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A Qualitative Study of Patients' Perceptions of Dental Care in Primary Health Care

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Abstract
Knowledge of patients' views can contribute to the strengthening of health services. The aim of this study is to describe the patients' perception of a public oral health service, contributing to evaluations in health services. This is a qualitative study in which a focus group was conducted, with the participation of six patients of the oral health system in the city of Belo Horizonte, MG, Brazil, all with a minimum experience of three years of using the service. A theoretical model with dimensions aimed at assessing integrality and primary care services was used. In conducting the research, a semi-structured script was used. The data were analyzed by content analysis. The most representative categories for evaluating oral health actions in primary care are the health unit; the welcoming and its relation with the creation of the bond; service with a strong emphasis on the humanized relationship between professional and patient and on teamwork and; as a highlight, citizen participation, based on the recognition of a "system" that prevents the proper functioning of services and that must be fought with citizenship. Patients' perceptions can be used to assess oral health in primary care from the perspective of those who actually use health services, seeking ultimately to constantly improve them. Knowledge of patients' perceptions may enable organizations to know their performance, through assessment methodologies based on the established perceptions.

Keywords: Primary Health Care, Health Evaluation, Qualitative Research, Patient Participation

1. Introduction

In 2018, the 40th anniversary of the Alma-Ata World Conference was celebrated, when primary health care (PHC) began to occupy a more central place on the countries' agendas. PHC represents a way to rationalize the increasing costs involved in health care and the possibility of including population contingents that were on the margins of this care. Furthermore, the returns on investing in health, based on methods that include both the benefits of improved economic productivity and the intrinsic value of health, can far exceed the costs (Watkins et al, 2018).

The need to improve the oral health conditions of excluded groups motivated the launch of the Oral Health Program of the World Health Organization (WHO, 2002) which includes among its proposals the strengthening of global oral health systems towards PHC (Petersen, 2009).

The Brazilian government decided that oral health should be included in this effort to universalize PHC, through its insertion in the Family Health Strategy (ESF) and based on the guidelines and principles of the Unified Health System (SUS), the Brazilian policy of health. Based on the principle of integrality, public health services must promote health, prevent risk factors and rehabilitate according to the dynamics of the health-disease process (Brasil, 2006).

However, there are challenges in the PHC consolidation process in the Brazilian (Mattos et al, 2014) and worldwide (Mosquera et al, 2014; Gurung et al, 2016) context. To overcome this obstacle, the performance and impact of health services on the population's health must be known and the patients' perception can be a sensitive indicator of the quality of the service provided, related to the greater adequacy in the use of the public health service (Campos, Filho & Castro, 2017). Evaluative research has sought to investigate the expectations and the symbolic universe of these actors, seeking to understand what quality of health services means for them (Amorim et al, 2019). Methodologies that use the patients' view are seen as an effort in which principles related to individual rights and citizenship are reaffirmed, such as expressed in the concepts of humanization, patient rights, empowerment, assuming a political dimension and a social end (Bosi & Uchimura, 2007).

The perception of patients can originate from factors such as their own experience in the use of services, the experience of other members of the family or the community, their health condition, their view on how the care provided by professionals in the area should be, or their perception of what is disclosed in the media (Vaitsman & Andrade, 2005). Even if the perception of a service is a personal judgment, it is important that the health professional or manager knows the patients' expectations for performance improvements (Fadel & Filho, 2009).

The identification of assessment categories for a given group may allow a more consistent assessment, either alone or as a complement to quantitative methodologies (Turato, 2005). The present study aimed to identify categories of evaluation of health services, through the perception of patients about the quality of a public oral health service.

2. Materials and methods

2.1 Qualitative methodology

When working with perception, the qualitative methodology was chosen, focused on the meanings and intentionality of actions in the contexts of social structures (Husserl, 1988). Qualitative research is concerned with deepening the understanding of a given issue, much more than the numerical factor. The focus group was the data collection strategy chosen for allowing, through an explicit interaction between the participants, under the guidance and facilitation of the researcher, to explore people's views and experiences on different aspects of daily life. It is possible to have a shared perception on the researched topic, covering the study object more broadly and to understand what people think and why they think about a certain topic, in this case, health services (Kitzinger, 1995).

