ASSESSMENT OF THE ATTRIBUTES ACCESS, COORDINATION, AND COMPREHENSIVENESS IN PRIMARY HEALTH CARE FOR CHILDREN

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ABSTRACT

Objective: Evaluating the attributes of access, coordination, and comprehensiveness of Primary Health Care for children under 12 years old in a municipality in southern Brazil. **Methods:** This is a quantitative, evaluative research, part of a multicenter study, in which records from 39 basic health units were evaluated. The Primary Care Assessment Tool - Child version was used, applied to 609 caregivers, to evaluate the attributes of access (use and accessibility), coordination (care integration and information system), and comprehensiveness (available and provided services). Scores equal to or greater than 6.6 were defined as high and equivalent to a value of 3 or more on the Likert scale. **Results:** The attributes of first contact utilization (9.4), coordination-care integration (7.4), coordination-information system (7.6), and comprehensiveness-provided services (6.9) presented a satisfactory level of orientation for Primary Health Care. Lower scores were observed in the attributes of first contact accessibility (4.8) and comprehensiveness-available services (6.5). **Conclusion:** The bond with Primary Health Care is good; however, there is a need to increase the availability of appointments, improve the speed of care, and expand technological communication resources. It is also suggested to increase the availability of specialized services for children with special needs.

Keywords: Assessment of health services; Primary health care; Access to health services; Child health.

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INTRODUCTION ────────────

The 1988 Constitution, which established the Unified Health System (SUS) in Brazil, treats health as the duty of the State and the right of all citizens in Article 196. In Article 198, it states that health services and actions must be integrated into a hierarchical and regionalized network, organized according to the guidelines of decentralization, comprehensive care, and social control[1]. Among the various sectors of development within the SUS, child health care has been a major concern for professionals, managers, and policymakers, representing a field of significant investment aimed at reducing infant mortality rates[2-3].

In this context, the importance of the daily routines of Primary Health Care (PHC) services is emphasized, as it plays a crucial role in the challenge of integrating workers, managers, and users in care practices, taking into consideration the socio-economic peculiarities of the places where they operate[4]. PHC is defined as the first level of access in a healthcare system (first-contact access), primarily characterized by longitudinality, comprehensiveness of care, and coordination of care within the healthcare system. It may also encompass complementary characteristics such as family and community orientation and cultural competence. This definition explicitly outlines the essential and derived attributes of PHC[5].

The first-contact access of an individual with the healthcare system refers to the accessibility and utilization of health services as the primary source of care for each new health issue or new episode of the same health problem – with the exception of true medical emergencies and urgencies. Comprehensiveness, on the other hand, refers to a variety of services available and provided by PHC, ensuring care for the individual not only when they are ill but also taking into account their cultural and psychosocial context. Coordination of care presupposes some form of continuity, either through care provided by the same professional or through medical records, or both, along with the recognition of problems addressed in other services and their integration into the overall patient care. The primary care provider, through coordination among services, should be capable of integrating all the care the patient receives, aiming for promotion, prevention, cure, and rehabilitation[4-5]. However, failures in this process can have significant consequences, especially in the pediatric area, leading to avoidable

hospitalizations due to the ineffectiveness of primary care[6].

The evaluation of PHC should focus on the adherence and performance of its attributes even before conducting simple indicator analyses, as these principles ensure greater effectiveness of the care provided[7-8]. Thus, this study aimed to assess the degree of orientation of PHC regarding the attributes of Access, Comprehensiveness, and Coordination, for children under 12 years old in a city in southern Brazil.

METHOD

This is an evaluative research with a quantitative approach that is part of a multicenter study conducted in two cities in the State of Paraná and one in the State of Paraíba, Brazil. For this work, records from 39 Basic Health Units (BHU) in the urban area of a city in southern Brazil were collected and evaluated. The population consisted of family members (parents) and/or caregivers (grandparents, aunts, legal guardians) of children under 12 years old.

The sample calculation originated from the number of appointments in the Basic Health Units (BHU) conducted from July to December 2011, in the mentioned units, comprising the age group up to 12 years old, totaling 38,138 appointments. The source of information was TABWIN® (TAB for Windows), developed by DATASUS, which allows importing health data tabulations, performing arithmetic and statistical operations, creating graphs, and constructing and applying production, planning, and service programming indexes and indicators, with reports generated by procedures.

