



## Satisfaction of older people with Primary Health Care services

### *Satisfação de pessoas idosas com o atendimento na Atenção Primária à Saúde*

### *Satisfacción del anciano con el atendimento en la Atención Primaria de Salud*

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#### ABSTRACT

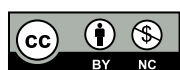
**Objective:** To analyze the satisfaction of older individuals with the care received in Primary Health Care (PHC) in a medium-sized city in Brazil. **Method:** Cross-sectional study with a probabilistic sample of 162 older individuals in Campina Grande, Brazil, conducted in 2017. Data were collected using an instrument containing sociodemographic variables, access to and use of health services, and satisfaction with care. The survey was conducted in person at the participants' homes. Univariate and multivariate analyses were performed using Poisson regression with Stata® software, considering a 95% confidence interval and statistical significance at  $p < 0.05$ . **Results:** The satisfaction rate of older people with PHC services was 70% (CI: 63%–77%). The adjusted estimate was 64% higher when the user had an appointment with a healthcare professional during their last visit (aRP = 1.64 [compared to those who did not]; CI: 1.11–2.43;  $p = 0.013$ ) and 21% higher when they received a home visit from a healthcare professional in the last 30 days (aRP = 1.21 [compared to those who did not receive one]; CI: 1.02–1.45;  $p = 0.029$ ). However, satisfaction was 36% lower when participants reported waiting in line for over two hours during their last appointment (aRP = 0.64 [compared to waiting up to two hours]; CI95: 0.43–0.96;  $p = 0.030$ ). **Conclusions:** The satisfaction of older people with PHC services is consistent with existing findings and is associated with factors such as access and use of services, including receiving care when needed, home visits, and waiting times for appointments.

**Descriptors:** Primary health care; Health of the Elderly; Patient satisfaction; Health services accessibility; Facilities and Services Utilization.

#### RESUMO

**Objetivo:** Analisar a satisfação de pessoas idosas com o atendimento na Atenção Primária à Saúde (APS) em uma cidade de médio porte do Brasil. **Métodos:** Estudo transversal, com amostragem probabilística de 162 pessoas idosas, em Campina Grande, Brasil, no ano de 2017. Os dados foram coletados com instrumento contendo variáveis sociodemográficas, de acesso e utilização de serviços de saúde e de satisfação com o atendimento, aplicado de forma presencial na residência dos participantes. Realizaram-se análises univariada e múltipla, por meio de Regressão de Poisson, com auxílio do Software Stata®, considerando um intervalo de confiança de 95% e significância estatística quando  $p < 0,05$ . **Resultados:** A taxa de satisfação da pessoa idosa com o atendimento na APS foi de 70% (IC: 63% – 77%). A estimativa ajustada foi 64% maior quando o usuário obteve consulta com um profissional de saúde na última vez que procurou atendimento (aRP = 1,64 [comparado com quem não obteve]; IC: 1,11 – 2,43;  $p = 0,013$ ) e 21% maior quando recebeu visita domiciliar de um profissional de saúde nos últimos 30 dias (aRP = 1,21 [comparado com quem não recebeu]; IC: 1,02 – 1,45;  $p = 0,029$ ). Entretanto, foi 36% menor quando os participantes relataram espera em fila superior a duas horas no último atendimento (aRP = 0,64 [comparado com espera de até duas horas]; IC95: 0,43 – 0,96;  $p = 0,030$ ). **Conclusão:** A satisfação de pessoas idosas com o atendimento na APS é consistente com achados disponíveis e está associada a aspectos de acesso e utilização dos serviços, como a obtenção de atendimento diante de uma necessidade manifesta, o recebimento de visitas domiciliares e o tempo de espera em fila para ser atendido.

**Descritores:** Atenção Primária à Saúde; Saúde do Idoso; Satisfação do Paciente; Acesso aos Serviços de Saúde; Utilização de Instalações e Serviços.



