



## Satisfaction of people with hypertension about the attributes of Primary Health Care\*\*

*Satisfação de pessoas com hipertensão acerca dos atributos da Atenção Primária à Saúde*

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### ABSTRACT

Cross-sectional study that assessed the satisfaction of people with hypertension about the attributes of Primary Health Care. Data collection took place in the first semester of 2016, using a developed and validated instrument, specific for the population with hypertension, which assessed access to diagnosis and treatment; adherence / bond; list of services; coordination of care; family focus; and community guidance. Descriptive and inferential statistics were used in the treatment of variables. 417 people with hypertension participated in the study, who evaluated the eight dimensions of primary care as satisfactory. The multivariate regression analysis showed that those with inadequate blood pressure control had more chances of evaluating the list of services and coordination of care as unsatisfactory. It is concluded that the services offered were evaluated as satisfactory in most of the dimensions evaluated, however, people with pressure inadequacy point out the need for improvement in the coordination of care and in the integrality of the services provided.

Keywords: Primary Health Care. Health Services Evaluation. Hypertension. Nursing. Family Health Strategy. Integrality in Health.

### RESUMO

Estudo transversal, que avaliou a satisfação de pessoas com hipertensão acerca dos atributos da Atenção Primária à Saúde. A coleta de dados ocorreu no primeiro semestre de 2016, utilizando um instrumento desenvolvido e validado, específico para população com hipertensão, que avaliou o acesso ao diagnóstico e ao tratamento; adesão/vínculo; elenco de serviços; coordenação do cuidado; enfoque familiar e orientação comunitária. Utilizou-se estatística descritiva e inferencial no tratamento das variáveis. Participaram do estudo 417 pessoas com hipertensão, que avaliaram como satisfatório as oito dimensões da atenção básica. A análise de regressão multivariada evidenciou que aqueles com controle pressórico inadequado possuíam maiores chances de avaliar o elenco de serviços e coordenação do cuidado como insatisfatórios. Conclui-se que os serviços ofertados foram avaliados como satisfatório na maioria das dimensões avaliadas, no entanto, as pessoas com inadequação pressórica apontam necessidade de melhoria na coordenação do cuidado e na integralidade dos serviços prestados.

Palavras-chave: Atenção primária à saúde. Avaliação dos serviços de saúde. Hipertensão. Enfermagem. Estratégia saúde da família. Integralidade em saúde.

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## INTRODUCTION

The hypertension is considered one of the main public health problems today, due to its potential risk for the development of comorbidities and which has been challenging health actions and services for its control, mainly due to its multifactorial nature<sup>1-2</sup>. Worldwide, hypertension is prevalent in more than 1 billion adults, and in Brazil, in 2017, data from the Ministry of Health (MH) pointed out that 24.5% population self-report having hypertension<sup>2-3</sup>.

Primary Health Care (PHC) is characterized by being a set of health actions that encompass both the individual and collective level, covering the promotion and protection of health, prevention, diagnosis, treatment, rehabilitation, damage reduction and maintenance of health. As a main purpose, PHC seeks to develop comprehensive care that positively impacts the health situation of the community. It is considered the preferred gateway to the Unified Health System (UHS) and the communication center with the entire Health Care Network, guided by the principles of universality, accessibility, continuity of care, comprehensive care, accountability, humanization and equity<sup>1-2,4-6</sup>.

It is able to organize the flow of services on the network, from the simplest to the most complex, developed with the highest degree of decentralization and capillarity, occurring as close to people's lives and families. Thus, PHC as a basis for coping with hypertension, offers treatment and presents positive results in the organizational and assistance scope<sup>4-6</sup>. In this respect, services provided by PHC are made up of structural elements, which are fundamental to the quality of care. Such services need to be evaluated in order to identify the weaknesses faced in the practices and in the management of health actions. This critical and reflective analysis of services can enhance the implementation of new actions for reorienting care, which promote improvement in the quality of work and control of important pathologies<sup>4,7-8</sup>.

Regarding the control of AH, the care practice comes up against difficulties with regard to PHC organizational and structural issues, such

as accessibility to treatment, the unavailability of medicines for blood pressure control, as well as trained human resources to meet the demand. These factors can favor inadequate blood pressure control, which can interfere with people satisfaction with the services provided by the PHC model<sup>7,9</sup>.

