Revista de Pesquisa Cuidado é Fundamental Online
E-ISSN: 2175-5361
rev.fundamental@gmail.com
Universidade Federal do Estado do Rio de Janeiro
Brasil

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Revista de Pesquisa Cuidado é Fundamental Online, vol. 8, núm. 1, enero-marzo, 2016, pp. 4056-4078
Universidade Federal do Estado do Rio de Janeiro
Rio de Janeiro, Brasil

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Federal University of Rio de Janeiro State
Journal of Research Fundamental Care Online
ISSN 2175-5361
DOI: 10.9789/2175-5361

INTEGRATIVE REVIEW OF THE LITERATURE

Fatores que interferem no acesso de primeiro contato na atenção primária à saúde: revisão integrativa

Factors that affect first contact access in the primary health care: integrative review

Factores que influyen en el acceso de primer contacto en la atención primaria de salud: revisión integradora

Cristiane Cardoso de Paula[1], Clarissa Bohrer da Silva[2], Taís Tasqueto Tassinari[3], Stela Maris de Mello Padoin[4]

ABSTRACT

Objective: to identify the evidence available in scientific articles about the factors involved in the access of first contact of the Primary Health Care (APS). **Method:** integrative review developed in LILACS, Scopus and PubMed database using the keywords “primary health care” and “access to health services”. There were 41 articles in full. **Results:** the results showed that there are factors that favor or disfavor the components of the access attribute of first contact, that is, aspects of structure and performance. Conclusion: to identify factors that interfere with access to APS, it aims to guide the formulation of policies for better performance of health systems. **Descriptors:** Primary health care, Health services accessibility, Nursing.

RESUMO

Objetivo: identificar as evidências disponíveis nos artigos científicos acerca dos fatores que interferem no atributo acesso de primeiro contato do usuário na Atenção Primária à Saúde (APS). **Método:** revisão integrativa desenvolvida nas bases de dados LILACS, PubMed e Scopus com os descritores "atenção primária a saúde" and "acesso aos serviços de saúde". Resultaram 41 artigos na íntegra. **Resultados:** Evidenciou-se que existem fatores que favorecem ou desfavorecem os componentes do atributo acesso de primeiro contato, ou seja, os aspectos de estrutura e de desempenho. **Conclusão:** ao identificar os fatores que interferem no acesso à APS, visa-se orientar a formulação de políticas para um melhor desempenho dos sistemas de saúde. **Descritores:** Atenção primária à saúde, Acesso aos serviços de saúde, Enfermagem.

RESUMEN

Objetivo: identificar la evidencia de los artículos científicos disponibles acerca de los factores que intervienen en el atributo de acceso del primer contacto de Atención Primaria de Salud (APS). **Método:** revisión integradora desarrollada en las bases de datos LILACS, Scopus y PubMed usando las palabras clave “de atención primaria de la salud” y “acceso a servicios de salud”. Resultaron 41 artículos en su totalidad. **Resultados:** los resultados mostraron que hay factores que favorecen o desfavorecen los componentes del atributo de acceso del primer contacto, es decir, los aspectos de la estructura y el rendimiento. **Conclusión:** para identificar los factores que interfieren en el acceso a la APS, se tiene como objetivo orientar la formulación de políticas para mejorar el rendimiento de los sistemas de salud. **Palabras clave:** Atención primaria de salud, Accesibilidad a los servicios de salud, Enfermería.

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INTRODUCTION

The Primary Health Care (APS) is configured as a doorway to health system. It is estimated that the services of APS are accessible and resolute for health demands of patients.[1-3]

Access is an APS attribute, characterized by having a service as a doorway to each new health problem or new episode of the same problem. The first contact defined as a doorway is the identification of particular service as the first resource used by the population when there is a health need. It is assumed that the health system is organized from less technological density service and that is easily accessible to the ascribed community.[2]

This attribute has a structure component (accessibility) and a performance component (use or access). Accessibility enables people to come to the health service, integrating geographic, financial and organizational aspects, in order to promote the availability of services and the ability to produce and respond to people´s needs. The use or access refers to the way people perceive the accessibility and correct use of the services to achieve better health outcomes, not restricted to entering the service. It considers the social, cultural, economic and psychological aspects that affect the decision to seek the service.[2]

The benefits of a first contact access are morbidity and mortality reduction, hospitalization, time to solve the health problem, unnecessary referrals to specialists and total costs. It results in efficient use of resources, proper attention to the needs and better health outcomes. It is noteworthy that this is not an exclusive feature of APS, however, it is a requirement for this service to be recognized as a doorway, facilitating access to health care.[2,4]

It is justified the need of searching for grants, adding elements to the improvement of health care through this attribute, since the effective use of primary care services is the result of a multiplicity of individual, contextual and related to quality of care provided.[5-6] The aim of this study was to identify the review available evidence in scientific articles about the factors that interfere with the first contact access attribute of the patient in the APS.

METHOD

Integrative literature[7] review study from the research question: what are the factors interfering with the first contact of the patient´s access to primary care health service? The search was conducted in May 2013, in the Virtual Health Library (VHL), the electronic database Latin American and Caribbean Health Sciences (LILACS), the Public MEDLINE (PubMed) and SciVerse Scopus (Scopus). The descriptors/MeSH Terms used were "primary health care" and "access to health services".

Inclusion criteria were: research articles about the topic; available in full online and free of charge; written in Portuguese, English or Spanish. As exclusion criteria were: articles without abstracts in the database or incomplete. In PubMed and Scopus databases tools available on the sites were used to search filtering.

The search amounted 8597 productions, which were selected by reading the titles and abstracts, and submitted to the inclusion and exclusion criteria. There were 41 articles in full (Figure 1).

