

Potential access to primary health care: what do the data from the National Program for Access and Quality Improvement show?

Severina Alice da Costa Uchôa¹
Ricardo Alexandre Arcêncio²
Inês Santos Estevinho Fronteira³
Ardigleusa Alves Coêlho⁴
Claudia Santos Martiniano⁴
Isabel Cristina Araújo Brandão⁵
Mellina Yamamura⁶
Renata Melo Maroto⁷
Anny Karine Freire da Silva⁸

Objective: to analyze the influence of contextual indicators on the performance of cities regarding potential access to primary health care in Brazil and to discuss the contribution from nurses working on this access. **Method:** a multicenter descriptive study using secondary data from External Evaluation of the National Program for Access and Quality Improvement in Primary Care, with the participation of 17,202 primary care teams. The chi-square test of proportions was used to verify differences between the cities stratified in the dimensions on size of the coverage group, supply, coordination and integration. When necessary, the chi-square test with Yates correction or Fisher's exact test were employed. For the population variable, the Kruskal-Wallis test was used. **Results:** the majority of participants were nurses ($n = 15,876$; 92.3%). Statistically significant differences were observed between the cities in terms of territory ($p=0.0000$), availability ($p=0.0000$), coordination of care ($p=0.0000$), integration ($p=0.0000$) and supply ($p=0.0000$), verifying that the cities that make up group 6 tend to perform better in these dimensions, with a better performance in all dimensions analyzed in groups 4, 5 and 6. **Conclusion:** weakness in smaller cities, confirming inequities in the potential access to Primary Health Care in Brazil as challenges for universal coverage. The preponderant role of nurses for its achievement is highlighted.

Descriptors: Health Services Accessibility; Primary Health Care; Universal Coverage.

¹ Post-doctoral fellow, Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa, Lisboa, Portugal. Associate Professor, Departamento de Saúde Coletiva, Universidade Federal do Rio Grande do Norte, Natal, RN, Brazil. Scholarship holder from Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq), Brazil.

² PhD, Professor, Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, PAHO/WHO Collaborating Centre for Nursing Research Development, Ribeirão Preto, SP, Brazil.

³ PhD, Assistant Professor, Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa, Lisboa, Portugal.

⁴ PhD, Professor, Departamento de Enfermagem, Universidade Estadual da Paraíba, Campina Grande, PB, Brazil.





⁵ MSc, Professor, Departamento de Enfermagem, Centro Universitário FACEX, Natal, RN, Brazil.

⁶ Doctoral student, Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, PAHO/WHO Collaborating Centre for Nursing Research Development, Ribeirão Preto, SP, Brazil. Assistant Professor, Escola de Enfermagem, Universidade Federal do Rio Grande do Norte, Natal, RN, Brazil. Scholarship holder from Fundação de Amparo à Pesquisa do Estado de São Paulo (FAPESP), Brazil.

⁷ Doctoral student, Departamento de Odontologia, Universidade Federal do Rio Grande do Norte, Natal, RN, Brazil.

⁸ Specialist in Reading and Text Production.

How to cite this article

Uchôa SAC, Arcêncio RA, Fronteira ISE, Coêlho AA, Martiniano CS, Brandão ICA, et al. Potential access to primary health care: what do the data from the National Program for Access and Quality Improvement show?. Rev. Latino-Am. Enfermagem. 2016;24:e2672. [Access   ]; Available in: . DOI: <http://dx.doi.org/10.1590/1518-8345.1069.2672>.
month day year URL

Introduction

In 2005, members of the World Health Organization (WHO) committed to achieve the universal health coverage target provided by the Millennium Development Goals and post-2015 agenda, aiming to improve the health and welfare of the population. Universal coverage is defined as access to and appropriate use of the services according to the understanding of the health system functions; health workers who are available, motivated and qualified; access to essential medicines and health products; integrated, quality, patient-centered services; health promotion and disease control; accurate information system for adequate decision-making; and financing with protection against financial risks⁽¹⁾. There is a growing movement in this direction among the 25 richest nations and those in development, such as Brazil, Mexico and Thailand, and even in those of low-income, as Ghana, Philippines, Rwanda and Vietnam⁽²⁾.

