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Evaluation of user satisfaction and service responsiveness in municipalities enrolled in the *Mais Médicos* (More Doctors) Program

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Abstract *The* Mais Médicos *(More Doctors) Program (PMM) addresses shortages of doctors, one of whose objectives is to reduce regional inequalities in access to health care. This descriptive cross-sectional study evaluated service responsiveness and user satisfaction with PMM doctors among 263 users of the public health system in 32 municipalities with 20% or more of extreme poverty. Questionnaires of open and closed questions were used. Users were satisfied with patient-doctor relationships, information about diseases and treatment and the clarity and comprehensibility of medical indications. The doctors' technical and humanised conduct helped ensure satisfaction among users, who stressed the importance of the programme's continuance. As regards responsiveness, most users were pleased with the non-medical aspects of care: prompt scheduling of appointments, waiting times of less than one hour and privacy. Users suggested improving infrastructure and making more medicines and more doctors available, which should be considered by SUS managers to help ensure access to the right to health guaranteed in Brazil's constitution.*

Key words *Distribution of doctors, Primary health care, Patient satisfaction, Health care quality, access, and evaluation*

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Introduction

Inequalities in the distribution of doctors are a problem in many countries, including Brazil. Studies up to 2013 have revealed inequalities in access to medical care between people living in different regions of Brazil. The primary health care personnel shortage index (*Índice de Escassez de Profissionais de Saúde na Atenção Primária*) developed by the *Estação de Pesquisa de Sinais de Mercado* demonstrated that populations in Brazil's North and Northeast regions were greatly affected by severe shortages of doctors; the inequities were also striking when comparing densities of doctors between state capitals and the interior[1,2].

Equity, one of the guiding principles of Brazil's unified public health system (*Sistema Único de Saúde*, SUS), is intended to compensate for unfair, avoidable and unnecessary inequalities[3]. The unequal distribution of doctors worsens inequity and, accordingly, should be corrected.

The More Doctors Programme (*Programa Mais Médicos*, PMM) was set up in 2013 in response to the problem of shortages of medical professionals, especially in rural and remote areas of Brazil. The policy agenda had its beginnings in a public rally by the National Front of Mayors (*Frente Nacional de Prefeitos*, FNP), which led a movement on 4 February 2013 titled "Where's the doctor?" (*Cadê o médico?*) and organised a petition for more doctors in the SUS. Demanding a response from the federal government, the front called for immediate measures to engage doctors trained in other countries[4]. In June that same year, widespread street protests called for improvements to public services, particularly education and health[5].

The Ministry of Health was aware that the national mean rate of doctors per 1,000 population was lower than needed by Brazil, which required larger numbers of health personnel in several regions. The North and Northeast regions were the most underserved in this distribution of doctors: parts of some states and municipalities had much less than one doctor per thousand population[6].

The *Mais Médicos* Programme (PMM) was instituted on 8 July 2013. In order to gain priority in receiving doctors under the programme, municipalities had to display at least one of the following characteristics: at least 20% of their population living in conditions of extreme poverty; population greater than 80,000 and with low socioeconomic status; and/or be a state capital or metropolitan region containing census tracts where high percentages of the population lived in conditions of extreme poverty. Priority was also given to placing doctors in Special Indigenous Health Districts (*Distritos Sanitários Especiais Indígenas*, DSEIs).

The government recruited for the PMM by publishing public service announcements in order to give priority to Brazilian doctors with qualifications valid in Brazil. Second priority was given to Brazilians trained at foreign universities and qualified to practise medicine abroad. The last option was for foreign doctors qualified to practise medicine abroad.

Official Ministry of Health figures for July 2014 record 14,462 doctors placed in 3,785 municipalities and 34 DSEIs. Provision of doctors was intended to comply with what were considered to be the principles and guidelines of the SUS, in an endeavour to assure the right to health for all Brazilians, with Primary Health Care (PHC) as the system gateway. Since the Alma-Ata Conference, PHC has been understood to be central and organisational to health systems and to integrate the care process with promotion, prevention and rehabilitation[7].

