Esc Anna Nery 2014;18(2):330-335

Elderly Health: perceptions related to the care provided

Saúde do Idoso: percepções relacionadas ao atendimento

Salud del anciano: percepciones relacionadas con el atendimiento

Lais Soares Vello[1]
Regina Célia Popim[2]
Elisabete Manieri Carazzai[3]
Maria Alice Ornelas Pereira[2]

1. Universidade de São Paulo. São Paulo - SP, Brazil.
2. Universidade Estadual Paulista. Botucatu - SP, Brazil.
3. Universidade Estadual Paulista. Nova Campina - SP, Brazil.

Abstract

Objective: This study was aimed at understanding how the elderly perceive the care provided in primary healthcare services. **Methods:** This is a qualitative study. **Results:** The analysis gave rise to the main topic to emerge: The duality in the perception of primary healthcare services, analyzed on the basis of two subcategories. It was shown that there is a controversy in the perception of primary healthcare services provided, bringing up positive and negative aspects. The statements show a demand for individualized care actions and, although in some cases complex healthcare services are needed, there is no demand for integrated care services. **Conclusion:** The research shows that, although there may be a certain degree of integrality in the actions of a well-articulated team, integral healthcare can only be achieved through the healthcare network and if integrated into all the organizational areas of the healthcare system, thus benefiting the people involved in these actions.

Keywords: Aged; Professional Practice; Primary healthcare; Qualitative research.

Resumo

Objetivou-se compreender como o idoso percebe o atendimento na atenção básica. **Métodos:** Trata-se de estudo qualitativo. **Resultados:** A análise possibilitou o emergir do tema central: A dualidade na percepção do atendimento na Atenção Básica, que foi analisada a partir de duas subcategorias. Revelou haver controvérsia na percepção do atendimento recebido, emergindo aspectos positivos e negativos. Os discursos pontuam demanda de ações individualizadas de cuidado, embora algumas vezes necessitem de cuidados complexos em saúde, não demandam cuidado em rede integrada. **Conclusão:** O estudo revela que, embora possa haver integralidade nas ações de uma equipe bem articulada, o cuidado integral à saúde poderá ser alcançado em rede, integrado em todos os espaços organizacionais do sistema de saúde, beneficiando, assim, os sujeitos dessas ações.

Palavras-chave: Idoso; Prática profissional; Atenção básica; Pesquisa qualitativa.

Resumen

Objetivo: Estudio cualitativo que visa entender cómo las personas mayores perciben el cuidado en la atención primaria. **Métodos:** Participaron de la investigación 13 ancianos de 70 a 90 años, acompañados por el área de salud mental en una Unidad de Salud. Se utilizaron la entrevista semiestructurada y el análisis temático para la comprensión de los datos. **Resultados:** La dualidad de la percepción del atendimiento en la Atención Básica fue analizada en dos subcategorías. Se reveló una controversia en la percepción de la atención recibida, emergiendo aspectos positivos y negativos. Los discursos apuntan una demanda de atención individualizada, aunque a veces requieren atención médica compleja. **Conclusión:** El estudio reveló que puede haber integralidad en las acciones de un equipo bien articulado, el cuidado integral a la salud podrá ser alcanzado en red, integrado en todos los espacios organizacionales del sistema de salud, así beneficiando a los sujetos de esas acciones.

Palabras-clave: Anciano; Práctica Profesional; Atención Primaria; Investigación cualitativa.

Corresponding author:
Regina Célia Popim.
E-mail: rpopim@fmb.unesp.br

Submitted on 05/27/2013.
Resubmitted on 11/05/2013.
Accepted on 11/22/2013.

DOI: 10.5935/1414-8145.20140048

INTRODUCTION

Brazil is currently going through a serious social and economic transformation, which is guided by the demographic changes. Mortality rates have been falling and the working age population is growing rapidly, as well as the elderly population.

This rapid growth of the Brazilian elderly population requires the development of strategies and policies to promote healthy aging and the guarantee of human rights. Considering the development of necessary health policies since 1994, legislation directed at the elderly population has been introduced in Brazil, emphasizing the peculiarities of healthcare and social inclusion in the National Elderly Policy and the Statute of the Elderly[1]. This Policy admits that the main issue affecting the elderly, as a consequence of the evolution of their illnesses and lifestyle, is the loss of functional capacity, that is, the loss of physical and mental abilities required to perform their basic and instrumental activities of daily living[1]. It aims to promote healthy aging, the maintenance and maximum improvement of the elderly's functional capacity, the prevention of diseases, the recovery of the health of those who fall ill and the rehabilitation of those who have their functional capacity compromised, in order to help them remain in the environment they live in, independently performing their duties within society[2].