Since the 1988 constitution, Brazil has made efforts towards universal coverage as a right through the Unified Health System (SUS). In 1994, the Family Health Strategy was implemented, based on comprehensive care and multidisciplinary teamwork. Through this strategy, the coverage rate was expanded, reaching 57% of the population (108 million people) in 2013⁽³⁾.

However, access has been strongly marked by social inequalities, with disadvantaged populations in vulnerable situations with an impact on the health status of these groups, causing more iatrogenic situations, poorer quality services and continued, more severe suffering with some health conditions, including preventable and premature deaths. Thus, new forms of system organization, with real universal coverage has been envisioned to achieve equity and integrality of actions⁽⁴⁾. Another challenge is shortage in the distribution, composition and competence of human resources, especially physicians, nurses and midwives⁽⁵⁾. In response to the most critical component, physicians, incentive programs were adopted to supply and qualify these professional, through the Enhancement Program of Primary Care, and by importing foreign physicians with the More Medical Doctors Program⁽⁶⁾.

A significant advance towards the access to health care services with quality and better working conditions occurred with the implementation of the first cycle of the National Program for Access and Quality Improvement in Primary Care (PMAQ-AB)⁽⁷⁾. The program is organized in four phases: voluntary participation of municipal managers; contracting by each Primary Care Team (PCT) of performance indicators for monitoring; development of self-assessment, institutional support and continuing education; external evaluation and re-contracting, starting a new quality cycle. In the external evaluation,

seven Higher Educational Institutions (IES) investigated throughout the country, *in loco*, the structure of the Basic Health Units (BHU) (census) and the working process of the contracted Primary Care Teams (PCT).

The complexity of the universal coverage paradigm has elicited theoretical studies in recent years⁽⁸⁾ on principles and repercussions in the Brazilian scenario, and some empirical studies about PHC⁽⁹⁾; use of services⁽¹⁰⁾; medications⁽¹¹⁾ and educational practices⁽¹²⁾.

Despite the contributions on the subject, national studies that evaluate the relationship between contexts and the centrality of professionals in the work teams, focusing on access and equity, remain scarce. The aim of this article is to analyze the influence of contextual indicators on the performance of cities, with regard to potential access to PHC in Brazil, based on external evaluation of the PMAQ-AB and to discuss the contribution of nursing work.

Method

Study design

This was a cross-sectional cohort study, using national data from the Bank of Evaluators of the External PMAQ.

Research scenario

Adherence to cycle I of the PMAQ amounted to 17,482 Primary Care Teams (PCT), distributed across 3,944 (70.8%) of all cities and 14,111 Basic Health Units (BHUs)⁽⁷⁾. In this group, 17,202 were recruited for the study, as their questionnaires were validated in the database of the Ministry of Health.

Population and sample

The study population included professionals linked to the primary care team and qualified in PMAQ⁽⁷⁾, namely physicians, nurses, and dentists. In each team, only one sampling unit was selected for the study.

Measures and data sources

The questionnaires with closed-ended questions were provided on tablets, administered by interviewers who had the same training, under supervision. Next, they were sent online to the Ministry of Health system, accessed and validated by the higher education institution, based on a consistency analysis protocol and validation of the data collected through Validator's *online*, PMAQ-AB. The characteristics of the respondents and four (4) dimensions of the Module II questionnaire - Interview with professional of Primary Care Team and Document Checking of the Health Unit External Evaluation of the first cycle of the PMAQ-AB, were included here for data analysis⁽⁷⁾. The dimensions that were representative of the potential levels of access

according to the authors' judgment were chosen and are described in the analysis plan.

Classification of cities according to the context variables

The cities listed in the study are classified into six groups, considering the per capita Gross Domestic Product (GDP), the percentage of the population with health insurance, the percentage of the population on the Bolsa Família (Family Grant) program, the percentage of the population in extreme poverty, and the population density.

