(Dis)Satisfaction of users: duplication and simulataneous use of services in family health

(IN)SATISFAÇÃO DOS USUÁRIOS: DUPLICAÇÃO E USO SIMULTÂNEO NA UTILIZAÇÃO DE SERVIÇOS NA SAÚDE DA FAMÍLIA

(IN)SATISFACCIÓN DE LOS USUARIOS: DUPLICACIÓN Y USO SIMULTÁNEO EN LA UTILIZACIÓN DE SERVICIOS EN LA SALUD DE LA FAMILIA

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ABSTRACT

This descriptive and exploratory study was performed with the purpose to identify the pattern of use of health services: duplication and simultaneous use in a District Reference Unit (URD, acronym in Portuguese) and four Family Health Units (USF, acronym in Portuguese). Secondary data were collected in two stages: the first stage involved identifying the Service Files of the District Reference Unit for 15 days of the month of June 2006; and the second stage involved verifying 856 services delivered among the selected USF to users who were seen at the URD. It was found that there was duplication in the use of health services corresponding to 0.35% of the users seen at the group of services, as well as simultaneous use, corresponding to 3.27% of users. The duplication of health service use is considered to be an indirect indicator for the analysis of user satisfaction, i.e., service use duplication may be understood as an expression of user dissatisfaction.

KEY WORDS

Family health.
Primary health care.
Consumer satisfaction.
Basic Health Services.

RESUMO

Estudo descritivo-exploratório, visando identificar padrão de utilização de serviços de saúde: duplicação e uso simultâneo em uma Unidade de Referência Distrital (URD)e quatro Unidades de Saúde da Família (USF). Os dados secundários foram coleta-dos em duas etapas: na primeira etapa, foram identificadas as Fichas de Atendimento da Unidade de Referência Distrital, referentes a 15 dias do mês de junho de 2006; na segunda etapa, verificou-se 856 atendimentos, distribuídos entre as USF selecionadas, de usuários que utilizaram a URD. Identificou-se a ocorrência de duplicação na utilização dos serviços de saúde que correspondeu a 0,35% dos usuários atendidos no conjunto dos serviços, e o uso simultâneo, correspondendo a 3,27% dos usuários. A duplicação da utilização de serviços de saúde é considerada indicador indireto para a análise da satisfação do usuário, ou seja, a análise da duplicação da utilização dos serviços pode ser analisada como expressão da insatisfação dos usuários.

DESCRITORES

Saúde da família.
Atenção primária à saúde.
Satisfação dos consumidores.
Serviços Básicos de Saúde.

RESUMEN

Estudio descriptivo exploratorio, apuntando a identificar el patrón de utilización de servicios de salud: duplicación y uso simultáneo en una Unidad de Referencia Distrital (URD) y cuatro Unidades de Salud de la Familia (USF). Los datos secundarios fueron recolectados en dos etapas: en la primera, fueron identificadas las Fichas de Atención de la Unidad de Referencia Distrital, referente a 15 días del mes de junio de 2006; en la segunda, se verificaron 856atenciones distribuidas entre las USF seleccionadas, de usuarios que hicieron uso de la URD. Se identificó la duplicación de la utilización de los servicios de salud, que correspondió al 0,35% de los usuarios atendidos en el conjunto de los servicios, y el uso simultáneo, correspondiendo al 3,27% de los usuarios. La duplicación de la utilización de servicios de salud es considerada un indicador indirecto para el análisis de la satisfacción de los usuarios; es decir, el análisis de la duplicación de la utilización de los servicios puede ser analizado como expresión de la insatisfacción de los usuarios.

DESCRIPTORES

Salud de la familia.
Atención primaria de salud.
Satisfacción de los consumidores.
Servicios Básicos de Salud.

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INTRODUCTION

The Family Health Strategy (FHS), adopted by the Ministry of Health to re-structure health care, was implemented in Brazil in1994 in order to enable changes in the rationale of the current care model focused on the biomedical and curative aspect of care, and individualized and fragmented actions, as well as on the work organization for care while considering the health-disease continuum in its diverse determinations[1].