Thus, inadequate blood pressure can lead to high costs for specialized health services, as it causes comorbidities such as stroke and acute myocardial infarction, in addition to preventable readmissions. Thus, understanding satisfaction with the services provided to people with hypertension, especially among those who have inadequate blood pressure control, will enable more efficient planning and actions in the context of the prevention and treatment of hypertension<sup>7-8,10</sup>.

Considering the importance of evaluative research, identifying its strengths and weaknesses in the results of health actions, which can generate changes in costs and in solving problems<sup>8,10</sup>, this study aimed to assess the satisfaction of people with hypertension, according to the essential attributes of PHC.

## METHODOLOGY

This is a quantitative cross-sectional study, derived from the master's thesis presented in 2017<sup>8,10</sup>, conducted in a municipality in southern Brazil, with an estimated population, in the period of data collection, of 403 thousand inhabitants. The municipality's health network is organized in a decentralized way, distributed in 34 Basic Health Units (BHU) and 74 teams of the Family Health Strategy (FHS), covering a population of 68.01% municipality's territory<sup>11</sup>.

As an inclusion criterion, it was adopted to have updated medical records, with a medical prescription, adherence to at least one routine consultation, scheduled by the BHU teams, with the year 2015 as a parameter for measuring and recording the clinical evolution of the participant in treatment of hypertension. The rural population was excluded because it belongs to a region far from the city, where

the FHS teams, even belonging to a BHU in the urban area of the city, performed care in a space provided by a local religious institution, which was considered a bias, having in view of the attributes of PHC in the issue of geographic accessibility. Pregnant and postpartum women were also excluded because they understand that the monitoring of these participants is exclusive to the women's health program and not to "*Sistema de Cadastramento e Acompanhamento dos Hipertensos e Diabéticos*" (SISHIPERDIA).

The Municipal Health Secretariat made available the list of the SISHIPERDIA program, which had 29,035 people with active registration. After using the filter that establishes the inclusion and exclusion criteria, 27,741 individuals were considered eligible. Representative random sampling was used and the estimates were generated considering 95% confidence intervals, plus an additional 15% for possible losses, resulting in a sample of 437 people. Subsequently, with the list with names and addresses made available, the population was stratified according to the number of people served in each BHU in the municipality and after the losses due to unregistered deaths and refusals, the final sample was composed of 417 people.

Participants were approached initially with the presentation of the study objectives and the forms of participation for the nurses responsible for SISHIPERDIA and, later, for the elected participants, according to the strategic calendar of the meetings, which took place at a fixed schedule, considering the reality of each FHS team, ranging from 8 am to 5 pm. It is noteworthy that the strategy adopted for data collection was established in the draw of participants and the agenda of the SISHIPERDIA meetings of each FHS team and its micro areas. Interviews were conducted between February and June 2016, at UBS facilities, in places previously reserved through individual interviews.

It was used an instrument developed and validated to assess the attributes of PHC. This instrument addresses issues related to the identification, sociodemographic, anthropometric profile, blood pressure, presence of concomitant

diseases resulting from complications of hypertension and the attributes related to PHC, composed of eight domains, namely: access to diagnosis; access to treatment; adhesion/bond; list of services; coordination; family focus; community guidance<sup>7</sup>.

Each dimension is made up of questions with Likert-type answers, assigning values on a scale between one and five, respectively, to answers 1) "never"; 2) "almost never"; 3) "sometimes"; 4) "almost always" and 5) "always"<sup>7</sup>. To classify the evaluation, cut-off points were used according to the score possibilities, classifying them as satisfactory ( $\geq 4$ ), regular ( $<4$  and  $\geq 3$ ) and unsatisfactory ( $<3$ )<sup>7,9</sup>.

To check the blood pressure values, an aneroid sphygmomanometer, duly calibrated, was used on the day of the interviews<sup>12</sup>. Blood pressure values were categorized as inadequate blood pressure control, when systolic blood pressure (SBP)  $> 140$  mmHg and diastolic blood pressure (DBP)  $> 90$  mmHg, as recommended by the VII Brazilian Guideline on Hypertension<sup>12</sup>. To assess the economic class, the Brazilian Economic Classification Criterion was adopted to estimate the purchasing power of urban people and families<sup>13</sup> and in this study they were grouped into AB (high), C (medium) and DE (low).