The composition of the extracts considered for each municipality were: the lowest score among the percentage of the population with Bolsa Família program, and the percentage of the population in extreme poverty: group 1 - Cities with scores lower than 4.82 and a population of up to 10,000 inhabitants; group 2 - Cities with scores lower than 4.82 and a population of up to 20 thousand inhabitants; group 3 - cities with scores lower than 4.82 and a population of up to 50 thousand inhabitants; group 4 - Cities with scores between 4.82 and 5.40, and population of up to 100 thousand inhabitants; group 5 - Cities with scores between 5.4 and 5.85, and population of up to 500 thousand inhabitants; and cities with a score lower than 5.4, and population between 100.1 and 500 thousand inhabitants; and group 6 - Cities with population over 500,000 inhabitants, or a score equal or higher than 5.85⁽⁷⁾.

The variables under consideration to evaluate the potential access are described in Tables 1, 2 and 3 with dimensions, variables, their characteristic and nature:

Analysis plan

Initially, the descriptive analysis of the characteristics of the cities' groups was undertaken in terms of resources offered. Regarding the performance of the cities in terms of access, this was measured using four dimensions of the PMAQ tool: coverage group, supplies, customer coordination and integration. Therefore, the variables were dichotomized into yes and no, using the chi-square test of proportions to verify differences between the cities in relation to the size of potential access was used. The chi-square test with Yates' correction or Fisher's exact test was applied when necessary. For the population variable, the Kruskal-Wallis test was used to verify differences in relation to the median inhabitants monitored by group. In all tests applied, alpha was set at 5% ($\alpha = 0.05$).

Ethical aspects

The multicenter project that led to the database was approved by the Research Ethics Committee at

Universidade Federal do Rio Grande do Sul, under number 21904, on March 13th 2012, and complied with the recommendations of National Health Council Resolution 196/1996 of the Ministry of Health.

Results

In total, 17,202 teams were recruited for the study, the majority being nurses ($n = 15,876$; 92.3%), with between one and three years of experience. In addition, 963 physicians participated in the study (5.6%) and 363 (2.1%) dentists with an equivalent length of experience.

Among the subjects enrolled, most professionals are affiliated with the Family Health Strategy (FHS) with oral health ($n = 12,075$; 70.2%). There was a median of one (1) physician, nurse, nursing technicians, and dentist per team. The data also reveal that 5991 (49.6%) participants could not answer whether the users covered by their unit could choose what health service to be followed at.

In Table 1, the performance of cities in terms of patient access is verified, considering the group established in PMAQ. Statistically significant differences were identified between the cities of groups 1, 2 and 3 with groups 4, 5 and 6, and the professionals of the last groups had more qualifications ($p=0.0000$). Regarding the career plan, statistically significant difference ($p = 0.0000$) were also observed, and the cities of group 4, 5 and 6 had better indicators; lowest values were found in groups 1, 2 and 3. Also, these groups showed statistically significant differences associated with their training and continuing education policy ($p=0.0000$).

According to Table 2, the performance indicators related to resource availability, coordination and integration capacity are highlighted. As observed, again, groups 4, 5 and 6 present better scores, with statistical significance, such as having the users' needs listened to ($p=0.0000$), welcoming with risk classification ($p=0.0000$) and organized agenda for home visits ($p=0.0000$). Records of complaints and team conducts for care coordination, as well as the existence of a registry system ($p=0.0000$) and the presence of an established regulation system ($p=0.0000$) were other aspects on which cities 4, 5 and 6 performed better.

Table 3 presents the cities' performance concerning the supply or list of services. Cities classified in groups 4, 5 and 6 presented better indicators in terms of sufficient drugs to attend to their population ($p=0.0000$). Nevertheless, a larger proportion of professionals in group 6 reported on the use of alternative or complementary health practices ($p=0.0000$).

Table 1 – Performance of cities concerning professional qualification and territorialization for users' access to the universal coverage systems by groups. Program for Better Access and Quality of Basic Care, Brazil, 2012.