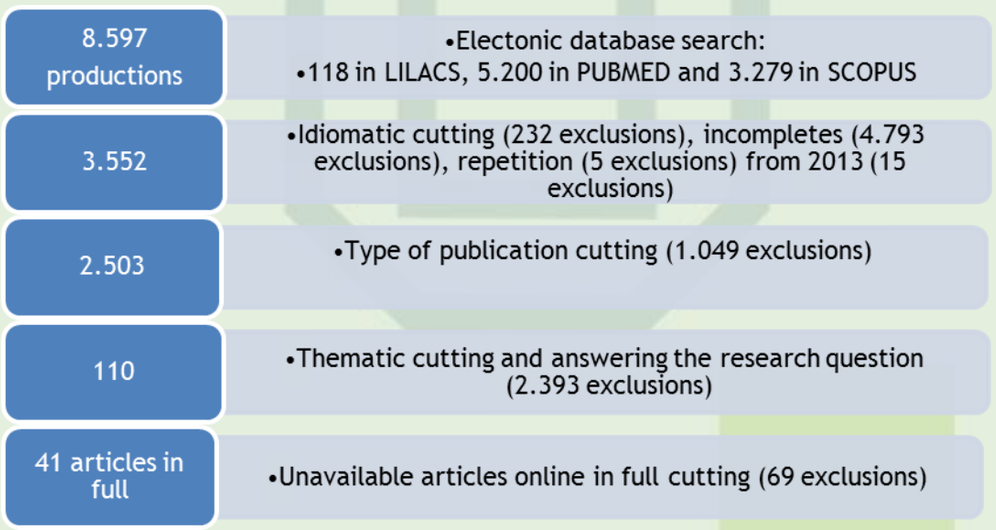

Figure 1 - Study selection flowchart in the databases LILACS, PubMed and Scopus, 2013.

Articles reading was conducted by two researchers independently in order to minimize possible bias of study selection (error in the interpretation of results). After the reading, a documentary extraction form of the selected studies was filled with the following items: article identification, study site, area of knowledge, year of publication, objective and study design, level of evidence and main findings.[8]

A descriptive analysis of data was performed to enable the evaluation of the quality of evidence through seven levels described by Melnyk and Fineout-Overholt.[9]

This review did not analyze the political organization of health services of studies´ origin. Studies were selected because their data collection site were the APS services as: community health centers, "general practice", basic care, primary health care, family

health.

Data were organized according to the aspects of care of the first contact access attribute (structure and performance) and the factors identified were divided according to their interference with the attribute (favoring or disfavoring). This division is merely didactic for data presentation. The characterization of the studies will be presented as absolute and relative frequencies, emphasizing the five-year distribution of production carried out.

With regard to ethical issues, ideas, concepts and definitions used by the authors of the articles analyzed presented in a reliable way, as described and cited.

RESULTS AND DISCUSSION

The characterization of the 41 analyzed articles is presented in Table 1.

Table 1 - Characterization of the analyzed articles. LILACS, PubMed and Scopus, 2014.

	N	%
Origin		
Portugal	1	2
Finland	1	2
Nepal	1	2
Saudi Arabia	1	2
Mexico	2	5
United Kingdom	3	7
USA	3	7
Australia	3	7
New Zealand	3	7
Canada	4	10
Brazil	19	49
Knowledge area		
Occupational therapy	1	2
Odontology	1	2
Medicine	4	10
Nursing	8	20
Multi-professional	26	66
Year of publication		
1998-2002	4	10
2003-2007	6	15
2008-2012	31	75
Research design		
Quantitative and qualitative	1	2
Qualitative	16	39
Quantitative cross-sectoral	24	59
Level of evidence		
6	41	100
Total:	41	100

Figure 1 - Synthesis of each production that answers the research question of this study, LILACS, PubMed e Scopus, 2013.

The synthesis of each production answering the research question of this study are shown in Figure 1.

Reference	Objective	Method	Results
Almeida PF, Fausto MCR, Giovanella L.[10]	To describe and analyze actions taken in four urban centers to strengthen the family health strategy (ESF) in Brazil.	Qualitative, quantitative; P=61 managers (qualitative) + 224 doctors and 261 Nurses and 3.311 families (quantitative).	According to managers, the main strategy for the organization of the doorway in ESF is the hosting, which seeks to articulate care to spontaneous demand and scheduled actions. In each city, this practice has peculiarities, considering the level of involvement, organization and resources available for the teams. ESF expanded the access to health actions from the traditional basic units from the conversion in family health units and the construction of new services, especially in more remote areas and less provided with social resources. The definition of acting territories reduce geographic barriers to access and contribute to the services becoming a regular use, although the traditional opening hours has not been modified by the implementation of ESF. APS performance as a gateway depends on the still fragile balance between care spontaneous demand and scheduled access to the registered population. From the families´ points of view, about 15% reported not knowing the ESF, reaching 30.0% in some cities. The level of tolerance for unscheduled consultations (emergency care function) was also evaluated as an element that influences the accessibility to USF. Another indicator to assess the accessibility to APS services was the facility to schedule doctor´s appointment, it was found more easily for scheduled appointments compared to those from the spontaneous demand.
De Souza MLP, Garnelo L.[11]	To analyze the results of an evaluation study in the city of Manaus, Amazonas State, Brazil, about primary health care for patients with hypertension and / or diabetes.	Ethnographic approach; P= one unit of PSF and in another primary health unit non-PSF.	The APS service implementation represented an extension of coverage that enable the provision of health actions to a previously excluded population. However, the lack of other urban infrastructure means compromises the customer´s access to services offered in the PSF unit. The steep slopes of a street in the rain is muddy, being an obstacle to access the service. Added to this difficulty, there is the low coverage of the PSF in the city, with a large urban areas having as the only health service available. As a result, as well as painful, the hikes can be long. Even the basic health unit has urbanized surroundings, but its location in the port area, with drug trafficking and prostitution in the vicinity also creates difficulties in accessing the unit. The unit is far for more than a kilometer from the main cluster neighborhood homes. The lack of a bus line that links the homes to the units forces patients to confront this distance on foot. The care service essentially done through spontaneous demand and the influx of large number of patients from diverse backgrounds generated demand pressure, and difficult access to care. The lack of pre-marking consultation required patients to leave home before dawn, exposing themselves to urban violence to get there early to the clinic and to get the consultation. The difficulty of access to higher levels of complexity of the system