Data were recorded in a Microsoft Excel 2013 electronic spreadsheet, with double entry and statistical analysis was performed in Statistical Package for Social Sciences (SPSS) software, version 20.0. Data normality was checked by the Kolmogorov-Smirnov test, with Lilliefors correction and, later, the Kruskal-Wallis test was applied to analyze variance, obtaining the mean scores of the domains, dispersion measurement and to indicate whether there was a difference in the means in relation to the appropriate and inadequate pressure control groups.

For the association between the pressure control classification and the assessed satisfaction domains, an analysis was carried out in two distinct stages. The univariate analysis took place through the unconditional logistic regression model, using the variables referring to the classification of attributes and the variable referring to pressure control. Subsequently, the Stepwise Forward method was used, in which only the variables that resulted in p

<0.20 in the univariate analysis were maintained in the multivariate model. The magnitude of the associations was estimated by calculating Odds Ratio (OR), with a significance level of  $p < 0.05$  between the tests performed.

The research was analyzed by the Standing Committee on Ethics in Research with Human Beings, receiving a favorable opinion (1407687/2016). All participants signed a Free and Informed Consent Form, in two copies.

## RESULTS

The sample consisted of 417 people undergoing treatment for AH, most of whom were female (67.9%), elderly (62.3%), with an education level equal to or less than eight years (80.8%), white (62.4%), married (59.7%), economic class C (43.9%). More than half (53.7%) had adequate blood pressure control.

**Table 1.** Sociodemographic profile of people with arterial hypertension, users of Primary Health Care according to blood pressure control. State of Paraná, Brazil, 2016

	Total n (%)	Adequate n (%)	Inadequate n (%)	Univariate analysis		
				OR	IC 95%	p
<b>Age</b>						
≤ 59 years	157 (37.6)	95 (42.4)	62 (32.1)	1		
≥ 60 years	260 (62.4)	129 (57.6)	131 (67.9)	1.55	1.04-2.32	0.031*
<b>Gender</b>						
Male	134 (32.1)	74 (33.0)	60 (31.1)	1		
Female	283 (67.9)	150 (67.0)	133 (68.9)	1.09	0.72-1.65	0.671
<b>Education</b>						
≤ 8 years	337 (80.8)	178 (79.5)	159 (82.4)	1		
> 8 years	80 (19.2)	46 (20.5)	34 (17.6)	0.89	0.50-1.35	0.301
<b>Race/Color</b>						
White	260 (62.4)	138 (61.6)	122 (63.2)	1		
Black	65 (15.6)	37 (16.5)	28 (14.5)	0.85	0.49-1.48	0.578
Brown	92 (22.1)	49 (21.9)	43 (22.3)	0.99	0.61-1.59	0.976
<b>Marital status</b>						
Married	249 (59.7)	141 (62.9)	108 (56.0)	1		
Single	95 (22.8)	47 (20.0)	48 (24.9)	1.33	0.83-2.14	0.234
Widow	73 (17.5)	36 (16.1)	37 (19.2)	1.34	0.79-2.26	0.270
<b>Socioeconomic classification</b>						
AB	148 (35.5)	75 (33.5)	73 (37.8)	1		
C	183 (43.9)	98 (43.8)	85 (44.1)	0.89	0.57-1.37	0.602
DE	86 (20.6)	51 (22.7)	35 (18.1)	0.70	0.41-1.20	0.203

AB: high; C: medium; DE: low.

According to the pressure control classification, it is observed that the dimension 'community guidance' showed the lowest mean value ( $3.32 \pm 1.33$ ), followed by 'family focus' ( $3.56 \pm 1.41$ ) and 'list of services' ( $3.60 \pm 0.76$ ), all in the group

with 'inadequate blood pressure control'. There was no statistical difference between the mean scores of the dimensions evaluated when comparing the groups of adequate and inadequate blood pressure control (Table 2).

**Table 2.** Distribution of the mean score, standard deviation and confidence interval for the dimensions of Primary Health Care assessed by users with hypertension according to pressure control. State of Paraná, Brazil, 2016

Dimensions	Pressure control		p*
	Adequate (n=224)	Inadequate (n=193)	
	M $\pm$ SD	M $\pm$ SD	
Access to diagnosis	3.98 $\pm$ 1.35	3.84 $\pm$ 0.94	0.204
Accessibility to treatment	4.16 $\pm$ 0.74	4.01 $\pm$ 0.84	0.635
Adhesion/Bond	4.22 $\pm$ 0.61	4.16 $\pm$ 0.60	0.281
List of services	3.79 $\pm$ 0.84	3.60 $\pm$ 0.76	0.289
Coord	3.90 $\pm$ 1.09	3.70 $\pm$ 0.98	0.823
Family focus	3.58 $\pm$ 1.40	3.56 $\pm$ 1.41	0.719
Community guidance	3.42 $\pm$ 1.35	3.32 $\pm$ 1.33	0.067

Legend: M  $\pm$  SD: Mean and Standard Deviation. \*Kruskal-Wallis test.

