

Access to Medicines Among Users With Chronic Diseases in Primary Care

Acesso a Medicamentos Entre Usuários com Doenças Crônicas na Atenção Primária

Acceso a Medicamentos Entre Usuarios con Enfermedades Crónicas en Atención Primaria

RESUMO

Objetivo: Estimar prevalência do acesso a medicamentos entre usuários com DCNT da Atenção Primária à Saúde em Salvador, Bahia, Brasil e fatores associados. **Métodos:** Estudo transversal realizado com adultos maiores de 18 anos com DCNT, realizado entre 2019 e 2020. Analisaram-se associações entre acesso aos medicamentos com fatores demográficos, socioeconômicos, perfil de saúde, hábitos de vida e acessibilidade geográfica, mediante regressão logística hierárquica. **Resultados:** Dos 283 entrevistados, 190 (67,1%) referiram ter acesso a medicamentos. Idade maior ou igual a 60 anos (OR=0,33; IC95%: 0,14 – 0,75) se mostrou como protetor, diferentemente de viver sem companheiro (OR=2,13; IC95%: 1,16 – 3,91) e ter dificuldade para chegar às unidades de saúde (OR=2,64; IC95%: 1,26 – 5,54) dificultaram o acesso aos medicamentos. **Conclusão:** Acesso a medicamentos foi considerado intermediário. Usuários sem companheiros e com dificuldade para chegar à APS têm mais dificuldade de acesso a medicamentos, diferentemente daqueles com idade igual ou superior a 60 anos.

DESCRIPTORIOS: Estudo Transversal; Inquéritos Epidemiológicos; Acesso a Medicamentos; Doenças Crônicas Não Transmissíveis; Farmacoepidemiologia.

ABSTRACT

Objective: To estimate the prevalence of access to medicines among users with NCDs in Primary Health Care in Salvador, Bahia, Brazil, and associated factors. **Methods:** Cross-sectional study conducted with adults over 18 years of age with NCDs, conducted between 2019 and 2020. Associations between access to medicines and demographic and socioeconomic factors, health profile, lifestyle habits, and geographic accessibility were analyzed using hierarchical logistic regression. **Results:** Of the 283 interviewees, 190 (67.1%) reported having access to medicines. Age greater than or equal to 60 years (OR=0.33; 95%CI: 0.14–0.75) was shown to be protective, unlike living without a partner (OR=2.13; 95%CI: 1.16–3.91) and having difficulty reaching health units (OR=2.64; 95%CI: 1.26–5.54) that hindered access to medications. **Conclusion:** Access to medications was considered intermediate. Users without partners and with difficulty reaching PHC have more difficulty accessing medications, unlike those aged 60 years or older.

DESCRIPTORS: Cross-Sectional Study; Epidemiological Surveys; Access to Medications; Chronic Noncommunicable Diseases; Pharmacoepidemiology.

RESUMEN

Objetivo: Estimar la prevalencia del acceso a medicamentos entre usuarios con ENT en Atención Primaria de Salud en Salvador, Bahía, Brasil y factores asociados. **Métodos:** Estudio transversal realizado con adultos mayores de 18 años con ENT, realizado entre 2019 y 2020. Se analizaron asociaciones entre el acceso a medicamentos y factores demográficos, socioeconómicos, perfil de salud, hábitos de vida y accesibilidad geográfica, mediante logística jerárquica. **Resultados:** De los 283 entrevistados, 190 (67,1%) informaron tener acceso a medicamentos. La edad mayor o igual a 60 años (OR=0,33; CI 95%: 0,14 – 0,75) resultó protectora, a diferencia de vivir sin pareja (OR=2,13; CI 95%: 1,16 – 3,91) y tener dificultades para alcanzar unidades de salud (OR=2,64; CI 95%: 1,26 – 5,54) dificultaron el acceso a los medicamentos. **Conclusión:** El acceso a los medicamentos se consideró intermedio. Los usuarios sin pareja y que tienen dificultades para acceder a la APS tienen más dificultades para acceder a los medicamentos, a diferencia de los de 60 años o más.