The family is the core unit of action of the FHS, which seeks to integrate itself with the community in which it is inserted and actively searches for cases to implement early and timely interventions, emphasizing prevention and health education but also performing actions to maintain and recover users' health[2].

Even though some question its power to achieve such a purpose, the FHS is certainly an extremely important strategy for the re-organization of primary health care in Brazil, in order to comply with the Single Health System (SUS) precepts[3-5]. From this perspective, there is a need within the process of the (re)organization of health services to establish work tools appropriate to the context of the FHS work process according to its premises, taking into account not only individual care but also including actions that promote and maintain health, and developing these actions in different contexts: health units, at home, social devices, and community[1].

The development of actions to organize the work process, monitor actions and evaluate care delivery[6] is essential to infer whether objectives are being met, highlighting positive and negative aspects so that constant transformation and improvement are possible.

The term *evaluation* refers to the act of evaluating, that is, to ascertaining or fixing a value, appraising something. The evaluation of services or programs within the field of social intervention refers to the systematic use grounded on a scientific basis to identify, obtain, and provide relevant information as well as to appraise the merit and value of something in a justifiable manner[7-8].

An evaluation consists of judging and estimating the value of an intervention or any of its components in order to facilitate decision-making. It is therefore an integrating and necessary part of the planning and decision-making process, can contribute to directing or re-directing actions, activities, programs and therefore should be exercised by all those involved in the planning and implementation of such actions[9].

In line with the preceding discussion, one of the evaluation methods to be considered is the evaluation of user satisfaction. Users are the direct beneficiaries of health actions and the importance of consulting this community is undeniable, since it has been a participant (passive, for the most part) of all changes precipitated by the FHS.

Satisfaction expressed by users is usually viewed with indifference or even suspicion in the health field, since studies addressing this topic

> would be insufficient to evaluate the quality of services and programs […], would not consider the users' perceptions and expectations since the richness and complexity of perceptions and expectations cannot be reduced to mere expressions of satisfaction […][8],

however this is an opportunity to indirectly give voice to users participating in the health system. Even though there are restrictions in relation to the use of studies addressing user satisfaction, they are essential in order to measure quality of care and can provide cues as to whether health services are being successful in meeting the users' expectations and can be an important tool to investigate, administrate and plan health services[8]. On the other hand, the existence of other indirect indicators might be considered to analyze user satisfaction, and one of these indicators is the analysis of the duplicate use of services as an expression of user dissatisfaction.

The evaluation of services or programs within the field of social intervention refers to the systematic use grounded on a scientific basis to identify, obtain, and provide relevant information as well as to appraise the merit and value of something in a justifiable manner[7-8].

The pattern of health service use is an important characteristic. In practice,

> several patterns of use constitute the ultimate expression of the search for medical care experienced by patients in the face of a health problem[10].
>
> Patients dissatisfied with the quality of care can generate inefficient patterns of use, with multiple providers and different types of articulation between them[10],

so that dissatisfaction with the quality of care received has its origin in the way users perceive care delivery.

Some aspects should be considered when determining the profile of health services use. The type of service sought is significant, chosen within a set of services that includes: basic health units, urgent care centers, emergency departments, outpatient units or specialized clinics and public and private hospitals, depending on proximity and access, which itself includes social and cultural values associated with consumption. Additionally, the reasons for and frequency of use, timely or late search, preventive, care, laboratorial, or therapeutic procedures are important aspects to be taken into account[2].

The literature associates the intensity and the way services are used with the individuals' quality of life and knowledge concerning health and the health service network. The ability of individuals to self-evaluate their health state and their care expectations and needs, self-care practices, existence of alternative networks and their relative degrees of autonomy combine to determine their pattern of use[11].