Regarding the assessment of users' satisfaction with the attributes of PHC, the access domain (58%) obtained the highest percentage, followed by coordination (57.8%) and family focus (56.1%), with a satisfactory level of assessment in more than half

of the interviewees. The list of services domains had a higher percentage of people who rated assistance practices as regular (43.4%). Community guidance was rated as unsatisfactory by 31.1% respondents (Table 3).

**Table 3.** Univariate analysis of the assessment of attributes of Primary Health Care, by users with hypertension according to pressure control. State of Paraná, Brazil, 201

(Continua)					
Attributes	Pressure control		Univariate analysis		
	Adequate	Inadequate	OR	CI95%	p
	n (%)	n (%)			
Access					
Satisfied	138 (33.1)	104 (24.9)	1		
Regular	62 (14.9)	56 (13.5)	1.19	0.77-1.86	0.422
Dissatisfied	24 (5.7)	33 (7.9)	1.82	1.01-3.27	0.044*
Accessibility					
Satisfied	123 (29.5)	92 (22.1)	1		
Regular	89 (21.3)	84 (20.1)	1.26	0.84-1.88	0.257
Dissatisfied	12 (12.9)	17 (4.1)	1.89	0.86 - 4.16	0.112*
Adhesion/Bond					
Satisfied	111 (26.6)	93 (22.3)	1		

(Continua)

(Conclusão)

Attributes	Pressure control		Univariate analysis		
	Adequate n (%)	Inadequate n (%)	OR	CI95%	p
Regular	87 (20.9)	76 (18.2)	1.10	0.59-2.04	0.759
Dissatisfied	26 (6.2)	24 (5.8)	1.04	0.69-1.84	0.843
<b>List of services</b>					
Satisfied	106 (25.4)	57 (13.7)	1		
Regular	83 (19.9)	98 (23.5)	1.86	1.21-2.86	0.005
Dissatisfied	35 (8.4)	38 (9.1)	1.82	1.04 - 3.18	0.033*
<b>Coordination</b>					
Satisfied	143 (34.3)	98 (23.5)	1		
Regular	38 (9.1)	53 (12.7)	2.03	1.24-3.32	0.004*
Dissatisfied	43 (10.3)	42 (10.1)	1.42	0.86-2.34	0.162
<b>Family focus</b>					
Satisfied	124 (29.7)	110 (26.4)	1		
Regular	28 (6.7)	28 (6.7)	1.12	0.62-2.02	0.687
Dissatisfied	72 (17.3)	55 (13.2)	0.86	0.55-1.33	0.5
<b>Community guidance</b>					
Satisfied	108 (25.9)	87 (20.9)	1		
Regular	48 (11.5)	44 (10.5)	1.13	0.69-1.87	0.61
Dissatisfied	68 (16.3)	62 (14.9)	1.13	0.72-1.76	0.586

OR: *Odds Ratio*; CI95%: Confidence Interval; \*Variables with *p-value* < 0.20, inserted in the multivariate model of logistic regression

In the multivariate analysis, the results showed that individuals with inadequate blood pressure control have a 1.75 (95% CI: 1.12-2.73) and 1.77 (95% CI: 1.07-2.93) chance, respectively, of evaluating the list of services and coordination as unsatisfactory. These same individuals have a 1.88 (95% CI: 1.02-3.47)

chance of assessing access to diagnosis as regular. All domains that showed statistical significance in the multivariate analysis were adjusted by the age variable (Table 4).