DESCRIPTORIOS: Estudio transversal; Encuestas Epidemiológicas; Acceso a Medicamentos; Enfermedades Crónicas No Transmisibles; Farmacoepidemiología.

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INTRODUCTION

Chronic non-communicable diseases (NCDs) account for 7 of the world's top 10 causes of death and include heart disease, stroke, cancer, diabetes and chronic lung disease, which account for 74% of deaths worldwide. ⁽¹⁾ Accordingly, in Brazil, these diseases were involved in around 54.7% of deaths in the same year. ⁽²⁾ The aging of the population, underdiagnosis and undertreatment are factors that contribute to the increased prevalence of these diseases. ⁽³⁾ Early diagnosis and ensuring access to medicines are considered one of the main strategies for combating NCDs and their provision through public policies is often the only alternative for access. ⁽⁴⁾

In Brazil, the Unified Health System (SUS) ensures the financing of

medicines for the treatment of people with NCDs, mainly through the Basic Component of Pharmaceutical Assistance (BCPA), inserted in the PHC care network. Access to these medicines is made possible through basic pharmacies, inserted in the Basic Health Units (UBS) of Primary Health Care (PHC) ⁽⁵⁾, or through the Farmácia Popular Program, through partnerships with private pharmacies and drugstores. ⁽⁶⁾

Access to medicines is still severely compromised by the low availability of medicines in health units, suggesting that this does not occur in a universal, equitable and effective manner for the population and continues to be a challenge for the SUS. ⁽⁷⁾ The lack of this technology affects user outcomes and the healthcare system, such as increased economic burdens, interference in care and dissatisfac-

tion. ⁽⁸⁻⁹⁾ Therefore, data on access to medicines are important tools for characterizing the health system and supporting policies and actions aimed at expanding it. ⁽¹⁰⁻¹²⁾ Given the lack of information on this topic in the PHC of the population of Salvador, Bahia, the objective of this study was to estimate the prevalence of access to medicines among PHC users with Chronic Noncommunicable Diseases (NCDs) in Salvador, Bahia, and the associated factors.

METHOD

This is a cross-sectional study conducted with users of PHC services in the city of Salvador, Bahia. The inclusion criteria were self-reported diagnosis of NCD, being 18 years of age or older, and being in the health units on the days of data

collection to purchase medication or seek care for themselves. Those who did not agree to sign the Free and Informed Consent Form and those who were unable to respond to the research instrument due to cognitive limitations were excluded.

The sampling included different selection criteria for health units (HU) selected from a list of PHC HUs, such as UBS, Health Centers (CS), and Family Health Units (USF) with dispensing pharmacies in the 12 HDs of Salvador, Bahia. Based on the identification of the total number of units in each HDs, a draw was made for those that would make up the representative sample of each one; however, the collection in the 12 HDs did not progress due to the Covid-19 pandemic. In each district, the sample of research users was defined through simple sampling with a sampling error of 10% and a 95% confidence interval (95%CI), and standards were established according to the average number of users served in the pharmacies of each selected unit.

Primary data were collected by trained interviewers at the health units from January 2019 to March 2020. A pilot study was conducted to calibrate the instrument and train the researchers. The form used contained questions on demographic and socioeconomic aspects, health profile and lifestyle habits, use of PHC health services, and finally, geographic access and use of medications.

In the present study, self-reported obtaining of medications at the health unit pharmacy was obtained through the question “Did you get the medications you were looking for at the UBS pharmacy?” considered as a dependent variable and categorized as full or no access. For analysis purposes, the variables were redefined considering the need for stratification. Thus, demographic

and socioeconomic variables such as gender and age in years were categorized into age groups of 18 to 39, 40 to 59, and 60 years or older. Self-reported skin color was collected according to the categories of the Brazilian Institute of Geography and Statistics (IBGE) as white, black, brown, yellow, and indigenous. For analysis purposes, in this study, only the colors that were self-reported by the patients were considered, specifically, white, black, and brown. Marital status was categorized according to the presence of a partner (with a partner and without a partner). Education was defined as higher education, high school, and elementary school/illiterate. Monthly family income was computed in Reais (R\$), considering the value stipulated for the year 2019 of R\$ 998.0 and classified as less than or equal to 1 (one) minimum wage (MW), greater than 1 and less than 3, and greater than or equal to 3. Receiving government assistance was categorized as yes and no.

