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EVALUATION OF COMPREHENSIVE HEALTH CARE FOR OLDER PEOPLE BASED ON PROFESSIONALS' PERCEPTIONS

Avaliação da atenção integral à saúde do idoso na percepção de profissionais

Evaluación de la atención integral para la salud del mayor desde la percepción de profesionales

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ABSTRACT

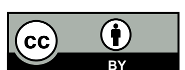
Objective: To evaluate comprehensive health care for older people based on the perceptions of professionals working in Family Health Care Centers (Unidades de Saúde da Família – USF). **Methods:** A qualitative descriptive and exploratory study was carried out in the second half of 2016 with multi-professional teams working in ten USF in a municipality located in the southwest of Mato Grosso State. Data were collected using the focus group technique. For analysis and interpretation, narratives were built and submitted to thematic content analysis. **Results:** The study showed that comprehensive health care for older people in Primary Health Care (PHC) in the municipality analyzed is delivered in a fragmented way and strengthens the biomedical culture. Comprehensiveness, which is acknowledged as one of the doctrinal principles of the Unified Health System (Sistema Único de Saúde – SUS), is weak and undervalued by professionals working at this level of health care. **Conclusion:** In the context of this study, comprehensive health care for the older population was delivered in a fragmented and disjointed way. The health professionals analyzed believed that the care delivered is purely clinical and focused on curative or preventive actions.

Descriptors: Primary Health Care; Health of the Elderly; Health Evaluation; Health Management.

RESUMO

Objetivo: *Avaliar a atenção integral à saúde do idoso segundo a percepção de profissionais em Unidades de Saúde da Família (USF).* ***Métodos:*** *Estudo de abordagem qualitativa, do tipo descritivo-exploratório, realizado no segundo semestre de 2016 em dez Unidades de Saúde da Família (USF) de um município localizado no sudoeste do estado de Mato Grosso, do qual participaram as equipes multiprofissionais das USF. Coletaram-se dados através da técnica de grupo focal. Para análise e interpretação, construíram-se narrativas e submeteu-se à análise de conteúdo do tipo temática.* ***Resultados:*** *O estudo evidenciou que a atenção integral à saúde do idoso na Atenção Primária à Saúde (APS), no município estudado, ocorre de maneira fragmentada e reforça a cultura biomédica. A integralidade, tida como um dos princípios doutrinários do Sistema Único de Saúde (SUS), se encontra fragilizada e pouco valorizada pelos profissionais desse nível de atenção à saúde.* ***Conclusão:*** *Concluiu-se que, no contexto deste estudo, a atenção integral à população idosa ocorre de forma fragmentada e desarticulada. Os profissionais de saúde investigados consideram que o cuidado realizado é puramente clínico e focado em ações curativas ou preventivas.*

Descritores: *Atenção Primária à Saúde; Saúde do Idoso; Avaliação em Saúde; Gestão em Saúde.*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RESUMEN

Objetivo: *Evaluar la atención integral para la salud del mayor desde la percepción de profesionales de las Unidades de Salud de la Familia (USF).* ***Métodos:*** *Estudio de abordaje cualitativo del tipo descriptivo-exploratorio realizado en el segundo semestre de 2016 en diez Unidades de Salud de la Familia (USF) de un municipio localizado en el sudoeste del estado de Mato Grosso del cual han participado los equipos multiprofesionales de las USF. Se recogieron datos a través de la técnica de grupo focal. Para el análisis e interpretación se han construido narrativas y se las han analizado por el análisis de contenido del tipo temático.* ***Resultados:*** *El estudio ha evidenciado que la atención integral para la salud del mayor en la Atención Primaria de Salud (APS) en el municipio estudiado se da de manera fragmentada y refuerza la cultura biomédica. La integralidad que es uno de los principios doctrinarios del Sistema Único de Salud (SUS) está fragilizada y poco valorada por los profesionales de ese nivel de atención a la salud.* ***Conclusión:*** *Se concluye que en el contexto de ese estudio la atención integral a la población mayor se da de manera fragmentada y desarticulada. Los profesionales sanitarios investigados consideran que el cuidado realizado es solamente clínico y dirigido para las acciones curativas o de prevención.*

Descriptores: *Atención Primaria de Salud; Salud del Anciano; Evaluación en Salud; Gestión en Salud.*

INTRODUCTION

The Unified Health System (*Sistema* Único *de Saúde – SUS*), which marks social inclusion in the country and a political affirmation of citizens' rights, is based on the doctrinal principles of universality, integrality and equity. It is one of the greatest social achievements and it is aimed at coordinating and integrating health actions at the three levels of government to meet health care demands, which are now universal and decentralized[1].