Macinko & Lima showed the association between Brazil's Family Health Strategy (*Estratégia Saúde da Família*, ESF) and improved access to, use of, and satisfaction with, PHC services in Brazil[8]. Rapid expansion of the ESF brought to light the poor distribution of doctors across Brazil, to which the country responded with the PMM. That measure was recently acknowledged in an article published in The New England Journal of Medicine as being one of the Brazilian government's largest programmes in response to the protests voicing the need for greater investment in the health sector[9].

User satisfaction: concepts and definitions

In this article, *user satisfaction* is considered to be a dimension of quality of care. As expressed by Barbara Starfield[10], the concept of quality has been used in a broad sense to mean *satisfaction with services, the costs of care, the qualifications of health services personnel, the safety and congeniality of the facilities in which services are provided, and the adequacy of the equipment (as in laboratories) that contribute to the provision of services.* She argues that user satisfaction with services is not directly a measure of quality of care, but rather an indirect measure of quality, because satisfaction may influence the seeking of certain

types of services that themselves influence health status.

Donabedian[11] defines satisfaction as a measure of the outcome of interaction between doctor and patient. The concept of user satisfaction has come to prominence since the 1960s, accompanying the development of *health service evaluation*[12]. Note that the idea of patient satisfaction defines users as agents of practices and regards them as being in a position to evaluate certain attributes that are considered important in care. That valuing of patients' opinions grants them pride of place as subjects of rights, and directly and indirectly strengthens the *culture of participation*[13].

Studies of user satisfaction generally comprise quantitative and qualitative methodological strategies. There is a wide variety of satisfaction studies using quantitative and qualitative methodologies, each with strong points and limitations[12]. One of the aspects most highlighted by researchers questioning the validity of satisfaction studies are the high levels of satisfaction found by applying instruments from a variety of different methodological traditions, signalling a limitation known as *gratitude bias*[14] and often described in the literature as a *satisfaction rate elevation effect*[12]. Feelings of gratitude can cloud a more critical appraisal of care, thus introducing gratitude bias[14].

Health service responsiveness

In order to give quality, health services have to achieve good performance, which entails respecting users in all senses: respecting the confidentiality of clinical data; respecting dignity, including humanised treatment and user decision-making autonomy; and offering quality installations and infrastructure. The World Health Organisation (WHO) refers to this proper health system performance as response capacity or responsiveness[15].

The WHO then incorporated the concept of 'responsiveness' to complement 'user satisfaction', which it had used since the 1960s. 'Satisfaction' contemplates the various dimensions involved in health care, from the doctor-patient relationship to quality of clinical care and of health personnel[14]. In contrast, 'responsiveness' is a concept that relates to *non-medical aspects of care*. The concept relates to how health systems recognise and respond to individuals' expectations regarding non-medical aspects of care. The WHO introduced the concept to refer to components not directly connected with health status, considering that in addition to promoting and maintaining people's health, health systems should treat users with dignity, facilitate their participation in decisions on medical procedures, encourage clear communication between health personnel and users and guarantee the confidentiality of patients' medical data[16].

Vaitsman & Andrade[14] operationalised the concept of responsiveness with the following variables: quality of installations; access to patient social support networks; freedom to choose the health service; and respect for people, comprising respect for dignity, confidentiality of user health information, autonomy to participate in health-related decisions and client guidance, including prompt care, with the possibility to choose according to needs. Studies of responsiveness differ from user satisfaction studies, because they evaluate the health system as a whole, to encompass both the non-medical aspects of care and individual perceptions regarding users' universally legitimate expectations. By contrast, studies of satisfaction are more subjective and evaluate users and their relations with health professionals and workers, clinical interactions between doctors and users and individually perceived needs[14].

For this study, the contributions of Vaitsman & Andrade[14] will be used. 'User satisfaction' is considered to reflect the medical aspects of care, while 'responsiveness' contemplates aspects that are not related to direct care, but which a health system should guarantee, such as respect on the part of health system professionals and workers, waiting times and the health services' cleanliness and comfort[15].