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## RESUMEN

**Objetivo:** Analizar la satisfacción de ancianos con el atendimento en la Atención Primaria de Salud en una ciudad de porte mediano en Brasil. **Método:** Estudio transversal, con muestreo probabilístico de 162 ancianos, en Campina Grande, Brasil, en 2017. Los datos fueron recogidos con instrumento conteniendo variables sociodemográficas, de acceso y utilización de servicios de salud y de satisfacción con el atendimento, aplicando de forma presencial en la residencia de los participantes. Fueron realizadas análisis univariada y múltiple, por medio de Regresión de Poisson, con ayuda del Software Stata<sup>®</sup>, considerando un intervalo de confianza de 95% y significancia estadística cuando  $p < 0,05$ . **Resultados:** La tasa de satisfacción del anciano con el atendimento en la Atención Primaria de Salud fue de 70% (IC: 63% – 77%). La estimativa ajustada fue 64% mayor cuando el usuario obtuvo consulta con un profesional de salud en la última vez que buscó atendimento (aRP = 1,64 [comparado con quien no obtuvo]; IC: 1,11 – 2,43;  $p = 0,013$ ) y 21% mayor cuando recibió visita domiciliaria de un profesional de salud en los últimos 30 días (aRP = 1,21 [comparado con quien no recibió]; IC: 1,02 – 1,45;  $p = 0,029$ ). Sin embargo, fue 36% menor cuando los participantes informaron espera en cola superior a dos horas en el último atendimento (aRP = 0,64 [comparado con espera de hasta dos horas]; IC95: 0,43 – 0,96;  $p = 0,030$ ). **Conclusión:** La satisfacción de ancianos con el atendimento en la Atención Primaria de Salud es consistente con hallazgos disponibles y está asociada con aspectos de acceso y utilización de los servicios, como la obtención de atendimento ante una necesidad manifiesta, el recibimiento de visitas domiciliarias y el tiempo de espera en cola para ser atendido.

**Descriptores:** Atención Primaria de Salud; Salud del Anciano; Satisfacción del Paciente; Acceso a los Servicios de Salud; Utilización de Instalaciones y Servicios.

## INTRODUCTION

Satisfaction is a measure of the quality of health care systems<sup>(1)</sup>, and it is important for adapting the services provided to the needs of health care users<sup>(2)</sup>. Common in Europe and the United States, the assessment of satisfaction has become increasingly popular in other countries<sup>(2)</sup>. In Brazil, there is a gradual focus on studying satisfaction in Primary Health Care (PHC) settings<sup>(3)</sup>, whose main users are older people because of the growing Brazilian aging population<sup>(4,5)</sup>.

The increase in chronic non-communicable diseases (CNCD) among older people<sup>(6)</sup>, combined with the increase in consultations, polypharmacy, repetition of medical examinations, often without clear indications, reflects a fragmented care model within the Brazilian Unified Health System (*Sistema Único de Saúde*, SUS)<sup>(7)</sup>. This scenario overloads both medium and high complexity services as well as PHC facilities, which are responsible for covering most of the health needs of Brazil's population. The overburdening of PHC, as demonstrated during the COVID-19 pandemic<sup>(8)</sup>, is likely to affect SUS users' perception of the health care provided.

Understanding the satisfaction of older people with PHC services goes beyond supporting criticism and debate among researchers, health care managers, and health care workers. It is an opportunity to identify areas for improvement in the planning and management of PHC services, with the goal of a health care system that prioritizes health promotion, disease prevention, and the maintenance of independence and autonomy. This contributes to ensuring that the increased longevity achieved by current generations is lived with quality<sup>(9)</sup>.

Thus, this study aims to analyze the satisfaction of older people with the care provided in PHC in a medium-sized city in Brazil.

## METHOD

The present cross-sectional study was conducted from January to March 2017 at the homes of older individuals enrolled in PHC facilities in Campina Grande, Brazil. Campina Grande is in the state of Paraíba, Northeast region of Brazil, and has a population of 419,379 inhabitants, a population density of 708.82 inhabitants/km<sup>2</sup>, a per capita income of R\$ 25,066.11, and a PHC coverage rate of 71.9%<sup>(10, 11)</sup>.