**Table 4.** Multivariate analysis of the assessment of attributes of Primary Health Care, by users with hypertension, according to pressure control. State of Paraná, Brazil, 2016

Attributes	Pressure control		Multivariate analysis		
	Adequate n (%)	Inadequate n (%)	ORaj	CI95%	p
<b>List of services</b>					
Satisfied	106 (25.4)	57 (13.7)	1		
Regular	83 (19.9)	98 (23.5)	1.69	0.94-3.05	0.079
Dissatisfied	35 (8.4)	38 (9.1)	1.75	1.12-2.73	0.013
<b>Coordination</b>					
Satisfied	143 (34.3)	98 (23.5)	1		
Regular	38 (9.1)	53 (12.7)	1.24	0.73-2.10	0.419

(Conclusão)

Attributes	Pressure control		Multivariate analysis		
	Adequate	Inadequate	ORaj	CI95%	p
	n (%)	n (%)			
Dissatisfied	43 (10.3)	42 (10.1)	1.77	1.07-2.93	0.026
<b>Access</b>					
Satisfied	138 (33.1)	104 (24.9)	1		
Regular	62 (14.9)	56 (13.5)	1.88	1.02-3.47	0.042
Dissatisfied	24 (5.7)	33 (7.9)	1.24	0.79-1.95	0.345
<b>Age*</b>					
≤ 59 years	95 (42.2)	62 (32.1)	1		
≥ 60 years	129 (56.8)	131 (67.9)	1.55	1.04-2.32	0.031

ORaj: Adjusted Odds Ratio; CI95%: Confidence Interval; \*As it has a *p-value* <0.20 in multivariate analysis, the age variable was inserted as an adjustment in the multivariate model.

## DISCUSSION

The results found showed that the majority of the interviewed population evaluated the PHC dimensions as unsatisfactory, especially the community guidance, family focus and the list of services, which obtained lower averages. The FHS is the primary operationalizing and strengthening agent of PHC, bringing multidisciplinary service to communities. The FHS is responsible for registering, classifying and stratifying the population in its territory according to risk groups, and SISHIPERDIA is intended for the registration and monitoring patients with hypertension and/or DM treated in the network<sup>1,4,8-9</sup>.

Currently, Brazil is experiencing a scenario in which the organization of care and assistance, and the expansion of citizens' access to services represent one of the main challenges for the three spheres of government. Such challenges express the inclusion of a large population contingent on the care provided by SUS, concomitant with low public investment in health. The results of the multivariate logistic regression analysis in the sample of this research showed that people with inadequate blood pressure control were more likely to evaluate services related to "access to diagnosis" as regular<sup>2,4,8</sup>.

Access can be understood as a gateway, a place for welcoming people when they need, as well as the paths the user takes in the system to solve his/her problem. Even with the implementation of the FHS in 1994, the Plano de Reorganização da Atenção à hipertensão arterial e ao diabetes Mellitus, in 2001, and the Pact in Defense of Life, in 2005, which together increased people's access to diagnosis, medical consultations and drugs, it is still possible to find difficulties in consolidating this principle<sup>4,5</sup>.

In a study carried out in Paraná<sup>15</sup>, participants reported that the search for the diagnosis of the disease is a difficult process, added to the need to change their lifestyle, hindering the process of adaptation and therapeutic adherence. Although access to diagnosis was a dimension assessed as unsatisfactory by people with inadequate blood pressure control, the attribute accessibility was positively assessed, with no significant differences between the groups of blood pressure control.

The accessibility attribute addresses several aspects related to the provision of services by the PHC, namely: the reception, the waiting for the consultation, the need to use transportation, the financial expense to get to the BHU. Such aspects are characterized as geographic, economic and

organizational accessibility, which reinforces reception as an important management tool, which can contribute to solving health problems and strengthening treatment adherence<sup>9-10,15-16</sup>.

The positive assessment of accessibility reiterates the strategies of the reorganization care plan for the attention to AH, which aims to ensure the monitoring with preventive health actions and the distribution of medicines. These strategies are considered responsible for the impact on the reduction of morbidity and mortality due to Cardiovascular Diseases (CVD), consequently, reducing expenses with urgent and emergency care. High costs of health systems come from the worsening and chronicity of AH, conditions considered sensitive to PHC, as they are related, mainly to non-adherence to drug treatment due to lack of effective monitoring and control of the disease<sup>9,15-16</sup>.

There was no significant association between the domain adhesion/bond and inadequate blood pressure control. This result corroborates data found in a study<sup>17</sup>, carried out with individuals with similar clinical characteristics, in which people with inadequate blood pressure control are the most assiduous to medical consultations.

The individualized and qualified consultation, as well as the monitoring carried out by the same professional, facilitates the formation of bonds and promotes a better understanding of the guidelines, favoring the continuity of treatment. Users who feel comfortable and have a greater opportunity to raise their doubts about the disease and its treatment make it easier for professionals to assess problems related to treatment, providing guidance to the real health needs of these people<sup>8,19-20</sup>. In addition, the creation of the bond strengthens the capacity for self-care and understanding on the severity of their chronic condition, which can contribute to the construction of individual care plans, centered on the person and family. Such plans can be followed or guided by the recommendations of the Ministry of Health, carrying out periodic monitoring and evaluation of the results<sup>8,19-20</sup>.

