



Rights of patients required in a public service ombudsman

Direitos dos pacientes requeridos em um serviço público de ouvidoria

Derechos de los pacientes requeridos en un servicio público de oidoría

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Objective: analyzing the rights of patients required in a public service ombudsmen. **Methods:** an exploratory, descriptive study of documentary research. 109 complaint forms coming from the basic network were analyzed, related to 12 Basic Health Units located within the Southern Health Technical Supervision. **Results:** grouped into four categories of required rights: access to goods and services (62.4%) being, access to specialized exams (28.7%), access to consultations (16.6%), referral to a specialist (5.7%), referral for urgent/emergency cases (1.3%), monitoring through home visits (7.6%), guaranteed medications (2.5%). Quality of health services (36.9%) divided into: decent, considerate and respectful care (26.8%), guidance/clarification (9.6%), and public disclosure of government programs (0.6%) and adequate infrastructure (0.6%). **Conclusion:** the rights that patients required are related to access, quality, treatment and adequate infrastructure.

Descriptors: Patient Advocacy; Primary Health Care; Patient Rights.

Objetivo: analisar os direitos dos pacientes requeridos em um serviço público de ouvidorias. **Métodos:** estudo exploratório, descritivo, do tipo pesquisa documental. Foram analisadas 109 fichas de reclamação, advindas da rede básica, relacionadas a 12 Unidades Básicas de Saúde, localizadas no território da Supervisão Técnica de Saúde Sul. **Resultados:** agrupados em quatro categorias de direitos requeridos: acesso a bens e serviços (62,4%) sendo, acesso a exames especializados (28,7%), acesso a consultas (16,6%), encaminhamento para especialista (5,7%), encaminhamento em casos de urgência/emergência (1,3%), acompanhamento através de visita domiciliar (7,6%), garantia de medicamentos (2,5%). Qualidade dos serviços de saúde (36,9%) subdivididos em: atendimento digno, atencioso e respeitoso (26,8%), orientação/esclarecimento (9,6%), divulgação a população de programas governamentais (0,6%) e infraestrutura adequada (0,6%). **Conclusão:** os direitos que os pacientes requereram estão relacionados ao acesso, qualidade, tratamento e infraestrutura adequada.

Descritores: Defesa do Paciente; Atenção Primária à Saúde; Direitos do Paciente.

Objetivo: analizar los derechos de pacientes requeridos en un servicio público de oidorías. **Métodos:** estudio exploratorio, descriptivo, del tipo investigación documental. Se analizaron 109 formularios de reclamación, procedentes de la red central, relacionados con 12 Unidades Básicas de Salud en territorio de la Supervisión Técnica de Salud del Sur. **Resultados:** agrupados en cuatro categorías de derechos exigidos: acceso a bienes y servicios (62,4%) siendo, acceso a pruebas especializadas (28,7%), acceso a las consultas (16,6%), encaminhamiento a un especialista (5,7%), remisión en los casos de urgencia/emergencia (1,3%), acompañamiento a través de visitas a los hogares (7,6%), garantía de los medicamentos (2,5%). Calidad de los servicios de salud (36,9%), dividido en: atención digna y respetuosa (26,8%), orientación/clarificaciones (9,6%), divulgación pública de los programas de gobierno (0,6%) y infraestructura adecuada (0,6%). **Conclusión:** los derechos que los pacientes requirieron estuvieron relacionadas con acceso, calidad, tratamiento e infraestructura adecuada.

Descritores: Defensa del Paciente; Atención Primaria de Salud; Derechos del Paciente.

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Introduction

In Brazil, health and social rights of citizens were legally assured with the promulgation of the 1988 Constitution, where basic rights to freedom of belief and conscience, health, education, housing, work, leisure, security, transport, social security and assistance in all stages of life were established⁽¹⁾.

After the Federal Constitution, political laws were enacted and established reinforcing rights and determining strategies to ensure that all Brazilian citizens can access them. Individuals, as users of health services and health actions, have their rights guaranteed by the regulations referred to all citizens and specific laws and policies that reaffirm the rights already acquired and promote others, considering their patient condition.