			also compromises the effectiveness of care, summarizes the absence of an organized system of reference and expressed the difficulties faced by patients seeking access to services and comprehensive care for their health needs.
Regmi K, Naidoo J, Pilkington PA, Greer A.[12]	To analyze and understand the effect of decentralization of the district health service from the perspective of patients and service providers	Qualitative Focal Groups; P= 20 patients and 20 professionals.	Decentralization was positively associated with increased service access and utilization and improved service offered.
Vargas AMD, Ferreira EF, Mattos FF, Vasconcelos M, Drumond MM, Lucas SD.[13]	To analize the access to health services.	Qualitative Interviews and focal groups; P=15 patients.	Situated in steep street, so with difficult accessibility. To worsen residents' situation, there is no bus line that leads them to the Health Centre. The geographical accessibility was a problem. Another complaint of patients was the carelessness with the place where the unit is located, with a "scrub at the entrance", revealing neglect of the population. All participants of the survey revealed to know well the functioning and strategies of access to health services. They know they are registered by the PSF through the Community Health Agents (ACS) and belonging to certain teams. It is considered that the accessibility of these patients is also affected, considering the cultural approach (the inclusion of health services in the habits and customs of the population) and certainly economic, since existing services are not available for all residents, resulting in clear and incomprehensible inequalities for the population. It is understood, too, that this was a complex issue and that access was defined by political agreements, not easily modified.
Souza CCBX, Rocha EF.[14]	To know the experiences of patients with disabilities and family when using the rehabilitation services of this program and to understand how they evaluate their access to it, considering different discourses, social positions, and cultural backgrounds, through semi-structured interviews and use of qualitative methodology.	Qualitative; P = nine People with disabilities, and nine families of people with disabilities.	Respondents reported aspects of architectural and urban accessibility as important factors in determining the ability to access health services because many people with disabilities have transport difficulties in these spaces. With specific regard to structural conditions of UBS, many have steep ramps, stairs, narrow corridors, lack of adapted toilets, among other architectural problems that hinder the movement of people with reduced mobility. The surroundings of UBS have steps, holes in the floors, and the presence of other barriers to access. Relationships between patients, carers and professionals also makes access to the service. The statements show that the presence of the PSF rehabilitation approaches significantly professionals from patients and community. Another factor that interferes with the relational access is the existence of a caregiver who can follow the disabled person in health care. This factor is not related directly with the professionals of UBS, however, alternative forms of

			assistance, such as home care can partly solve this problem. So the fact that there is a home rehabilitation service is regarded as a facilitator, as it does not restrict the right to assistance to those who move independently. Also Public policies that democratize access to support facilities such as new and efficient wheelchairs, best suited urban transport and to enable the existence of social carers, according to the needs of each patients/territory are needed.
Sala A, Luppi CG, Simões O, Marsiglia RG.[15]	Avaliar processos de integralidade em unidades de APS localizadas no Município de São Paulo, sob o ponto de vista dos usuários dos serviços To assess comprehensive processes in PHC units located in São Paulo, from the point of view of service patients	Quantitative; Cross-sectional; P= 184 patients.	The results pointed to the difficulties of access to PHC services. It is highlighted the difficulties in both models of care, to obtain consultation and especially for consultation in 24 hours. It is interesting to note that one of relative accessibility issues - finding the open unit after 6 pm - occurred more among the patients linked to the ESF. Probably the ESF are already organized to offer greater flexibility of time that the units that operate in the Programming and Health model.
De Souza ECF, De Vilar RLA, Rocha NDSPD, Uchoa ADC, Rocha PDM.[16]	To evaluate access to primary health care and responsiveness from the point of view of patients and healthcare professionals of traditional primary care units and family health units	Qualitative; Focal groups; P= six with an average of fifteen participants each.	It was found that there are still many difficulties of accessibility and access due to the imbalance between demand and offer of services. In the family health unit, patients have acknowledged facilitating factors such as dialing calls by some community health worker. However, as the team prioritizes the schedule for patients linked to programmatic actions, part of them are dependent on vacancies and due to high demand, there are still queues and dissatisfaction, to the extent that the problems arriving in the unit are not even addressed. Professionals had opinions similar to those of patients, highlighting the difficulty of access to dental care, pointing limited number of teams and the low program coverage. The difficulty of accessibility in primary health care unit was due to high demand, predominantly spontaneous and expresses sorrow for professionals and patients. Another factor that interferes with access was equipment failure. In the family health unit, patients were unhappy with the scheduling of the unit and the welcome at reception. For professionals, the host appears as an important element to organize the demand and the labor process, but it requires much effort and professional dedication. Pressure by patients for immediate assistance and the refusal to be received by another professional, such as the auxiliary or nurse before they get to the doctor, reflected in the team as stress, exhaustion and search for solution. They declared the existence of unfavorable conditions for hosting, as the great demand and work overload. They

			reported differences in how they are treated in the unit by different professionals and claimed a good care as a right. Limitations on access showed queues and dissatisfaction, and part of the population cannot be met in their needs.
Thumé E, Facchini LA, Tomasi E, Vieira LAS.[17]	To evaluate factors associated with home health care for the elderly and their characteristics, according to Family Health Strategy care models and traditional family model.	Quantitative cross-sectional; P= 1.593 individuals.	Home care provides access to care, reaffirming its importance in the care of disabled people to go to health services.
Cunha ABO, Vieira-da-Silva LM.[18]	To analyze the implementation of measures for accessibility to primary health care in a city	Study of one case in the city of Bahia.	On the other hand, the analysis of service organization, persist accessibility problems both in the characteristics of care as the existence of organizational and geographical barriers. Part of these results relates to the characteristics of the service in the units studied, with the absence of actions for the reception, no use of waiting list for the replacement of defaulting and the weakness of the system of reference and counter reference, across geographical distances between these units and the residence of patients. The consultation system has proved to be an obstacle to the use of services. In ESF, appointments to the spontaneous demand was made only by request of ACS, and from the screening/reception. In UBS, there are daily appointments, however, in one, it was possible to get an appointment every day without time restrictions, and, in another, only at specific times, at the beginning of each shift. The existence of practices aimed at the reception were only referred by professionals of USFs, and yet closely related to the administrative screening process used to prioritize patients who come from the spontaneous demand. The opening of the basic units in evening hours could facilitate the use by workers due to the mismatch between the hours of operation and work. However, in practice, the third shift does not work as expected. In UBS, the third shift corresponded to the time from 17 pm to 21 pm. It was observed that the early opening hours suffered the influence of the professional who was serving, and may vary. Patients from different areas revealed that, when they needed to move to the central city for other procedures, they walked several times due to lack of financial resources for transportation.
Coelho MO, Jorge MSB, Araújo ME.[19]	To discuss how patients perceive access to basic health units by the	Qualitative; P= 30 patients.	According to the perceptions of patients, which refer to the importance of access by the hosting as a guarantee of care, other aspects were also referred as listening to complaints, presence of instruments to