Regarding the variables related to the health profile and lifestyle habits, the frequency of use of the SUS was questioned and categorized as always/almost always and sometimes/rarely, and having a health plan, defined as yes or no. The number of chronic diseases was categorized as none and greater than or equal to one. Self-perception of health was reported as very good or good and fair/poor/or very poor. Smoking was categorized as a dichotomous variable and the frequency of alcohol consumption was defined as rarely or never and always or almost always. The variables practice of physical exercise, having been hospitalized in the last 12 months and having been treated in an emergency room in the same period were defined as yes or no.

To investigate the geographic accessibility of users, questions were

included about the level of difficulty in accessing the health unit, which was defined as easy or difficult, the mode of travel to the health unit, classified as bus/car/motorcycle/other and on foot and, finally, the distance from the residence to the health unit, defined categorically as yes or no.

Bivariate analyses were performed to identify the set of variables that contributed most to explaining access to medication by PHC users diagnosed with NCDs. Subsequently, multivariate analyses were performed using the unconditional logistic regression model. Based on the logistic regression parameters, the specific measures and the crude and adjusted 95% confidence intervals were estimated.

The multivariate analysis was conducted based on a theoretical model defined a priori, discriminating the associated factors into hierarchical blocks, respecting the hierarchy between the levels of determination of access to medication. The strategy used to enter the blocks of variables was the “forward” type (anterograde process), through the module in steps: first block – demographic and socioeconomic variables; second block – health profile and lifestyle habits; third block – geographic accessibility. The variables that showed levels of statistical significance, according to a value of $p < 0.20$, remained in the model. A significance level of 0.05 was set for the study. The statistical packages used were Excel for Windows and Stata (version 14.0).

The research project was approved by the Plataforma Brasil/Research Ethics Committee of the State University of Bahia, CAAE 93991118.5.0000.0057, opinion No. 2,791,392 on July 31st, 2018 as part of the umbrella project Municipal Research on Access, Use and Promotion of Rational Use of

Original Article

Brandão MFBO, Cruz JJS, Fraga-Maia HMS, Arrais PSD, Araújo PS
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Medicines in the municipality of Salvador, Bahia (PMAUM), also submitted and approved by the same Committee under CAAE No. 69697923.5.0000.0057.

RESULTS

A total of 283 individuals met the eligibility criteria. Of the participants, 190 (67.1%) reported

having full access to medications in the pharmacies of the units investigated. The majority were female (83.7%), aged between 40 and 59 years (37.6%), with black or brown skin color (93.9%) and who reported having partners (54.8%). It was also observed that the majority of the respondents had a high school education (48.0%), received up to 1 minimum wage (52.9%), and report-

ed not receiving government assistance (68.2%). In the crude and adjusted logistic regression analyses for the outcome access to medicines, an association was found with age for the age group ≥ 60 years (OR=0.39; 95%CI: 0.17–0.92) and with the marital status of not having a partner (OR=2.29; 95%CI: 1.24–4.21) (Table 1).

Table 1. Characteristics of interviewees, prevalence of access to medicines and association between access to medicines and demographic and socioeconomic variables of users with Chronic Noncommunicable Diseases of Primary Health Care services, Salvador, Bahia, 2019-2020. (n=283).