Methodology

Goals, methods, sampling and data collection and analysis

This descriptive study examined user satisfaction and service responsiveness in 32 selected municipalities participating in the *Mais Médicos* Programme (PMM). Municipalities were selected on the criteria of having 20% or more extreme poverty and being registered in the first or second cycle of the PMM, having fewer than five doctors working in the municipality and fewer than 0.50 doctors per 1,000 population in June 2013. The final selection was random and proportional to the number of municipalities with 20% or more

extreme poverty registered in the PMM by region and by state. That process resulted in 32 municipalities from all regions of Brazil: 14 in the North region, 12 in the Northeast, 3 in the Southeast, 2 in the Mid-West and 1 in the South.

A questionnaire of open and closed questions was developed and pre-tested, drawing on a previously published instrument for evaluating user satisfaction and service responsiveness[13]. The variables contained in the questionnaire corresponded to the following dimensions of user satisfaction: satisfaction with the PMM doctor's conduct, with the information provided, with the understanding of the explanation and an overall satisfaction index measured on a facial hedonic scale. The variables for responsiveness were: prompt scheduling of appointment, waiting time on day of appointment, duration of appointment, privacy, home visits and suggestions for improving the PMM. In addition, data were collected on interviewees' demographic characteristics, socioeconomic status and schooling.

The field work was carried out between November 2014 and June 2015 in visits to the health facilities in the municipalities selected. Patients were approached either when waiting for, or when leaving, their medical appointment. In all, 263 questionnaires were applied to 50 Family Health Teams in the 32 municipalities.

The quantitative analysis was performed using descriptive statistics procedures (mean, median, mode and frequency) and the study variables were examined against social and demographic variables. Responses to the open questions on the questionnaire were analysed using content analysis techniques. Some qualitative data were represented in the form of words clouds using the free software, WORDLE (available at http://www.wordle.net).

The Municipal Human Development Index (*Índice de Desenvolvimento Humano Municipal*, IDHM) and Municipal Human Development Indices for Education, Income and Longevity, were categorised using criteria from the Atlas Brasil[17].

This analysis forms part of a research project to evaluate the effectiveness of the *Mais Médicos* programme in realising the universal right to health and establishing health service systems ("*Avaliação da efetividade do Mais Médicos Programme na realização do direito universal* à *saúde e na consolidação das redes de serviços em saúde*"). The study was approved by the Ethics Committee of the Faculdade de Ciências da Saúde, Universidade de Brasília – CEP/FS-UNB (Opinion 399.461/ 2013).

This study is limited by methodological biases proper to health service evaluations based exclusively on user subjectivities. However, using the instrument to evaluate responsiveness did in part reduce the subjectivity of the service quality assessment. This characteristic is inherent to the method, which measures care performance more objectively, eliminating user value judgement, which may vary in similar situations. Nonetheless, some type of bias may have occurred. One important consideration has to do with the phenomenon that some studies term the "satisfaction paradox"[18], which has to do with the perception bias that occurs when, despite health services' suffering from problems of structure, organisation and access, users express a high degree of satisfaction. In this study, such bias – *gratitude bias* or feeling grateful – may derive from the possibility of accessing health services provided by the PMM to populations previously completely excluded from the system or even forgotten, because they live in remote areas that are difficult to access.

Results

Characterising the municipalities

The 32 municipalities selected had populations of 4,000 to 50,000 (mean = 14,500; median = 11,200). IDHM ranged from 0.496 to 0.643 (mean = 0.576; median = 0.572) and was generally considered low. Distribution of the municipalities by IDHM revealed that only one had an IDHM categorised as very low, 22 had IDHMs considered low and nine had medium IDHMs. IDHM-Education values, which ranged from 0.317 to 0.550 (mean = 0.454; median = 0.440), were considered very low in all the municipalities selected. IDHM-Income ranged from 0.470 to 0.658, that is, from very low to medium (median = 0.553; mean = 0.549). IDHM-Longevity showed life expectancy at birth of 68.4 to 75.8 years (mean = 71; median = 70.8).