	hosting.		support service and classification of level of risk. Access through the hosting should be felt, experienced and integrated into the daily life of health facilities.
Mäntyselkä P, Halonen P, Vehviläinen A, Takala J, Kumpusalo E.[20]	Studying people´s opinions on the accessibility and continuity of primary health care provided by different suppliers: a public primary health center (PPHC), health professionals (OHC) and a private practice (PP)	Quantitative Cross-sectional; P= 6437 patients.	There was a tendency to increase access to care for all providers when the number of chronic diseases has increased. People who live in cities with a medical staff system to the public health center perceived access to care as slightly better than those who do not have access to a personal medical system. Suffering from chronic diseases was inversely associated with good access to a doctor. Being unemployed or retired was associated with good access. Involvement with personal medical system was related with good access and especially for good continuity.
Ludeke M, Puni R, Cook L, Pasene M, Abel G, Sopoaga F.[21]	To identify the main characteristics of general clinic services in Christchurch, New Zealand, which act as barriers to access to these services for the people of the Pacific.	Qualitative; P= 20 participants.	The analysis revealed themes that highlight the characteristics of services that can influence access to primary care. Many patients found communication difficult during consultations, not only for those with limited English proficiency, but it was also attributed to the used medical terminology that may contribute to intimidation and/or inferiority feelings. The limited opening hours and inflexible scheduling systems were commonly seen as barriers to care. Employment obligations were often discussed as hamper access during business hours, and it was suggested that the extension of opening hours would improve the availability of services to the population. A hostile reception by the staff service was seen as a significant problem of access.
Lima WCMB, Assis MMA.[22]	To analyze access to services in the PSF Family Health Program in Alagoinhas (BA) in the composition of the health care model	Qualitative; P= 21 people (10 professionals, 5 patients and 6 key informants).	Access is focused to restrict public service to certain services or programs. As for the universal care, it translates into a targeted system; revealed the services in the PSF, characterized mostly by a tight supply at the gateway - the reception - modulated by informative posters about the number of vacancies in order of arrival and for specific days to meet the particular population group, presence or absence of professionals and characterized by a spontaneous demand, repressed in their health needs. One of the PSF units searched operates with the hosting as a way to organize the service, but has kept the book appointments for medical system with a difference because the patient “do not have to get in line, get the number for attendance”. The USF keeps a daily scheduling system for medical appointments, always giving priority to referrals of ACS, through articulated listening to community demand.
Bernard D, Quine S, Kang M, Alperstein G, Usherwood T, Bennett D, et al.[23]	To explore the extent of congruence between the views of service providers and young people (in	Qualitative; Focal groups P= 27 adolescents.	Young people identified a number of barriers to access to services, the most important were personal concerns. Confidentiality and trust were greater prominence. This difficulty includes the disclosure of health problems that were personal, fears around what professionals can tell parents and

	relation to health, barriers to access to health services and service ideal model) in order to improve and enhance the appropriateness, quality and use of primary health services.		teachers, as well as concerns about being seen when accessing a service. Young people often felt vulnerable or ashamed because they need help. They believe that would be negatively judged by providers. However, some young people who knew a provider and have a trusting relationship with them would be much more willing to access services. Another barrier was the lack of young people aware of the services or what they provide. Only a small number of young people mentioned structural issues regarding the operation of services, such as opening hours, the inappropriate transport lists, cost and waiting. Perspectives of service providers that have structural barriers represented the greatest impediment to the young who access health care. These times included, access to public transportation and scheduling systems, as well as the attitude of receptionists, scary/unpleasant service sites, location and age of service providers.
Haggerty JL, Pineault R, Beaulieu MD, Brunelle Y, Gauthier J, Goulet F, et al.[24]	To identify attributes of clinic organization and doctors´ practice providing for accessibility, continuity and coordination of care experienced by patients.	Quantitative cross-sectional; P= 100 doctors.	The most important predictor of first contact accessibility was offering telephone access to patients 24 hours a day, 7 days a week in community health centers in remote areas. They could meet the accessibility levels expected by having a nurse (0.12), providing continuous telephone service (0.30) and adjust the scheduling appointments so that appropriate cases can be seen within 1 week. Increasing opening hours also increases access. Improving links with other health places also positively influences accessibility (0.03 for each place).
Buetow S, Adair V, Coster G, Hight M, Gribben B, Mitchell E.[25]	Suggest a framework of how to conceptualize differences in professional and cultural understanding of the practice of time management in Auckland, New Zealand, access to GP influence of care for children with chronic asthma.	Qualitative; P= 11 mothers of children with asthma.	These barriers of access to GP, none of which is specific for asthma: opening hours; to interviews traditional systems; practice intolerance of poor maintenance schedules; long waits in practice, and lengths of inadequate consultation. Restricted opening hours indicates the time focused in practice because they are focused on practical personal needs. Most mothers said they would increase the use of GP services if usual opening hours of practices were extended. Some practices aim to meet requests for appointments on the same day, others are heavily booked at the beginning of each day and get a piece of their busy schedule to emergency slots. Service intolerance for missing appointments was considered a barrier beyond the control of patients, such as problems with transportation and child care and lack of familiarity with appointment systems. Personal practice may show little tolerance for missed appointments, limiting access to GP care.
Wellstood K, Wilson K, Eyles J.[26]	To explore through qualitative research methods, when individual and form factors of	Qualitative; P= 41 participants.	The barrier of access to the system mentioned was the waiting time for medical consultation. The second most cited barrier was the geographic location of medical facilities, especially for those without private transportation. The third most cited barrier system to receive care was limited