Access to medicines in PHC						
Variables	n (%)	Full access n (%)	Null access n (%)	raw OR (CI95%)	OR ajustada (CI95%)	p-value
Gender						
Female	237(83,7)	160 (67,5)	77 (32,5)	1	1	
Male	46(16,3)	30 (65,2)	16 (34,8)	1,11 (0,5 – 2,1)	1,62 (0,73 – 3,58)	0,235
Age range (in years) ^a						
18 to 39	83 (29,9)	51 (61,5)	32 (38,5)	1	1	
40 to 59	104(37,5)	64 (61,5)	40 (38,5)	0,99 (0,5 – 1,8)	0,95 (0,47 – 1,92)	0,876
≥ 60	90 (32,5)	69 (76,8)	21 (23,3)	0,48 (0,2 – 0,9)	0,39 (0,17 – 0,92)	0,031
Skin color ^b						
White	17 (6,1)	14 (82,3)	3 (17,7)	1	1	
Black/brown	264 (93,9)	174 (65,9)	90 (34,1)	2,41 (0,6 – 8,6)	1,62 (0,39 – 6,66)	0,503
Marital status ^c						
With partner	154 (54,8)	111 (72,1)	43 (27,9)	1	1	
Without partner	127 (45,2)	79 (62,2)	48 (37,8)	1,57 (0,9 – 2,5)	2,29 (1,24 – 4,21)	0,007
Education ^d						
Higher education	20 (7,17)	14 (70,0)	6 (30,0)	1	1	
High School	134 (48,0)	89 (66,4)	45 (33,5)	1,17 (0,42 – 3,27)	1,41 (0,43 – 4,55)	0,525
Elementary school/illiterate	125 (44,8)	85 (68,0)	40 (32,0)	1,11 (0,39 – 3,07)	1,46 (0,45 – 4,64)	0,564
Monthly family income (MW) ^e						
≥ 3	58 (22,8)	46 (79,3)	12 (20,7)	1	1	
≤ 1	135 (52,9)	85 (63,0)	50 (37,0)	2,25 (1,12 – 4,65)	2,12 (0,9 – 4,7)	0,065
> 1 até < 3	62 (24,3)	40 (64,5)	22 (35,5)	2,1 (0,92 – 4,79)	1,73 (0,7 – 4,1)	0,219
Government aid ^g						
Yes	85 (31,8)	56 (65,8)	29 (34,1)	1	1	
No	182 (68,2)	123 (67,6)	59 (32,4)	0,92 (0,54 – 1,59)	1,24 (0,67 – 2,32)	0,488

Variables with p-value ≤ 0.20 were included in the multivariate logistic regression model in the first step, block 1 (demographic and socioeconomic variables). MW = minimum wage. Ignored Data: (a) 6, (b) 2, (c) 2, (d) 4, (e) 10, (f) 28, (g) 16.

The variables related to the health profile and lifestyle habits are presented in Table 2. Considering the frequency of use of the SUS, in general, individuals reported always or almost always using it (80.2%) and not having private health insurance (91.3%). Among the users interviewed, it was more common

to have more than one chronic disease (58.2%) and to report self-perceived health as fair/poor/very poor (53.3%). Regarding lifestyle habits, the majority of users denied smoking (92.8%) and reported that they rarely or almost never consumed alcohol (89.9%). The majority reported not practicing physical activity (56.3%).

Regarding health profile, it was observed that only 13.0% reported hospitalization, however 48.5% reported emergency room visits in the last 12 months. In the bivariate and multivariate analyses, the results were not statistically significantly associated with access to medicines in PHC (Table 2).

Table 2. Characteristics of interviewees, prevalence of access to medicines and association between access to medicines and variables related to the health profile and lifestyle habits of users of Primary Health Care services, Salvador, Bahia, 2019-2020. (n=283).

