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The Implementation of Senior Health Care in the Family Health Strategy: The View of Professionals and Managers

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Abstract *Changes in the demographic profile over recent decades, especially population aging, have implications for Brazilian public policies. This study aims to analyze how family health strategy teams implement and carry out care for the elderly in a Brazilian municipality. The qualitative field research was conducted by collecting data through semistructured interviews using Minayo as a point of reference and employing thematic content analysis. One observation was that the National Health Policy for Elderly People (Política Nacional de Saúde da Pessoa Idosa – PNSPI) has been facing challenges in its implementation at the municipal level in terms of the lack of specific actions by the PNSPI, limited actions or lack of accessibility, lack of training for health professionals, hiring and management of workers, intersectoral actions, and management. It was concluded that a better outlook for the implementation of the PNSPI in the context of the aging population will require strengthening actions through the precepts of comanagement, an expanded clinic, and health education to increase individuals' independence.*

Key words *Health care for the elderly, Health management, Family health*

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Introduction

The growth of Brazil's elderly population has brought societal challenges related to the economy, retirement funding, urban infrastructure, and services. In the same context, the health sector must deal with a country geared to the needs of young people while facing the need to adjust its structure and organization due to an increase in the chronic, noncommunicable diseases associated with aging[1,2]. The same scenario is also found in other countries, such as Canada, leading to serious concerns in light of the ills caused by aging due to the lack of sustainability in health care systems[3].

Recent data from the Brazilian mortality table (2016) indicates a life expectancy of 75.8 years[4]. In 2010, the Brazilian Institute of Geography and Statistics (Instituto Brasileiro de Geografia e Estatística – IBGE) indicated that a rapid process of increasing lifespans starting in the mid-1960s meant that by 2010, Brazilians were living 25 years longer, up to 73.4 years of age; this increased population age was combined with a reduced fertility rate[5].

Furthermore, in a municipality in the center-west region of the State of São Paulo, residents over the age of 60 represent 16% of the population, two percentage points higher than the average for the state overall, which is 14%. An analysis of the demographic behavior of the State of São Paulo shows decisive inflection points: in the mid-2020s, there will be more individuals aged over 60 than children and adolescents under the age of 15. In 2050, this number will be triple its 2010 value[6]. The number of elderly Brazilians in 2012 surpassed 22 million, making them more numerous than the elderly in several European countries, according to United Nations estimates[2].

Therefore, keeping in mind that aging is not a homogeneous process[7], we conclude that these data reveals not only an achievement but also the repercussions these demographic changes have for public policy, requiring investment in promoting autonomy for healthy living and meeting the needs of this social group[2]. In this context, the Ministry of Health (MS) issued Decree No. 2.528/2006, the National Policy on Health for the Elderly (Política Nacional de Saúde da Pessoa Idosa – PNPSI), in 2006[8].

Active aging, associated with the likely predominance of chronic, noninfectious diseases, requires, above all, changes in how work is organized, based on a general and specialized development of health management technologies[9], as well as a model of health care based on the expanded clinic[10].

Comanagement is emphasized that is aware of the need to operationalize care through the integration of professionals, managers, and users in a way that establishes the therapeutic project based on the users' needs, making them active participants, as well as working with changes in relations and team work[11].

The reorganization of the health system in our country is envisioned through the establishment of a Health Care Network (Rede de Atenção à Saúde – RAS). This network, coordinated by Basic Care (Atenção Básica – AB), has the potential to have significant impacts on the context under analysis[12]. However, Cecilia Arruda et al.[13] warn us that the health system is marked by rigid and bureaucratic models that prevent the dynamic movement of health care recommended by the RAS.

It should be noted that there are also concerns about the fragmentation of care for the elderly in countries such as England. Brazil has also identified similar difficulties[14]. It is noted that for RAS to be implemented and operate effectively, changes are required in the management, culture, and training of professionals who work in the Unified Health System (SUS), as it is the dynamic practices of social actors that will make innovations in health care effective[15].

Similarly, the Family Health Strategy (Estratégia Saúde da Família – ESF) is seen as a means to reorganize health practices to address and encourage active aging. This strategy may be accomplished through comprehensive care for the elderly that considers their place in the social context and their ability to develop their potential[16].

In this scenario, we ask how the actions of ESF professionals and administrators of the Municipal Health Secretariat (Secretaria Municipal da Saúde – SMS) are established in constructing the reality of the elderly population's health and seeking to understand the universe of meaning, motivations, aspirations, values, beliefs, and attitudes that arise from a given social reality[17]. Similarly, studies have been conducted in the United Kingdom to understand how the elderly and their caregivers face challenges, aiming at coparticipation in developing the care plan[18,19].