	the access system to primary care services		working hours in family medical offices often in conflict with work schedule. The job responsibilities were the most commonly mentioned individual barrier. Only women described family responsibilities as barriers to care.
Kontopantelis E, Roland M, Reeves D. [27]	To identify predictors of patient´s satisfaction and experience to English primary care access	Quantitative Cross-sectional; P= 1.999.523 questionnaires	The younger people and people of Asian ethnicity, who work full time or have long commuting times to work, reported the lowest levels of satisfaction and access experience. For people at work, the ability to get away to visit the GP effectively eliminated the disadvantage in access. Practice with a higher proportion of the doctor for the patient have been reported to be better in terms of telephone access and availability of appointments within the next two days.
Perry C, Thurston M, KilleyM, Miller J.[28]	To explore the role of a nurse in primary care, especially if the provision of a nurse facilitated access to care that met the needs of patients.	Qualitative; P= 14 patients.	Staff interviewed commented that the nurse service had increased access, because of their presence, had no increase in the total number of consultations available in practice but had allowed all clinicians to increase the length of their appointments for 15 minutes. Furthermore, the increased access is spoken in the range of times during the day when the nurse was available for consultation. Many patients felt that GPs remained inaccessible and realized that this was due to the level of demand for their services.
Anikeeva O, Katterl R, Bywood P.[29]	To assess the activities developed by GP divisions to improve Indigenous Australians access to primary care.	Quantitative Cross-sectional; P= 86 divisions of general clinic,	The main barriers are: the cost of consultations and medication; lack of knowledge about services; the inadequate public transportation services; the difficulty of accessibility to services by public transportation; opening hours reduced; the lack of cultural awareness and sensitivity in the conventional care; the identification of indigenous patients.
Crosson JC, Heisler M, Subramanian U, Swain B, Davis GJ, Lasser N, Ross S, et al.[30]	To evaluate patients´ perceptions of barriers to control CVD risk factors.	Qualitative; P= 34 doctors of primary care.	System barriers related to care access that affect patients and difficulties getting appointments and referrals, transport, weather, financial barriers and confusion about system requirements for access to health care. Financial barriers such as medication costs and disruptions in insurance coverage were seen as preventing diabetes patients to get needed care. Interruptions Insurance affects the treatment because it is a question of accessibility to the system. If people lose their jobs, changing jobs or changing their insurance affects the continuity of care.
Trevena LJ, Simpson JM, Nutbeam D.[31]	To examine patterns of utilization of health care from a seriously disadvantaged population services.	Quantitative cross-sectional; P= 140 individuals.	The difficulties of access were associated with homelessness (including boarding house residents), lack of transportation, poor self-reported health, a history of mental health disease or cancer, lack of knowledge about health services available, participant embarrassment on the demand for health care, and do not believe that their problem would be solved. Patients were more likely to fail in the follow-up they also reported embarrassment about seeking counseling (10%; P = 0.05), a belief that their problems would not be addressed (19%, P = 0.05) ,

			lack of confidence in reported health professionals (14%, P = 0.04), and a history of not knowing where to seek help when needed (24%, P = 0.05).
Copland RJ, Denny SJ, Robinson EM, Crengle S, Ameratunga S, Dixon R.[32]	To determine the prevalence of self-reported pregnancy among high school students with sexual experience, and the association between adolescent pregnancy and access to primary health care	Quantitative cross-sectional; P=96 students.	Use of health services: students reporting pregnancy were twice as likely to report problems accessing health care. One of the most common reasons for not accessing health care when needed was the concern for privacy. Not knowing how to access health care and lack of transportation to get to health services were additional barriers. Both reasons were reported more among those who had been through a pregnancy.
Goodridge D, Hutchinson S, Wilson D, Ross C.[33]	To explore the impact of living with advanced chronic respiratory disease in a rural area.	Qualitative Interpretative; P= 7 individuals.	All participants commented long distances as a barrier to access to health care. The challenges of traveling long distances meant that driving a vehicle is extremely important to access health care. Most participants also drove and were proud to be able to maintain their independence. Taxis and public transportation were not widely available in this rural area, although one of the participants had been a volunteer driver who took people around his own community site for consultation. Those who do not have access to such voluntary service in their community or they could not drive had to wait and rely on the goodwill of family and friends when they needed to have access to health care.
Scatena LM, Villa TC, Netto AR, Kritski AL, Figueiredo TM, Vendramini SH, et al.[34]	To evaluate the difficulties of access to tuberculosis diagnoses in the health services in Brazil.	Quantitative cross-sectional; P= 514 patients.	The two dimensions “locomotion to the health service” and “service” composed the factors that were associated with access to TB diagnosis being made by the variables: spent money on transportation; sought health services closer to home; number of times sought the health center to get an appointment and get an appointment within 24 hours.
Arredondo A, Nájera P.[35]	To determine costs for patients to seek and receive health care in public and private institutions	Quantitative Cross-sectional; P= 50.943 individuals.	Accessibility was also affected by urban and rural character of the community of origin. The cost of transportation for the rural population was more than double for the urban population. These findings are particularly interesting since that rural communities have the lowest annual income and their health is put more at risk because of poor access to health care and living conditions in general.
Carreira L, Rodrigues RA.[36]	To identify the difficulties experienced by the families of elderly people with chronic conditions and seeking assistance in the Basic Health Unit (UBS).	Qualitative; P= eight families of elderlies (29 people).	The difficulty of access to basic health unit was also a question raised by the families and the elderlies, both because of the geographical distance between the residence and the service, as also the problem of transportation, which involves from lack of private commuting, depending in these cases, public transportation or ambulance, to the physical limitations from the health problems of the elderly. It is also noted that the geographical distance can be aggravated by the way how is delimit the