Access to medicines in PHC						
Variables	n (%)	Full access n (%)	Null access n (%)	raw OR (CI95%)	OR ajustada (CI95%)	p-value
Uses SUS						
Always and nearly always	227 (80,2)	156 (68,7)	71 (31,3)	1	1	
Sometimes and seldom	56 (19,8)	34 (60,7)	22 (39,3)	1,42 (0,77 – 2,60)	1,21 (0,51 – 2,70)	0,651
Healthcare plan ^a						
Yes	24 (8,7)	19 (79,2)	5 (20,8)	1	1	
No	251 (91,3)	165 (65,7)	86 (34,3)	1,98 (0,71 – 5,48)	1,20 (0,31 – 4,68)	0,791
Number of chronic diseases ^b						
None	81 (28,9)	51 (62,9)	30 (37,0)	1	1	
>1	163 (58,2)	139 (69,8)	60 (30,2)	0,73 (0,43 – 1,26)	0,60 (0,26 – 1,41)	0,243
Self-perception of health ^c						
Very good /good	121 (46,7)	76 (66,8)	45 (37,2)	1	1	
Regular /bad / very bad	138 (53,3)	81 (71,7)	32 (28,3)	0,81 (0,62 – 1,08)	1,07 (0,51 – 2,26)	0,851
Smoking habit ^d						
No	258 (92,8)	174 (67,4)	84 (32,6)	1	1	
Yes	20 (7,2)	13 (65,0)	7 (35,0)	1,12 (0,43 – 2,90)	1,10 (0,32 – 3,76)	0,876
Frequency of alcohol consumption ^e						
Rarely and never	250 (89,9)	169 (67,6)	81 (32,4)	1	1	
Always and almost always	28 (10,1)	18 (64,3)	10 (35,7)	1,16 (0,51 – 2,62)	1,26 (0,4 – 3,4)	0,644
Physical exercise practice ^f						
Yes	121 (43,7)	83 (68,6)	38 (31,4)	1	1	
No	156 (56,3)	103 (66,0)	53 (34,0)	1,12 (0,68 – 1,87)	1,26 (0,62 – 2,60)	0,519
Hospital admission in the last 12 months ^g						
No	194 (87,0)	133 (68,6)	61 (31,4)	1	1	
Yes	29 (13,0)	23 (79,3)	6 (20,6)	0,57 (0,22 – 1,47)	0,72 (0,24 – 2,17)	0,560
Emergency care in the last 12 months ^f						
No	140 (51,5)	94 (67,1)	46 (32,9)	1	1	
Yes	132 (48,5)	91 (68,9)	41 (31,1)	0,92 (0,55 – 1,53)	1,24 (0,61 – 2,54)	0,539

Note: Adjustment in the second step of the variables of block 2 (health profile and lifestyle habits) by the variables with a p-value ≤ 0.20 from block 1 (sex, age, marital status and monthly income). Ignored data: (a) 8, (b) 3, (c) 24, (d) 5, (e) 5, (f) 6, (g) 60 and f (11).

Table 3 presents the variables related to geographic accessibility according to access to medicines. It was observed that 26.4% of patients reported having difficulty accessing the health unit and walking was the

most common mode of transportation reported to reach the health unit (62.4%). It was also detected that 50.2% reported that the health unit was far from their residence. Having difficulty accessing the UBS

was positively and statistically significantly associated with not having access to medicines in the PHC (OR=2.65; 95% CI: 1.24–5.66) (Table 3).

Table 3. Characteristics of respondents, prevalence of access to medicines and association between access to medicines and variables related to geographic accessibility of users with Non-Communicable Chronic Diseases of Primary Health Care users, Salvador, Bahia, 2019-2020. (n=283)

Access to medicines in PHC						
Variables	n (%)	Full access n (%)	Null access n (%)	raw OR (CI95%)	OR ajustada (CI95%)	p-value
Difficulty accessing the health unit ^a						
Easy	208 (73,8)	148 (71,2)	60 (28,8)	1	1	
Difficult	74 (26,4)	41 (55,4)	33 (44,6)	1,98 (1,15 – 3,43)	2,65 (1,24 – 5,66)	0,012
Mode of travel to the health unit ^b						
On foot	171 (62,4)	113 (66,1)	58 (33,9)	1	1	
Bus, car, motorcycle, others	103 (37,6)	72 (69,9)	31 (30,1)	1,19 (0,70 – 2,02)	0,98 (1,24 – 5,66)	0,960
Distance from home to the health unit ^c						
No	140 (49,8)	95 (67,9)	45 (32,1)	1	1	
Yes	141 (50,2)	94 (66,7)	47 (33,3)	1,05 (0,64-1,73)	0,68 (0,33 – 1,39)	0,291