2.2 Participants

The subjects of this research were patients of the public oral health system in Belo Horizonte-MG, a large municipality in Brazil, with approximately 2,500,000 inhabitants, divided into nine health districts and with a tradition in the development of its municipal health system within of PHC. The inclusion criteria aimed to guarantee the heterogeneity and multivocality of the participants, according to the different districts of the municipality. Thus, it was requested that dentists based in different basic units, covering the nine health districts, indicate patients who had a minimum experience of three years of effective use of the oral health service (that is, who sought the service seeking treatments and not just emergency care). They should be adults, of both genders and who show a potential interest in participating in the research.

2.3 Data collection

Subsequently, the researcher responsible for data collection contacted the patients indicated by the dentists, when clarifications were made about the research (the objective, the importance of their participation, anonymity), as

well as the invitation to participate in the focus group. After attempts to reconcile the availability of those who were interested in participating, six participants remained, who actually attended the activity. The researcher who conducted the data collection had previous experience in conducting qualitative research and had no connection with the others involved (patients and dentists from the basic units).

Data collection took place in 2015, in a room specially provided by the Research Institution, which provided the necessary adaptation (comfort, silence, tranquility) for the realization of the focus group. The expenses for locomotion of patients to this location were assumed by the researchers. Initially, the participants were again clarified about the research objectives, oriented about their participation in the group, how to avoid overlapping speech or always talking towards the recorder (in the center of the circle). All 6 subjects remained until the conclusion of the group. There were no interruptions during data collection.

For the realization of the focus group, a semi-structured script was used, elaborated from a theoretical model that includes proposals for the evaluation of PHC (Starfield, Shi & Macincko, 2005) and integrality (Silva Jr et al, 2008). After the first conversation with the objective of clarifying and relaxing the group, the motivating question was asked: "How is your arrival, your entry into the dental service at the health unit?" Then the script was explored, in continuity with the established conversation.

2.4 Data analysis

The activity was considered finished when all the topics defined in the script were covered and saturation was observed. The recorder was only turned off after everyone had left the site, allowing observations to be recorded after the formal termination of the group. The content obtained was transcribed by the same researcher who conducted the focus group. Data obtained were processed using the content analysis method. The first stage, called pre-analysis, involved the first contacts with the documents to be analyzed and the formal preparation of the material. Subsequently, a fluctuating, exhaustive and repeated reading of the texts was made, which allowed the transformation of raw data into themes and later the obtaining of categories. Next, inferences were made from the data already treated, qualitatively analyzing the themes and categories that constituted the patients' perception of oral health care in PHC. This process was carried out by two researchers, simultaneously and independently and after discussion between the researchers, the categories were agreed (Bardin, 1977).

This research was approved by the Research Ethics Committee of the Belo Horizonte City Hall, number 0059.0.410.203-10. All subjects signed an informed consent form.

3. Results

The focus group activity was characterized by intense and spontaneous dynamics, lasting 120 minutes, without fatigue or inattention of the participants. All manifested similarly, without the predominance of the speech of some more than others. Of the six participants, five were women and one was a man. The average age of the participants was 40.1 years (25-61). Only one participant had completed high school, and the other five had incomplete high school or complete elementary school. The statements were grouped into four themes, as shown in Chart 1. The patients will be identified at the end of the speeches through a number, as a way of preserving anonymity.

Chart 1: Themes and categories observed in the focus group on dental care in PHC units, Belo Horizonte, Brazil, 2015.

THEMES	*CATEGORIES*
My health unit	Access Physical structure and inputs Services/procedures offer Attention network
I am welcomed and recognized	Welcoming Bond
The service is good	Humanized relationship

	Team work
My citizen participation	Political system

3.1 My health unit

Participants reported the difficulties in gaining access to dental treatment in PHC. Despite the improvement made possible by the insertion of dentistry at PHC, problems persist. Patients speak in few places and at an inappropriate time, in addition to highlighting the need for easy geographic access as a matter of urban planning.
"The hours should be longer because there are people who work all day, only at night to look for it (P2)"
"... when you are going to create a neighborhood, you have to think about the school, the public health services... the health service unit had to be close to everyone, it is difficult but it had to be. (P4) "