Given the sampling criteria, the municipalities included were in fact vulnerable, remote and distant from the state capitals. In the field, 49 PMM doctors were encountered in all 32 municipalities, 47 of them Cuban and two, Brazilian.

The study participants were 263 SUS users, most of them (214; 81.4%) female with mean age 61 years and median age 37 years (minimum 14 and maximum 94 years). Race/colour was predominantly mixed (138; 52.2%), followed by

white (46; 17.5) and black (32; 12.2%). Levels of schooling proved rather low, mostly incomplete middle schooling (97 cases; 37.5%), followed by complete middle schooling (63 cases; 24%). However, most people (215; 83%) reported being able to read a text or newspaper well. Occupations included a high number of rural workers (48; 18.5 %), housewives (48; 18.5%), civil servants (32; 12.3%) and house maids (19; 7.3%).

User satisfaction with the *Mais Médicos* Program

User satisfaction was generally high (Table 1). More specifically as regards medical care and the doctor-patient relationship, the great majority of users (98.1%) considered that the doctor listened carefully to all their complaints and 95.8% reported that they received all the necessary information. In addition, 93.5% of users declared that they received all the information on the treatment and 87% said they understood the recommendations they were to follow.

Even though the great majority understood the recommendations they received, communication with the foreign (Cuban) doctors, who spoke Spanish, was assessed as difficult by some: 57.5% of users interviewed reported some difficulty in understanding the indications given by the doctor.

Overall satisfaction with the doctor of the *Mais Médicos* Programme was high. The great majority (94.6%) selected good or very good as their level of satisfaction.

In the data obtained by the open questions, the main comments centred on being well attended to by the doctors. Second among the arguments for high levels of overall satisfaction was that there had been no doctor before the PMM, which had meant travelling to other municipalities. Other users' responses were based on favourable remarks about the doctors' posture or attitude, describing them as *always smiling, attentive, modest* and *polite*. Another set of users remarked favourably on their experience during the appointment, either at the surgery or at

Table 1. Aspects of user satisfaction examined in 32 selected municipalities with 20% or more poverty, registered with the *Mais Médicos* Program – Brazil, 2014-15.

Dimensions of user satisfaction	Values	N	%
During the appointment, did the doctor listen carefully to all your complaints?	Yes	257	98.1
	Partly	3	1.1
	No	2	0.8
	Total	262	100.0
During the appointment, did the doctor you give all the information you needed?	Yes	251	95.8
	Partly	7	2.7
	No	4	1.5
	Total	262	100.0
During the appointment, did the doctor explain all your treatment clearly?	Yes	243	93.5
	Partly	10	3.8
	No	7	2.7
	Total	260	100.0
Did you understand the explanations and indications given by the doctor?	Yes	227	87.0
	Partly	29	11.1
	No	5	1.9
	Total	261	100.0
Did you have any difficulty understanding the indications given because the doctor was foreign?	Yes	64	26.7
	Partly	74	30.8
	No	102	42.5
	Total	240	100.0
I would like you to choose the face that shows how satisfied you are with the doctor of the *Mais Médicos* Program at this facility.	Very bad	5	1.9
	Bad	2	0.8
	Indifferent	7	2.7
	Good	104	39.5
	Very good	145	55.1
	Total	263	100.0

Source: produced by the authors from data collected in the field.

home, pointing out that they *were treated well, felt treated considerately,* and that the doctors were interested in their lives. One user's remark, which is representative of a good number of the declarations, was that *they touch us and are not disgusted by us*.

Figure 1, in the form of a word cloud, shows the analysis of the open question responses on overall satisfaction. It emphasises the words used most often to describe the group's shared evaluation of the phenomenon. Note that the most conspicuous words are: well, people, doctor, attend to, care, good (*bem, gente, medico, atende, atenção, bom*).