Note: Adjustment in the third step of the variables of block 3 (geographic accessibility) by the variables with a p-value ≤ 0.20 from block 1 (sex, age, marital status and monthly income) and block 2 (health profile and lifestyle habits). Ignored data: (a)1, (b)9, (c)2.

Table 4 shows the final model of the multivariate logistic regression between access to medicines in the PHC and selected variables. The variables that remained in the model

and were shown to be statistically significantly associated with access to medicines in PHC were age group ≥ 60 years (OR=0.33; 95%CI: 0.14 – 0.75), marital status without a

partner (OR=2.13; 95%CI: 1.16 – 3.91) and difficulty in reaching the health unit (OR=2.64; 95%CI: 1.26 – 5.54).

Table 4. Final logistic regression model between access to medicines and users with Chronic Noncommunicable Diseases of Primary Health Care services, Salvador, Bahia, 2019-2020. (n=283).

Access to medicines in PHC			
Variáveis	Raw OR (CI95%)	adjusted OR (CI95%)	p-value
Age (≥ 60 years)	0,4 (0,2-0,9)	0,33 (0,14 – 0,75)	0,008
Marital status (no partner)	1,5 (0,9-2,5)	2,13 (1,16 – 3,91)	0,015
Difficulty accessing the health unit (Yes)	1,9 (1,1-3,4)	2,64 (1,26 – 5,54)	0,010

Variables with a p-value ≤ 0.05 were included in the multivariate logistic regression model adjusted for sex, monthly family income and distance from the residence to the health unit.

DISCUSSION

This study shows the prevalence of self-reported access to medicines among users with NCDs in PHC in Salvador, Bahia (67.1%). The results of the analysis show the existence of an association between this indicator and socioeconomic and geographic factors. Significant differences were observed between the factors associated with access to medicines; being ≥ 60 years old was found to facilitate access, while not having a partner and difficulty in reaching the UBS were found to be barriers. This indicates that, despite the strengthening of Pharmaceutical Assistance in Brazil in recent years, access to medicines for the treatment of users with NCDs needs to be improved in the PHC of the municipality studied.

The prevalence of access to medicines for the treatment of people with NCDs found in this research is higher than the results previously found in other research in Brazil.⁽¹²⁻¹³⁾ The study from PNAUM showed that among those who had full access to treatment, 47.5% obtained all their medication free of charge.⁽¹⁴⁾ Similarly, the National Household Sample Survey (PNAD), which assessed the population that had medications prescribed by the SUS, found that 45.3% obtained them from the public health system itself.⁽¹³⁾ However, caution is needed when comparing these data due to the methodological differences of Brazilian studies, in addition to paying attention to the fact that the prevalence found in this study is below the target established by the WHO, which is to guarantee 80% availability of basic technologies and essential medicines for the control of NCDs.⁽¹⁾ The results show that, considering the WHO parameters, this percentage is classified as intermediate, especially in the context of a universal health system, in which a political

paradox emerges that indicates flaws in the National Policy on Medicines and Pharmaceutical Assistance, affecting and compromising access to medicines. Additionally, information made available in the Municipal Health Plan of Salvador for the years 2022-2025 indicates organizational problems within the scope of Pharmaceutical Assistance, such as lack of regularity in the distribution and supply of medicines.⁽¹⁾ Likewise, it is not possible to guarantee access if the medicines are not available at the time of dispensing to the user, which may reveal deficiencies in the planning, organization, structuring and financing of the AF provided⁽¹⁶⁾, may demonstrate low institutionalization of AF and low autonomy.⁽¹⁷⁾ This scenario also raises the hypothesis of the influence of the enactment of Constitutional Amendment 95, which poses risks of compromising the functioning of the SUS, such as measures to freeze public spending, which influence the availability of medicines and, therefore, the guarantee of the right to health.⁽¹⁸⁾