The State of São Paulo is one of the pioneers in the adoption of a specific law in defense of this population, when the Law which governs the rights of users of health services and actions in the State was enacted establishing guidelines for the care and treatment of the individual in all care spheres. Ensuring the patient the power to decide freely on conduct, through prior clarification on the possibilities of diagnostic methods and treatments available, the right to be treated with respect, privacy and confidentiality, among others⁽²⁾.

The Unified Health System (Brazilian National Healthcare) understands that every citizen is entitled to access prioritized/ordered and organized health systems, to appropriate and effective treatment for their problem, to humanized service free of discrimination/prejudice, to care that respects themselves and their own rights that every citizen has, but also responsibilities for treatment to happen properly, participating in decision making. These principles refer to the universal character of the Unified Health System⁽³⁾.

One way of user participation is through ombudsman services that receives complaints from users through these channels of communication with the Unified Health System. In turn, the ombudsman

service contemplates user's right to express themselves and to be heard in their complaints, accusations, needs, suggestions and other opinions. Therefore, patients become co-participants, developing political consciousness.

The ombudsman service is an important management tool. In the public sector it collaborates in monitoring the functioning of the health system, in prioritizing problems, in identifying critical areas and intermediating the relations between professionals and users. It also contributes to the advancement of the practice of democratic and participatory management⁽⁴⁻⁵⁾.

When users have a voice, it is possible to identify problems and possible direct administrative and continuing education actions for the staff, in order to rectify these problems. It can also possibly be an assessment tool of the quality of health services.

Understanding the content of the complaints brought to the ombudsman service can improve the quality of health services and its facility collaborates in the satisfaction of its users, therefore this study aims to analyze the rights of patients required in a public service ombudsman.

Method

This is an exploratory, descriptive study of documentary research with retrospective data collection. Data were obtained from ombudsman service records of the City of São Paulo, generated in 2013 and related to 12 basic health units managed by a public-private partnership with a coverage area serving 277,091 people, enrolled into 75 Family Health Teams.

The Technical Health Supervision of Campo Limpo which accounts for the study area provides a phone number and an e-mail to receive contact from users. A professional receives complaints and forwards them to the responsible Basic Health Unit manager, who has 10 days to position themselves regarding the issue. Data collection was conducted between

December/2013 and January/2014 in time scheduled with the supervision and with the professional of the sector, so that it would not affect the smooth running of the service.

Data were grouped by similarity of claims. Subsequently, the rights were analyzed based on the State Law no. 10.241/99⁽²⁾. The study followed the relevant ethical aspects and was approved by the Ethics Committee in Research of the University of São Paulo School of Nursing (Protocol 378.045/2013) and the Municipality of São Paulo (600.858-0/2013).

Results

During the year of 2013, 109 complaints were generated concerning 12 basic health units administered by the partner Family Health Program/ Adventist University Center of Sao Paulo, making an annual average of nine cases per Basic Health Unit/year, with standard deviation of 4.7 and a ratio of one ombudsman case for every 2542 inhabitants/year (1:2542), with a minimum of three and maximum of 19 per Basic Health Unit.

For a better presentation, the content of the claims has been divided into three groups of rights with its subgroups, as shown in Table 1.

Table 1 - Rights required by users of the ombudsman service

Rights required	n(%)*
Access to goods and services	
Specialized exams	45(28.7)
Access to consultations	26(16.6)
Referral to a specialist	9(5.7)
Monitoring - Home visits	12(7.6)
Guaranteed Medications	4(2.5)
Urgency/emergency - receiving/care or referral	2(1.3)
Subtotal	98(62.4)
Quality of health services	
Decent care and respectful service	42(26.8)
Guidance/clarification	15(9.6)
Disclosure to population	1(0.6)
Subtotal	58(36.9)
Infrastructure	
Adequate infrastructure	1(0.6)
Subtotal	1(0.6)
Total	157(100.0)

*N is greater than the number of ombudsman services because some patients required more than one right in the same contact

Access to goods and services

With regard to access to goods and services, the situations that have the highest number of complaints are the lack of access to specialized exams and obtaining their results (28.7%), such as colonoscopy, bone densitometry, endoscopy, and biopsies, among others. Cases were found where patients were waiting for scheduling of these tests for over eight months and awaiting results for more than two months.