The reorganization of care in the SUS based on Primary Health Care (PHC) has contributed, in the Brazilian territory, to bringing PHC objectives closer in the set of individual and collective actions in the fields of promotion, protection, prevention, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance through integrated care, quality management and multi-professional care in delimited territories[2].

The focus of the actions organized by the SUS should be on the user's first contact with the care network and its continuity through coordination of the care system in order to allow progress in integrality, an essential attribute for strengthening PHC[3].

In this scenario, there is evidence of a substantial advance in the construction of SUS over the last years; therefore, the need to evaluate the implementation of initiatives that recognize the quality of the services offered to the population through the monitoring and evaluation of processes and results has become essential[4].

The culture of evaluation has not yet been consolidated in Brazil, but it is understood that evaluation is a fundamental tool for management as it supports decision making in a more assertive way[5] and is present in the political guidelines as its use is advocated as a resource for improving health services[6]. Its internal constitution and articulated use in decision making strengthen its recognition and incorporation as a relevant management tool[7].

In this regard, the Ministry of Health (MoH), through Ordinance No. 1.654 issued by the Office of the Minister on July 19, 2011, implemented the National Program for Improving Primary Care Access and Quality (*Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica – PMAQ-AB*), which presents the Self-evaluation for Improving Primary Care Access and Quality (*Autoavaliação para Melhoria do Acesso e da Qualidade da Atenção Básica – AMAQ*) as a tool for a permanent and progressive process of improving access to and quality of PHC management, care and participation[8].

The main objective of PMAQ is to boost access to and improve the quality of primary care and ensure a comparable quality standard nationally, regionally and locally so as to allow greater transparency and effectiveness of government actions directed to Primary Health Care[9].

The use of self-evaluation tools improves the quality of processes in PHC as it allows reflective action when guiding the work of the teams. In addition, self-evaluation tools are used as a permanent strategy for decision making[8]. The definition of comprehensive care used by PMAQ-AB states that health care involves the embracement of programmatic and spontaneous demand of different population groups at different stages of human development, such as childhood, adolescence, adulthood and old age[10].

In this context, older adults' comprehensive care should be highlighted as this population group is growing worldwide and in our country. Currently, 11.8% of the Brazilian population consists of people aged 60 or over,

corresponding to approximately 23 million people. Statistical projections indicate that by 2025 Brazil will rank 6th in the world in the number of older adults[11].

Given that, this study aimed to evaluate comprehensive health care for older people based on the perceptions of professionals working in Family Health Care Centers *(Unidades de Saúde da Família – USF).*

METHODS

A descriptive and exploratory qualitative study was carried out in the second half of 2016 with multi-professional teams working in ten Family Health Care Centers *(Unidades de Saúde da Família – USF)* of a municipality located in the southwest of Mato Grosso State.

The adherence of the municipality of Tangará da Serra, located in the southwest of Mato Grosso State, to PMAQ-AB occurred in 2016, which corresponds to the third cycle of PMAQ in Brazil. Since 2014, this municipality has exponentially accelerated the process of expanding primary health care through the More Doctors Program (*Programa Mais Médicos*). It became a benchmark in the state, with 100% coverage[7].

The Municipal Health Secretariat/Primary Health Care Coordination Office invited the Health Organizations Quality Office (*Escritório de Qualidade para Organizações de Saúde – EsQualos/UNEMAT*), an extension program interfaced with research, to practice the process of sensitization and simulation of evaluation phases with the teams registered in PMAQ-AB. Thus, an exploratory and descriptive qualitative study was designed to be part of one of the evaluation axes of the main study titled "Professional perceptions of comprehensive care based on the organization of the work process in primary health care centers".

