


Health service accessibility and service users' position in the social space in Salvador, Bahia, Brazil, 2006: a cross-sectional study

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Abstract

Objective: To analyze association between social position and access to health services. **Methods:** This was a cross-sectional study carried out in primary health care centers in Salvador, Bahia, Brazil, where a project for improving accessibility was implemented. Pearson's chi-square test and logistic regression were used. **Results:** 467 users took part in the study, 75.6% had not finished high school; 78.7% had <2 minimum wages; 51.8% had intermediate/qualified occupations. Low income was associated with starting to queue at the health care center the night before or before 8 a.m. (odds ratio = 2.09 – 95%CI 1.13;3.87) and spending more time scheduling an appointment (odds ratio = 2.13 – 95%CI 1.05;4.31). Having an elementary occupation was associated with face-to-face appointment scheduling (odds ratio = 1.68 – 95%CI 1.14;2.45). Education and social trajectory showed no significant association with use of health services. **Conclusion:** Social inequalities in access to health services remained after the intervention to improve accessibility.

Keywords: Health Services Accessibility; Primary Health Care; Health Status Disparities; Cross-Sectional Studies.

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Introduction

The quest to reduce health inequalities has been a World Health Organization (WHO) guideline,¹ and has been incorporated by several countries, although insufficiently.²⁻⁴ Although their main causes are social, accessible availability of quality health services continues to be highlighted as an important action to reduce these inequalities.⁴

Some initiatives regarding the expansion of care coverage and improving accessibility to health services have been implemented in different national contexts and have produced differentiated results. Taking these results, it can be concluded that increasing service availability by itself is not enough to facilitate access. In Sweden, for example, it proved to have a paradoxical effect: a Primary Health Care Choice Reform which increased service availability, benefitted higher income groups and increased social inequalities in the country.^{3,5} In Brazil, the expansion of the Family Health Strategy coverage has been related to infant mortality reduction in regions with the worst social indicators.⁶ Progress in the use of services and improving accessibility, by adopting reception practices and reorganization of the work process, are also reported in some Brazilian cities.^{7,10}

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Although there are several evaluation studies of these interventions and others on barriers to the use of health services by users,¹⁰⁻¹³ few of them have analyzed the influence of social inequalities under concrete situations in intervention target health centers for improving their accessibility. In other words, the question is: are universal programs aimed at improving access to health used equally by people from different social groups?

The answer to this question requires investigation at various health system levels, given the complexity of health interventions. If nationwide analyses are necessary for a large-scale view, local assessments allow a deeper understanding, based on the observation of

specific interventions, particularly regarding the socio-organizational component of accessibility.¹⁴

In Salvador, state of Bahia, in June 2005 the Municipal Health Department developed a project aimed at improving accessibility and reception for primary health care users in Bahia's largest city. Among other objectives, this project aimed to extinguish avoidable queues, implement appointment scheduling and optimize patient flow.¹⁵ The following year, an evaluation of the project's implementation showed an improvement in access to primary health care centers, especially in the reduction of avoidable queues and waiting times for appointments. However, in those health centers, some users did not benefit from the measures adopted and continued to have difficulties in accessing services.¹⁶ Thirteen years after the aforementioned intervention, the problem of social inequality in access to services still remained.

Although initiatives aimed at overcoming these barriers have been implemented, few studies have evaluated the persistence of inequalities after the carrying out of programs specially designed to abolish waiting queues and the reduction of waiting times for care services, within the territorial scope of this experience. The evidence produced here on the possibilities and limits of this type of health intervention may contribute to health policy improvement and actions aimed at upgrading access to services.

This article aimed to fill, albeit partially, the gaps indicated, and analyze association between position in the social space and access to services among users of primary health care centers where a project for improving accessibility and humanization of the reception of users of the Brazilian National Health System (SUS) was implemented.