Regarding the physical structure of the basic units and the availability of equipment, inputs and human resources, some aspects were pointed out as important in the day-to-day services.
"*I see the following: ... and if it wasn't so bureaucratic, that it wasn't missing so much material* (P5)"
"*... our biggest difficulty is the number of professionals* (P2)"

Regarding the offer of services, patients pointed to PHC as a place where basic clinical procedures are performed, unable to respond to demands. There is dissatisfaction in relation to the functional aspect of access, as there is no provision of enough procedures to the needs of the population.
"*At the health center, it is really basic, it is the basic of the basic* (P6)"
"*Because in the basic* [PHC] *you did the basics, I dream about orthodontics, I want to make a channel treatment, I want to solve my problem ...* (P3)"

3.2 I am welcomed and recognized

Although PHC is considered the priority access door to the health system, paradoxically, the main barrier can be located in PHC itself, due to barriers to reception.
"*Well, it is very complicated to go through the" Can I help?* "[first contact at reception], *the health agent, the doorman ...* (P1)"
"*The doorman already has to deal with so many things, so many diferente areas of the public health service, ... if there was an entrance straight to the dentist, it would already make it easier. ...* (P3) "

Welcoming may also be in practice a difficulty for those seeking treatment.
"*Many times the professional thinks that the reception hours have passed, but does reception have a schedule? And if I left the service, I was feeling sick there, I resisted as long as I could, won't you be welcomed? .... I can't understand it...* (P4) "

The participants perceive what it feels like to be welcomed and point out in the service organization itself an impediment for this to occur. They recognize that "welcoming" is not being a welcoming moment.
"*Welcoming is receiving the person, listening to the person, looking at them, even if I had to go back home I would have been treated with respect and I want that from all the professionals, the cleaning lady, the doorman ... I think because due to the demand, they place the reception with a schedule, but reception is not that ...* (P4) "
"*In the reception they do not let you talk to any professional, or even ask a question to have an answer* (P1)"

There may be a greater establishment of a bond when the patient and his demands and needs are welcomed. This relationship was perceived and reported.
"*...I also understand because they* [health workers] *work a lot, and then it affects the welcoming and the bond... the doctor I deal with calls us by name, knows my husband, knows my son but how much time she spent to achieve this? That's where you have a bond, but it could be longer if you had more professional time ...* (P4) "

3.3 The service is very good

The quality of care was consistently related to the humanized and compromised relationship that occurs between patients and professionals, capable of overcoming common structural difficulties in the daily lives of countless public health units.
"*The conditions of the dentist there... it is basic, but the care he does for any human being who enters there are the best possible (...) he does not do it anymore because he has no conditions, but his care for the patient it is the best possible* (P3) "

Teamwork was another category perceived as a quality item in care. The statements indicate the perception that, if there is integration between professionals, there is gain.
"*And this fact of helping* [team work] *is very important because sometimes in the conversations between them* [professionals] *there is an exchange of information from patients... I have already witnessed this. The dentist also plays this role, they know a little bit of our life, our day-to-day lives they know a little about our history* (P6) "

3.4 My citizen participation

The presence of what they called "system" was remarkable, that is, a series of factors, especially related to public policies and management, that hinder or prevent the health care of the population from being offered according to their needs.
"*No, it is everybody, he alone* [the dentist] *will not do anything, the system will not allow him to do anything alone (...) I think it is a huge neglect* [structural problems] *and I think it's our fault and the politicians' fault, ours because we vote for them..* (P1) "
"*It is the system that does not allow certain things (...) this is very sad, this is the system that makes it difficult and then they come and offer us a denture; why didn't you offer a decent treatment back there??* (P3) "

However, some patients are aware of their potential citizens and know the strength that their citizenship has in defining different aspects of service management.
"*that's the issue of the city health council. Patients, health professionals mobilize to demand improvements* (P2) "

4. Discussion

4.1 My health unit

The patients' perception points to access difficulties in its multiple dimensions. Although there are ethical issues that define health as a good that should be accessible to every human being, this is not what is observed, because for patients access means having public health services available, in places close to the homes, and with permissive hours for use, especially for those who work daily hours. This perception is consistent with other studies (Viegas, Carmo & Luz, 2015; Al-Jaber & Da'Ar, 2016) that pointed to similar difficulties, related to the number of professionals, the geographical issue and the costs of dental treatments, an impediment for many people. This situation, especially in times of financial or political crises, should necessarily lead to reflection among professionals and managers involved, due to the increase in the number of unemployed or people without health insurance coverage, as they may increase the demand for care.