The study included Family Health Care centers that were registered to receive the evaluation visit in the third cycle of PMAQ-AB[12]. A total of ten family health care teams participated in the study, totaling seventy-eight professionals: nurses, physicians, nursing technicians, receptionists, community health workers (CHW), dental surgeons and oral hygiene technicians. Exclusion criterion was being on leave or on vacation on the day scheduled for the meeting.

Data were collected in the second half of 2016 by the researchers responsible for the study using the focus group technique[13]. The interviews were guided by the tool validated by the Ministry of Health, the AMAQ, particularly its subdimensions: Organization of the Work Process and Comprehensive Health Care.

The AMAQ checks whether professionals provide quality care through responses based on the description of the quality standards established in the tool, i.e., health quality is defined as the degree of compliance with previously established quality standards of rules, protocols and guidelines that organize actions and practices[10].

The eight items that make up the description of the quality standard for the comprehensive follow-up of older adults' health are: (a) Existence of an updated register of this population in the territory; (b) Provision of home care for older adults unable to travel; (c) Monitoring of vaccination coverage; (d) Examination of the oral cavity and body surface in all medical and nursing appointments with the purpose of identifying cancerous lesions and ill-treatment; (e) Interventions for the early detection of major dementias affecting this population (Parkinson's, Alzheimer's, etc.); (f) Follow-up by the oral health team; (g) Interventions with families to identify and train caregivers who will provide adequate home care; (h) Use of the older person's health record book in all health care situations[12].

Each team discussed and evaluated the degree of adequacy of their practices to the quality standard presented through a score scale ranging from 0 to 10 points, with 0 (zero) indicating non-compliance with the standard and 10 indicating full compliance. The scores of 0 to 10 represent the different degrees of compliance of the situation analyzed with the desired quality. After assigning the score, the team had to explain the reason for the consensus. Therefore, the method of analysis chosen considered the average of the scores assigned by each team to the standard of older adults' comprehensive health care[12].

The audiotaped meetings lasted about four hours and were later transcribed verbatim. To identify the speakers and not miss the importance of each participant the research team used a logbook[14] and had four researchers at each meeting. The material was subjected to exploratory reading for the understanding of the entire content and later to exhaustive reading for the thorough understanding the content of the material.

For analysis and interpretation, the researchers constructed narratives[15]. They then analyzed the argumentative nuclei of each narrative and compared them to one another in order to identify their differences and similarities, thus subjecting them to Bardin's[16] thematic content analysis following the pre- analysis, analysis and exploration stages[17].

The project was approved by the Research Ethics Committee of the Mato Grosso State University (*Universidade do Estado de Mato Grosso*) under Approval No. 1.385.829.

RESULTS AND DISCUSSION

The scores assigned by each team to the standard "The primary health care team delivers comprehensive health care to older adults" averaged 7.5 points, with a minimum score of of 3.0 points and a maximum score of 9.0 points.

After analyzing the material and dividing the core meanings, two categories emerged: "Challenges in the management and organization of the work process for older adults' comprehensive care" and "Challenges in the implementation of quality older adults' care".

Challenges in the management and organization of the work process for older adults' comprehensive care

The older population grows faster than any other age group; therefore, the adoption of public strategies targeted at this population group is key to optimizing health, participation and safety opportunities in aging[11].

The following statements show some aspects related to the management and organization of the work process that impact older adults' comprehensive health care, namely the use of the older person's health record book, changes in the information systems, monitoring of the older population and home care for older adults.

With regard to the older person's health record book, primary health care professionals say its non-use is due to the lack of the tool in the health care centers:

> *"The record book is not coming to us [...] the last record book that came was in 2014 [...]. I think that the record book is the only thing that is missing [...] the record book is not coming to the center." (USF 2 Community Health Worker)*
>
> *"I do not have the older person's health record book. I will ask for it." (USF 4 Physician)*
>
> *"Not the older person's health record book [...] but the use of the record book is very low, many do not even know the record book." (USF 6 Physician)*
>
> *"[...] now, as for the use of the record book, it is missing." (USF 7 Physician)*

There are three situations. The first is the absence of the record book in the centers. The record book is a formulary intended for both the older person and the center to follow up the care and it is considered a document. The second is the low utilization of the older person's health record book by professionals (those who have them). The third situation is the duality of its use as a tool that is part of an evaluation process.