Methods

This was a cross-sectional study, covering users of primary health care centers in Salvador, Bahia, where a broad intervention project entitled 'Reception in primary health care in Salvador, state of Bahia: a project for improving accessibility and humanization of reception' was implemented.¹⁵

In 2007, Salvador had 419 health facilities (primary and specialized health centers, and emergency services), 38% public, 6% philanthropic and 56% private/profit-oriented.¹⁷ Primary Health Care coverage

in December 2007 was 34%, according to the Primary Health Care Department of the Ministry of Health.¹⁸

The intervention to improve accessibility and humanize reception occurred in 2005, in all 103 primary health care centers in the municipality, and consisted of implementing a permanent appointment system, face-to-face or over the phone, and also implementing waiting lists, aiming to abolish waiting queues and enable same-day service. Subsequently, other actions to qualify service user care were included.¹⁹

The impact of these actions was evaluated in June 2006, through a survey with users of primary health care centers.¹⁶ The total number of users to be included in that survey was estimated at 600, considering a 0.50 maximum proportion, 0.02 accuracy and 0.80 power; and defining a 95% confidence interval (95%CI). 20% were added to the value found in order to compensate for losses, thus totaling 720 users. In all, 740 users were interviewed, but 30 interviews were discarded due to data incompleteness, resulting in a final sample of 710 users, 467 of whom came from the ten health centers where the intervention was fully implemented. In our study, the service users were selected based on the total number of medical consultations per health center in 2005, using simple random sampling, without replacement, with allocation proportional to the service capacity of each health center. All 467 interviewees of the previous survey comprised the population to be analyzed. No difference was found in the power of the two samples: (i) 710 users comprising the sample of the previous survey, from which (ii) a sample of 467 users of the health centers addressed in the present study was extracted. There was no discrepancy between the main sociodemographic characteristics of the service users who comprised both samples, they were reasonably similar.

The range of characteristics of health centers that enable them to be more easily used by system users was considered to be 'accessibility', as per Avedis Donabedian's definition.¹⁴ Bourdieu defined "the social space" as being the relations between social agents, in this case users of the primary health care network in Salvador who occupy different positions in society, according to the amount and composition of different species of capital proper to these individuals, in particular economic capital and cultural capital, as well as their social trajectory.²⁰

The 'cultural capital' and 'economic capital' categories were measured approximately, based on schooling and family income, respectively. To estimate cultural capital, questions about the user's education level, his/her parents' schooling and his/her spouse's schooling were asked. The different education levels were grouped into two categories: low-middle, for those who had incomplete or complete elementary school education and those who had incomplete high school education; and high, for those who had completed high school and those with incomplete or complete higher education or an even higher education level.

Each participant's social trajectory was obtained from the comparison of their schooling level with that of their family. Based on the answers about their mother's and father's education levels, the highest of these levels was selected for the 'family education' category. Thus, social trajectory was classified as follows: rising (participant's education higher than family education); stable (participant's education equal to family education); and falling (participant's education lower than family education). Subsequently, the 'falling' and 'stable' categories were unified because they did not distinguish sufficiently well these differences, due to the relative social homogeneity of the sample.

Economic capital was defined based on the monthly family income of the primary health care center users, stratified by the number of minimum wages received: high/medium economic capital (for users with monthly family income of two minimum wages upwards); and low (for those with a monthly family income of less than two minimum wages). It should be noted that in 2006, the minimum wage in Brazil was BRL 350.00.

The occupations informed by the users, as well as their father's, mother's and spouse's occupations, were coded according to the 2020 version of the Brazilian Classification of Occupations, and grouped according to Santos,²¹ with appropriate adaptations: qualified workers; workers; elementary workers; self-employed; precarious workers; domestic employees; specialists; supervisors; students and interns; 'housewife' (unpaid domestic work); and never having worked. These occupations were regrouped into two socio-occupational categories: elementary category (domestic employee; self-employed; precarious worker; elementary worker); and intermediate and

qualified categories (qualified worker; specialists; supervisor). For the socio-occupational category of students/trainees, housewife or those who had never worked, schooling capital was considered. Thus, individuals with medium-low education were included in the elementary occupational category, and those with high education formed part of the intermediate/qualified occupational category. Some users were not able to inform their mother's schooling; in these cases, this information was inferred from the socio-occupational category of their fathers.