According to the content of user complaints, users face difficulties in scheduling appointments with a medical professional (15.9%), they also showed dissatisfaction for having consultations with nurses more frequently than with doctors (0.6%). Patients report that because nurses do not prescribe most medications when they have consultation with these professionals, they end up needing to have consultations with doctors as well in order to get prescriptions for the medications they need.

The complainants have shown dissatisfaction related to necessary referrals, highlighting the lack of referral to specialists (5.7%). The specialists were gynecologists, pediatricians, gastroenterologists, pulmonologists, and speech therapists, among others, for the resolution of urgent cases. Two situations were found (1.3%) that required surgery, but patients did not receive appropriate referral.

In regards to monitoring by home vVisit, the aforementioned complaints relate to the non-continuity of care of bedridden patients or those unable to leave their homes and the non-compliance of the agenda scheduled by Community Health Agents (5.1%) and physicians (2.5%).

The lack of continuous use of medications (2.5%) is also among the complaints. Patients report that when they do not receive the drugs from the Basic Health Unit, they do not have financial resources to buy them.

Quality of health services

As for the quality of health services, the displeasure of the users (24.8%) can be seen in relation to the attitude of some professionals who meet them disrespectfully and express little interest in the needs of the patient.

Among those needs is continuity of service, i.e., patients who need special transport report facing difficulties in scheduling it (1.9%), affecting their attendance to health services.

It was found that users' doubts were not clarified with respect to the collection of material for tests (1.9%), the reason being a lack of doctors (1.9%), the availability of nurses for consultation (2, 5%) or a delay in treatment due to internal meetings of health professionals or lack thereof (1.3%).

Users (1.3%) indicated that for the most part, the Community Health Agent does home visits, fills out all the papers and walks away without offering any guidance on family health. Also with regard to guidance, one user (0.6%) complained that they did not understand the explanations made by the Community Agent on a prescription, and that it should be made by the doctor himself.

The lack of disclosure on government programs, such as Smiling Brazil, was also claimed by a user (0.6%).

Infrastructure

One case was reported in the ombudsman reporting the absence of a drinking fountain (0.6%), highlighting the inadequate infrastructure of the site.

Discussion

Regarding the number of complaints received in the study area, it can be considered that there was a low rate when compared with a similar study, the reported ratio was one ombudsman for each 412 inhabitants/year (1:412)⁽⁴⁾. Even with a low rate

of complaints, a re-evaluation of these results is necessary in order to further reduce this figure.

The low number of complaints may show user satisfaction related to the investigated units. A parameter of this condition is the result of the Monitoring Program and Quality Assessment in Primary Care, where 95.12% of the teams of the Family Health Program administered by the Adventist University Center of Sao Paulo achieved 'well above average' performance in the external evaluation conducted by the Ministry of Health in 2012, a performance of 42.8 percentage points above the City average in this category.

As for the rights required in the ombudsman service, the need to improve the access of users was highlighted, especially in the specialized services and consultations.

Access to goods and services of health ensures the user the promotion, protection and recovery of health. Access must be universal, equal and orderly starting with initial care services and is completed with the entry into the regionalized and hierarchical network, according to the complexity needed by the user, in order to ensure the completeness of health care, attending user needs⁽³⁾.

In the Unified Health System, the right of access is fundamental, since all the service happens through it. This right is implemented with user input in the system with their access to consultation with experts and complementary examinations and also in performing more complex procedures⁽⁶⁾.

Problems related to access recur in research involving primary care and receive the highest number of complaints in ombudsman services. The repressed demand for medical specialities, few places for exams and drug shortages are frequent complaints from users, corroborating the findings in this research^(4-5,7).