The MoH issued the first edition of the Older Person's Health Record Book in 2008 and it is currently in its fourth edition, which was published in 2017. The new record book was subjected to public consultation and many different segments of society, including municipal, state and federal health managers, participated in its development[18]. The record book assists in the good management of the older person's health and it is used by both the health teams and the older people, their relatives and caregivers because it allows data entry and follow up for a period of five years[19].

It should also be noted that the information required to complete it must be reported by the older person, a family member or caregiver in order to maintain the accuracy of the data obtained and hence develop a care plan that will meet all their health needs[18].

Another statement shows that one of the health professionals confused the HIPERDIA (System for Registration and Monitoring of Hypertensive and Diabetic People) record book with the older person's health record book, as shown in the following passage.

> *"[...] yes, the record book. The girls have a green record book that belongs to HIPERDIA. Then when the patient comes to measure blood pressure with us for the first time and it is an older person we have never met we map their blood pressure. The girls, during the home visits, are using the record book at the time of enrollment [...]." (USF 10 Nurse)*

In Mato Grosso, the Older Person's Health Record Book is distributed only after the manifestation of interest by the Municipal Health Secretaries through the issuance of an official letter to the Ministry of Health[20]. In this context, despite being a tool that serves as a guide for the provision of quality care to the older people, the record book may be underutilized in many municipalities due to lack of knowledge or limited access[18].

The lack of necessary inputs and equipment is a factor that hinders the development of several actions and the problem-solving capacity of primary health care centers, thus limiting their ability to respond to the population's health problems[21].

The changes in the information systems are also pointed as barriers to the provision of comprehensive care to older adults. In the centers where this study took place, the professionals reported the following weaknesses:

> *"[...] "every hour there is an attempt and a different information system [...]" (USF 10 Nurse)*
>
> *"[...] we filled in all the information, we did it again, we worked twice, right, and we simply lost it [...]" (USF 04 Nurse)*
>
> *"[...] I do not know if I should enter information into the system or fill in the medical record... sometimes it is electronic, sometimes it is not [...]" (USF 08 Physician)*
>
> *"[...] I must enter information every hour, and the older population does not change that much, but the data seem to disappear. If I did not have my notebook, I would have to do it again every hour [...]" (USF 1 Community Health Worker)*

Given this scenario, the monitoring of the population through technological resources is an essential element in the pursuit of comprehensive health care. In PHC, the use of information systems and electronic medical records is a means to evaluate the structure and monitor health indicators that will support centralized decision-making regarding individuals' real needs(22).

It is up to the professionals working in the family health care centers to monitor the population assigned to their coverage area, and that should be basis for comprehensive and equitable health care(2). The statements show that the team believes that older adults' monitoring actions are only those purely related to clinical care:

> *"[...] there is the Day of Older Persons, there is the follow-up." (USF 2 Receptionist)*
>
> *"Oh, we care a lot about the older people: we measure their blood pressure, we measure their glucose levels." (USF 5 Nurse)*
>
> *"One of the things that work here is the monitoring of older adults." (USF 9 Nurse)*
>
> *"We monitor the older person quite often. We worry a lot about their wounds, their medication." (USF 10 Nurse)*

PHC, for being the user's gateway to the health system, must provide universal and egalitarian access based on the assessment of individual and collective risk severity and chronological criteria and the observation of the various specificities of people under special protection, such as the older population(6). Two centers carried out group activities and cited walking as one of the actions. The fragmentation of care is evident when the professionals state that they have a "whole day" for monitoring older adults and the "timetable day" and when they focus on clinical aspects, as expressed in their concern with "wounds", "medication", "Blood pressure" and "glucose levels", thus reinforcing the biomedical model of care.

In the contemporary scenario, it is urgent to build alternatives for providing comprehensive health care to older people considering the complexity of the reality that circumscribes it, and the focus should be on the unpreparedness of health services, especially in the field of PHC, to appropriately deal with this matter. Considering the paradigm of functionality, home care and professional training, it is noticed that the older people are being seen in clinical specialties or care groups(23).