A probabilistic sample was estimated using the formula:  $n = N \cdot Z^2 \cdot p \cdot (1-p) / Z^2 \cdot p \cdot (1-p) + e^2 \cdot (N-1)$ . A sample size of 162 participants was obtained considering the population of older individuals aged 60 or more ( $N = 36,720$ )<sup>(10)</sup>, the variable associated with a 95% confidence level ( $Z = 1.96$ ), the sampling error ( $e = 5\%$ ), and the expected rate of satisfaction with PHC ( $p = 88\%$ ).

A cluster sampling strategy was developed to probabilistically assign study participants. Clusters were the six health districts of Campina Grande (I, II, III, IV, V, and VI), comprising 80 Family Health Units (*Unidades Básicas de Saúde da Família*, UBSF). A simple random sample was drawn from a general list of older people associated with each UBSF who were assigned sequential numbers until the total sample size was reached.

Participants were enrolled if they met the eligibility criteria: older individuals aged 60 years or older who had received care at a PHC facility at least one year prior to the study and lived in urban areas. The presence of cognitive impairments, whether self-reported or reported by family members, was considered an exclusion criterion. In the preliminary selection, 20% of the participants were replaced due to death, change of address, or difficulty in contact. Data were obtained by the research team during the home visits for data collection.

Data collection was conducted at the participants' homes by using a standardized questionnaire developed by the research team specifically for this research. The questionnaire included sociodemographic variables, satisfaction with health care, and access to and use of PHC services, based on the participants' most recent visits to PHC facilities. Quality checks were conducted via phone calls with 10% of the sample, randomly selected, to confirm that the participants had indeed completed the survey.

Analyses were performed using Stata® software, version 14.0, considering the following sociodemographic variables: sex (women or men); age (60–65 years; 65–70 years; 70–75 years; 75–80 years; and 80 years or more); race (Black or White); years of education (up to five years; more than five years); personal income (up to one minimum wage; between one and two minimum wages; and more than two minimum wages); satisfaction with the last visit (satisfied or dissatisfied); whether a consultation was obtained during the last time care was sought (did not obtain or obtained); waiting time for the last appointment (up to two hours or more than two hours); communication with the health care worker during the last visit (inadequate or adequate); receipt of home visits by a health care worker in the last 30 days (did not receive or received); participation in programs for health promotion and disease prevention (does not participate or participates); and exclusive use of public health services (does not use or uses).

Poisson regression with robust adjustment, which allows the analysis of proportions including different groups, was used to estimate the satisfaction of older people with PHC. Associations were estimated from univariate (unadjusted) and multivariate (adjusted) models that included satisfaction (the dependent variable) and sociodemographic, access, and service utilization aspects (independent variables). The prevalence ratio (PR) was calculated as the measure of association, the pseudo- $R^2$  as the variation explained by the variables and models, the confidence interval (CI) at the 95% level, and the p-value from the Fisher's exact test, with statistical significance when  $p < 0.05$ .

The ethical principles outlined in Resolution 466/12 of the Brazilian National Health Council were followed. The research protocol was approved with the CAAE no. 62471316.4.0000.5187, issued by the Human Research Ethics Committee at State University of Paraíba.

## RESULTS

A total of 162 older adults participated in this study. They were predominantly women (67.3%;  $n=109$ ), aged between 60 and 65 years (33.3%;  $n=54$ ), black (64.2%;  $n=104$ ), with up to five years of education (55.6%;  $n=90$ ), and with a personal income of up to one minimum wage (53.7%;  $n=87$ ) (Table I).