Service responsiveness
where PMM doctors work

The results for the dimensions of service responsiveness are given in Table 2. Waiting time on the day of the appointment was less than one hour for 75.7% of users (mean = 59.8 minutes; median = 30 minutes) and evaluated as 'not long' by 57.6% and 'more or less long' by 33.2%. When asked to choose a face to show their satisfaction with waiting time between arriving at the facility and being seen by the doctor, 78.7% of users' evaluations were 'good' or 'very good'. Note that, when asked by open questions about difficulties, some users reported difficulties in accessing laboratory and diagnostic test results.

As regards the duration of the appointment, most users (98.1%) reported that it lasted less than half an hour, in fact, varying from 2 to 60 minutes (mean = 21 minutes; median = 20).

The great majority (84.5%) of users had their privacy respected during the medical appointment or tests. However, 15.5% of users stated that they were interrupted by another person's entering during the medical procedure; of these, 69.6% declared having agreed to the person's entering. Lack of privacy was reported by 16% of the people who could read and 9% of those who could not.

When asked about home visits, 28.9% of users reported that they had received a home visit from the doctor and most of these (71.6%) evaluated the visit as satisfactory. The population visited were mostly older adults, the disabled, pregnant mothers with complications and children with an acute disorder. The visits served as appointments, for taking blood pressure and giving guidance on self-care and caring for relatives and, occasionally for the environment with a view to preventing disease.

Waiting time from the moment the user requested an appointment to the day when they were seen was evaluated as very good or good by 87.3% of users, demonstrating easy access to appointments after introduction of the PMM.

Figure 2 shows the word cloud for words in the responses to open questions on waiting time

Figure 1. How often each word appears in user comments on overall satisfaction in 32 selected municipalities with 20% or more poverty registered with the *Mais Médicos* Program – Brazil, 2014-2015.

Source: produced by the authors from data collected in the field.

Table 2. Dimensions of service responsiveness in 32 selected municipalities with 20% or more poverty, registered with the Mais Médicos Programme – Brazil, 2014-2015.

Dimension of responsiveness	Values	N	%
Today, how long did you wait to be seen?	A long time	24	9.2
	More or less long	87	33.2
	Not long	151	57.6
	Total	262	100.0
How many hours did you wait to be seen?	1. Less than one hour	199	75.7
	2. From one to two hours	48	18.3
	3. More than two hours	16	6.1
	Total	263	100.0
How long did the appointment last?	1. Less than half an hour	258	98.1
	3. More than an hour	5	1.9
	Total	263	100.0
During the appointments or tests, did anyone else enter the room while the doctor was examining you?	Yes	40	15.5
	No	218	84.5
	Total	258	100.0
Now please point to the face that best shows your satisfaction with the waiting time from the moment you asked for an appointment and the day of the appointment.	Very bad	3	1.2
	Bad	16	6.5
	Indifferent	12	4.9
	Good	115	46.9
	Very good	99	40.4
	Total	245	100.0
Now please indicate the face that best shows your satisfaction with the waiting time from the moment you arrived at the facility to when you were seen by the doctor.	Very bad	5	1.9
	Bad	21	8.0
	Indifferent	30	11.5
	Good	133	50.8
	Very good	73	27.9
	Total	262	100.0
Did the *Mais Médicos* doctor visit your home?	Yes	76	28.9
	No	187	71.1
	Total	263	100.0

Source: Produced by the authors from data collected in the field.

responsiveness. The words repeated most frequently were: day, seen, appointment, time, delay (*dia, atendida, consulta, tempo, demora*).

When asked for suggestions on how to improve the programme's responsiveness, most users replied that there was nothing to improve, because the PMM was good the way it was. Those who offered suggestions said they wanted *improvements in infrastructure, more medicines made available, More Doctors* (more doctors enrolled in the *Mais Médicos* Programme), *more support from the municipality for the doctors, improvements in transport for easier access by rural and remote communities* and *more specialists*. Others said they wanted *the programme to continue*.