			covering area of the UBSs, because not always the residence belongs to the area of operation of the nearest health facility. The difficulty of getting medical consultations in primary care unit was another problem mentioned by families. It is evident that the elderly with greater health care needs to seek care in other services in relation to the basic unit of reference health, which suggests that primary care is not equipped to provide appropriate care to this population.
Carvacho IE, de Mello, MB, Morais SS, Silva JLP.[37]	To assess determinants of access to primary care services in pregnant adolescents	Quantitative cross-sectional; P= 200 first pregnancy adolescents (10 to 19 years old).	Administrative barriers such as the requirement by some services that the minor should be accompanied by an adult and the requirement for documents to schedule an appointment. 37% of young people had difficulties in accessing administrative and access to information. Approximately one-third (29.5%) were identified as having greater difficulty in geographic access and 19.5% of economic access. Access to information was significantly associated in the bivariate analysis with partner's age, paid work and the kind of relationship with the partner.
Reis DC, Kloos H, King C, Quites HFO, Matoso LF, Coelho KR,et al.[38]	To compare the accessibility and use of the diagnosis and treatment of schistosomiasis in a small village and surrounding rural area in the northern state of Minas Gerais, Brazil	Quantitative Cross-sectional; P= 1.228 individuals.	The rural population has relatively less access to the health center because of distance and mountainous terrain.
Reyes H, Tomé P, Gutiérrez G, Rodríguez L, Orozco M, Guiscafré H.[39]	To assess access to health services and care to children process under five years old who died of acute diarrhea (AD).	Quantitative cross-sectional; P=553 children deaths.	Geographic and economic access barriers were identified in rural areas. It is evident the difficulty of access to health services in communities with fewer than 500 inhabitants.
Rosa RB, Pelegrini AH, Lima MA.[40]	Analyze the views of patients on the resolution capacity of service issues in the Family Health Unit and its relationship to their satisfaction.	Quantitative/ qualitative; P= 93 patients (quantitative) + 22 patients (qualitative).	For some patients, the changes offered by the service in health status were related primarily to the UBS geographic proximity to home because it facilitated geographic access and obtaining consultations.
Paskulin LM, Valer DB, Vianna LA.[41]	To describe the use and geographical access of the elderly to primary health care (CSP), in Porto Alegre	Quantitative Cross-sectional; P= 292 elderlies.	Among the reported reasons for use primary care services, there are: location nearby to the residence (28.5%); consider good service (26.5%) and the gratuity (22.9%). There was a significant association between education and use of a SAB ($p < 0.001$), in which the majority of illiterate elderly or with incomplete primary (72.1%) used a SAB, and

	(RS), and to analyze the association between the variables of interest for the study and access to APS.		those who had high school and college did not use it (74.0%). It was also observed that most of them (81.0%) considered themselves healthy and there was a significant association between subjective health status and use of a SAB (p = 0.008). Elderly people who considered themselves healthy did not use a basic service (54.3%), and among those who considered themselves sick, used it (65.5%). They referred suffering from chronic damage 69.2% of the elderly, and there was also an association between this variable and the use of the SAB (p = 0.007). Factors negatively associated to the use of SAB were "education" and the fact of "perceiving themselves healthy", and the positively associated variable was "self-reported chronic damage".
Dias S, Gama A, Silva AC, Cargaleiro H, Martins MO.[42]	Understanding the perspective of different groups of health professionals on barriers to access and utilization of services by immigrants	Quantitative cross-sectional; P= 320 health professionals.	Most professionals agree that the frequent change of residence, lack of economic resources, beliefs and religious and cultural traditions, fear of denunciation when they are in an irregular situation, ignorance of the law of access to health services and its mode of operation, and linguistic differences may affect access and utilization of services. The highest proportion of participants also considered as barriers among health professionals reduced social and cultural skills for the care of immigrants, and the level of services the complex bureaucratic procedures on access, cost and lack of interpreters.
Forrest CB, Starfield B.[43]	It examined the relationship between access and use of primary care doctors as a first contact sources and continuity with the medical system.	Quantitative cross-sectional; P= 11024 individuals.	Little care time, long time in the waiting room and longer travel times reduced the chances of a visit from the first contact with a primary care doctor for acute health problems.
Baker R, Bankart MJ, Murtagh GM.[44]	To determine whether the practices having high experience in patient QOF points in 2005/2006 or 2006/2007 also delivered good patient access.	Quantitative; P= 2.3 million people.	Increase service was associated with a decrease in the patient´s experience of all access points (the opening hours, being able to see a private doctor, telephone access, being able to see a GP within 48 hours, and be able to make an appointment in advance). People who were white, younger and males tend to experience better access.
de França IS, Pagliuca LM, Baptista RS, de França EG, Coura AS, de Souza JA.[45]	To characterize the conditions aimed at Disability in Basic Health Unit	Quantitative descriptive; P= 20 Basic Health Units Paraíba Brazil.	The study data reflect the difficulties of access for people with physical or sensory disabilities to health services. Architectural barriers identified in the way from home to the Basic Health Unit that hinder the access of disabled people to these institutions. The worst results refer to non-availability of security instruments in transit and visual signal indicative of the location of UBS. Certain sections of the route to UBS is marked by the absence of sidewalks; unevenness on the sidewalk; presence of trees and debris on the access roads; and

			vehicle parking opposite user access ramp with limited mobility. Environment not accessible to people with disabilities within UBS. The main barriers to the access of disabled people to the interior of UBS: staircase; main entrance door; areas of collective movement at odds with the technical standard; filter located in a private balcony; and toilets without clearance towards the sanitary supplies to transposition of people using wheelchair.
Ianni A, Pereira PCA.[46]	To introduce the particularities of access of the deaf population to primary care services and the perception of the health unit managers about it.	Qualitative-quantitative; P= 2 patients and 2 administrators of the Municipal Health Secretary; and 21 managers.	Following aspects related to access: Communicational barriers: difficulties in telephone consultation appointment, no interpreter, deaf confused with mentally handicapped, lack of common language, lack of patience; Technological inputs: shortage of hearing aids Individual (AASI), deaf phones (TDD), few adaptations in the use of lighting, cell phones, e-mails and fax, and lack of visual communicative means; Public Policy: shortage of professionals for rehabilitation, absence of subtitles in campaigns, hearing policies, welfare policies, transport gratuity, preferential queue, lack of services; Nonspecific complaints: unwillingness of the professional, low quality care, socioeconomic difficulties; Human Resources: lack of training of staff for the care of this population and the use of technological inputs, besides the lack of interpreters.
Mahfouz AA, Al-Sharif AI, El-Gamal MN, Kisha AH.[47]	To study the pattern of use of primary health services and satisfaction among the elderly in Asir region.	Quantitative; Randomized P= 253 elderly people.	On average, elderly people visited APS centers significantly fewer times per year than the younger adult age group. The smallest item of satisfaction of accessibility services was related to the long waiting time spent in the center.
Jerant A, Fenton JJ, Franks P.[48]	To examine whether the patient´s reported access to selected primary care attributes are associated with lower risk of individual mortality.	Quantitative Cross-sectional; P= 52,241 patients.	Racial/ethnic minorities, poorer and less educated people, individuals without private insurance, healthy people, and the inhabitants of other Northeastern regions reported less access to primary care attributes than others.
Andersen RM, Yu H, Wyn R, Davidson PL, Brown ER, Teleki S.[49]	To assess the impact of variables at the level of community beyond the effects of individual health access features for low-income adults and children living in large metropolitan statistical areas.	Quantitative documentary; P= 500.000 individuals.	Access is best for people with health insurance and a regular source of care and for those living in communities with more health centers funded by the federal government. Low-income children and adults of Latino origin and Asia, and those with lower level of education were at greater risk for not having access to medical care. Among adults in the sample, the younger age (19-39) and male were also risk factors for not visiting a doctor in the last year.