Based on this total, the sample size was estimated for the application of the Primary Care Assessment Tool (PCATool) - Brazil, child version, in the specific services, using stratified simple random probability sampling, with proportional allocation by region, unit, and the number of children in each unit. This choice is justified due to the heterogeneity of the population. The sample was stratified as: $\dfrac{N_h}{N} = \dfrac{n_h}{n}$

N_h: population stratum size
N: population size
n_h: sample stratum size
n: sample size

The calculation of the sample margin of error with a 5% level of significance (α) was performed, which gives us Z = 1.96, where Error E = 2.53:

$$E = Z_{\alpha/2}\sqrt{\dfrac{(1-p)\,p}{n}}$$

The total estimated number of participants was 609, with a 5% margin of error and a 95% confidence interval. The choice of participants was done through systematic sampling in the waiting line for medical or childcare consultation, between October 2012 and February 2013. Thus, the last family member in the waiting line was invited for an interview, and if they declined, the immediately preceding person was approached, and so on until the predetermined sample quota for the unit was reached. Data collection was conducted by undergraduate and postgraduate students in Nursing, who were previously trained for the task.

For the application of the instruments, the following inclusion criteria were considered: the participant should reside in the urban area of the municipality; they should have the capacity to understand, express, and comprehend the presented documents to be able to respond to the form; the child's main caregiver should be the accompanying person at the health unit; the age of the child should be up to 12 years old; and the caregiver/respondent should be familiar with the health unit being evaluated. Thus, individuals were included if they had taken the child for care at that specific health unit on at least two previous occasions before the one they were waiting for. Respondents who were residents living outside the territorial area but chose to use that service were also retained in the study.

In this study, issues related to the attributes of access (utilization and accessibility), coordination (care integration and information system), and comprehensiveness (available and provided services) were analyzed. The data collection and evaluation followed a form validated by Harzheim et al.[9], with the usage manual published by the Ministry of Health. (7). The responses are in the form of a Likert scale, with the option to choose between 1 and 4 for each attribute, meaning "definitely yes" (value = 4), "probably yes" (value = 3), "probably not" (value = 2), "definitely not" (value = 1), and "don't know/can't remember" (value = 9).

Once the data for the attributes were obtained, the values were transformed into a continuous scale, ranging from zero to ten, using the following formula: Adjusted Score = [(obtained score - 1) / (4 - 1)] x 10. Scores equal to or greater than 6.6 were defined as high and equivalent to a value of 3 or more on the Likert scale. Scores below this threshold were considered low[10].

The data was tabulated and analyzed using simple statistics such as absolute and relative frequency distributions, means, and medians, with the help of quantitative data analysis software such as SPSS® version 2.0 and Excel® 2010. The final score for each indicator of the PCATool-Brazil child version was calculated as the average of the respondents' answers.

The research was conducted following the norms of Resolution 196/1996 and 466/2012 of the National Health Council, after approval by the Committee of Ethics in Research Involving Human Subjects, under the opinion number 061/2012 and CAAE 01295412.2.1001.0107. Caregivers were invited to participate in the study when they sought care for the child at the Basic Health Unit (UBS), and data collection was performed there after obtaining their signed informed consent form.

RESULTS

From the 609 interviews conducted, it was deduced that mothers were the main caregivers of the children (79.2%), followed by grandmothers (13.9%). The predominant age group was between 20 and 59 years old (87.2%). Regarding the number of children per family, 39.7% had only one child, and 34.3% had two. Regarding education, 54.9% of caregivers had more than ten years of schooling. The majority of mothers were homemakers (35.8%), and 41.4% of fathers had formal jobs. As for the marital status of the parents, 61.3% were married, 16.6% were in a stable union, and 12.7% were single.

When asked about their family income, 78.2% stated that they earned between two to four minimum monthly wages, and among these respondents, 85.8% depended on this income to support three to five people. Approximately 50% owned their own homes, and the main means of transportation for them was the car.