It was observed, in the current study and, similarly, in the national literature^(19,20) that older individuals reported greater access to medicines. A study on access to medicines for NCDs in adults and the elderly in two regions of the country carried out in 2005 observed an overall prevalence of greater access for the elderly (87.0%).⁽²⁰⁾ A household survey carried out in 2016, part of the household survey of the National Survey on Access, Use and Promotion of Rational Use of Medicines (PNAUM), indicated greater access among those over 60 years of age.⁽¹⁹⁾ This issue can be justified by the need for the elderly Brazilian population to use health services more, which is also due to the greater frequency of chronic diseases, frailties and functional losses, greater use of medications, in addition to fewer so-

cial and financial resources found in this age group.⁽²⁰⁾

“ In the present study, a significant association was observed between marital status and access to medication, and not having a partner was found to be a barrier to access. ”

These data corroborate the results of a study that analyzed the prevalence of medication use and found a lower prevalence of use in those who

did not have a partner. In an attempt to explain this phenomenon, there is a growing literature on the concept of “marital protection”. This concept implies a protective role of a strong social relationship that can result in better health because spouses function as caregivers, providing physical and emotional support. ⁽²²⁾

As in other investigations carried out, this study evaluated two dimensions of access to medicines ^(13,23,24), availability and geographic accessibility.

“ Among the results, it was observed that having difficulty accessing the UBS was positively associated with not having access to medicines. ”

One hypothesis for this issue would be that the spatial distribution of the service units constitutes a geographic barrier for part of the population, since the distance between the residence and the service unit, especially for those who are already physically weakened, constitutes a strong impediment to access. Contributing to this outcome are both the lack of personal transportation, the lack of financial conditions for access to public transportation, or even the lack of transportation routes that include the units. ⁽²⁴⁾ Although a standardized distance was not used in this study, the WHO uses as an indicator the percentage of households located more than five kilometers from a health center/pharmacy. It is important to note that the combination of insufficient growth in the supply of services in the face of population growth, in turn, generates an increase in the demand for care. Data extracted from the e-Gestor Atenção Básica information systems, a space for information and access to PHC systems, show that during 2019, the average coverage of primary care was 38.2%. ⁽²⁵⁾ The organization by assigned population, that is, the population of the area covered by a health unit, adopted in the APS probably minimizes the problems of geographic accessibility.

This research is not without limitations. It is worth noting that there was no recall period for questions about the use of medications used to minimize recall errors in data collection through questionnaires. However, in a study conducted to assess the prevalence of general and public access to prescription medications in the Brazilian population aged 15 years or older and to identify inequities in access, researchers indicated that the interference of this bias was minimal. ⁽²⁶⁾ Another limitation was the lack of verification that the necessary medication was on the list of

medications selected and made available in the PHC, which may have led to an underestimation of the prevalence of access to medications and, thus, made comparisons difficult. There is also a limitation of representativeness, considering that the pandemic caused by Covid-19 restricted the possibility of carrying out the study in all Health Districts (HD). It should be noted, however, that the HDs included in the investigation were very populous.

CONCLUSIONS

Access to medicines was considered intermediate. Users without partners and with difficulty reaching the PHC have more difficulty accessing medicines, unlike those aged 60 or over. It is worth noting that this is the first study in the PHC of the city of Salvador, Bahia, designed to estimate the prevalence of access to medicines for the treatment of people with NCDs and associated factors. Access to medicines has been a measure used in pharmacoepidemiological studies and is considered adequate, with the advantages of speed and low cost in obtaining information. ¹⁰ It is important to mention that by prioritizing the user as a participant in the evaluation process, the study brings new contributions.

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