Dimension	Variables	Groups						p value*
		1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	6 n (%)	
Professional Qualification	Do you have or are you taking a complementary degree (n=17,202)							0.000
	Yes	1,708 (9.93)	1,795 (10.43)	2,050 (11.92)	2,694 (15.66)	2,460 (14.30)	3,642 (21.17)	
	No	457 (2.66)	478 (2.78)	477 (2.77)	572 (3.33)	354 (2.06)	515 (2.99)	
	Is there a career plan (n=16,93.6)							0.000
	Yes	253 (1.49)	159 (0.94)	246 (1.46)	574 (3.39)	581 (3.43)	1,810 (10.69)	
	No	1,877 (11.08)	2,069 (12.22)	2,245 (13.26)	2,647 (15.63)	2,194 (12.95)	2,279 (13.46)	
Are there continuing education actions involving basic care professionals (n=17,113)							0.000	
Yes	1,432 (8.37)	1,596 (9.33)	1,878 (10.97)	2,601 (15.20)	2,481 (14.50)	3,969 (23.19)		
No	720 (4.21)	658 (3.85)	630 (3.68)	650 (3.80)	325 (1.90)	173 (1.01)		
Territorialization	How many people are under the team's responsibility							0.0001†
	Average	2165	2273	2527	3266	2814	4157	
	Were risk and vulnerability criteria considered to define the people under the team's responsibility (n=15,691)							0.0000
	Yes	1,024 (6.53)	1,141 (7.27)	1,323 (8.43)	1,705 (10.87)	1,423 (9.07)	2,648 (16.88)	
	No	951 (6.06)	877 (5.59)	937 (5.97)	1,265 (8.06)	1,115 (7.11)	1,282 (8.17)	
	Is the team's coverage group defined (n=17,150)							0.0000
	Yes	2,086 (12.16)	2,197 (12.81)	2,456 (14.32)	3,190 (18.60)	2,763 (16.11)	4,113 (23.98)	
	No	68 (0.40)	60 (0.35)	63 (0.37)	71 (0.41)	43 (0.25)	40 (0.23)	
	Is there population uncovered by basic care within the coverage group of the team (n=17,092)							0.0000
	Yes	369 (2.16)	534 (3.12)	888 (5.20)	1,083 (6.34)	1,391 (8.14)	1,513 (8.85)	
	No	1,783 (10.43)	1,724 (10.09)	1,618 (9.47)	2,170 (12.70)	1,406 (8.23)	2,613 (15.29)	
	How frequently does this team attend to people from outside the coverage group (n=16,855)							0.0000
All weekdays	900 (5.34)	828 (4.91)	1,001 (5.94)	1,247 (7.40)	1,255 (7.45)	2,152(12.77)		
Some weekdays	966 (5.73)	1,135 (6.73)	1,201 (7.13)	1,502 (8.91)	1,222 (7.25)	1,673 (9.93)		
No weekdays	248 (1.47)	243 (1.44)	266 (1.58)	451 (2.68)	287 (1.70)	178 (1.65)		

* statistically significant p value (p<0.05).

† Application of Kruskal-Wallis test.

Source: Database of Program for Better Access and Quality of Basic Care – 1st cycle, Ministry of Health, Brazil, 2012.

Table 2 – Performance of cities concerning the availability of resources, care coordination and integration capacity among services for user access to universal coverage systems by groups, Program for Better Access and Quality of Basic Care, Brazil, 2012.