When evaluating the *access* attribute, its utilization component received a highly positive score, with a continuous score of 9.4. This value was derived from the question "If the child has a new health problem, do you go to the usual health unit before seeking another service?"

Continuing with this attribute, there is the component of *accessibility*. This component presented an overall continuous score of 4.8, with all items evaluated as unsatisfactory (scores below 6.6), as detailed in Table 1.

The coordination attribute was subdivided in the PCATool manual (7) into two categories: care integration and information system. Table 2 presents the items related to care integration. This item expresses the relationship between the UBS and specialist care, with an overall continuous score of 7.4.

The *coordination* of information systems reflects how the exchange of records for the child is developed, such as vaccination cards and other exams, as well as the filling

Table 1 - Descriptive measures of the mean Likert scale scores and continuous scores (0 to 10) of the Attribute/Component First-Contact Access - Accessibility of primary health care for children. Paraná, Brazil, 2012-2013.

Indicator	Mean Likert scale score	Continuous score 0-10
When the "*name of the health service / or name of the doctor/nurse*" is open, and your child becomes sick, does someone from this health service attend to them on the same day?	2,8	6,1
Do you have to wait for a long time or talk to many people to schedule an appointment at "*name of the health service / or name of the doctor/nurse*"?	2,5	4,9
Is it easy to schedule an appointment for a child's follow-up consultation ("routine check-up") at "*name of the health service / or name of the doctor/nurse*"?	2,9	6,5
When you arrive at "*name of the health service / or name of the doctor/nurse*," do you have to wait for more than 30 minutes for your child to be seen by the doctor/nurse (excluding screening or reception)?	1,6	2,1
Is it difficult for you to get medical care for your child at "*name of the health service / or name of the doctor/nurse*" when you think it is necessary?	2,4	4,7
When "*name of the health service / or name of the doctor/nurse*" is open, can you get quick advice over the phone if you need it?	2,3	4,4
Overall score	2,4	4,8

and presence of medical records during the consultation, and the caregiver's access to this information. In this item, the value of the overall continuous score was close to the previous one (7.6), with details observed in Table 3.

The attribute of comprehensiveness was also evaluated, based on two categories: available services and provided services. The first set of questions presented in Table 4 lists

Table 2 - Descriptive measures of the mean Likert scale scores and continuous scores (0 to 10) of the Attribute/Component Coordination - Care Integration of primary health care for children. Paraná, Brazil, 2012-2013.

Indicator	Mean Likert scale score	Continuous score 0-10
Did the "*name of the health service / or name of the doctor/nurse*" suggest or recommend that your child should consult with this specialist or specialized service?	3,4	8,1
Did the "*doctor/nurse*" of your child know the results of this consultation?	3,5	8,3
After this consultation with the specialist or specialized service, did your "*doctor/nurse*" talk to you about what happened during this consultation?	3,2	7,4
Did your "*doctor/nurse*" seem interested in the quality of care provided to your child by the specialist or specialized service?	3,0	6,6
Did the "*name of the health service / or name of the doctor/nurse*" suggest or recommend that your child should consult with this specialist or specialized service?	3,0	6,6
Overall score	3,2	7,4

Table 3 - Descriptive measures of the mean Likert scale scores and continuous scores (0 to 10) of the Attribute/Component Coordination - Information System of primary health care for children. Paraná, Brazil, 2012-2013.

Indicator	Mean Likert scale score	Continuous score 0-10
When you take your child to "*name of the health service / or name of the doctor/nurse*," is their medical record always available during the consultation?	3,8	9,2
When you take your child to "*name of the health service / or name of the doctor/nurse*," do you bring any of the child's health records or treatment reports that they received in the past? (For example, if you don't understand "records": emergency treatment forms, vaccination cards)	3,7	8,9
Could you read (consult) your child's medical record or file if you wanted to at "*name of the health service / or name of the doctor/nurse*"?	2,4	4,7
Overall score	3,3	76

the available services in the health unit and the caregivers' responses regarding their presence and use, resulting in an overall continuous score of 6.5.