This study acknowledges that there may be challenges to implementing the current policy at the local level with regard to organizing care in health services, given that the PNSPI is recent

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and the municipality has not planned for this, and proposes to analyze how health care for the elderly is implemented by teams at the health posts in the ESF in a municipality in the center-west region of the State of São Paulo.

Methodology

An exploratory study with a qualitative approach was conducted, as recommended by Minayo[17], employing thematic content analysis. This article is part of the Master's thesis "Analysis of Health Care for the Elderly in the Context of the Family Health Strategy in a Municipality in the State of São Paulo" ["Análise das Ações de Saúde do Idoso no Âmbito da Estratégia Saúde da Família em Município do Interior do Estado de São Paulo"][20]. The research project was approved by the Research Ethics Committee of the educational institution associated with the Master's program in "Health and Aging" in accordance with Resolution 466/2013.

Data were collected from five of the 31 service locations of the ESF in a municipality in the State of São Paulo[21]. The subjects included five managers of the primary care system (one coordinator of elderly health care, three coordinators of the Family Health Strategy, and the municipal Secretary of Health) and local professionals in the different specializations that make up the Family Health Strategy team, namely, nurse, dentist, doctor, nursing assistant, community health agent, dental assistant, dental hygienist, and secretary. The units were randomly selected, including one from each of the municipality's regions (north, south, east, west, and rural areas).

Data were collected between October 2012 and January 2013 through semistructured interviews that lasted from 10 to 40 minutes. Permission was requested to record the interview, and participants were asked to sign the informed consent document, in compliance with CNS Resolution 466/2013. The criterion of speech saturation was used to determine the number of participants, and the sample was deemed sufficient when the interviewees' remarks began to show significant redundancy and repetition[17], which occurred when the sample size reached 26 participants.

Thematic content analysis was employed, as it is considered appropriate for understanding the universe that surrounds elderly persons' health by revealing the participants' perceptions, values, and culture[17]. The topic "Management and Organization of Work in Caring for the Elderly" was chosen based on the following nuclei of meaning: 1) implementation of the policy of health care for the elderly; 2) challenges in caring for the health of the elderly related to the absence of specific actions, limited actions/accessibility, lack of adequate professional training, insufficient development of intersectoral practice, hiring/management of workers, and management.

In the analysis of responses, the interviewees were designated by an abbreviation indicating their profession and their corresponding ESF number: ENF-I, ME-I, ACS-I, AE-I. For ethical reasons, the managers were identified only as G-1, G-2...G-5.

Most of the managers were between 30 and 37 years of age, with undergraduate and graduate degrees in the health field. One had a doctorate, and all had held their current positions for six to eight years. Most of the health professionals were between 31 and 40 years old, with seven to nine years' experience in their current ESF.

The Municipal Health Plan (2010-2013)[22] and the Annual Management Report (2011)[23] were subjected to documentary analysis. The systemized data from these analyses was compared to the data collected in the interviews using a script consisting of questions that addressed aspects of the planning process, implementation/operationalization, and assessment of actions aimed at care for the elderly, as well as financing.

Results and discussion

Analysis of the municipal documents

The municipal documents were analyzed according to the guidelines of Decree no. 2,528/GM of 2006, which approved the PNSPI. The guidelines aspire to a broad approach to the elderly population, which includes presenting the policy to professionals, managers, and users of the SUS; providing training and ongoing education for professionals; promoting active and healthy aging; providing comprehensive and integrated health care for the elderly; encouraging intersectoral actions with a view to providing comprehensive care; providing resources for quality health care; encouraging participation and oversight by society; and providing support for research.

It was thus found that there was no specific municipal plan for the elderly. The existing documents did not address most of the issues covered

by the PNSPI guidelines. The Municipal Health Plan (2010-2013)[22] contained the goal "implement the Health Care for the Elderly Program," while the Annual Management Report (2011)[23] identified the goal of implementing the "PNSPI," planning actions such as "presenting the PNSI to 80% of the SMS technical staff and to 50% of the primary health care staff and, finally, training 60% of doctors in the medical clinic and general practitioner areas of the primary care network in the diagnosis and treatment of osteoporosis."

