the negative answers referring to questions C1 and C5 keep the score of this attribute close to the cut-off point, highlighting of the professionals´ knowledge of the consultations made by the patients and the difficulty in obtaining the counter-reference of the specialized services/professionals.

DISCUSSION

By the evaluation, it is highlighted that the essential attributes of "integrality" presented high scores; and the longitudinality and coordination attributes were close to the cutoff value, but were classified as satisfactory. The only PHC attribute that scored poorly was the first contact access.

The integrality attribute was rated as satisfactory and indicates that immunization and counseling services to quit smoking are offered in the BHU. The negative points were related to the treatment of licit and illicit drugs and corroborate the study carried out in Alfenas, Minas Gerais, with professionals of higher education, doctors and nurses, who obtained the satisfactory classification, but they point out the lack of advice to stop smoking and using illicit drugs.[6] Availability for the treatment of the drugs user is not the only responsibility of health. The actions of the policy of integral care for alcohol and other drugs users provide for the participation of other sectors of education, security, justice, and social assistance.[7] The BHU, in this policy, is considered to be the executor of health care in aspects of prevention due to proximity to the population, but studies reveal that drug user service is not incorporated into the routine care of the BHU.[8]

The attribute of access of first contact obtained the worse evaluation in the perception of the health professionals who participated in the research. There were weaknesses in the service to patients since the health service does not allow people to use the services in a way that meets the needs of the population. BHU does not operate on weekends and holidays and maintains service during business hours, closing the doors of the units for two hours for lunch. That is, the health team is not available to attend to acute events and workers´ out of service hours, as evidenced in other evaluations.[9-13] It is imperative that the user finds the door open and a team capable of responding to users' complaints[14], and using technologies such as cellphone and e-mail to increase access to health care so the BHU to become one of the main entry points into SUS.

Table 4 - Percentage of professionals´ answers to the items of the coordination attribute, Sinop/Mato Grosso, 2016 (n=192)

Evaluation	C1	C2	C3	C4	C5	C6
	%	%	%	%	%	%
Absolutely, no/I do not know/I do not remember	27.6	9.9	1.0	1.5	44.2	16.1
Probably, no	33.8	16.7	2.0	2.6	18.2	5.7
Probably, yes	30.2	28.2	13.5	11.4	15.1	32.8
Absolutely, yes	8.3	45.0	83.3	84.3	22.4	45.3
Total	**100**	**100**	**100**	**100**	**100**	**100**

Notes: C1 - Are you aware of any consultation your patients make to specialists or specialized services? C2 - When your patients need a referral, do you discuss with the patients about the different services where they could be go? C3 - Does anyone at your health service help the patient do the referral? C4 - When your patients are referred, do you provide them with written information to take to the specialist or specialist service? C5 - Do you receive useful information about the referral from specialist or specialized service? C6 - After consultation with the specialist or specialized service, do you talk with your patient about the results of this consultation?

The longitudinality attribute obtained a satisfactory classification (6.83), despite obtaining results close to the cutoff value (≥6.6). This attribute showed that health professionals have little knowledge about the health history and the socioeconomic conditions of the patients and family members enrolled in the scope of the BHU. This result shows that there are points to be improved, especially in the continuity of care, in the relationship between the patient and the health service, in the building of bonds and accountability between professionals and patients over time and permanently.[15,16]

Then, the coordination attribute is understood as continuity and integrality of health care, so the BHU is the gateway of the health system and the regulatory source of patients in the service network. The lower classification of this attribute was in the coordination integration care with 6.87 and stayed slightly above the cutoff value. This implies the need for improvement in referral and counter-referral. The poor quality of this service was found in other studies, whose participating professionals refer to the poor information of referrals to the specialties.[17] The information coordination revealed that the professional has the patient´s record and allows the patient to consult it. The patients´ rights in this area are respected, creating conditions for the autonomy of the subject.[18-20]

In Sinop-MT, waiting for appointment scheduling in the specialized service and for special exams may take months, which leads patients to seek care in private services, with consequent burden on the family budget or search for emergency services, which strengthens the fragmentation of care.[21,22]

The general evaluation of the quality of service provided in the BHU was evaluated as being partially satisfactory, with the exception of the first contact access attribute. Even with some notes not reaching the expected, health services are provided and supply the needs of the population, from the perspective of these health professionals.