**Table I.** Characterization of the study participants. Campina Grande/PB, Brazil, 2017.

Variables	N (%)
<b>Sex</b>	
Women	109 (67.3)
Men	53 (32.7)
<b>Age</b>	
60–65 years	54 (33.3)
65–70 years	35 (21.6)
70–75 years	30 (18.5)
75–80 years	21 (13.0)
80 years or more	22 (13.6)
<b>Skin color<sup>e</sup></b>	
White	58 (35.8)
Black	104 (64.2)
<b>Years of education*</b>	
≤ 5 years	90 (55.6)
> 5 years	72 (44.4)

**Personal income\***

Up to 1 minimum wage	87 (53.7)
Between 1 and 2 minimum wages	51 (31.5)
Two or more minimum wages	24 (14.8)

N = 162; <sup>‡</sup>Black includes Brown people; \*dichotomous variable based on the arithmetic mean ( $x = 5 \pm 4$ ); \*Brazilian monthly minimum wage as of 2017, R\$ (BRL) 937.00.

Satisfaction with PHC among older people was 70.4% (95% CI: 63.2%–77.5%), higher among those who had a home visit from a health care worker in the last 30 days (86.8%; 95% CI: 75.6%–98.1%;  $p = 0.011$ ), had an appointment with a health care worker at their most recent visit (76.5%; 95% CI: 69.1%–83.8%;  $p < 0.001$ ), used the public health care system exclusively (76.5%; 95% CI: 68.1%–84.8%;  $p = 0.027$ ), and waited up to two hours at their last visit (74.5%; 95% CI: 67%–81.8%;  $p = 0.008$ ) (Table II).

**Table II.** Satisfaction with PHC among older people according to sociodemographic aspects, access, and use of health services. Campina Grande/PB, Brazil, 2017.

Variables	Satisfaction rate (IC95%)	p-value
<b>Sex</b>		
Women	73.4% (64.9%–81.8%)	<b>0.227</b>
Men	64.2% (50.8%–77.5%)	
<b>Idade</b>		
60–65 years	70.4% (57.8%–82.9%)	<b>0.782</b>
65–70 years	65.7% (49.2%–82.3%)	
70–75 years	66.7% (48.8%–84.6%)	
75–80 years	80.9% (62.6%–99.2%)	
80 years or more	72.7% (52.5%–92.9%)	
<b>Skin color<sup>‡</sup></b>		<b>0.770</b>
White	68.9% (56.7%–81.2%)	<b>0.817</b>
Black	71.2% (62.3%–80.0%)	
<b>Years of education*</b>		
≤ 5 years	71.1% (61.6%–80.7%)	<b>0.547</b>
> 5 years	69.4% (58.5%–80.3%)	
<b>Personal income*</b>		
Up to 1 minimum wage	72.4% (62.8%–81.9%)	<b>0.000</b>
Between 1 and 2 minimum wages	64.7% (51.1%–78.3%)	
Two or more minimum wages	75% (56.3%–93.7%)	
<b>Obtaining a consultation with a health care worker at the most recent visit</b>		<b>0.008</b>
Did not obtain	43.3% (24.5%–62.1%)	<b>0.011</b>
Obtained	76.5% (69.1%–83.8%)	
<b>Waiting time for the last appointment</b>		<b>0.027</b>
Up to 2 hours	74.5% (67%–81.8%)	<b>0.531</b>
More than 2 hours	48% (27%–69%)	
<b>Received a home visit by a healthcare professional in the last 30 days</b>		
Did not receive	65.3% (56.8%–73.8%)	<b>0.027</b>
Received	86.8% (75.6%–98.1%)	
<b>Exclusive use of public health system services</b>		
Does not use	60% (47.2%–72.8%)	<b>0.027</b>
Uses	76.5% (68.1%–84.8%)	
<b>Participation in programs for health promotion and disease prevention</b>		
Does not participate	69.5% (61.8%–77.2%)	<b>0.531</b>
Participates	76.2% (56.3%–96.1%)	

N = 162; p-value: Fisher's exact test; <sup>‡</sup>Black includes Brown individuals; \*dichotomous variable based on the arithmetic mean ( $x = 5 \pm 4$ ); \*Brazilian monthly minimum wage as of 2017, R\$ (BRL) 937.00.