Distinct standards of health services use are identified in the routine of primary care service: users search for a health service close to their homes or workplaces; users go directly to an Emergency Department (ED), which should be used more specifically for urgent situations or emergencies, or for cases referred by health units due to the complexity of a user's problems; simultaneous use of health services in a Basic Care unit and an ED as a way to confirm the diagnosis or the therapy proposed by the health service where the user was initially cared for; use of several health services in the network (basic care unit, urgent care center, ED) in the same day or week for the same health problem.

Duplication of services is defined as care provided more

> than two times to the same patient by a health service other than the one previously used; providing care with the purpose of diagnosis, treatment and/or rehabilitation of the same episode of illness[10].

There are few studies addressing duplication of services, which

> is due to the lack of knowledge we have about this issue, as well as the characteristics and situations experienced by patients, providers and related services[10].

Based on the previous discussion, this study analyzes the use of health services of a Health District in Ribeirão Preto, São Paulo, Brazil (Family Health Unit (FHU) and urgent care center of a District Unit (DU), identifying duplication and simultaneous use of primary health care services within the FHS as being the expressions of users' dissatisfaction.

METHOD

This is an exploratory-descriptive study. Studies of this nature allow the researcher to increase his/her experience with a given problem, describing and analyzing factors and phenomena of a given situation[12]; in this study, the simultaneous and duplicate use of health services in primary health care.

The study was approved by the Research Ethics Committee at the University of São Paulo at Ribeirão Preto, Medical School's Health Center (HCS-FMRP-USP) according to protocol nº 271/CSE-FMRP-USP and complied with the guidelines provided by the National Research Ethics Commission (CONEP), Resolution CNS 196/96 and Chapter IV of Resolution 251/97, ensuring confidentiality of the study's participants.

The field of study was the city of Ribeirão Preto, SP, Brazil with an estimated population of 504,923 inhabitants according to the 2000 Demographic Census. The study setting was the West Health District that included 13 FHS teams in 2007, four of which are linked to the University of São Paulo (USP). These four FHUs have a peculiar characteristic in relation to the remaining since they are located within the scope area of the DU (the Health Center School at FMRP-USP), headquarters of specialized care and 24-hour urgent care for the set of health units of the West Health District . The four FHUs linked to the DU of the CSE-FMRP-USP are the study's units of analysis. They have been in operation since April 2001 when they were empowered by the Ministry of Health. They are located in the DU's scope area and are responsible for delivering health care to about 3,600 families and present defined areas registered in the Primary Care Information System (SIAB).

Secondary data originated from a database composed of Medical Consultation Forms (MCF) regarding consultations rendered in the urgent care center in the DU of the CSE-FMRP-USP and medical files of users cared for in the urgent care center but who belong to the scope areas of the studied FHU. This database was composed in 2006 based on 14,245 consultations (medical and nursing consultations) conducted in June 2006 in the DU urgent care center care. It refers to visits of users originating from health units from the DU scope area. A specific database for the four studied FHUs was developed for this study.

The 14,245 consultation records were separated according to the users' addresses based on the definition of regional areas of use adopted by the health services in Ribeirão Preto. Records related to the four FHUs scope areas were identified. The database was then structured with records related to 15 days of consultations (the 1st and the 3rd weeks of June 2006). This period of time was chosen aiming to select typical periods in the month, that is, periods in which there were no intercurrences that would indicate an anomalous pattern of use of health services (e.g. World Cup soccer games, health services stoppage). Then, data related to the users' names, addresses, times they entered urgent care, motives for seeking the service, diagnoses, proposed therapeutic actions, condition in which the users left the service (deceased, hospitalized, referred to diagnostic support service, referred to the unit of origin). Based on these data the users from the scope areas of the FHUs selected for this study were identified.

In the second phase, users were identified by FHU and the medical records of the selected FHUs were analyzed. We identified in the FHU of origin the day of consultation, motive for seeking the service (spontaneous visit or, scheduled visit for follow-up), and proposed therapeutic action for July 2006. The search for the medical records aimed to identify whether users visited two health units more than once for the same problem (e.g. FHU and DU's urgent care center), which characterizes simultaneous use; and whether the user visited two health units for the same problem more than twice, which indicates duplicate use of the studied health services.