Analyzing the sub-item provided services, an overall continuous score of 6.9 was found. Table 5 presents the fractional scores by questions, representing whether the caregiver received guidance on the child's nutrition, home safety, growth and development, and behavior.

Table 4 - Descriptive measures of the mean Likert scale scores and continuous scores (0 to 10) of the Attribute/Component Comprehensiveness - Available Services of primary health care for children. Paraná, Brazil, 2012-2013.

Indicator	Mean Likert scale score	Continuous score 0-10
Vaccines (immunizations).	3,9	9,6
Family planning or contraceptive methods.	3,6	8,6
Counseling and HIV testing request.	3,5	8,2
To check if your family is eligible for any social assistance program or social benefits.	3,0	6,6
Nutritional supplementation program (e.g., milk and food).	2,9	6,4
Counseling or treatment for harmful drug use (licit or illicit, e.g., alcohol, cocaine, sleeping pills).	2,6	5,4
Suturing a cut that requires stitches.	2,6	5,5
Counseling for mental health issues.	2,4	4,6
Identification (some form of assessment) of visual problems (to see).	2,2	3,9
Overall score	2,9	6,5

Table 5 - Descriptive measures of the mean Likert scale scores and continuous scores of the Attribute/Component Comprehensiveness - Provided Services of primary health care for children. Paraná, Brazil, 2012-2013.

Indicator	Mean Likert scale score	Continuous score 0-10
Guidance on keeping your child healthy, such as healthy eating, good hygiene, or proper sleep.	3,7	8,9
Changes in the growth and development of the child, that is, what things you should expect at each age. For example, when the child will start walking, controlling urine, etc.	3,3	7,6
Home safety: how to safely store medications.	3,0	6,8
Ways to keep your child safe, such as: preventing falls from heights or keeping children away from the stove.	2,9	6,3
Ways to deal with your child's behavioral problems.	2,5	5,1
Overall score	3,1	6,9

DISCUSSION ─────────────

The results presented demonstrate that the attributes of first-contact access (utilization), coordination (care integration and information systems), and comprehensiveness (provided services) were better evaluated by caregivers than the attributes of first-contact access (accessibility) and comprehensiveness (available services).

Access can be described as the timely use of health services to achieve the best personal outcomes in health promotion and disease prevention. In this definition, the core of the concept becomes synonymous with utilization, characterizing part of the instrument of the first-contact access attribute - utilization[7,11], which showed highly positive results in this research, with a score of 9.4. Similar results were identified in Quatá (SP), with a score of 9.2[12], and Cascavel (PR), which 8,6[13]. However, in Montes Claros (MG)[14], the score was 5.5. In this study, the good score presented by the municipality reflects the existence of a bond between the user and the health unit, considering it as a reference for initial care of health problems presented by the population. Starfield[10] refers to this initial access as the "gatekeeper," which should be easily accessible and inherent to the organization of health services by level of care (primary, secondary, and tertiary).

The concept of accessibility is broader than mere availability of resources at a specific time and place. It refers to the characteristics that facilitate or limit the use of these services by potential users. In this research, accessibility obtained a score of 4.8, which is not satisfactory in terms of the degree of orientation of the attribute in primary health care. It is important to reflect on what causes this dissatisfaction, as this component is essential in the structure of a health system to achieve first-contact care[11,14-15]. In this context, the role of the Family Health Strategy (ESF), promoted by the federal government, is emphasized in creating a bond and guiding the user in primary health care. However, a decrease in the coverage of the ESF teams due to changes in public management, political influences, and inadequate funding significantly contributes to the decline in the positive evaluation of the effectiveness of primary health care[16].

Effectiveness can be more precisely specified as the degree to which the care - whose quality is being evaluated - reaches the level of health improvement that efficacy studies have established as achievable. It is not valid to assess effectiveness without diagnosing the structural and process points of what will be evaluated. The structure includes objectives, physical, human, material, and financial resources, while the process includes all activities developed between healthcare professionals and patients[17].