The variables related to health service accessibility were: arrival time at the health center (did not have to queue and health center working hours; the night before or before 8:00 a.m.); type of appointment scheduling (by a health center employee, over the phone or by waiting list; face-to-face); waiting time for appointment scheduling (did not wait or waited up to 15 minutes; waited between 15 minutes and more than one hour); and time elapsed time between appointment scheduling and consultation (on the same day or up to two weeks; between three weeks and more than one month).

Univariate and bivariate descriptive analysis was performed, through distribution of sociodemographic variable and access variable frequencies according to participants' socioeconomic position (education, income, occupation and social trajectory). Pearson's chi-square test was applied to verify possible differences between the groups. Association between socioeconomic position and access variables was verified by prevalence ratios (PR) and their respective 95% confidence intervals - 95% CI -, estimated according to the odds ratio (OR), by bivariate logistic regression. A 5% significance level was adopted.

This study project was approved by the Research Ethics Committee of the Institute of Public Health of the Federal University of Bahia (CEP/ISC/UFBA): Opinions No. 046/2005 and No. 1.023.121/2015. All interviews were conducted after the participants signed a Free and Informed Consent Form.

Results

Among the 467 users of primary health care centers where the intervention project had been implemented, 77.3% were female, 64.7% were between 20 and 49 years of age, 60.4% were married/lived with somebody, 75.6% had not completed high school and 78.7% had

a family income less than two minimum wages; 71.1% were unemployed and 51.8% had intermediate or qualified occupations (Table 1).

Table 2 presents the distribution of users according to the characteristics of their position in the social space and health service utilization indicators. It was found that medium-high economic capital was associated with greater access to health services, especially the time of arrival in the queue ($p=0.017$), waiting time ($p=0.032$) and appointment scheduling time ($p=0.048$). Having an intermediate or qualified occupation was a socio-occupational condition associated with appointment scheduling over the phone, face-to-face, or by being put on a waiting list ($p=0.007$).

Having low economic capital was associated with service users being twice as likely to wait in a queue (OR=2.09 - 95%CI 1.13;3.87) and to arrive at the health center the night before or before 8 a.m., and to wait longer for appointment scheduling (OR=2.13 - 95%CI 1.05;4.31). The fact of service users being in the elementary occupation category was associated with scheduling an appointment in person (OR=1.68 - 95%CI 1.14;2.45), when compared to users who had intermediate or qualified occupations; and therefore did not use the other appointment scheduling options made available by the intervention for better access to primary health care centers. No significant associations were found between health services utilization indicators, when considering the users' education and social trajectory (Table 3).

Discussion

The results of this study showed that among the users of the primary health care centers where the intervention for improving accessibility had taken place, there were no significant differences in health service utilization, when their schooling and social trajectory were considered. However, those with low income were more likely to spend more time in order to have access, regarding the time of arrival at the health center, and waiting for scheduling an appointment and consultation. Having an occupation classified as elementary was also a fact associated with making an appointment in person. In other words, despite the implementation of a project specifically aimed at improving accessibility, inequalities in access

Table 1 – Number and percentage of users of primary health centers where an intervention was implemented for improving accessibility, according to socioeconomic and demographic characteristics (n=467), Salvador, Bahia, 2006

Characteristics	n	%
Sex		
Male	106	22.7
Female	361	77.3
Age group (in years)		
10-19	55	11.8
20-49	302	64.7
50-59	43	9.2
≥60	67	14.3
Schooling		
Medium/low	353	75.6
High	114	24.4
Marital Status		
Single	140	29.9
Widower/widow	20	4.3
Married/live with someone	282	60.4
Divorced	25	5.4
Professional situation		
Employee	135	28.9
Unemployed	332	71.1
Family income (in minimum wages)^{a,b,c}		
<2	350	78.7
≥2	95	21.3
Residence time in the municipality		
Not a resident	4	0.9
<10	47	10.1
≥10	166	35.5
Have always resided	250	53.5
Socio-occupational category^b		
Elementary	222	48.2
Intermediate and qualified	239	51.8

a) Eight users had a family income higher than five minimum wages; b) Users excluded due to unknown information; c) Current minimum wage in Brazil in 2006: BRL 350.00.