Dimension	Variables	Groups						p value*
		1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	6 n (%)	
Availability	Users who arrive spontaneously have their needs heard and assessed (n=17,140)							0.0000
	Yes	2,121 (12.37)	2,202 (12.85)	2,442 (14.25)	3,180 (18.55)	2,689 (15.69)	4,078 (23.79)	
	No	38 (0.22)	59 (0.34)	80 (0.47)	83 (0.48)	108 (0.63)	60 (0.35)	
	The team performs risk and vulnerability assessment in users welcoming (n=13,739)							0.0066
	Yes	1,265 (9.21)	1,385 (10.08)	1,645 (11.97)	2,286 (16.64)	2,050 (14.92)	3,442 (25.05)	
	No	192 (1.40)	221 (1.61)	248 (1.81)	324 (2.36)	236 (1.72)	445 (3.24)	
The agenda is organized to make home visits (n=13,951)							0.0000	
Yes	1,418 (10.16)	1,628 (11.67)	1,865 (13.37)	2,391 (17.14)	2,253 (16.15)	3,697 (26.50)		
No	134 (0.96)	115 (0.82)	114 (0.82)	149 (1.07)	104 (0.75)	83 (0.59)		
Care Coordination	Maintains registry of highest-risk users forwarded to other care services (n=17,104)							0.0000
	Yes	826 (4.83)	818 (4.78)	1,104 (6.45)	1,474 (8.62)	1,353 (7.91)	2,385 (13.94)	
	No	1,310 (7.66)	1,439 (8.41)	1,405 (8.21)	1,785 (10.44)	1,449 (8.47)	1,756 (10.27)	
	Are there documents that prove the coordination (n= 7,960)							0.0000
	Yes	605 (7.60)	638 (8.02)	913 (11.47)	1,206 (15.15)	1,132 (14.22)	1,978 (24.85)	
	No	221 (2.78)	180 (2.26)	191 (2.40)	268 (3.37)	221 (2.78)	407 (5.11)	
Are there protocols to guide the prioritization of the cases that need forwarding (n=17,037)							0.0000	
Yes	581 (3.41)	613 (3.60)	807 (4.74)	1,213 (7.12)	1,228 (7.21)	2,907 (17.06)		
No	1,558 (9.14)	1,636 (9.60)	1,685 (9.89)	2,036 (11.95)	1,567 (9.20)	1,206 (7.08)		
Is there a regulation central (n=17,201)							0.0000	
Yes	1,880 (10.93)	2,006 (11.66)	2,239 (13.02)	2,907 (16.90)	2,540 (14.77)	4,027 (23.41)		
No	284 (1.65)	267 (1.55)	288 (1.67)	359 (2.09)	274 (1.59)	130 (0.76)		
Integration	Is there a form for forwarding users to the other care services (n=17,201)							0.0000
	Yes	1,752 (10.19)	1,828 (10.63)	2,138 (12.43)	2,970 (17.27)	2,615 (15.20)	4,055 (23.57)	
No	412 (2.40)	445 (2.59)	389 (2.26)	296 (1.72)	199 (1.16)	102 (0.59)		

*statistically significant p value (p<0.05).

Source: Database of Program for Better Access and Quality of Basic Care – 1st cycle, Ministry of Health, Brazil, 2012.

Table 3 – Performance of cities concerning supply and list of services for user access to universal coverage systems according by groups, Program for Better Access and Quality of Basic Care, Brazil, 2012.

Dimension	Variables	Groups						p value*
		1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	6 n (%)	
Supply	Receives sufficient drugs from basic pharmacy to attend to its population (n=17,161)							0.0000
	Yes	1,459 (8.50)	1,490 (8.68)	1,722 (10.03)	2,210 (12.88)	1,830 (10.66)	2,898 (16.89)	
	No	378 (2.20)	457 (2.66)	614 (3.58)	644 (3.75)	718 (4.18)	2,077 (6.28)	
	Does not receive drugs	316 (1.84)	320 (1.86)	187 (1.09)	406 (2.37)	263 (1.53)	172 (1.00)	
	Offers integrative and complementary practices to users within the territory (n=17,199)							0.0000
	Yes	235 (1.37)	230 (1.34)	305 (1.77)	381 (2.22)	512 (2.98)	1,546 (8.99)	
	No	1,929 (11.22)	2,042 (11.87)	2,222 (12.92)	2,885 (16.77)	2,301 (13.38)	2,611 (15.18)	
	Performs home visits (n=17,199)							0.0075
	Yes	2,146 (12.48)	2,262 (13.15)	2,521 (14.66)	3,253 (18.91)	2,802 (16.29)	4,148 (24.12)	
	No	18 (0.10)	10 (0.06)	6 (0.03)	13 (0.08)	11 (0.06)	9 (0.05)	
	The families within the coverage group are visited periodically according to risk and vulnerability assessments (n=17,132)							0.0000
	Yes	1,963 (11.46)	2,069 (12.08)	2,345 (13.69)	2,997 (15.30)	2,621 (15.30)	3,986 (23.27)	
	No	183 (1.07)	193 (1.13)	176 (1.03)	256 (1.49)	181 (1.06)	162 (0.95)	

*Statistically significant p value (p<0.05).