Data from the MCF and the medical records of the selected units were described and systematized in spreadsheets and included in an Excel 2003 database, enabling characterizing the data. Data were then grouped and processed using simple descriptive statistics and the results were presented in tables.

Two specific situations were observed:

1. The same user visited the DU's urgent care more than twice for the same problem or for different problems during the period of 15 days in June 2006. When data were cross-referenced, two or more visits for the same problem were identified. Once these users were identified, their medical records in the FHU of origin in June were analyzed in order to identify the day of the last visit, motive of the visit (spontaneous visit to the FHU or scheduled for follow-up), and therapeutic action proposed for the problem presented. This search aimed to identify whether the user visited two health units (FHU and DU's urgent care center) more than twice for the same problem.

2. Simultaneous use of two health services was identified when medical records in the unit of origin were cross-referenced with those in the DU's urgent care center. The same user identified as belonging to the FHU scope area visited the FHU and the DU's urgent care on the same day or same week for the same health problem.

RESULTS AND DISCUSSION

The medical and nursing consultations in the DU's urgent care center concerning June 2006 totaled 14,245 MCF. The consultations in the DU's urgent care center and registered in the MCF refer to medical and nursing consultations provided to users who spontaneously visited the sector, users referred by health units from the DU's scope area, or brought by the city's Mobile Emergency Medical Care Unit (SAMU).

Table 1 presents the distribution of visits and users by number and percentage of residents in the four FHU scope areas cared for in the DU's urgent care center: 566 users who visited the DU's urgent care center corresponded to 856 consultations, 58.3% of which were medical and 41.7% were nursing consultations.

A total of 206 users belonged to the FHU 1 scope area and required 335 consultations in urgent care: 56.7% medical and 43.2% nursing consultations. Of these 206 users, 102 (49.5%) were men and 103 (50.0%) were women, while the gender of one newborn (0.5%) was not recorded in the MCF. It is worth highlighting that MCFs usually present incomplete records, not only regarding identification data but also other important and necessary data for planning services and organizing users' care, e.g. the diagnosis generated given the reason the user sought the health service.

Table 1 - Numerical and percentage distribution of users cared for in the DU's urgent care center according to medical and nursing consultations and FHU of origin- Ribeirão Preto, Brazil - 2008

Health Unit	Users	Medical Consultations		Nursing Consultations		Total of Consultations	
		N	%	N	%	N	%
FHU 1	206	190	56.7	145	43.2	335	100
FHU 2	107	92	55.8	75	44.2	167	100
FHU 3	147	129	65.5	68	34.5	197	100
FHU 4	106	88	56.0	69	44.0	157	100
TOTAL	566	499	58.3	357	41.7	856	100

Users belonging to FHU 2's scope area totaled 167 consultations that corresponded to 107 users: 92 (55.8%) were medical consultations and 75 (44.2%) were nursing consultations. Of the 107 users, 46 (43%) were male and 61 (57%) were female. A total of 197 consultations were identified in FHU 3, which correspond to 147 users: 129 (65.5%) medical consultations and 68 (34.5%) nursing consultations. Of these, 68 were male (46.2%) and 79 (53.8%) were female. In FHU 4, 106 users where identified, who required 157 consultations, of which 88 (56%) were medical and 69 (44%) were nursing consultations. Of these, 39.6 % were male and 60.4 % were female.

A predominance of women among FHU users cared for in the DU's urgent care center was identified, which is in agreement with other studies that indicate a higher use of health services by women. Women of fertile age visit the health services more, suggesting gynecological and obstetrical motives. Another likely motive is that women perceive potential risks to health more easily than men since they have more access to health information[13-14].

In relation to the number of medical and nursing consultations provided in urgent care , FHU 1 stands out with the highest number of medical and nursing consultations, while medical consultations totaled 38.1%. This fact reveals the current culture of our society in which health care is greatly focused on the disease and on the figure of the physician. It seems that nursing actions in health care have not been sufficiently potent to trigger changes in this context. Even though a study carried out in basic care units in Porto Alegre, RS, Brazil evidenced that there are places where nursing provides effective care, well-articulated with other professionals, there is still much to be done so that preventive actions and collective activities occur in these services, since nurses still maintain care delivery restricted to individual care given the high demand of users[15].