Situations where patients do not get specialized consultation or examination are considered negative experiences because they could not access all the technologies to meet their needs⁽⁷⁾. The overvaluation of complementary examinations by patients can

denote a reductionist view that they have of the Family Health Strategy⁽⁸⁾.

Accessibility is linked to access. The distance between the home of the patient and the site of the consultation and specialized exams, which are generally outside the Basic Health Unit, is considered a barrier to access⁽⁹⁾. Accessibility can be considered as the first purpose to provide care, and is mainly materialized by the health worker's attitude towards the user⁽⁸⁾. In the case of primary health care, it is important to highlight the role of welcoming users as a facilitator of accessing health actions and services. Welcoming done with a sensitive eye and qualified listening promotes greater user satisfaction and, consequently, decreases complaints related to service⁽¹⁰⁾.

Regarding the number of offered consultations, the Department of Primary Care of the Ministry of Health recommends that each Family Health Team must cover an area of up to 4000 people, which occurs in the researched area. What happens is that there are users requiring referral to specialist or tests that are not offered in the Basic Health Unit and few places available in the scheduling system, which slows down the service.

The Family Health Teams are supported by the Centers of Support for Family Health which offer service with specialists in paediatrics, gynecology and psychiatry. If other areas are necessary, the patient is inserted into the schedule list of the municipality, which in most cases takes a long time and generates user dissatisfaction. The same goes for the examinations where the requested procedures are not performed in the Basic Health Unit, such as colonoscopy, bone densitometry, and endoscopy, among others, so the patient goes to the waiting list in their area of the city and competes for the few vacancies with hundreds of thousands of patients in the same condition.

The long waiting time delays diagnosis. This causes psychosocial problems beyond the physical and emotional ones for patients and their families. The long road between the patient's consultation with

the general practitioner, the referral to the specialist, and conducting additional tests until the laboratory diagnosis is complete is traversed by anxiety, fear, anguish, doubt and hope⁽¹¹⁻¹²⁾.

This reality shows a weakness in the health care network and needs for strengthening the organization of the Unified Health System and the service.

Access is a right that guarantees the individual the comprehensiveness of health care. Access to professional experts when necessary, examinations and their results is mandatory so users can achieve an early diagnosis of their condition and therefore receive quick and decisive treatment.

The service to users is not limited to the physical space of the Basic Health Units. In primary health care the continued assistance extends to the home. The Ministry of Health recommends the monthly visit of a Community Health Agent in every household and of a doctor or nurse when relevant.

Home visits are seen as a means of assistance to bedridden patients and as a place for health promotion and the creation of bonds. In the Family Health Strategy, it is a tool to establish and strengthen the bond between family, community and health professionals⁽⁸⁾.

Medication is ensured to all patients, based on the right to comprehensive service/treatment. When users do not receive the prescribed drug, some choose to petition the judiciary to achieve it. The Ministry of Health's spending on drugs has undergone a significant increase. The largest share of this expenditure is of primary care medications, strategic programs such as antiretroviral drugs, and distribution of exceptional circumstance drugs which are comprised of a large number of drugs protected by patents, which greatly burdens the public treasury⁽¹³⁾.

The actions to meet the urgent and emergency situations are also factors that must be seen in a judicious manner. The Basic Health Units need to be ready to receive these cases and refer them to appropriate services.

Adequate access to health actions and

services offered by Basic Health Units reduces inappropriate use of emergency services⁽¹⁴⁾. However, the implementation of healthcare for urgency and emergency situations within the Basic Health Units is configured as a challenge for local management. Changes are needed in the current health care model, adequacy of physical infrastructure and inputs available in the Units, and also providing specific funding for these actions⁽¹⁵⁾.

The quality of health care is much more than answering a query, performing a procedure, hearing a complaint or conducting an orientation. It involves a relationship of respect, listening, empathy, interest and understanding. When addressing the human being, it is important to visualize them with all their needs, because the individual not only requires the resolution of health problems, but also of feeling welcomed and establishing a connection with the service being essential features of Primary Health Care⁽¹⁶⁾.