Source: Database of Program for Better Access and Quality of Basic Care – 1st cycle, Ministry of Health, Brazil, 2012.

Discussion

The prevailing participation of nurses as respondents in all groups reveals their involvement with PHC. The organization of nurses in international networks, recognized by the Pan American Health Organization, highlights this role for universal health coverage⁽⁵⁾. In the assessment of the influence of contextual indicators and health on professional qualification and territorialization, groups 4, 5 and 6 showed better performance with a larger population size and socioeconomic development. This reflects the unequal distribution of physicians and qualified nurses, a limiting factor of universal coverage^(3,13). This factor also happens in different countries, such as the United States, Australia⁽¹³⁾, Mexico, Ghana and Thailand⁽³⁾, China⁽¹⁴⁾. The strategies to attract and fix the professionals are context-based and multifaceted and their qualification in the course of their career stands out in the global scope^(13, 15).

The PMAQ revealed qualification and continuing education strategies for the teams, combined with the use of information and communication technologies, which facilitate the qualification, improve the problem-solving ability and enhance the communication between general PHC practitioners and specialists⁽¹⁶⁾.

With regard to territorialization, each health team attends to an appropriate number of people. In Brazil, the territorialization gains further depth with the expanded coverage of the Family Health Strategy, following the logic supply-service-territory, despite the increasing

flexibility of the territory for the population's needs, bonding and accountability. Nevertheless, planning based on the service logic ends up limiting the supply⁽¹⁷⁾.

On the one hand, Family Health takes form as a strategy towards universal coverage, including populations that used to be unattended. On the other hand, despite respecting parameters, the large number of people, the wide range of tasks, with promotion, prevention and treatment for priority groups, chronic illnesses, strategic situations of vulnerability put a strain on the professionals⁽¹⁸⁾. The Brazilian experience affirms that multiprofessional teamwork enhances the different dimensions of care in view of the expanded coverage⁽¹⁹⁾. This aspect concerning the greater impact of the primary care teams' interprofessional cooperation, particularly in cases of chronic illnesses, can be observed in the literature from other countries, clearly showing the need for clarifications on its potentials and limits⁽²⁰⁾.

In terms of availability, it is verified that the needs of the users who spontaneously visit the service are assessed and attended to in all groups, also with better performance for groups with larger populations. The Family Health initiatives to integrate the two types of demands – spontaneous and scheduled – represent one of the main challenges for access. There is a change from technical to user-centered care, the base of the PHC principles. Based on the international accumulation of lessons learned since the 1990's in Denmark and the United Kingdom, in 2005, the Institute of Medicine (IOM) launches a proposal to implement it by 2020 as

one of the quality domains of the primary health care reform in the United States⁽²¹⁾.

In this study, the home visit is present on the agenda of professionals from cities in all groups. The home visits are fundamental for PHC and are a positive element of the access. Nevertheless, assessing their occurrence is not enough. Their impact on the health conditions and quality of the processes should also be assessed. In a research undertaken in Germany, it was revealed that the PHC professionals are in doubt on their efficacy, consider it as an obligation and do not feel motivated to make the visits⁽²²⁾. This reflection reveals, for the Brazilian reality as well, the need to debate with the professionals on their effects and forms of incentive.

In the forwarding to other care points, despite significant differences between groups, it is observed that all groups present hardly satisfactory behavior, revealing difficulties in user accountability outside the BHS. Regulation centrals more frequently exist in the same groups highlighted earlier. These points reveal weaknesses in the coordination, continuity and integration of care at the different levels of network care. The Health Care Networks represent the Brazilian option to further the access and quality recommended by the Pan American Health Organization, as a way to fight the fragmentation and promote the integration of health systems in Latin America and the Caribbean. In these systems, despite particularities and complexities, a range of challenges is faced due to the coexistence of subsystems and different degrees of integration in the same system, besides structural issues⁽²³⁾.