In the unadjusted univariate model, satisfaction with PHC among older people was associated with aspects of access to and use of services such as: obtaining a consultation with a health care worker at their most recent visit to PHC services (PR = 1.77 [compared to those who did not obtain]; 95% CI: 1.16–2.69;  $p = 0.008$ ); waiting in line for more than 2 hours during the last visit (PR = 0.64 [compared to waiting up to two hours]; 95% CI: 0.42–0.98;  $p = 0.041$ ); receiving a home visit from a health care worker in the last 30 days (PR = 1.32 [compared to those who did not receive]; 95% CI: 1.11–1.59;  $p = 0.002$ ); and exclusively using the public health care system (PR = 1.27 [compared to non-exclusive]; 95% CI: 1.01–1.61;  $p = 0.042$ ).

**Table III.** Univariate analysis between the satisfaction of older individuals with PHC and aspects of access to and use of health services (unadjusted model). Campina Grande/PB, Brazil, 2017.

Variables	PR (95% CI)	p-value	R <sup>2</sup>
<b>Sex</b>			
Women	1		
Men	0.87 (0.69–1.10)	0.255	0.0014
<b>Age</b>			
60–65 years	1		
65–70 years	0.93 (0.69–1.26)	0.651	
70–75 years	0.95 (0.69–1.29)	0.730	
75–80 years	1.15 (0.88–1.51)	0.311	0.0016
80 years or more	1.03 (0.76–1.41)	0.835	
<b>Skin color<sup>‡</sup></b>			
White	1		
Black	1.03 (0.83–1.28)	0.773	0.0001
<b>Years of education*</b>			
≤ 5 years	1		
> 5 years	0.97 (0.79–1.19)	0.819	0.0001
<b>Personal income*</b>			
Up to 1 minimum wage	1		
Between 1 and 2 minimum wages	0.89 (0.70–1.14)	0.361	0.0012
Two or more minimum wages	1.03 (0.79–1.35)	0.796	
<b>Obtaining a consultation with a health care worker at their most recent visit</b>			
Did not obtain	1		
Obtained	1.77 (1.16–2.69)	<b>0.008</b>	0.0140
<b>Waiting time for the last appointment</b>			
Up to 2 hours	1		
More than 2 hours	0.64 (0.42–0.98)	<b>0.041</b>	0.0075
<b>Received a home visit by a health care worker in the last 30 days</b>			
Did not receive	1		
Received	1.32 (1.11–1.59)	<b>0.002</b>	0.0059
<b>Exclusive use of public health system services</b>			
Does not use	1		
Uses	1.27 (1.01–1.61)	<b>0.042</b>	0.0048
<b>Participation in programs for health promotion and disease prevention</b>			
Does not participate	1		
Participates	1,10 (0.84–1.42)	0.495	0.0004

N = 162; PR: prevalence ratio; CI: confidence interval; p-value: Fisher's exact test; R<sup>2</sup>: pseudo R<sup>2</sup>; <sup>‡</sup>Black includes Brown individuals; \*dichotomous variable based on the arithmetic mean ( $x = 5 \pm 4$ ); \*Brazilian monthly minimum wage as of 2017, R\$ (BRL) 937.00.

In the final multivariate model, except for exclusive use of the public health system, the significant associations remained after controlling for confounders. Satisfaction with PHC among older people was 64% higher when a consultation with a health care worker was obtained at their most recent visit to PHC settings (aPR = 1.64 [compared to those who did not obtain]; 95% CI: 1.11–2.43;  $p = 0.013$ ) and 21% higher when a home visit by a health care worker was received in the last 30 days (aPR = 1.21 [compared to those who did not receive]; 95% CI: 1.02–1.45;

$p = 0.029$ ); and 36% lower when waiting in line for more than two hours during the last visit ( $aPR = 0.64$  [compared to waiting up to two hours]; 95% CI: 0.43–0.96;  $p = 0.030$ ) (Table IV).

**Table IV.** Multivariate analysis between the satisfaction of older individuals with PHC and aspects of access to and use of health services (adjusted model). Campina Grande/PB, Brazil, 2017.