Table 2 presents the distribution of FHU users who used urgent care according to age groups. Analyzing the general demand of users of the four FHU for the DU's urgent care center we observe that 32% are children and adoles-

cents, that is, a population between zero and 15 years of age. If this group is totaled for those between 15 and 20 years of age, it reaches 36.4%, while adults up to 60 years of age accounts for 55.2% of the demand, while 46.6% are of adults are in the productive age group (20 to 50 years of age).

Table 2 - Numerical and percentage distribution of users cared for in the DU's urgent care according to age group and FHU of origin- Ribeirão Preto, Brazil - 2008

Unit of Origin	FHU 1		FHU 2		FHU 3		FHU 4		TOTAL	
Age group	N	%	N	%	N	%	N	%	N	%
0 |– 1	6	2.9	5	4.7	10	6.8	6	5.7	27	4.8
1 |– 5	18	8.7	7	6.5	25	17.0	11	10.4	61	10.8
5 |– 10	11	5.3	14	13.1	16	10.9	15	14.2	56	9.9
10 |– 15	14	6.8	10	9.3	6	4.1	7	6.6	37	6.5
15 |– 20	12	5.8	5	4.7	8	5.4	11	10.4	36	6.4
20 |– 30	37	18.0	18	16.8	23	15.6	18	17	96	17.0
30 |– 40	21	10.2	11	10.3	17	11.6	7	6.6	56	9.9
40 |– 50	23	11.2	12	11.2	18	12.2	11	10.4	64	11.3
50 |– 60	20	9.7	3	2.8	18	12.2	7	6.6	48	8.5
> 60	44	21.4	21	19.6	5	3.4	13	12.3	83	14.7
No information	-	-	1	0.9	1	0.7	-	-	2	0.4
TOTAL	206	36.4	107	18.9	147	26.0	106	18.7	566	100

The highest percentage of users older than 60 years are among those from FHU 1 and 2 and represents 21.4% and in 19.6%, respectively. It is worth noting that the population from the scope area of these two units is older. FHU 3 and FHU 4 have an age distribution concentrating a younger population mainly composed of children, adolescents and younger adults in their scope areas.

When we observe the distribution of users specific for each FHU that demanded the DU's urgent care center, we verify that users from FHU 1 between zero and 15 years of age represent 23.7%, the smallest percentage of the four FHUs. The demand of users in this same age range in FHU 3 represents 38.8%. In general, the demand is composed of adults between 20 and 60 years of age for the four FHU: 49.1%, 41.1%, 51.6% and 40.6% for the USF 1, 2, 3 and 4, respectively.

The age group between 20 and 30 years of age is the most prevalent in FHU 1 and FHU 4: 18% for USF 1 and 17% for FHU 4. FHU 3 has the highest concentration of users who needed the DU's urgent care center, mainly users between one and five years of age (17%), followed by users between 20 and 30 years of age (15.6%).

The nursing consultations recorded in the MCF are all considered procedures of therapeutic support performed by the nursing team (auxiliaries, technicians and nurses). As presented in Table 1, the nursing consultations in urgent care corresponded to 357 consultations, that is, 41.7% of all consultations in this sector were provided to users from the selected FHUs' scope areas.

Table 3 shows the numerical and percentage distribution of nursing and medical consultations provided to users from FHU 1, FHU 2, FHU 3 and FHU 4 according to time and number of consultations performed in the DU's urgent care center. Nursing consultations more frequently occur between 7:01am to 12pm (20.1%, 8.4%, 7.5% and 7.5%, respectively, the FHUs 1, 2, 3 and 4) while 59.1% of the nursing consultations provided in the urgent care center occurred during the FHU working hours.