The effectiveness of integrality is permeated by many challenges, especially due to the strong power of the biomedical model of care and outpatient production, which still prevail in the health system(23). There have been few movements that succeeded in bringing to light models of preventive, curative and health promotion actions based on a biopsychosocial model integrated into a broader and holistic view on the individual(24). The main factors that interfere with the quality of care and older adults' comprehensive care are the demand, the shortage of time and professionals, and the pressure to achieve goals(25).

AMAQ-AB points out that older adults' comprehensive care requires the provision of home care for older adults, especially those who are unable to travel. Older adults' home care is understood as the whole set of actions carried out by a multidisciplinary team at the home of the older person and their family(10).

In the present study, the PHC teams carried out home visits on a daily basis and rated them in a satisfactory way:

> *"[...] We visit our older people more than once a month." (USF 4 Nurse)*
>
> *"Yes, I think more than 90% of the home visits are made to older people." (USF 4 Physician)*
>
> *"[...] We carry out visits [...] those people who cannot come, the family asks us to go to their home, the nurse and the physician go there." (USF 5 Community Health Worker)*
>
> *"We can monitor the visits, it is satisfactory." (USF 8 Physician)*

The home visit should be planned in order to meet all the health needs of the older person and it is aimed at monitoring them and their family/caregiver, thus constituting a unique moment for the provision of care to users. This moment is used to provide care with emphasis on autonomy and functional skills within their own environment. Thus, in addition to the visits, planning is needed in order to respond to the social and health demands of the population served[26].

Challenges in the implementation of quality older adults' care:

Aging is accompanied by physical, psychological and social changes that should be the focus of differentiated care services. In addition, aging can be accompanied by a decrease in functional capacity, chronic and degenerative diseases, and difficulties in performing basic and instrumental activities of daily living, which reduces autonomy and self-care. This requires the PHC team to be present in the routine of the older person[27,28] and work in partnership with the care network and caregivers to promote autonomy and self-care[29].

The following statements reveal some aspects that can be understood as challenges for the implementation of quality care for older people, namely: the training of caregivers, comprehensive oral health care and health education practices.

Some items of the AMAQ-AB[12] point to PHC interventions with families to identify and train caregivers to provide adequate home care. In this study, the teams identified the caregivers, but training activities were not carried out:

> *"[...] we do identify the caregivers, but we do not train them. We have already intervened with some things related to the caregivers, but we did not train them […]." (USF 6 Physician)*
>
> *"There is no training for caregivers." (USF 9 Community Health Worker)*

Higher education professionals are best suited to train caregivers of older adults, especially with regard to tasks that could assist in the recovery or maintenance of the quality of life of these older people through: provision of emotional support and social relations; assistance and accompaniment in routine personal and environmental hygiene; assistance in feeding, preventive health care, drug administration and other health procedures; assistance and accompaniment in mobility in educational, cultural, recreational and leisure activities[10].

The literature differs the formal caregiver from the informal caregiver, the first being an individual who gets paid to perform the task of caring and the latter being a family member, neighbor or friend who voluntarily takes on the role of caring[29].

Most of the time the caregivers of frail older adults and/or patients are their family members. Therefore, a proper network of support and help is essential. Because caregivers are not always trained to provide care, they have been increasingly seeking the health team for guidance. In this regard, the process of education, guidance and training of caregivers must be present in PHC services, and information on appropriate care should be disseminated and worked as a praxis[30,31].

The Ministry of Health states that the programmed planning for the maintenance of the health of caregivers and families of needy older adults has often been neglected and that institutionalization often occurs due to the lack of services capable of meeting the needs of both the older person and the family/caregiver[31].

Oral health care coverage for older adults' comprehensive health care presupposes the examination of the oral cavity[10]. In the present study, the teams rated the oral health care offered to the older adults as unsatisfactory.

> *"Oral cavity examination is not always performed." (USF 8 Physician)*
>
> *"Oh, dental care does not work […]." (USF 10 Community Health Worker)*
>
> *"Oral health care is more symptomatic, it is very hard. They do not attend all the appointments. Scheduled appointments do not work very well […]." (USF 10 Dental Surgeon)*
>
> *"I just wanted to put the program into effect, to value the consultation, because they just want a consultation when they are symptomatic." (USF 10 Dental Surgeon)*

During the meetings, there were no reports of specific or group work for oral disease prevention and oral health promotion. The oral health of the older adults is compromised by many factors that make them susceptible to various mucosal changes and lesions, especially the presence of pathological conditions inherent to aging. Therefore, the promotion of oral health in older adults is fundamental[32].