Variáveis	aRP(IC95%)	p
<b>Sex</b>		
Women	1	
Men	0,82(0,66 – 1,02)	0,081
<b>Age</b>		
60–65 years	1	
65–70 years	0,87(0,67 – 1,14)	0,317
70–75 years	0,87(0,65 – 1,17)	0,364
75–80 years	1,06(0,84 – 1,33)	0,637
80 years or more	1,01(0,75 – 1,36)	0,960
<b>Skin color<sup>‡</sup></b>		
White	1	
Black	1,12(0,93 – 1,35)	0,230
<b>Years of education*</b>		
≤ 5 years	1	0,685
> 5 years	1,04(0,86 – 1,26)	
<b>Personal income*</b>		
Up to 1 minimum wage	1	
Between 1 and 2 minimum wages	0,93(0,74 – 1,16)	0,511
Two or more minimum wages	1,12(0,89 – 1,41)	0,328
<b>Obtaining a consultation with a health care worker at their most recent visit</b>		
Did not obtain	1	<b>0,013</b>
Obtained	1,64(1,11 – 2,43)	
<b>Waiting time for the last appointment</b>		
Up to 2 hours	1	<b>0,030</b>
More than 2 hours	0,64 (0,43– 0,96)	
<b>Received a home visit by a health care worker in the last 30 days</b>		
Did not receive	1	<b>0,029</b>
Received	1,21 (1,02– 1,45)	
<b>Exclusive use of public health system services</b>		
Does not use	1	0,074
Uses	1,23(0,98 – 1,53)	
<b>Participation in programs for health promotion and disease prevention</b>		
Does not participate	1	0,954
Participates	1,01(0,78– 1,27)	

N = 162; aPR: adjusted prevalence ratio; CI: confidence interval; p-value: Fisher's exact test; R<sup>2</sup>: pseudo R<sup>2</sup>; <sup>‡</sup>Black includes Brown individuals; \*dichotomous variable based on the arithmetic mean ( $x = 5 \pm 4$ ); \*Brazilian monthly minimum wage as of 2017, R\$ (BRL) 937.00.

## DISCUSSION

Overall satisfaction rate with PHC among older individuals was found to be 70.4% (63.2–77.5%), which is very close to that reported by SUS users across all regions of Brazil (76.7%)<sup>(12)</sup>. However, it is only higher than that found in the North (63.2%) and lower than that reported for the South (82.9%), Southeast (80.1%), Midwest (77.5%), and Northeast (71.5%) regions of Brazil<sup>(12)</sup>.

However, besides the lack of a universally accepted definition of satisfaction with health care<sup>(13)</sup>, regional disparities in Brazil limit comparisons of findings on the satisfaction of older individuals with PHC<sup>(12)</sup>. For example, regarding living conditions, access to, and use of health care services, the North and Northeast regions are generally



below the national average and are very different from those found in the Midwest and, especially, the South and Southeast regions<sup>(12)</sup>.

In the broader context of determining satisfaction with PHC, different factors are important, including for older people: health status, sociodemographic aspects such as sex, age, skin color, years of schooling, and income, as well as those inherent to the delivery of care<sup>(14)</sup>. Thus, although we found no significant associations with satisfaction, these variables were useful for statistical adjustment, thereby making the model more robust.

Considering only aspects related to PHC services, satisfaction was found to be 64% higher (aPR = 1.64; 95% CI: 1.11–2.43;  $p = 0.013$ ) among older individuals who managed to obtain a consultation with a health care worker at their most recent visit to a PHC facility. PHC has gradually positioned itself as the entry point to the health care system. Furthermore, according to available evidence from a large study, the coverage of this level of care increased from 64.3% to 74.7% between 2008 and 2019. This increase was also accompanied by the success of health users in obtaining care when sought, rising from 55.4% in 2008 to 86.8% in 2019<sup>(7)</sup>.

When access is available as needed by the user, there is presumably a significant increase in the positive perception of older individuals about the service provided in PHC. However, it is believed that this can only be fully achieved when adequate resources are available for this level of care to address most of the population's health problems<sup>(15)</sup>. In PHC, however, there are still issues with infrastructure, availability of essential supplies, information and communication technologies, service organization, and the professional practices of teams, despite the established reference standards, guidelines, goals, and protocols<sup>(15)</sup>.