Deficiencies in these aspects compromise the service provided to patients and, consequently, society's view of SUS or any other public health system in the world. The availability of human resources to work in the basic units is, in fact, considered important, as it relates to the possibilities (or not) of providing services that the community needs. The issue of human resources is not limited to just a numerical factor, since the characteristics and attitudes of the professionals involved influence the population's access (Tesser, Neto & Campos, 2010). This situation was highlighted when commenting on the reception at the health unit. Theoretically, the organization of reception of the patients, a moment called welcoming, includes among its purposes, facilitating patients' access (Coelho & Jorge, 2009). However, it was observed that some organizational aspects of health units, aimed at benefiting welcoming, may actually be preventing this from happening. Thus, access and the construction of the SUS itself may be compromised (Souza et al, 2008), as well as other national health policies based on PHC.

It was also possible to verify in the statements that there is dissatisfaction with the list of clinical procedures offered. There is a great demand for oral health among the population, which often requires different procedures. PHC should be able to take care of providing, in addition to curative/restorative procedures, the prevention and promotion of health. In the medium or long term, the population's demand could be reduced (Mc Manus, 2015).

In the Brazilian case, dental services are organized on levels of complexity or healthcare networks (primary, secondary, and tertiary) and it cannot be forgotten that some procedures are performed by the Dental Specialty Centers (CEO). These health units are aimed to perform some clinical procedures that are not performed in basic units, such as surgerys, endodontics and care for special patients, but it also fails to meet these needs (Chaves et al, 2011), compromising the integrality and generating a feeling of dissatisfaction among patients, since they apparently do not know the network operation of the services, but expect attention beyond the “basic”. An important benefit of the existence of adequate flows between basic and specialized services is the maintenance of the bond between patients and the professional of origin, considered a reference for the individual or family in primary units. Apparently, there is no uniformity of procedures among the professionals involved in basic and specialized health units, with situations in which the user's “walk” through the health system takes place in an appropriate manner and, at other times, in a unsatisfying way, compromising the integrality and user satisfaction.

Some statements were linked to the lack of human resources in the units' daily lives. These problems could be solved with management mechanisms that are more committed to better structural work conditions and more attractive salary and career plans, for example. However, in addition to technical capacity, team members need to identify themselves with a work proposal that often requires creativity, initiative and a vocation for community and group work, something that should start in training professional (Ronzani & Silva, 2008).

4.2 I am welcomed and recognized

It was observed a relantionship between the welcoming and the bond, with the first acting as a facilitator for the second. The coexistence time, despite having its fundamental base in access/reception, is an indispensable factor in longitudinality and can, consequently, interfere in the patients' satisfaction and in the resolution. The bond created is not limited to different clinical moments, it expands to different situations in the participants' daily lives and is not limited to the figure of the dentist, being a category that arises from the humanized relationship that took place with this professional. Bond allows integrality to be more easily achieved and also contributes to longitudinality and long lasting therapeutic bond between patients and professionals, from the recognition of a regular source of primary care (Cunha & Giovanella, 2011).

The bond must be based on the activity of the multidisciplinary team, as the population must believe in the team's ability to solve their health problems and the team must accept these demands. The bond contributes to more accurate diagnoses and treatments, lower costs of care and greater user satisfaction. It can be said that there is a direct relationship, based on access, between welcoming and bonding, the result of which is care, obtained when health professionals feel and experience the reality of patients. Empowered by multiprofessional work, workers must reconcile work and care, which are not opposing categories, but complement each other (Rodrigues, Lima & Roncalli, 2008).

Patients also expressed themselves in relation to the lack of bond in secondary care. They stated that, unlike what happens in PHC, at the secondary level there is no bonding. The service organization itself exacerbates this situation, as the specialized professional is placed as a person who fulfills procedures on patients, does what is requested and forwards them to the unit of origin, not even the documentation remains in place. Everything contributes to the distance perceived by patients. In addition, the majority of professionals working in specialized public care have a dual professional activity, as they work in public and private clinics. Although this double action is not conflicting, it can make it difficult to adjust to the field of public health (Chaves et al, 2011).