Additionally, 40.6% of the identified consultations are provided to users from FHU 1. It is important to note that none of the FHUs selected for this study perform nursing procedures (e.g. inhalation therapy, dressings, administration of routine medication), which certainly requires users cared for in the FHU to go to the DU, especially to administer treatment. This situation indicates that the principle of integrality[a] of care is not being met, which might generate dissatisfaction among users[7,14]. A study addressing user satisfaction was carried out in these same FHUs and observed that

[a] T.N. Integrality refers to the idea that individuals are historical, social and political subjects and should be considered as a whole during the care delivery process. It also assumes that health care actions should be combined and focused on health promotion, prevention and healing at the health system different care levels.

the non-administration of medication and procedures (exams' collection, dressings, aerosol, vaccines, simple suture excision, removal of stitches, among others), which harms longitudinally and continuity of care, stood out as the main reason for user dissatisfaction[7,16].

Table 3 - Numerical and percentage distribution of nursing and medical consultations provided to users from FHU 1, FHU 2, FHU 3, and FHU 4 according to time and number of consultations in the Ribeirão Preto, Brazil - 2008

Working hours	NURSING AND MEDICAL CONSULTATIONS																			
	FHU 1				FHU 2				FHU 3				FHU 4				TOTAL			
	E	%	M	%	E	%	M	%	E	%	M	%	E	%	M	%	E	%	M	%
7:01 - 12:00	72	20.1	74	14.8	30	8.4	28	5.6	27	7.5	32	6.4	27	7.5	24	4.8	156	43.7	158	31.7
12:01pm - 1pm	4	1.1	6	1.2	4	1.1	9	1.8	7	1.9	4	0.8	4	1.1	5	1.0	19	5.3	24	4.8
1:01pm - 5pm	16	4.4	37	7.4	18	5.0	20	4.0	8	2.2	29	5.8	13	3.6	22	4.4	55	15.4	108	21.6
5:01pm - 10pm	46	12.8	49	9.8	20	5.6	22	4.4	23	6.4	47	9.4	25	7.0	26	5.2	114	31.9	144	28.9
10:01pm - 7am	7	1.9	24	4.8	3	0.8	11	2.2	3	0.8	17	3.4	0	0	10	2.0	13	3.6	62	12.4
No information	0	0	0	0	0	0	2	0.4	0	0	0	0	0	0	1	0.2	0	0	3	0.6
TOTAL	145	40.6	190	38.4	75	21.0	92	18.4	68	18.2	129	25.9	69	19.0	88	17.4	357	100	499	100

In relation to medical consultations provided to the users from the selected FHUs, we verified that FHU 1 presents the highest percentage of medical consultations provided in the DU's urgent service, corresponding to 38.1%, followed by FHU 3 with 25.9%, FHU 2 with 18.4% and FHU 4 with 17.4%. The times with the highest number of visits of users from the selected FHUs to the DU's urgent care center are those in which FHUs were not working (12:01 pm to 1pm, 5pm to 5am) and correspond to 46.1% of consultations, contrary to what was observed for the nursing consultations.

According to the medical consultations provided to users from each of the FHUs, the period between 7:01am to 12pm has the greatest demand among users of FHU 1 and FHU 2 with 14.8% and 5.6%, respectively.

The time most in demand in FHU 3 and FHU 4 is the period between 5:01pm and 10pm with 9.4% and 5.2%, respectively, indicating there is a higher demand after FHU are closed. It is also important to stress that similar to the case of nursing consultations, users from FHU 1 were also those who most needed the DU's urgent care center, 38.4% of the consultations.

When the set of consultations provided in the DU's urgent care center is considered, we observe that 136 (38.8%) out of the 335 consultations provided to users from the FHU occurred outside of the FHU's working hours; the smallest percentage among the four FHUs. For the remaining FHUs 2, 3 and 4, 41.3%, 51.3% and 44.6% of the consultations were provided out the FHU working hours. However, we can state that the great part of the consultations still occur during weekdays within the FHUs' working hours.