The incompleteness of many health care teams is a recurring problem in PHC, especially in rural and remote cities, where the scarcity of the workforce is a challenge<sup>(16)</sup>, which presumably hinders relevant activities such as planning meetings, group activities, community and home actions, and outpatient care<sup>(17)</sup>. The lack of doctors, for example, represents a significant barrier to care for older individuals, leading to difficulty in securing appointments or slots for consultations and procedures<sup>(7)</sup>. Thus, this model encourages the formation of long lines before the start of working hours in order to ensure the use of health services<sup>(18)</sup>.

Considering the waiting lines, waiting for more than two hours reduced the satisfaction rate with care by 36% (aPR = 0.64; CI: 0.43 – 0.96;  $p = 0.030$ ). For older individuals, who often face physical limitations, it is reasonable to believe that long waits may further reinforce negative perceptions about the efficiency of the health service. Scheduling, spontaneous demand, the allocation of each professional in the team, and the relationships with other services in the network need to be discussed and agreed upon in PHC to address this issue<sup>(19)</sup>. Furthermore, the inclusion of educational activities (when possible) can be considered a health education resource that leads to health promotion, disease prevention, and the strengthening of citizenship<sup>(20)</sup>.

Another relevant finding was the 21% increase (aPR = 1.21; 95% CI: 1.02–1.45;  $p = 0.029$ ) in satisfaction, observed among older individuals who received home visits in the last 30 days, demonstrating the impact of this component of PHC on perceived quality<sup>(11, 21, 22)</sup>. These home visits have a high potential to promote a closer bond between health care workers and health users and their families. Thus, home visits to bedridden older individuals, those with vaccination delays, using oxygen therapy, with pressure ulcers, or with delays in collecting controlled medications, to name a few examples, are fully feasible and can increase health users' positive perception. Furthermore, in addition to strengthening equity by considering disparities in access for this population, this context primarily promotes coordination, continuity, and the longitudinality of care, essential attributes of PHC<sup>(23)</sup>.

Therefore, although the association did not persist in a multivariate model controlled for confounding factors, it is important to highlight that, in the univariate analysis, exclusive use of public health services increased satisfaction with care in PHC among older individuals by 27% (PR = 1.27; 95% CI: 1.01–1.61;  $p = 0.042$ ). Evidence suggests that individuals who exclusively use public services tend to evaluate PHC more positively<sup>(5)</sup>. On the other hand, those who are not exclusive users may primarily associate their experience with its shortcomings, such as waiting lines, infrastructure issues, and difficulties in scheduling consultations and exams.

The approach to satisfaction in a dichotomous manner may not have allowed for a more critical analysis. Not controlling for other variables that could mediate the variability in satisfaction, such as health status, expectations, desires, vulnerability, social inequalities, and participants' lack of awareness of their rights; using a sample without a population base, which makes it difficult to generalize the results; and the low statistical power for the associations found are limitations of this study.

## CONCLUSION

Satisfaction of older individuals with PHC is associated with aspects of access to and use of services, such as obtaining health care when a need is expressed, receiving home visits, and waiting time in line to be attended.

The value of this study lies in strengthening the premise that it is possible to increase the satisfaction of older individuals with PHC through improvements in aspects of access to and use of services such as those addressed herein, which could be further explored in future studies.

Finally, the demographic reality in Brazil is gradually changing, with a significant increase in the older population, which presents complex needs to be managed, especially in terms of chronic diseases. Therefore, the consolidation of PHC may be particularly important in coordinating care for older people, but it necessarily requires the improvement of its infrastructure, human resources, and work processes.

## CONFLICTS OF INTEREST

The authors declare that the manuscript does not present any relationships that could imply potential conflicts of interest.

## CONTRIBUTIONS

The authors equally contributed to the conception and design of the study, data analysis, writing, and approval of the final version of the manuscript.

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