CONCLUSION

The qualities of the evaluated services were partially satisfactory by the professionals and the attribute of access of first contact was a barrier to be transposed so they can meet the needs of the patients.

The study identified the need to move forward to provide effective access to strengthen the link between health team and patient. Thus, welcoming, attentive listening, dialogue and knowledge of the reality in which the patient is inserted are essential for the access to health care, meeting needs and involving families in solving problems and promoting health.

The intention bias is registered as a limitation of this study, since the instrument only evaluates the experience of the professionals, not incorporating the technical evaluation of the services provided. It is noteworthy that the subject matter is universal and research still lacks knowledge in this area.

It is expected that the information of this research can contribute to a reflection of the care offered to the population of Sinop-MT, with discussions about the accomplishment of a work with a priority in the development of the PHC attributes.

REFERENCES

1. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Política Nacional de Atenção Básica. Brasília: Ministério da Saúde; 2012. [cited 2017 Aug 16]. Available from: http://189.28.128.100/dab/docs/publicacoes/geral/pnab.pdf.
2. Starfield B. Atenção primária: equilíbrio entre necessidade de saúde, serviços e tecnologia. Brasília: Unesco; 2002. [cited 2017 June 26]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/atencao_primaria_p1.pdf.
3. Ministério da Saúde (BR). Secretaria de Atenção em Saúde. Departamento de Atenção Básica. Manual do instrumento de avaliação de atenção primária à saúde. Brasília: Ministério da Saúde; 2010. [cited 2017 Aug 16]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/manual_avaliacao_pcatool_brasil.pdf.
4. Ministério do Planejamento, Orçamento e Gestão (BR). Instituto Brasileiro de Geografia e Estatística. Censo 2010. Rio de Janeiro: IBGE; 2010. [cited 2017 June 26]. Available from: http://censo2010.ibge.gov.br/noticias censo?busca=1&id=3&idnoticia=1866&view=noticia.
5. Harzheim E, Starfield B, Rajmil L, Álvarez-Dardet C, Stein AT. Internal consistency and reliability of Primary Care Assessment Tool (PCATool-Brasil) for child health services. Cad Saúde Pública. 2006[cited 2017 June 26];22(8):1649-59. Available from: http://www.scielo.br/pdf/ csp/v22n8/13.pdf
6. Silva SA, Nogueira DA, Paraizo CMS, Fracolli LA. Assessment of primary health care: health professionals' perspective. Rev Esc Enferm USP. 2014[cited 2017 June 26];48(Spe):122-8. Available from: http://www.scielo.br/pdf/reeusp/v48nspe/0080-6234-reeusp-48-esp-126.pdf
7. Ministério da Saúde (BR). Secretaria Executiva, Coordenação Nacional de DST e AIDS. A Política do Ministério da Saúde para a Atenção integral a usuários de álcool e outras drogas. Brasília: Ministério da Saúde; 2003. [cited 2017 Aug 16]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/politica_atencao_alcool_drogas.pdf
8. Paula ML, Jorge MSB, Vasconcelos MGF, Albuquerque RA. Assistance to the drug user in the primary health caren. Psicol Estud. 2014[cited 2017 June 26];19(2):223-33. Available from: http://www.scielo.br/pdf/pe/v19n2/06.pdf
9. Castro RCL, Kanauth DR, Harzheim E, Hauser L, Ducan BB. Quality assessment of primary care by health professionals: a comparison of different types of services. Cad Saúde Pública. 2012[cited 2018 Jan 15];28(9):1772-84. Available from: http://www.scielo.br/pdf/csp/v28n9/v28n9a15.pdf
10. Silva AS, Baitelo TC, Fracolli LA. Primary health care evaluation: the view of clients and professionals about the Family Health Strategy. Rev Latino-Am Enferm. 2015[cited 2017 June 26];23(5):979-87. Available from: http://www.scielo.br/pdf/rlae/v23n5/0104-1169-rlae-23-05-00979.pdf
11. Chomatas E, Vigo A, Marty I, Hauser L, Harzheim E. Evaluation of the presence and extension of the attributes of primary care in Curitiba. Rev Bras Med Fam Comunidade. 2013[cited 2017 June 26];8(29):294-303. Available from: https://www.rbmfc.org.br/rbmfc/article/view/828/587
12. Lima EFA, Sousa AI, Leite FMC, Lima RCD, Souza MHN, Primo CC. Evaluation of the family healthcare strategy from the perspective of health professionals. Esc Anna Nery Rev Enferm. 2016[cited 2018 Jan 15];20(2):275-80. Available from: http://www.scielo.br/pdf/ean/v20n2/en_1414-8145-ean-20-02-0275.pdf
13. Marin MJS, Moracvick MYAD, Marchioli M. Access to health services: comparing the perspectives of professionals and users on primary care. Rev Enferm UERJ. 2014[cited 2017 June 26];22(5):629-36. Available from: http://www.e-publicacoes.uerj.br/index.php/enfermagemuerj/article/view/4238/12287

14. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Acolhimento à demanda espontânea. Brasília: Ministério da Saúde; 2013. [cited 2017 June 26]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/acolhimento_demanda_espontanea_cab28v1.pdf

15. Frank BRB, Viera CS, Ross C, Obregón PL, Toso BRGO. Evaluation of the longitudinality in Primary Health Care units. Saúde Debate. 2015[cited 2017 June 26]:39(105):400-10. Available from: http://www.scielo.br/pdf/sdeb/v39n105/0103-1104-sdeb-39-105-00400.pdf

16. Paula CCP, Silva CBS, Nazário EG, Ferreira T, Schimith MD, Padoin SMM. Factors interfering with the attribute longitudinality in the primary health care: an integrative review. Rev Eletrônica Enferm. 2015[cited 2018 Jan 15];17(4):1-11. Available from: http://dx.doi.org/10.5216/ree.v17i4.31084.

17. Pereira JS, Machado WCA. Reference and counter-reference between physical rehabilitation services of Persons with Disabilities: (dis) articulation in the Fluminense Central-South region, Rio de Janeiro, Brazil. Physis. 2016[cited 2017 June 26];26(3):1033-51. Available from: http://www.scielo.br/pdf/physis/v26n3/0103-7331-physis-26-03-01033.pdf

18. Tonello IMS, Nunes RMS, Panaro AP. Prontuário do paciente: a questão do sigilo e a lei de acesso à informação. Inf Inf. 2013[cited 2017 June 26];18(2):193-210. Available from: http://www.uel.br/revistas/uel/index.php/informacao/article/ view/16169.

19. Fausto MCR, Giovanella L, Mendonça MHM, Seidl H, Gagno J. The position of the Family Health Strategy in the health care system under the perspective of the PMAQ-AB participating teams and users. Saúde Debate. 2014[cited 2018 Jan 15];38(Esp):13-33. Available from: http://www.scielo.br/pdf/sdeb/v38nspe/0103-1104-sdeb-38-spe-0013.pdf

20. Van Stralen CJ, Belisário AS, Van Stralen TBS, Lima AMD, Massote AW, Oliveira ADL. Perceptions of primary health care among users and health professionals: a comparison of units with and without family health care in Central-West Brazil. Cad Saúde Pública. 2008[cited 2017 June 26];24(Suppl. 1):s148-s58. Available from: http://www.scielo.br/pdf/csp/v24s1/19.pdf

21. Nora CRD, Junges JR. Humanization policy in primary health care: a systematic review. Rev Saúde Pública. 2013[cited 2017 June 26];47(6):1186-200. Available from: http://www.scielo.br/pdf/rsp/v47n6/0034-8910-rsp-47-06-01186.pdf

22. Pressato MF, Duarte SRMP. Evaluation of primary care in the view of health professionals. Rev Ciênc Saúde. 2016[cited 2018 Jan 15];6(2):1-10. Available from: http://200.216.240.50:8484/rcsfmit/ojs-2.3.3-3/index.php/rcsfmit_zero/article/viewFile/492/309