The list of services representing the health actions offered by health professionals, such as blood

pressure measurement, scheduled appointments and medication dispensing, presented a regular and unsatisfactory evaluation. Such data indicates that people with inadequate blood pressure control are more likely to assess the service as insufficient to meet their health needs<sup>7,15</sup>.

A study carried out in Paraná<sup>9</sup> pointed out that the difficulty in therapeutic adherence was associated with the low frequency of consultations and meetings of SISHIPERDIA. People's participation is essential to reduce acute conditions and decrease comorbidities. Therefore, professionals need to be attentive, improving clinical management, since only drug therapy and the replication of prescriptions for controlling hypertension are not enough to guarantee pressure control<sup>21-22</sup>.

The regular assessment of coordination, which represents the articulation of PHC and other health care services in the network, by people with inadequate blood pressure control, is similar to studies in other Brazilian states<sup>21-22</sup>. Among the evaluative questions of the domain, it was in the referral and counter-referral of the services, which when not carried out, impairs the continuation and resolution of the treatment<sup>20</sup>.

A study carried out with PHC health professionals pointed out that the lack of referral and counter-referral to the actions performed in the UBS interferes with the effectiveness of clinical interventions<sup>23</sup>. The difficulty of communication between services affects the monitoring of users within the health care network, generating dissatisfaction in relation to the interventions offered. In this regard, there is a need to implement actions in favor of strengthening PHC, seeking to carry out referral and counter-referral actions and services, consolidating their resolution capacity<sup>14,19</sup>.

The attribute family focus that presents the family as a unit of health care and care showed a satisfactory average in more than half of the interviewees. The integration of health professionals with families allows the recognition of people's territorial reality, which can provide good self-care practices and treatment adherence, since family



support is the main facilitator for therapeutic continuity<sup>24,25</sup>.

The attribute community guidance, responsible for diagnosis of potential problems, epidemiological competence and identifying the priority needs of the population, obtained a regular and unsatisfactory average in more than half of the interviewees. However, there was no association with inadequate pressure control of individuals. Community-oriented PHC seeks to combine epidemiological and clinical skills to regulate programs and access the priority health needs of a defined population. For each territory, area or micro-area, there are specific community characteristics that should be highlighted by professionals when formulating unique therapeutic projects<sup>25</sup>.

Although the National Primary Care Policy (PNAB) recommends that actions developed at the community level should privilege democratic and participative care and management practices, centered on the user and that permeate the development of their autonomy, it is necessary to incorporate this attribute in the academic training of health professionals, as well as in education and training actions for professionals already included in the service. A study<sup>26</sup> carried out in Japan showed a similar result and highlights the need for professional training to be carried out to strengthen the relationship between the team and the community.

The study is limited to its territorial scope, in which the results indicated in this study are not a representative sample of the State because it is carried out in only one municipality, as well as the impossibility of attributing casualty to its results, considering the nature of cross-sectional studies, which reduces its potential for generalization.

The contributions of the findings to nursing and public health policies are inherent to the need to expand the scope of PHC, so that it is more effective, with resolute interventions and that ensures coordinated and continuous care. Concerning this, promote the capacity for governance, partnership and successful integration between PHC and specialty services and the participation of the community in

decision-making, expanding the effective results to the entire population.

## CONCLUSION

The assessment of health services from the perspective of people with hypertension allowed to identify that the FHS has satisfactory points for attributes related to the PHC organizational structure, in which most of the attributes obtained high averages in the scores. The attributes that presented lower satisfaction indices were the list of services, family focus and community guidance. There was an unsatisfactory and regular assessment regarding the list of services, and regular regarding the coordination of care, when associated with people with inadequate blood pressure control, with the need for new approaches to the studied population, taking into account their health needs.

According to the results, the study points out important findings that can be improved in the provision of services, highlighting the importance of working with health professionals and identifying the needs of this population, using intersectoral collaboration as a strategic tool in the work between teams, which address the main actions to be addressed, especially when related to users with hypertension and to identify ways to reduce inequities in care, in order to promote better working conditions for professionals and better quality care for the population, adhering to PHC services.

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