The quality of health services can be associated with humanization. By humanizing we understand the value of different subjects involved in the health production process, ensuring the autonomy and the role of the subjects, the responsibility between them, solidarity bonds and collective participation in health practices⁽¹⁷⁾.

Humanization provides a worthy service, being considerate and respectful to all users. Also, it is a duty to bestow the same treatment for other users and for the team to assist it. The information from these individuals must be provided clearly in both directions: users providing the complete information needed for diagnosis and treatment, and the professional guiding and clarifying the doubts of users⁽²⁾.

Humanization can also be seen as a proposal for the articulation of good use of technology, whether in the form of equipment or relational, associating the procedures and knowledge with a proposal for qualified listening, open dialogue, administration and enhancement of affects in a process with compromised

human happiness⁽⁶⁾.

When the service is provided with low quality, some users associate it with being a free service and therefore being a 'system for the poor,' the misinformation, disqualification and disinterest of some professionals are system features, injuring the principles of equity, universality and humanization⁽³⁾.

It is important to reaffirm that there are situations that are outside of the Basic Health Units capacity to solve, for example, in some reports to ombudsmen, the user does not like to have consultation with nurses, only with doctors; another complaint is to have their child seen by the family doctor because the patient would like to be attended by a pediatrician; woman who would only like to be referred to gynecologists or even pregnant woman who would only like to have prenatal consultations with an obstetrician. It is the patient's right to be served in all their needs, however, their rights and needs cannot be confused with their wishes.

These reports underline the need for humanization of assistance and strengthening of ties in Primary Health Care. This bond becomes truth from the moment that, on the one hand the user who is in need of care can trust their professional with their fragility, who in turn receives the user offering quality services. This linkage can be considered as the central axis in the process of humanization^(16,18).

The health service should also be organized to favor, a clean, protected, ventilated environment while waiting for care, with access to drinking water and adequate sanitation, guaranteeing the right of humanized and welcoming services.

A study evaluating the appropriateness of Basic Health Units to the needs of elderly and disabled considered 60% of the units evaluated as inadequate for access of this group. The existence of steps and the lack of handrails, ramps, toilets adapted for wheelchair users and inadequate waiting rooms were a constant need. Architectural barriers hindered access to health services⁽¹⁹⁾.

It is noticeable, however, that the Unified

Health System, over time, has achieved a remarkable coverage in relation to access. However, it is still not enough to ensure access to the public health system. It is necessary to strengthen political awareness so that users become more than mere recipients of government proposals. The more the planning of this system is flexible and integrated with the population, the greater the guarantee of quality and comprehensive health service. It is noteworthy, therefore, the importance of consolidating the Health Councils⁽²⁰⁾ and the existence of feedback tools for the population, such as ombudsman services.

Conclusion

The most requested rights by users of the Family Health Program administered by the São Paulo Adventist University Center refer to access to goods and services of health, which shows a weakness in the system and in the network service organization. The claims made by the ombudsman service help identify problems, showing where to dispense more accurate attention.

The quality and the humanization of health services are also among the rights most requested by users, pointing to a gap in professional practice.

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Collaborations

Martins MS contributed to the design and writing of the project, analysis of results and article revision. Goese PB and Barrionovo MM contributed to the collection, data analysis and article writing. Massarollo MCKB contributed to the conception, article revision and final version approved for publishing.