Analysis showed that the last goal was not achieved. Although the first two actions were achievable, we consider that all three are insufficient for effective implementation of the program, as they are limited to the mere presentation of the proposal and do not even involve all relevant teams and professionals as called for by the policy. Moreover, they do not they give broad coverage to the PNSPI guidelines, which explain the need for care in terms of active aging, the establishment of risk-based criteria for receiving patients, home visits, and specialized treatment with regard to hospitalization and pharmaceutical care, among others[8].

The Municipal Health Plan (2010-2013) aims to align the health care network to promote intersectoral action and establish a method of patient reception that uses colors to indicate different levels of risk, but it does not specifically mention elderly users[22].

Management and organization of work for care of the elderly

With regard to the implementation of the PNSPI in the city under examination, the interviewees' remarks indicated that an implementation process was underway, but with different views. Professionals in the local services described the implementation with vague and general dates.

...care for the elderly took a little longer, it was about five or six years ago, because we had other programs (AE-III)...I think it started relatively recently, about 15 or 20 years ago, gradually (ME-II)...there isn't a program, a group geared towards caring specifically for the elderly, working with older people who are diabetic or have high blood pressure or are bedridden. We haven't managed to work with prevention yet (ENF-II).

In contrast, the managers showed that three different phases had taken place by the time the data were collected. The first phase was characterized by the publication of the policy and the implementation of actions without effective results:

...Publication of the policy in 2006, implementation of the notebook, ongoing education, various problems, not enough notebooks, unprepared elderly people, no effective implementation (G-4).

The second phase emphasized the application of services to strengthen the policy, but the period was seen as ineffective:*...establishment of the NASF in 2009, attempts to implement the notebook in 2007 or 2008...the year after 2010, the proposal was considered the NASF's role, a better experience, but not effective* (G-4).

The third phase showed more specific organization of the Policy:*...with specific coordination to care for the elderly, more re-structured. A diagnosis was made, proposing the implementation of the notebook and the policy with special attention. A small number of units was proposed to gain experience with the challenges and see what worked well* (G-4).

An effort was made to revise the implementation process, paying attention to the planning and partial establishment of the actions called for by the policy. What stands out is the concern that although the first two actions mentioned above seem to have been achieved, they are considered insufficient for what was needed to implement the policy and were portrayed as a "presentation." Actions such as the use of a notebook for the elderly are only a first step, as a notebook is only a tool for recording data; it would require the shared commitment and training of professionals to bring about changes in practices to offer the coordinated services envisioned by the concept of the RAS. It should also be noted that the participants cited only the training received, which may indicate that no broader actions occurred that would allow the professionals to put this training into practice.

The professionals consider the implementation superficial, as we did not find any mention of strategic policy actions; those actions that were found took a superficial approach, and in some cases were not clearly addressed to the elderly:

...I don't remember about the municipality, but there isn't anything much yet; there's no protocol for treating the elderly, no program for rehabilitation or social inclusion of the elderly (ENF-I)*... we don't work with groups or care for the elderly, advising them on their medications, questions that have more to do with nursing, assessing elderly people with wounds, the more curative part. No groups specifically for the elderly*, (AE-III)*...I know there is now a specific law for the elderly, a manual for*

elderly people. Here in this unit, it was done a long time ago (ASG-II)*; it's been eight months since I've been here and we haven't formed a group for elderly people. I see there are some units that have activities, go on walks, have handicrafts* (ACS-I).

The actions pointed out by professionals highlight actions such as the use of the senior manual and identification card, care for people who have been neglected, care for hypertension and diabetes, prevention of oral cancer, and flu vaccines, with the last two being most frequently cited; it should be remembered that these both take the form of health campaigns.

...for 12 years, I've been observing piecemeal care, but these [programs] have always existed, vaccinations for influenza, more specific care for hypertension and diabetes, and the diseases associated with aging (Enf-II)*...I've* been in the ESF for 14 years; ever since I started, I've always taken special care of the elderly, with regard to my profession, to oral health, to exams for the prevention and early detection of oral cancer (DE-I); *I've heard a lot of talk about abuse of the elderly, about hotlines* (AE-III).

In their 2007 assessment of the PNSPI in Brazil, Rodrigues et al.[24] state that the action plans should permit sectoral agencies to use their attributes and undertake actions in accordance with the needs of the elderly based on the PNSI. As an example, they cite the holding of formal and informal forums, although this action was not mentioned in interviews with the professionals. In their interviews, managers mentioned forums and training for the prevention of home accidents, but these were held intermittently.

...a forum about the elderly was held with representatives from the police department for women's issues and the public prosecutor's office, trainings for how to make the home a safe place for the elderly, I can't say these are ongoing; they occur from time to time (G-5).