Concerning the supply of health actions and services, statistical significance was verified in the groups for all aspects assessed, including basic drugs. According to WHO, the systems that implemented the universal coverage need to address appropriate medication use, verify its benefits and avoid waste in order to guarantee sustainability⁽²⁴⁾. The low level of integrative and complementary practices was verified for users on the territory, as the SUS has recommended since 2006. In addition, WHO reaffirms the importance of integrating scientific and traditional medicine for the purpose of global health⁽²⁵⁾.

Limitations

The generalizability of the external evaluation committee of the first PMAQ cycle is limited because it did not cover all teams and worked with a statistically non-representative sample that, due to feasibility issues and/or the political nature of the assessment, presupposes the municipal health manager's voluntary adherence. Nevertheless, its unique range across the

Brazilian territory with a homogeneous method, is undeniable. The cities' grouping reveals inequities in the supply, advances and critical knots among the groups of cities. The main limitation is that, because of its multifaceted nature, the object needs to be analyzed by parts. Based on the available data, the needs dimensions could not be assessed, nor could the effective use of the services and their impact on population health. The information was based on "done/not done" answers, and further depth is needed as to how the actions are being accomplished and their appropriateness to the demands and quality parameters. Other studies are needed, using multiple methods capable of articulating quantitative data with qualitative case studies, with a view to better apprehending the complexity of the object.

Conclusions

The study showed that there is a relationship between access and socioeconomic conditions: as the group of the cities increases, the access to services tends to be better. However, within a context of social inequalities and inequities, weaknesses are perceived that jeopardize the organization of health activities in the cities regarding the availability, care coordination, integration, and supply, particularly in the cities grouped in groups 1 to 3. Given the involvement of the nurse with the organization of health care, this professional has contributed to the potential access to PHC in Brazil. The curricula for work in this group are aligned with the social policies of the SUS, which include contents on anthropology, sociology, health management, leadership and health practices in the communities. This factor makes the nurses more porous to innovations and team leaderships in the PHC context, with greater motivation to promote changes, as opposed to low remuneration in the private sector. Their engagement entails the challenge of recognition for nursing competencies and autonomy in prescription and in care not exclusive to the medical category.

References

1. Abihiro GA, De Allegri M. Universal health coverage from multiple perspectives: a synthesis of conceptual literature and global debates. *BMC Int Health Hum Rights*. 2015;15(17):1-7.
2. Rodin J. Accelerating action towards universal health coverage by applying a gender lens. *Bull World Health Organ*. 2013;91(9):710-11.
3. Campell J, Buchan J, Cometto G, David B, Dussault G, Fogstad H et al. Human resources for health and