References

1. Brasil. Constituição da República Federativa do Brasil, 1988. Brasília: Senado; 1988.
2. Secretaria do Estado de São Paulo. Lei estadual nº 10.241, de 17 de março de 1999. Dispõe sobre os direitos dos usuários dos serviços e das ações de saúde no Estado e dá outras providências. São Paulo: Secretaria do Estado de São Paulo; 1999.
3. Bakes DS, Koerich MS, Rodrigues ACRL, Drago LC, Klock P, Erdmann AL. O que os usuários pensam e falam do Sistema Único de Saúde? Uma análise dos significados à luz da carta dos direitos dos usuários. *Cienc Saude Coletiva*. 2009; 14(3):903-10.
4. Nardo LRO, Juliani CMCM. Ombudsman: evaluating the access to health services. *Rev Rene*. 2012; 13(3):613-22.
5. Silva RCC, Pedroso MC, Zucchi P. Ombudsmen in health care: case study of a municipal health ombudsman. *Rev Saude Publica*. 2014; 48(1):134-41.
6. Falk MLR, Falk JW, Oliveira FA, Motta MS. Acolhimento como dispositivo de humanização: percepção do usuário e do trabalhador em saúde. *Rev APS*. 2010; 13(1):4-9.
7. Assis LCF, Veríssimo MLÓR. Expectativas e necessidades de acompanhantes de criança na consulta de saúde. *Rev Bras Cresc Desenv Hum*. 2010; 20(2):317-29.
8. Nery AA, Carvalho CGR, Santos FPA, Nascimento MS, Rodrigues VP. Saúde da Família: visão dos usuários. *Rev Enferm UERJ*. 2011; 19(3):397-402.
9. Corrêa ACP, Ferreira F, Cruz GSP, Pedrosa ICF. Acesso a serviços de saúde: olhar de usuários de uma unidade de saúde da família. *Rev Gaúcha Enferm*. 2011; 32(3):451-7.
10. Nascimento PTA, Pekelman R. Acesso e acolhimento: "ruídos" e escutas nos encontros entre trabalhadores e usuários de uma unidade de saúde. *Rev APS*. 2012; 15(4):380-94.
11. Pimentel AV, Panobianco MS, Almeida AMA, Oliveira ISB. A Percepção da vulnerabilidade entre mulheres com diagnóstico avançado de câncer do colo do útero. *Texto Contexto Enferm*. 2011; 20(2):255-62.

12. Salimena AMO, Oliveira MTL, Paiva ACPC, Melo MCSC. Mulheres portadoras de câncer de colo de útero: percepção da assistência de enfermagem. *Rev Enferm Cent-Oest Min*. 2014; 4(1):909-20.
13. Vieira FS. Gasto do Ministério da Saúde com medicamentos: tendência dos programas de 2002 a 2007. *Rev Saude Publica*. 2009; 43(4):674-81.
14. Carret MLV, Fassa AG, Domingues MR. Prevalência e fatores associados ao uso inadequado do serviço de emergência: uma revisão sistemática da literatura. *Cad Saude Publica*. 2009; 25(1):7-28.
15. Soares SS, Lima LD, Castro ALB. O papel da atenção básica no atendimento às urgências: um olhar sobre as políticas. *J Manag Prim Health Care*. 2014; 5(2):170-7.
16. Medeiros FA, Araujo-Souza GC, Albuquerque-Barbosa AA, Clara-Costa IC. Acolhimento em uma Unidade Básica de Saúde: a satisfação do usuário em foco. *Rev Salud Publica*. 2010; 12(3):402-13.
17. Nora CRD, Junges JR. Política de humanização na atenção básica: revisão sistemática. *Rev Saúde Pública*. 2013; 47(6):1186-200.
18. Monteiro MM, Figueiredo VP, Machado MFAS. Bonding to implement the family health program at a basic health unit. *Rev Esc Enferm USP*. 2009; 43(2):358-64.
19. Siqueira FCVI, Facchini LA, Silveira DS, Piccini RX, Thumé E, Tomasi E. Barreiras arquitetônicas a idosos e portadores de deficiência física: um estudo epidemiológico da estrutura física das unidades básicas de saúde em sete estados do Brasil. *Ciênc Saúde Coletiva*. 2009; 14(1):39-44.
20. Cotta RMM, Martins PC, Batista RS, Franceschini SCC, Priore SE, Mendes FF. O controle social em cena: refletindo sobre a participação popular no contexto dos Conselhos de Saúde. *Physis*. 2011; 21(3):1121-38.