Elderly health actions, as per the above mentioned Policy, are mostly directed at keeping the elderly within the community and with their families. Their move to a long-stay facility, either if this is a hospital, a nursing home or similar, may be considered an alternative only when all previous efforts have failed[2].

The increase in the demand for health services for the elderly shows the need to restructure primary healthcare, being the state's responsibility to develop policies and make decisions to proceed with the healthcare actions to meet the needs of the population. These epidemiological studies are essential to identify high-priority issues in order to guide decisions related to priority setting, thus assisting to better direct the healthcare actions and avoiding unnecessary expenditures[3].

It is evident that the community care of the elderly should be specially based on the family and on primary healthcare, through the Primary Healthcare Units (UBS), particularly in relation to those under the family health strategy, which should ideally represent the link to the healthcare system for the elderly[2].

The importance of viewing the family as a care unit is often expressed by the statement 'the patient is not alone, he comes from somewhere and the work is based on valuing the caregivers of people who need care, whether they are relatives and/or other professionals[4].

The systemic and integral perception of people in their family and social context is provided by working "with the real local needs, through an appropriate, humanized and technically competent practice, combining the popular knowledge with the technical and scientific knowledge in a real situation of people taking care of people". Concerning the Family Health Program and Psychiatric Reform, it is believed that the effective improvement in the quality of life converges to the delivery of healthcare within the family unit[4].

The professionals working in primary healthcare need to be clearly aware of the importance of keeping the elderly as part of the daily life of the family and the life within the community, being those essential factors for maintaining their physical and mental balance. One of the important tasks for those who embraced the proposal of the resolutive, integral and humanized primary healthcare is to view and consider essential the presence of the elderly within the family and the society in a participatory and constructive way. Not only the longevity of the human being should be accepted as the main victory of modern society, but this human being should have the assurance of a good quality, happy life and an active participation in the community. Therefore, the "elderly situations" should not be viewed as a determination but rather as a possibility[2].

Due to their strategic position in the Unified Health System (SUS) to ensure universal access and coverage, it is the responsibility of the primary healthcare services to provide integrality: integration of programmatic actions and spontaneous demand, articulation of health promotion initiatives, disease prevention, health surveillance, treatment and rehabilitation, interdisciplinary and team work, and coordination of care in the healthcare services network. The Family Health Strategy (ESF) is the main type of primary healthcare. Its principles are: acting in the area with a focus on the situational diagnosis, dealing with health issues with the help of the community, aiming for care delivery to people and families over time; for the integration with social institutions and organizations, as a place for developing citizenship[4]. The integrality, throughout the introduction of the SUS, has been viewed as a social and political practice, which makes it necessary to know and understand the people's lifestyle in order to permit integral care[4,5].

The implementation of the Family Health Strategy enables the integrality of care and the creation of commitment and shared responsibility bonds between the healthcare services and the population. Therefore, the healthcare actions undertaken by professionals who work in the Family Health Strategy (ESF) need to overcome the old proposition exclusively focused on the disease, using managerial and health, democratic and participatory practices, aimed at the population of defined areas for which they take responsibility. This requires that family healthcare professionals are prepared to deal with aging without the division of working processes, and establish a relationship with the elderly recognizing their experience and wisdom[5].

The practice of integrality depends on the sensitivity and availability of the professionals to understand the different aspects that influence the health status of the person they are taking care of[6].

It is therefore assumed that the integrality starts with the organization of the work processes in primary healthcare, where care should be multi professional and operated through guidelines such as the link between care and patient, in which the staff is responsible for their care[7].

The integrality entails the flexibility of the technical division of the work. Integral healthcare is only achievable when the work is connected and the division between knowledge and practice is ended. In order to move towards integrality, it is important to identify the difficulties in dealing with the elderly[7,8].

Integral care goes beyond the hierarchical and local organization structure of the healthcare, is extended to the real quality of individual and collective healthcare assured to users of the healthcare system, requires commitment to continuous learning and to multi professional practice[9].