Table 2 – Number and percentage of users of primary health centers where an intervention was implemented for improving accessibility, according to characteristics of position in the social space and health service utilization indicators (n=467), Salvador, Bahia 2006

Access indicators	Time of arrival		Type of scheduling		Waiting time		Scheduling time							
	n	Did not have to queue Night before until 6 a.m. Between 6 a.m and 8 a.m	P-value ^a	n	Over the phone, health worker, waiting list face-to-face	P-value ^a	n	From 15 minutes to more than 1 hour	Same day up to 2 weeks Between 3 weeks and More than 1 month	P-value ^a				
Cultural capital	Medium-low	353	74.8	25.2	352	37.2	62.8	352	80.7	19.3	325	68.6	31.4	
	High	114	73.7	26.3	0.814	114	42.1	57.9	83.3	16.7	0.528	106	75.5	24.5
Economic ^c capital	Low	350	73.4	26.6	0.017	349	37.3	62.8	79.9	20.1	0.032	317	67.5	32.5
	Medium-high	95	85.3	14.7	0.017	95	47.4	52.6	89.5	10.5	0.032	92	78.3	21.7
Socio-occupational ^b category	Elementary	222	72.9	27.0	0.433	222	31.9	68.0	80.6	19.4	0.720	206	67.5	32.5
	Intermediate and qualified	239	76.1	23.9	0.433	238	44.1	55.9	81.9	18.1	0.720	219	72.6	27.4
Trajectory ^b	Falling and stable	187	78.6	21.4	0.662	187	40.6	59.4	85.0	15.0	0.791	169	66.9	33.1
	Rising	99	80.8	19.2	0.662	99	48.5	51.5	83.8	16.2	0.791	94	63.8	36.2

a) Pearson's chi-square test; b) Users excluded due to unknown information.

Table 3 – Association between characteristics of position in the social space and health service utilization indicators in primary health care centers where an intervention was implemented for improving accessibility (n=467), Salvador, Bahia, 2006

Access indicators	Time of arrival		Type of scheduling		Waiting time		Scheduling time	
	OR ^b	IC95% ^c	OR ^b	IC95% ^c	IC95% ^c	OR ^b	IC95% ^c	
Social space								
Cultural capital								
High	1.00		1.00			1.00		
Medium-low	0.95	0.67;1.36	1.08	0.90;1.29	1.15	0.72;1.84	1.27	0.88;1.85
Economic ^b capital								
Medium-high	1.00		1.00		1.00		1.00	
Low	2.09	1.13;3.87	1.19	0.96;1.46	2.13	1.05;4.31	1.49	0.98;2.27
Socio-occupational ^b capital								
Intermediate and qualified	1.00		1.00		1.00		1.00	
Elementary	1.13	0.82;1.54	1.68	1.14;2.45	1.07	0.73;1.56	1.18	0.88;1.58
Trajectory ^b								
Rising	1.00		1.00		1.00		1.00	
Falling and stable	1.11	0.68;1.81	1.15	0.92;1.44	0.92	0.52;1.62	0.91	0.64;1.29

a) Users excluded due to unknown information; b) OR: odds ratio; c) 95%CI: 95% confidence interval.

to primary health care services and other health services have persisted in Salvador, with regard to income and occupation.

These findings may be related to the study population characteristics, which were very homogeneous in terms of sociodemographic profile, and are consistent with those of other similar studies: predominance of females, low income and low schooling.^{22,23}

Possibly, the absence of a statistically significant difference between service users' education level, their social trajectory and use of health services, as observed in other studies, resulted from the relative homogeneity of the sample when analyzed according to these factors.