To emphasize the need to expand actions to promote the health of the elderly, Branco da Motta et al.[25] point out the need for greater discussion about how the SUS can be better equipped to meet the demands of society with regard to the prevalence of chronic, noninfectious diseases that accompany non-active aging[9], with actions based on the expanded clinic being indispensable[11].

The management of the expanded clinic based on health care management education aims to coordinate comprehensive care through a dialogue among management, health care, and health education, seeking changes in practice[26]. In this context, the training of professionals through ongoing health education (EPS) becomes important in encouraging engagement and reflection about the work process.

The health sector must reorganize its work process and re-evaluate the processes of health and illness to shift the focus away from diseases and towards individuality. Therefore, it is not enough for the Ministry of Health to publish the PNSPI if there is no change in the care paradigm based on the biomedical model.

With regard to health education activities, the documentary analysis showed a decrease originating in the organization of the health system; the establishment of the ESF to deal with less complex situations ended up generating greater spontaneous demand, making health education activities more difficult[23].

The challenges of providing care for the elderly were observed to be related to the lack of specific actions, limited actions/accessibility, shortcomings in professional training, insufficient development of intersectoral coordination, hiring/management of workers, and management.

To resolve the lack of actions specifically designed for the elderly, it will be important to plan actions that go beyond and reaffirm the need for care that takes into account the expanded clinic. This remark supports the needs outlined above:

...we need a different perspective for those who are growing old: they need leisure opportunities, they have to stay active (DE-1).

The participants emphasize the proposal for implementing the organization of primary care for the elderly along two lines: care for the elderly who are independent and care for those who struggle with daily activities. Decree No. 2,528 of October 19, 2006[8], refers to important issues that can guide local planning of primary care, providing for the establishment of strategies to promote health and prevent disease, as well as provide rehabilitation[11].

With regard to limited actions and difficulty accessing them, there was no evidence of support or dedicated structure for the implementation and expansion of opportunities to include the elderly in society:*...I've held bingo matches at my home, but going to the movies requires transportation* (ASG-1).

Paskulin et al.[27] report that although the health system calls for universal and comprehensive health care, it lacks resources.

This concern increases as we notice that the elderly population is growing at a faster rate and

that municipalities still have difficulty reorienting resources and developing plans for elderly individuals' autonomy intended to identify and meet the needs of the elderly.

With regard to the training of professionals, the interviews revealed that the knowledge base was insufficient: *...the units were not prepared; many professionals were hired but not trained* (G-1).

This situation is an opportunity to review the training of professionals in various health services. It is imperative that degree programs in health explicitly include gerontology and geriatrics in their curricula and value these fields[25]. Tavares et al.[28] add that achieving this more extensive professional training will require broad learning scenarios that value the political dimension, development of personal and collective skills, community involvement, sustainability, and the reorientation of health services. This enhanced training will help professionals develop their abilities to meet the specific needs of different regions and offer a greater chance of overcoming the biomedical model.

With regard to the problem of training in the health services, the interviews showed that most of the professionals who worked in the ongoing health education program (EPS) in earlier periods no longer work in the ESF, and many of the professionals who were hired subsequently were not trained. Training was provided for only one specialty in the medical professional category[23]. Unquestionably, there is an imperative need for professional training based on the context of social needs and the SUS. The interviews also emphasized that the National Policy of Ongoing Health Education (PNES) should be seen as touching on the initiatives to reorient training, especially at the undergraduate level, and will later have significant repercussions on the practice of health care services[28].

It is clear that the perspective of elderly people and the aging process still needs to be treated as an essential topic in the curricula of the various professions to support building technologies for care that support individuals' autonomy. However, the approaches of professionals in the services are focused on the biomedical model, and planning by management shows that action is urgently needed to rethink interventions. The EPS is one strategy to rebuild practices through reflection and construction of meanings for these practices, making it possible to plan new actions that take regional needs into account[29].

Another difficulty is the insufficient development of intersectoral coordination in the work process. The participation of sectors such as the Center for Psychosocial Care (CAPS) and the Center for Family Health Care (NASF) in the implementation of care for the elderly was not mentioned by any of the health teams interviewed. As in other Brazilian scenarios, problems were noted with regard to carrying out and developing the purpose of the NASF, such as lack of coordination between management of the ESF and the NASF and differing views of the matrix, which has not contributed to the development of comprehensive, shared, and collaborative practice[30].