Pineault R, Provost S, Hamel M, Couture A, Levesque JF.[50]	To analyze the extent to which service experience ranges from chronic diseases and to analyze the relationship of primary health care organizational models with the experience of care reported by patients in different situations of chronic disease.	Quantitative Cross-sectional; P= 6.222 patients.	Accessibility of care is lower for all chronic conditions and shows little variation among diseases.

The highlighted factors that interfere with the first contact access are presented in Figure 2.

Figure 2 - Factors that interfere with the first contact access at APS. LILACS, PubMed, Scopus, 2013.

Attribute components access first contact		**Factors**
Geographic or organizational accessibility [Structure]	Favorable	Presence of ESF[10-16] Home assistance[14,17] Hosting or responsiveness[10,14,16,18-23] Opening hours[10,15,18,21,23-26] Balance between fulfilling spontaneous demand and scheduled[10-11,16] Telephone contact offer [24,27] Nurse on the place[24,28]
	Unfavorable	Transportation difficulties [11,13,18,23,25-26,29-36] Geographic location [10,11,18,23,26-27,33-43] Structural conditions[11,13-14,16,18,36,44-46] Waiting time[25-26,43,47] Cultural and economic focus absence[13,29-30,37,42] Restricted offer[16,22] Difficulty query schedule[10-11,15-16,18,21-25,27,30,34-36] Age of service providers [23] Political agreements [13]
Access individual factors [Performance or Use]	Favorable	Consider a good service[23] Availability of information[10,23,25,29-32,37,42] Gratuity[20,23]
	Unfavorable	Insurance interruption[30,48-49] Language and communication[21,42,46] Referral difficulty to other services[11,18,24,30] Lack of confidentiality and trust [23,31-32] Patient´s health conditions [20,23,31,50] Patients´ sociodemographic characteristics[20,23,27,31,39,44,47-49] Frequent change of residence[42] Employment obligations[21,26-27] Family responsibilities[14,25-26,37]

Care aspects relating to structure

The component accessibility is favored by the presence of the Family Health Strategy (ESF) near the patient. The expansion of the ESF increased the accessibility from the conversion of Basic Health Units (UBS) in family health strategies and the construction of new services, especially in remote and less equipped with social resources areas,[10] enabling the delivery of healthcare actions to a population previously excluded.[11] Decentralization was positively associated with the timely use and qualification of the service.[12] It is emphasized the importance of the enrolled community to know the functioning and strategies of access to service and recognize that it is registered to the ESF by Community Health Agents (ACS), which is linked to certain professional team.[13] The presence of ESF approaches professional to patients and community[14] and is usually organized to offer greater schedule flexibility than UBS.[15] However, the low coverage of ESF[16] causes that urban areas have UBS as the only service available.[11]

The home care of primary care services can serve as an alternative care modality to solve in part the difficulties of accessibility of patients. Thus, it guarantees the right to assistance to those who have limitation to move.[14,17]

The hosting and responsiveness in the APS service favors the accessibility. The hosting was associated with the administrative screening process being used to prioritize patients coming from the spontaneous demand.[18] It presents peculiarities of both the involvement of professionals, as the organization of the resources available to the teams.[10] Patients refer to the hosting as a guarantee of care, being felt, experienced and integrated into the daily life of health facilities.[19]

Relationships among patients, caregivers and professionals also enable access to the service.[14,20] A hostile reception can cause significant access problems.[21] It is noteworthy that the service organization through the hosting results in the classification of the responsiveness and scheduling appointments.[22]

The hosting demands effort and professional dedication and an important element of the organization´s demand and the labor process. The gap between the expectations of patients for immediate service and the service organization as the hosting by other professionals beyond the medical results in stress and fatigue by the health team in the search for solution. The high demand and work overload evident unfavorable conditions for conducting hosting[16] as well as the way they are treated by professionals[16] and receptionists can be a barrier to access.[23]

It was evident that the extension of opening hours also favors accessibility.[24] The limited opening hours is a barrier[21,23] and indicates that the service is focused on the needs of the service and not for the pateints.[25] The functioning of the services during the night shift facilitates accessibility to workers patients.[18,26] However, the third shift does not work as expected. In UBS, the third shift corresponded to the time from 5 pm to 9 pm, and there

may be variations depending on the professional.[18] In the ESF, there are easier access to the service after 6 pm because of the time flexibility in the organization of these services.[15] However, there are those where the implementation of the ESF did not change the opening time.[10] The extension of opening hours can increase the use of APS service.[25]

The balance between fulfilling spontaneous demand and scheduled favors accessibility. When there is imbalance between demand and services offer[10,16], and patients from diverse backgrounds result in overload and difficult accessibility.[11]

The telephone contact offer favors accessibility, due to the proportion between doctor and patient, enabling the short-term appointment scheduling,[27] also taking place in primary care services in remote areas.[24]

Having a nurse at the APS service favors the accessibility, since their presence has increased the availability for consultation of a health professional.[28] Thus, it could meet the accessibility levels expected to have a nurse on site. 24

The difficulty with transportation to the service disfavors accessibility. Among the difficulties, there are: the inadequate public transportation services;[29] limited hours;[29] difficulties in getting transportation due to lack of access to public transportation systems;[23,25,29-32] lack of bus lines[11,13] or volunteer driver who take them to the service;[33] its cost;[18,34-35] unavailability of taxis and public transportation in rural areas;[33] absence of private commuting;[26,36] reliance on public transportation or ambulance with physical limitations from the health problems,[36] also preventing them from driving.[33]