- universal health coverage: fostering equity and effective coverage. *Bull World Health Organ.* 2013;91:853-63.
4. Victora CG, Wagstaff A, Schellenberg JA, Gwatkin D, Claeson M, Habicht JP. Applying an equity lens to child health and mortality: more of the same is not enough. *The Lancet.* 2003;362(1):233-41.
5. Cassiani SHDB. Strategy for universal access to health and universal health coverage and the contribution of the International Nursing Networks. *Rev. Latino-Am. Enfermagem.* 2014;22(6):891-2.
6. Molina J. Para não perder o trem da história! *Rev. esc. enferm. USP.* 2014;48(1):8-17.
7. Pinto HA, Sousa ANA, Ferla AA. O Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica: várias faces de uma política inovadora. *Saúde debate.* 2014;38(spe):358-72.
8. Noronha JC. Cobertura universal de saúde: como misturar conceitos, confundir objetivos, abandonar princípios. *Cad. saúde pública.* 2013;29(5):847-9.
9. Cardoso MO, Vieira-da-Silva LM. Avaliação da cobertura da atenção básica à saúde em Salvador, Bahia, Brasil (2000 a 2007). *Cad. Saúde Pública.* 2012;28(7):1273-84.
10. Tomasi E, Facchini LA, Thumé E, Piccini RX, Osorio A, Silveira DS, et al. Características da utilização de serviços de Atenção Básica à Saúde nas regiões Sul e Nordeste do Brasil: diferenças por modelo de atenção. *Ciênc. saúde coletiva.* 2011;16(1):4395-404.
11. Leão C, Caldeira AP. Avaliação da associação entre qualificação de médicos e enfermeiros em atenção primária em saúde e qualidade da atenção. *Ciênc. saúde coletiva.* 2011;16(11):4415-23.
12. Taddeo PS, Gomes KWL, Caprara A, Gomes AMA, Oliveira GC, Moreira TMM. Acesso, prática educativa e empoderamento de pacientes com doenças crônicas. *Ciênc. saúde coletiva.* 2012;17(11):2923-30.
13. Oliveira FP, Vanni T, Pinto HA, Santos JTR, Figueiredo AM, Araújo SQ et al. Mais Médicos: um programa brasileiro em uma perspectiva internacional. *Interface (Botucatu).* 2015;19(54):623-34.
14. Wang X, Zheng A, He X, Jiang H. Integration of rural and urban healthcare insurance schemes in China: an empirical research. *BMC Health Serv Res.* 2014;14(42):1-10.
15. Huicho L, Dieleman M, Campbell J, Codjia L, Balabanova D, Dussault G, et al. Increasing access to health workers in underserved areas: a conceptual framework for measuring results. *Bull World Health Organ.* 2010;88(5):357-63.
16. Giovanella L, Mendonça MHM, Almeida PF, Escorel S, Almeida PF, Fausto MCR, et al. Potencialidades e obstáculos para a consolidação da Estratégia Saúde da Família em grandes centros urbanos. *Saúde em Debate.* 2010;34(85):248-64.
17. Faria RM. A Territorialização da Atenção Primária à Saúde no Sistema Único de Saúde e a construção de uma perspectiva de adequação dos serviços aos perfis do território urbano. *Hygeia.* 2013;9(16):121-30.
18. Souza MB; Rocha PM; Sá AB; Uchoa SAC. Trabalho em equipe na atenção primária: a experiência de Portugal. *Rev Panam Salud Publica.* 2013;33(3):190-5
19. Tesser, CD, Norman AH. Repensando o acesso ao cuidado na Estratégia Saúde da Família. *Saúde soc. São Paulo.* 2014;23(3):869-83.
20. Morgan S, Pullon S, McKinlay E. Observation of interprofessional collaborative practice in primary care teams: An integrative literature review. *Int J Nurs Stud.* 2015;52(7):1217-30.
21. Davis K, Schoenbaum SC, Audet AM. A 2020 Vision of Patient-Centered Primary Care. *J Gen Intern Med.* 2005;20(10):953-57.
22. Theile G, Kruschinski C, Buck M, Müller CA, Hummers-Pradier E. Home visits - central to primary care, tradition or an obligation? A qualitative study. *BMC Fam Pract.* 2011;12(24):1-11.
23. Ramagem C, Urrutia S, Griffith T, Cruz M, Fabrega R, Holder R, et al. Combating health care fragmentation through integrated health services delivery networks. *Int J Integr Care.* 2011;11(Suppl):1-2.
24. Wagner AK, Quick JD, Ross-Degnan D. Quality use of medicines within universal health coverage: challenges and opportunities. *BMC Health Serv Res.* 2014;14(357):1-6.
25. Falkenberg T, Smith M, Robinson N. Traditional and integrative approaches for global health. *Eur J Integr Med.* 2015;7(1):1-4.

Received: May 31st 2015

Accepted: Sept. 13th 2015

Corresponding Author:
Severina Alice da Costa Uchôa
Universidade Federal do Rio Grande do Norte
Centro de Ciências da Saúde
Rua General Gustavo Cordeiro de Faria, s/n
Bairro: Petrópolis
CEP: 59012-570, Natal, RN, Brasil
E-mail: alicedacostauchoa@gmail.com

Copyright © 2016 Revista Latino-Americana de Enfermagem
This is an Open Access article distributed under the terms of the Creative Commons (CC BY).
This license lets others distribute, remix, tweak, and build upon your work, even commercially, as long as they credit you for the original creation. This is the most accommodating of licenses offered. Recommended for maximum dissemination and use of licensed materials.