Faced with this reality, the oral health team in PHC should perform and prioritize actions and the assessment of the oral health of this population. These actions should include: consultation and assessment of the clinical status; diagnosis and restorative treatment; request for complementary tests; minor surgeries; drug prescription; home care; provision of information on the importance of hygiene of the mouth and the prosthesis to the older adults, family and/or caregivers; and refer, when necessary, to medium- and high-complexity oral health services[(31)].

With the increase in life expectancy, providing oral health care to older adults through SUS has become necessary. In this regard, the dental surgeon must work together with the team in the search for intersectoral actions for health promotion and everyone should work with purpose of improving the quality of life and self-esteem of the older adults[(33)].

The activities carried out in the health care centers, such as health education practices, are fundamental for the expansion and dissemination of knowledge and give prominence to self-care[(34)]. The professionals' statements show the devaluation of health education practices targeted at older adults, as seen in the following passages:

> *"My dear, I think we will have to close the center to provide health education (laughs) and work with groups […]." (USF 1 Physician)*
>
> *"[...] we will never be able to get there. We will never be able to prevent, we take care of what comes to us." (USF 1 Nursing Technician)*

The physician's statement shows a dissociation of health education from other health practices. Health education is instrumental in PHC; however, these actions seem to be devalued by the professionals who work in this area[(35)]. Given that, investment is necessary to recognize that spaces intrinsic to professional practice, such as embracement, consultations and home visits, are spaces for health education and that the group should not necessarily foster this action only.

In the last century, these practices constituted one of the main forms of health promotion, enabled significant changes in public health, promoted advances in curative and preventive medicine, contributed to longevity, helped reduce mortality rates, and improved quality of life on the planet[(36)]. Health education strategies have a significant influence on people's health and lifestyle. In the case of older adults, it may be the main alternative to promote health[(37)].

In this regard, a study carried out to analyze the impact of health promotion and education actions on the pursuit of quality of life in older adults concluded that health education is a powerful tool to promote health and guarantee older adults' autonomy and self-care[(38)].

Special attention should be drawn to human resources. With regard to training in older adults' health care, the managers of the Municipal Health Secretariat should invest in professional training programs focused on older adults' health care[(39)].

The limitations of this study are related to the inclusion of centers evaluated by the PMAQ. If on the one hand it may be a limitation, on the other it may represent a certain characterization of these centers. As for the non-participation of users and caregivers of older adults – although it is also a limitation herein – we chose to privilege professionals whose responsibility for care is differentiated.

It is important to emphasize that the participants of the present study did not address issues related to the monitoring of vaccine coverage and interventions for the early detection of dementias. In the context of this study, fragmentation and disarticulation were perceived as important problems in primary health care[(40)] as the work done is influenced by the biomedical model of care. It is necessary to remodel the service and build a new care model based on SUS principles, thus seeking to maintain the functionality of the older adults and their quality of life with health promotion and integral care being the main focus of care[(23,25)].

FINAL CONSIDERATIONS

The present study showed that the older adults' health care in Family Health Care centers occurs in a fragmented way, strengthens the biomedical care culture and is largely permeated by clinical care routinely delivered in the centers and/or at home through a set of curative actions rather than through preventive measures.

In the context of this study, health promotion actions were ineffective in guaranteeing comprehensive care as they are disarticulated and underutilized by professionals. The study showed weaknesses in health education practices, the non-use of the Older Person's Health Record Book, lack of training of caregivers, poor follow-up of users with chronic conditions who need to go through all levels of health care, and the poor use of the oral health program – and even its absence – in some centers.

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There are no conflicts of interest.

CONTRIBUTIONS

Juliana Fernandes Cabral contributed to the study conception and design; **Jeniffer Fernanda Gonçalves da Silva, Josué Souza Gleriano and Priscila Balderrama** contributed to the acquisition, analysis and interpretation of data; **Angélica Pereira Borges and Ageo Mário Cândido da Silva** contributed to the writing and/or revision of the manuscript.

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