The geographical location does not favor accessibility, due to: location,[23] sometimes in the port area, with drug trafficking and prostitution;[11] distance[18,26,33,36] or difficult geographic access;[37] living in rural areas.[35.38-39] It causes the demand for services near residence,[34,40-42] mainly because of travel times that reduce the chances of a visit from the first contact for acute health problems[43] or travel time between work and service.[27] The definition of acting territories reduce geographic barriers to access in order to contribute to the regular use of services.[10,36]

The structural conditions of the APS service can discourage the accessibility due to: the increase in the service structure;[44] architectural barriers identified in the route between home and the service[11,13-14,45] and within the APS service;[14] peculiarities of the population with disabilities[14,45-46]; equipment failure[16] and the need for resources, such as wheelchairs, adapted urban transportation and social caregivers.[14] Furthermore, the existence of organizational barriers is due to lack of actions for the reception, no use of waiting list for the replacement of faulty patients and the weakness of the patients of the transfer system between the various departments, plus the geographical distances between units and residence of patients.[18] The search service in other services suggests that APS is not prepared to provide assistance to certain populations.[36]

The waiting time is unfavorable accessibility, both the long waiting time for consultation in the service[25-26,43,47] as the reduced consultation time with healthcare provider.[25,43]

The absence of cultural and economic approach disfavors accessibility seen that compromises the existence of services available, resulting in inequalities.[13] This reflects the absence of a conventional service,[29] without considering the lack of economic resources[30,37], religious beliefs and cultural traditions[42] of patients. The barrier affects health professionals, since they have low social and cultural skills for the care of immigrants, and services due to bureaucratic and complex procedures, cost and lack of interpreters.[42]

The tight offer of specific actions to certain population disfavors accessibility as they affect the universal care. Some services restrict access at the gateway (reception) through posters on the number of places (in order of arrival and specific days for service), a particular population group, presence or absence of professional and characterized by a spontaneous demand, repressed in their health needs.[22] The restriction occurs in the prioritization schedule for patients linked to programmatic actions.[16]

The difficulty for medical consultation scheduling was evidenced as a factor that works against accessibility. This difficulty[10,21,30,35-36] was appointed by the number of times sought the clinic to get care in the short term (24 hours to 1 week).[15,24,27,34] The traditional scheduling system[11,18,23], which sometimes results in queues and dissatisfaction[16], the level of tolerance for unscheduled consultations (emergency care)[10] and the difficulty to reschedule lost consultations[25] were also considered organizational barriers to access.[18] A strategy that favored was the referral of assistance by ACS.[16,18,22]

The service providers' age disfavors accessibility since it is considered as a structural barrier to young people.[23] The political agreements disfavor accessibility, since they are dealing with a difficult complex subject to change.[13]

Health care aspects related to the performance or use of APS

Consider APS as a good service was one of the reported reasons for access and use.[23] It was evident that the availability of information favors access. This is because knowledge of the functioning of the service,[29-30,42] for example, as in an appointment scheduling and rescheduling of missed appointments,[25] of available health services[10,23,31,37] and care actions.[23,32,42]

Gratuity was highlighted as one of the reasons for the use of primary care services.[23] Access to APS was better realized if compared to those using other services.[20] Insurance interruptions affect patients access to the system. This fact was pointed out in studies in the United States, usually in losing or changing jobs and changing insurance.[30,48] Access was best for those with health insurance, regular source of care and living in communities with services financed by the government.[49]

Language and communication can also affect access and utilization of APS services, especially for the difficult communication during consultations, both by linguistic differences[42] as the medical terminology used.[21] Both can contribute to feelings of intimidation and/or inferiority of patients.[21] In addition, there are communication barriers for the deaf.[46]

The difficulty of getting referrals to other health services disfavors access to APS. The lack of communication with other healthcare facilities[24] influences access to care,[30] demonstrating the fragility of an organized system of patients transfer between services.[18] This difficulty of access also compromises the effectiveness of care and expressed the difficulties faced by patients seeking access to services and comprehensive care for their health needs.[11]

Concern about the confidentiality and trust in professionals was highlighted as one of the reasons patients do not access the APS services.[23,32] The embarrassment of patients on the demand for health care, sometimes not believing that their problem would be solved.[31]

The patients´ health conditions disfavor access, especially when having chronic disease,[20,50] regular health, mental illness or cancer self-perception.[31] However, a study of elderly people shows that have a subjective health condition or a chronic disease[23] may favor the access.

The sociodemographic characteristics of patients indicate that: white people, young people;[27,47,49] male;[49] full-time workers;[20,27] racial/ethnic minorities;[27,48-49] with low income;[39,48-49] with less education;[48-49] who considered themselves healthy[23,48]; residents of remote regions,[48] and homeless,[31] had most likely to lack access to primary care. On the other hand, studies show that white people, young, male, 44,47 with less education[23] have more ease of access to the service. The frequent change of residence may affect access and utilization of services.[42]

It was evident that employment obligations disfavor the first contact of access to APS.[21,26-27] Family responsibilities also disfavor access, evidenced by the existence of a caregiver who can follow the disabled person in the service[14], the burden of care for children[25-26] and the requirement for some services that minor must be accompanied by an adult.[37]

CONCLUSION

The available evidence in scientific articles about the factors that interfere with the first contact access attribute in the APS show that they can both favor as disfavor. Those in

favor were related mainly to the structural aspects of the service and the individual characteristics of patients who promote to recognize the availability and use the service. The disadvantages are linked to shortcomings in the organization and management of health services added to the individual difficulties, which may negatively influence the use of care in APS.

The first contact access attribute must enable the offering of actions considering the geographical, financial and organizational aspects of the enrolled population to APS service. They should encourage patients to make appropriate use of services, considering the socio-cultural and economic context of patients, in order to promote better health indices. It stresses the need to identify the factors that interfere with access to APS to guide the formulation of policies for better performance of health systems.

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Received on: 12/08/2014
Required for review: No
Approved on: 17/09/2015
Published on: 07/01/2016

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