Discussion

The users who participated in this study came from small, poor and remote municipalities. Many of these municipalities have been without proper health services for a long time, due mainly to a lack of qualified health personnel, especially doctors. That situation has resulted from the unequal geographical distribution of health professionals, who are concentrated in urban centres, and from encouragement for the trend towards specialised medical training, centred on the hospital and sophisticated technologies out of tune with the population's health needs and with the needs of the health system[19].

In that context, it can be inferred that these are people who live a very long way from urban

Figure 2. Number of appearances of each word in user responses on waiting time responsiveness in 32 selected municipalities with 20% or more poverty registered in the *Mais Médicos* Program – Brazil 2014-2015.

Source: produced by the authors from data collected in the field.

centres and, accordingly, need a doctor closer to their domicile in order to guarantee access to the SUS. As already mentioned, the PMM was set up to close that gap. However, the Brazilian doctors who enrolled in the programme generally did not choose the poorer and more distant municipalities and, as a result, the municipalities studied here were provided almost exclusively with cooperating Cuban doctors.

Profiling of the users at the facilities served by the PMM found them to be predominantly female, adults and with little schooling. The interviewees were in employment requiring little vocational qualification. The larger numbers of women who approach health services has been demonstrated by several studies[20,21], the explanation being the importance they give to health services and for care for themselves and their families.

User satisfaction with the doctor-patient relationship specifically was high, because the doctors demonstrated the capacity to listen attentively to all the users' needs. Attentive listening is fundamental to good communication, by which it is possible to understand patients' different individual physical, psychological and social dimensions, and contributes to closing the distances between doctors and users[22]. This finding is similar to that of the 2010 study of PHC in major Brazilian cities, in which satisfaction with relationships and communication with health per-

sonnel was the most strikingly positive feature[23].

Communication was also perceived as satisfactory because the doctors endeavoured to offer all the information and explanations necessary about the disease and treatment and to settle all doubts. The extent to which this information was understood may have been limited by language difference between most of the doctors, who speak Spanish, and the users, who speak Portuguese. Almost half the users reported finding some difficulty in understanding the indications they received. This, however, did not seem to impair effective communication, understood as obtaining objective information about the disease and subjective information, such as the implications of illness for the routines of family and patient, and the fears and concerns raised by the clinical complaint[22].

The dimensions that scored highest were the clarity and completeness of the information and explanations given by the doctor. That finding is similar to those of Brandão et al., where these two dimensions also scored highest[23].

Starfield[10] points to the importance of users' expressing their evaluation of services. She argues that analysing satisfaction means of entering users' field of subjectivity, of the interpersonal relations between users and health personnel that are entailed by care and go beyond the technical procedures. In this study, the qualitative data show that users were very well cared for

in the health services. The doctors' attention to users during appointments appears to modulate that positive evaluation. In both this study and another in a suburban district of Fortaleza, users' subjective qualitative evaluation was observed to be "good"[24]. In the study in Fortaleza, however, the same population showed the ability to recognise when the health services were "not good". That situation was not tested with the reference population of this present study. With those findings as evidence, the authors warn that caution should be exercised in further analysis and that these results cannot be generalised[24]. Other studies in Brazil have also emphasised the importance of good doctor-user relations, which go beyond merely technical aspects to strengthen confidentiality, dignity and humanised care[25].

As regards service responsiveness, most users evaluated access to PHC positively, particularly because they managed to be seen promptly by the doctor, nearly always on the same day. It is possible to meet spontaneous demand, even with no prior appointment, which breaks down the institutional barriers raised by the need for prior appointment, besides cutting waiting times. It is possible that, in addition to the greater availability of doctors, the fact that most of the municipalities were small, and thus had little repressed demand, contributed to shorter waiting times. In this study, the services were seen to attempt to provide care promptly, nearly always on the same day. This availability on the part of the personnel to attend to users when approached certainly contributed to increasing the degree of satisfaction and of service responsiveness. Difficulty in accessing PHC services has been confirmed to be one factor influencing the degree of responsiveness in Europe and in Africa[26,27].