4.3 The service is very good

The importance of the humanized relationship between professionals and patients is highlighted. A relationship based on respect and humanistic aspects can overcome several difficulties that PHC units face in their daily lives,

helps to qualify assistance, the quality of care and contributes to a process of reorientation in the production of care (Medeiros, Araújo-Souza & Albuquerque-Barbosal, 2010). Quality is not placed sole under the responsibility of the professional. Patients recognize the limit of this dimension. But a professional with a humanizing capacity can control conflicts that will inevitably not bring benefits in the construction of the desired public health service.

The importance of the humanized relationship in PHC services is pointed out, as humanization is particularly important in this type of service, focused on the most frequent health demands, which are often on the border between “life problems” and “pathology”, as defined by biomedicine (Nora & Junges, 2013). Hence the importance of multi-professional action and intersectoral articulation, since PHC has this vocation as a “gateway” not only for the health service network, but for a multiplicity of other social demands, which end up being translated into health demands or simply present themselves in the absence of other social spaces for expression.

Patients expressed themselves in favor of teamwork. Teamwork is something that, in the view of patients, should happen in the daily life of services and that can qualify the assistance and the relationship between the team and the family. For this, it is essential to develop a communicative practice oriented towards mutual knowledge (Peruzzo et al, 2019; Nora & Junges, 2013). This study confirms the understanding that the specific knowledge of each area can and should be used together to understand certain situations that involve the patients' health.

4.4 My citizen participation

The perception expressed by patients about the political system was highlighted. For them, this system, which is external to the units' daily life, but dictates rules, commands, has immense responsibility in the daily life of public health services, in what they come from positive or negative for the population. It is important to note that this category "system" was addressed several times among the participants, generating debates that revealed a feeling of rejection of political practices that are not committed to the well-being of the population.

One of the reasons for maintaining uncompromised and disconnected management practices from what SUS proposes may be the municipalization of health. This is a principle that guides Brazilian health policy, thought as a possibility to facilitate greater participation of society in health policies, due to a greater proximity between citizens and local managers. However, municipalization does not take into account the demographic reality of most municipalities, which do not have enough population to demand a health system with different levels of complexity, nor the fact that local power in Brazil has traditionally been the basis for representing private interests linked to land ownership and the basis of the oligarchic domination system. There is a natural stimulus for competition between local authorities and power is usually concentrated in a few hands in small municipalities. Power is priority in relation to the broader interests of the population (Rodrigues, 2014).

In contrast to the perceived "system", patients continued to demonstrate, affirming their power as citizens. This citizen vision contributes to social control and integral practices, as they can mobilize managers. It will favor the construction of a society more aware of its rights and responsibilities and contribute to changing the health profile of the population. These perceptions are in line with the concept of empowerment and its interface with health promotion, pointing towards a collective utopia/expectation of social justice and inclusion, especially in national contexts characterized by needs and exclusion. Empowerment contributes to the constant need to debate politicization and health practices (Carvalho & Gastaldo, 2008).

The improvement of any national health policy based on PHC involves the victory over disenchantment or discrediting over that policy. Its concrete performance depends on overcoming the problems historically present in societies, such as uncompromised politics and the lack of efficient management (Campos, 2007). Citizen participation is essential for the promotion of sustainable health and health care. The citizen posture presented is very positive, as it will make it possible to create potential conditions to improve health public services (Willianson, 2014).

5. Conclusions

In this study, it was observed that, for patients, the health unit is an important topic in the evaluation of a public oral health service; welcoming and creating the bond; care with an emphasis on the humanized relationship between professional and patient and teamwork. The critical citizen view on public management was highlighted, which is incompatible with the development of SUS or any other national health policy based on PHC.

The presence of patients, as well as professionals and managers in the effort to build public health systems is essential, The knowledge of the patients' perceptions may enable the elaboration of a characterization of the service provided. The evaluation will allow organizations to know their performance and organize their services not only for the demand, but according to the needs pointed out by the patients, true reasons for the existence of public health services.

Although there is a need to caution in generalizing qualitative studies, the results may have applicability in similar contexts. The fact that not all invited patients wanted or were able to participate generated a small universe of participating patients, which may have omitted unreported perceptions and experiences. It is suggested that further studies be carried out using different qualitative approaches and in different contexts.

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