According to Table 4, the highest number of medical consultations in the DU's urgent care center were provided to users from FHU 1 followed by FHUs 3, 2 and 4, respectively with 25.9%, 18.4% and 17.4%.

Table 4 - Numerical and percentage distribution of users cared for in the DU's urgent care center, their situation in relation to the FHU of origin and type of care received by users according to the FHU of origin Ribeirão Preto, Brazil - 2008

Health Unit	FHU 1		FHU 2		FHU 3		FHU 4		
Situation of users in the FHU and consultations	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**TOTAL**
Users	206	36.4	107	18.9	147	26.0	106	18.7	566
Address out of the FHU scope area	10	4.8	14	13.1	8	5.4	0	0	32
No registration in the FHU	111	53.9	43	40.2	49	33.3	24	22.6	227
No visits to the FHU within the month	40	19.4	29	27.1	26	17.7	39	36.8	134
Moved to another scope area	23	11.1	7	6.5	13	8.8	13	12.3	56
Deceased residents in the FHU scope area	1	0.5	0	0	0	0	1	0.9	2
Total Consultations	335	39.1	167	19.5	197	23.0	157	18.3	856
Medical Consultations	190	38.1	92	18.4	129	25.9	88	17.4	499
Nursing Consultations	145	40.6	75	21.0	68	18.2	69	19.0	357
Consultations for different reasons	7	2.1	3	1.8	8	4.1	5	5.7	23
Simultaneous use (Users)	8	3.9	5	4.7	4	2.7	11	10.4	28
Duplications (Users)	2	0.97	0	0	0	0	1	0.94	3

In regard to users registered in the FHUs, the unit with the highest number of users cared for in the DU's urgent care center without registration is FHU 1, with53.9% of users who did not have a family registration in the FHU, followed by FHU 2 with 40.2%. We highlight that family registration is important in the FHS because it is what triggers the process of follow-up with families, which in turn permits determining a diagnosis of the community's health, establishing health needs and problems that will be the focus of interventions[17]. The large number of non-registered users suggests that they might have problems accessing the services, which harms the implementation of the principles of continuity, longitudinally and integrality of care[7,14,16].

To compute simultaneous and duplicate use of health services we consider, in addition to the set of users cared for in the DU's urgent care center, the number of users in each FHU who belonged to the selected FHUs, users' registration in the FHU, the users who moved from areas receiving health care in other health units, and also deceased users. Hence we identified duplication in the use of health services for 0.35% of all users cared for in the DU's urgent care center and that originated from the set of services and simultaneous use of 3.27% of users.

When the FHU are considered in isolation, duplication of services is identified in FHU 1 (0.97%) and FHU 4 (0.94%) with no cases identified in FHUs 2 and 3. Simultaneous use was identified in FHU 4, which presents the highest percentage; 10.4% of its users are in simultaneous use, followed by FHU 2 (4.7%), FHU 1 (3.9%) and FHU 3 (2.7%).

CONCLUSION

As previously discussed, studies addressing users' expressed satisfaction are criticized because they are considered insufficient to evaluate the quality of services and programs. However, one cannot disregard the possibility of giving a voice to users, permitting them to express their opinions concerning the production of actions and services provided by the health system.

One possibility is to use indicators to evaluate user satisfaction through the concept of duplication of health services. Duplication is considered an indirect indicator of user satisfaction, that is, the duplication of services use can be seen as an expression of user dissatisfaction.

Duplication and simultaneous use of health services were identified in this study considering health services structured according to the Family Health Strategy, which has an agenda of deepening analysis of aspects such as the large number of non-registered users with a limited possibility of follow-up as a consequence. Additionally, there is a significant number of users who occasionally directly access the services, such as the DU's urgent care center, not concerned with longitudinally and coordination of care, which are striking characteristics of primary health care and which might indicate a lack of bond between these users and the FHUs.

Finally, we stress the relevance of identifying simultaneous and duplicate use of health services since it allows further analysis of the reasons they occur, enabling health services to dimension care delivery, seeking to improve its quality and better use available resources.

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