Nevertheless, the interviews showed the importance of the NASF's role in the municipality, where it acts as an intermediary between the UESF and the Council on the Elderly. Along the same lines, it may be added that difficulties were identified in accessing certain sectors, depending on the network established for the elderly person. The difficulty of involving other sectors in elderly care and the fragmented nature of the municipal health system due to insufficient cooperation between the health services was evident in the Municipal Health Plan (2010-2013)[22]. However, faced with the fragmented nature of health services, the Municipal Secretariat of Health proposed a broad reorganization of practices in the primary care network with the aim of aligning the health care network through a collective, multiprofessional structure[22].

Although Branco da Motta et al.[25] show that other Brazilian municipalities face the same difficulty in consolidating networks of care for the elderly, they also show that the process of care must be based on strengthening the network of health systems. The coordination of this RAS carried out by the primary care system requires reordering the health system so that care is guided through the network[31]. This perspective on the fragmentation of the system with an eye to integrating health care services is seen in England, leading us to conclude that it is a problem common to Western countries[14].

The need to reflect on this context is urgent, particularly in view of the importance of intersectoral coordination deriving from the articulation of various sectors and actors to share powers and knowledge to act in an integrated manner to meet the needs of the elderly population[32]. This topic has been discussed internationally, demonstrating its relevance[33] and effectiveness in the development of public policies[34].

Another aspect of the problem mentioned in interviews with managers is the difficulty of hiring professionals, which also extends to various

categories of professionals and specialists:...*they hire new graduates, who only stay temporarily until they get admitted to a specialist program; those with degrees in family health are aggressively recruited by municipalities and go to whoever offers the highest price* (G-5).

Special circumstances contribute to this situation in Brazil, such as a short supply of doctors, fragile employment contracts, an inadequate material infrastructure, and sociopolitical circumstances that frequently interfere with the work process[29]. Other countries face similar shortages of human and material resources to meet their care needs[35].

Based on this national and international reality, local policy must be developed that is consistent with Brazil's strategies and purpose to consolidate this organization of the studied municipality's system into care networks. Furthermore, the recruitment of professionals who want to establish themselves in primary care must be strengthened, especially doctors who have a high turnover rate due to the lack of a coherent financial policy, and a proposal must be developed for organizing work that is capable of retaining these professionals on teams to offer comprehensive care.

With regard to management difficulties, this study identified different organizations of the work process in the municipality's UESF related to existing specific circumstances produced by factors such as macro- or micromanagement with regard to autonomy, a view of the health-illness process, and the work process. Autonomy of health services is better suited to local planning, but one might ask whether this autonomy at the local level derives from participatory management, with the teams taking coresponsibility for the proposed actions, or whether it is simply a result of macromanagement having difficulty performing its tasks with local services[36]. Closer coparticipation among managers, health teams, and users increases the users' autonomy in their care plan and helps bring about changes in practice in terms of relations and the work context[11].

Final considerations

This analysis of the implementation of PNSPI actions at the local level found that population aging is a growing topic of discussion due to its repercussions on various political sectors of the country. This analysis gathered relevant points for developing health care for the elderly in the municipality. The analysis also prompted reflections on the need to develop a work process underpinned by the expanded clinic, seeking full implementation of the PNSPI.

In the scenario studied, attempts have been made to implement the policies since the PNSPI was approved, with little progress with regard to the ESF teams. One of the causes for this lack of progress is associated with insufficient planning, and what has been accomplished did not result from the perspective of comanagement with the UESF teams, nor did it arise from the region's needs, producing a policy that has had little impact on teams' practices, considering that managers have also not fully adopted the PNSPI.

The training of professionals has also interfered with practices and technologies that meet the needs of the population, are based on the expanded clinic, and give the elderly an active role in their own care. As life expectancy has increased, so has the longevity of people over the age of 80. Thus, it is necessary to rethink the formation of the multidisciplinary team at the level of undergraduate- and graduate-level education and in the health services to meet the demands of the epidemiological transition and the needs of the demographic.

It will be essential to encourage broader implementation of the PNSPI through municipal managers committed to the needs of this demographic transition, with a view to the expanded clinic and the establishment of specific protocols, greater investment in the tools for comanagement, and the development of a network for comprehensive health care for the elderly.

This study was limited, as it did not cover elderly users' views on our national and local

health care situation. New studies are therefore needed to address how elderly people and their family members see the implementation of the PNSPI, considering health care practices and technologies, as well as access to health services in the RAS.

Collaborations

MJCF Damaceno participated in the conception, design, analysis, and interpretation of the data, as well as the writing and critical review of the article. MQ Chirelli participated as the research supervisor and reviewer at all stages of the article's development. Both participated in approving the version to be published.

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