Therefore regarding the first-contact access, in the structural aspect where utilization is assessed, the result obtained was positive, as the user seeks and needs this service and sees it as a place where they can find care for their child. However, in the process aspect, there seems to be difficulty regarding accessibility, such as scheduling appointments, prompt attention, and other contact methods like phone communication. Accessibility can be seen as the quality of what is accessible and enables people to reach health services. In general terms, accessibility refers to the characteristics of the care offered, while access is how people perceive that accessibility[7].

Coordination is indispensable for the achievement of the other attributes of Primary Health Care, even with adequate access, as it implies the professional knowledge of all the patient's health problems. The information provided from various services' appointments needs to be related to each other to ensure continuity of care for current demands[5]. In Curitiba (PR)[18] and Montes Claros (MG)[14], the coordination attribute also received satisfactory evaluation from caregivers, reaching scores of 6.9 and 7.7, respectively. It is worth noting that these studies did not separately present the values of the subgroups within coordination.

In the integration of care category, the question to the caregiver about whether the child's doctor discussed the consultation with the specialist received a score close to the satisfactory threshold ($\geq$ 6.6). This may be a reflection of the challenges faced in the coordination attribute, where the process of primary care involves various team members with different information, as well as various specialists with both short-term and long-term follow-ups[19]. There is still difficulty in managing cases of reference and counter-reference between different sectors and levels of care (education, sanitation, transportation, etc.), which require ongoing dialogue and monitoring through the transfer of qualified information[5-19].

When asked if the interviewee could have access to the child's medical record to read it, the score was significantly low, demonstrating a lack of information to users about their rights. The ordinances of the Ministry of Health nº 1286, of 1993, in its article 8, and nº 74, of 1994[20], guarantee that "The patient has the right to have his medical record prepared in a legible manner and to consult it at any time", and should, therefore, receive information about it.

Healthcare systems can enhance coordination between care levels through the following reforms: improvement of the information recorded in health records, use of technologies (such as computers for patient notes), changes in the primary care level to address the demands of chronic diseases, and reevaluation of resource allocation in the outpatient sector due to the progressive shift of procedures from hospital care to this level[5,19].

The analysis of the dimensions of the attribute "integralidade," carried out separately by evaluating each question, and not only the final value of the attribute as a whole, allowed us to identify the different elements involved and diagnose the available and provided services in the UBS according to the caregivers' perceptions. The same method of evaluation and interpretation was used in a study evaluating Primary Health Care (APS) in the city of São Paulo (21), in which the item "vaccination" also received greater attention, despite low scores in other available services. This result was attributed to better control of immunobiologicals through the UBS information systems, active search for vaccination cards of children with delays by community agents, and campaigns conducted to update the vaccination schedule [21].

The present research, however, distinguished itself by presenting a satisfactory value in the items "family planning" and "counseling for HIV". Other evaluative studies of Primary Health Care (APS) only presented the final score of the attribute, and not each question that composes it[22-24]. The services most well recognized by users are related to health promotion and prevention, such as family planning, nutritional supplementation, and participation in social programs. However, when it comes to follow-ups that require longitudinal care and complementary specialties, such as in the areas of mental health and interventions for alcohol and drug use, the evaluation was unfavorable.

The available services component of the comprehensiveness attribute deserves to be highlighted for evaluating the structure of APS services, considering their variability, in addition to the capacity that each unit must

have to manage the health problems of the population linked to it[13,22]. The process evaluation is related to the component of services provided by PHC professionals for the child[22]. In this study, good scores were obtained for questions that evaluated whether caregivers received information on how to keep the child healthy and safe regarding accidents with medications, as well as on growth and development. On the other hand, caregivers did not give a good evaluation regarding guidance on behavioral management in childhood. These findings reinforce the need for professionals to consider care for children from a holistic perspective, encompassing biopsychosocial areas, with a multidisciplinary approach, especially in the field of child psychology, as recommended by the ministry[25-27].

CONCLUSION

The study demonstrated that the attributes of access *(utilization)*, coordination *(integration of care and information systems)*, and comprehensiveness *(services provided)* were better evaluated by caregivers compared to the attributes of access *(accessibility)* and comprehensiveness *(services available).* Incentive strategies that increase the availability of appointments, expedite care, and expand technological communication resources should be strengthened. Additionally, there is a need for greater availability of specialized services for children with specific needs.

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