The differences found between low-income users (less than two minimum wages), with regard to the time of arrival at the health center, waiting time and appointment scheduling time, can be explained both by objective questions and by lack of financial resources for transportation, in addition to other subjective reasons, regarding the so-called '*habitus* of need'.²⁰ This concept, developed by Bourdieu, can explain several practices among popular classes that prioritize what is right and safe.

Sleeping in the line and arriving before the health center opening hours, although a consultation can be got during working hours, may result either from a decision driven by low autonomy at work or by the optimization of available time or simply by the lack of knowledge of the existence of facilitated appointment scheduling.

This relationship between income level and better use of health services has been evidenced in other studies, both on a national scale, such as Cambota & Rocha's analysis of the country's macro-regions and states;²⁴ Andrade et al. with regard to macro-regions;²⁵ as well as Barata's investigation on the São Paulo metropolitan region.²⁶

On the other hand, belonging to an intermediate or qualified socio-occupational category can influence higher income and schooling, expansion of social networks, in addition to causing other important effects, such as the increase of symbolic recognition capital. All this, associated with an upward social trajectory, may be related to the greater normativity²⁷ of these people, and thus explain the better use observed of the resources provided: appointments over the phone, face-to-face or waiting list, among others.

The relationship already established between work and access to health services,^{24,28} also found

in the population studied, may show more than just incompatibility between health center opening hours and the time service users who also work have available. It may also be due to the fact that the SUS is the only care alternative for unemployed people.

The analysis of the sample of users of primary health care centers taking part in this study revealed a slight internal differentiation, despite the majority of them being classified as belonging to intermediate and qualified socio-occupational categories. Thus, occupying a position in the social space defined by a greater amount of economic capital, and having an occupation classified as intermediate or qualified, positively influenced the use of organizational rearrangements introduced by the program and, consequently, ensured better access to health services.

This study brings elements to a discussion about potentiality and limits of interventions focused on the socio-organizational dimension of accessibility to health services. Moreover, a critical bottleneck is revealed in access to Primary Health Care in the case observed: i.e. the queues for appointment scheduling. Unlike recent and relevant initiatives which induced modifications through evaluation, such as the National Program for Improving Primary Care Access and Quality (PMAQ-AB), the project for improving accessibility to primary health care in Salvador implemented and monitored changes. Its results indicate that improving accessibility and reducing barriers to health service use require specific actions, focused on more vulnerable groups, even within the lower classes themselves. The results also corroborate the conclusions of previous studies: inequalities are not reduced only through interventions in health services, but also, albeit partially, through actions that go beyond the sector and beyond economic and social policies.^{29,30} Incipient scientific production, with regard to the evaluation of interventions promoting accessibility to health and the influence of social inequalities, also reflects the lack of these specific interventions, either at the municipal level or at the state or national levels.

Extrapolation of the findings of this study should be done with caution, given that it refers to a single municipality and its sample is not population-based, because only users who sought and had access to primary health services were interviewed. As the data presented resulted from a cross-sectional study, it is not possible to establish a temporal relationship. Despite the time that has elapsed, the evaluated intervention

represents an exemplary case, to be observed in its historical time, capable of contributing to monitoring programs for reducing inequalities in access to primary health care and its improvement.

Without neglecting the search for quality and effectiveness improvement in health actions, the adoption of strategies aimed at positive discrimination can reduce health inequities and favor the use of services by users who have fewer economic and cultural resources. This is an important measure for the fulfillment of a right guaranteed by Brazil's Constitution of 1988, that defines health as universal right and access to health services as a state obligation, especially in a situation of fiscal adjustment and budget cuts in Public Health.

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Authors' contributions

Melo DC collaborated with the concept and planning, data analysis and interpretation, and drafting the manuscript. Vieira-da-Silva LM collaborated with the concept and planning, data analysis and critical reviewing of the manuscript's content. Cunha ABO collaborated with the design and planning, and critical reviewing of the manuscript's content. Costa MCN and Cruz SA collaborated with data analysis and interpretation, and critical reviewing of the manuscript's content. All authors have approved the final version of the manuscript and declare themselves to be responsible for its accuracy and integrity.

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