Waiting times for appointments were about 30 minutes in the services studied and thus within the time recommended by students of health service quality[10,11]. Waiting times have been assessed in other studies in Brazil and the findings have generally been unfavourable. Complaints observed in this dimension related to the need to receive care more promptly[28], to long waiting times[29] and to difficulties in scheduling appointments[23].

Appointments lasted a mean of 20 minutes, which is considered reasonable for an appointment at a PHC facility. In this respect, it should be noted that the appointment is a key moment in the process of diagnosis and therapy, requiring an understanding of the user's individual subjectivity and of how psychosocial, cultural, religious and other considerations influence clinical complaints. On a user-centred model, the duration of the appointment should allow time to address: the doctor's agenda as regards symptoms and disease; the user's agenda, which includes concerns, fears and the experience of falling ill; and to integrate between the two agendas[22].

Although only a small number of users reported their privacy being invaded during the appointments and procedures, this does point to a need for PHC services to improve in this regard, which involves the ethical dimension of care, because all users are entitled to confidentiality[14]. In that regard, not only should the services' physical infrastructure provide private rooms or surgeries, but health personnel should be properly trained to keep information confidential[18]. These findings and the difficulties reported in accessing diagnostic tests indicate a need for greater investment in improving infrastructure and equipping PHC facilities, in addition to introducing health services at other levels of complexity in the municipalities and corresponding regions. These are territories with enormous care voids, due to historically low levels of financial investment.

Around one third of users had received a home visit from PMM health personnel. Users expressed considerable satisfaction with the doctors' home visits, especially the attention they gave to the more fragile and dependent (older adults, the disabled, pregnant women and people with mental disorders). This activity enabled the doctors to see the user population's needs closer at hand, as well as bringing a broader approach to bear, directed to identifying health-related environmental conditions. Studies have shown that, in recent years, the situations health personnel have to address in the living territory are so complex that doctors have increasingly ceased making home visits, preferring to delegate them to community health workers (CHWs) and occasionally to nurses[21].

Conclusions

Users were satisfied with the medical care (user satisfaction) and non-medical aspects of care (responsiveness) in 32 municipalities registered with the PMM. The fact that populations that had rarely or never had access to a doctor in their municipality now had such access contributed to these results. In addition, the PMM doctors had evidently performed well, especially as regards their manner of relating to users, families and the

community. Their availability and sensitivity and the respect and dignity with which they treated patients led the user population to reiterate the importance of continuing the programme. From that perspective, the doctors' technical and humanised performance contributed to guaranteeing access and the right to health.

Users also evaluated the health services' responsiveness favourably. Contributing to that result were the facts that, in nearly all cases, users: managed to be seen quickly, even with no prior appointment; experienced waiting times and appointment durations considered reasonable for PHC services; and had their privacy respected during the appointments and medical procedures and their confidentiality preserved. How-ever, the infrastructure of PHC services is still deficient, pointing to a need for more investment in order to equip facilities better, in addition to the need to offer health services at other levels of complexity in the municipalities and their corresponding regions.

Users' suggestions for improving the responsiveness of the programme, such as customising infrastructure, making more medicines available, having more doctors enrolled in the *Mais Médicos* Programme, more specialists and more transport support for access by rural and remote communities, should all be taken into consideration by federal and municipal managers of the SUS in order to contribute to assuring access and the constitutional right to health.

Collaborations

We declare that the author Y Comes contributed to the research project design and study planning, analysis and interpretation of the results, drafting of the manuscript and critical review of content; JS Trindade, to analysis and interpretation of the results, drafting of the manuscript and critical review of content; HE Shimizu, to research project design and study planning, development of the discussion and critical review of content; EM Hamann, to research project design and study planning, development of research findings and critical review of content; F Bargioni and L Ramirez, to the introduction and to analysis and interpretation of results; MN Sanchez, to research project design, study planning and critical review of content; and LMP Santos, to research project design and study planning, drafting of the manuscript and critical review of content. All authors approved the final version of the manuscript.

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