Thus, Mattos highlights three major groups for integrality, related to: 1) attributes of the healthcare professionals' practice, being these the values related to what is defined as good practice, whether or not they occur in the scope of the SUS; 2) attributes of the organization of the services; and 3) government responses to healthcare issues. Such concept is very broad and leads to a reflection about the role of the various people involved in the practice of the integrality principle[10]. Based on these considerations, the question is: how do the elderly perceive the care provided to them in the primary healthcare service? From these considerations, this research was aimed at understanding the perception of the elderly concerning the care provided in the Family Healthcare Unit.

METHOD

The research has a qualitative scope that, according to Minayo, is seen as that capable of incorporating the meaning and intentionality issue as inherent to the acts, relationships, and social structures, being the latter considered both in their origin and in their transformation, as significant human constructions[11].

This study was developed in a Family Health Strategy unit, located in a country town in the state of São Paulo. The suburb where the unit is located has a low income population and complex family network. It could be observed that a large number of elderly people make use of psychiatric medication, with a high rate of depression. The unit has three healthcare teams and each team consists of a doctor, a nurse, three nursing assistants and four community health agents (ACS). The unit has a dental service and has the matrix support of the mental health team.

The choice of participants started with a contact between the researcher and the professionals working in the Family Health Strategy unit. Thirteen people were interviewed, aged 70 or over, who were assisted in the unit, had a diagnosis related to their mental health and who at the time of the interview were able to answer the questions posed. The saturation criteria established by Minayo was used[11].

After the positive assessment of the Research Ethics Committee of the School of Medicine, Registration Number 3555-2010, the interviews were conducted through home visits (HV), based on referral by the Community Health Agents.

After this stage, a semi-structured interview was conducted. In this interview, after the identification records (gender, age, marital status, number of children, who they live with, whether they receive any payments), a recorder was used with the following guiding questions:

> *"Concerning the Family Health Strategy, how do you consider the care provided?"*

A pilot interview was initially conducted in order to test the instrument and perform the necessary changes. The interviews were performed in the homes of each participant and, for such, the researcher was accompanied by the Community Agent. The interviews lasted an average 10 to 20 minutes and, in all of them, the researcher was welcomed by the participants and their families and/or caregivers.

The data collected in the interview were transcribed by the researcher. Then, the Attention Fluctuation of Minayo[11] was used and the text was read several times with the purpose of establishing the best possible contact with the material, so that its contents were absorbed. In the next stage, the thematic analysis proposed by Bardin was used[12]. This author argues that the thematic analysis consists of finding out the core meaning that is involved in the statements and whose frequency of appearance may mean something for the analytical objective chosen. Based on this view, the thematic analysis follows these organizational stages: pre-analysis, material study, handling of the resulting data, inference and interpretation[12].

RESULTS

For data collection, thirteen participants were interviewed, being nine women and four men. Their age ranged from seventy to ninety years. Concerning their marital status, eight are married and five widowed. In relation to housing, two of the interviewees live on their own, eight live with their partners, one lives with a niece and two only with their children.

Therefore, based on the participants' statements, it was possible to define a core theme, titled: The duality in the perception of primary healthcare services, analyzed on the basis of two subcategories: Satisfaction; Dissatisfaction, as shown by Figure 1.

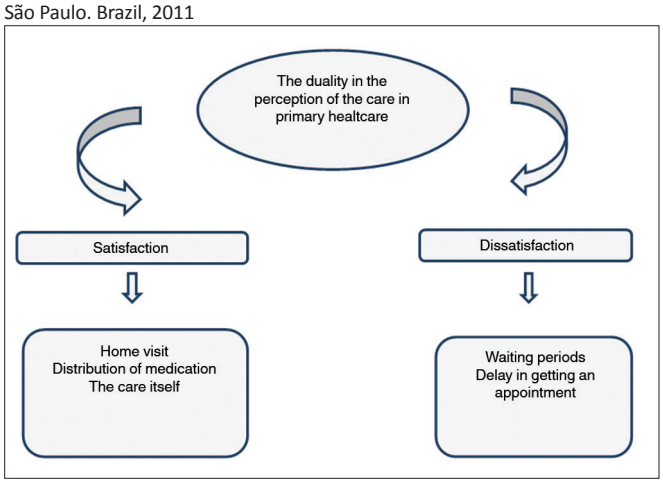
DISCUSSION

Satisfaction

Vulnerability in the health field is an appropriate concept to encourage social responses and one that does not have direct application to issues involving the health of elderly people. In this sense, it can be asked whether elderly people are socially recognized as citizens with rights and who, regardless of social status, have the right to achieve a healthy aging and successful old age[13].

The healthcare services are present in the daily lives of families who experience the care to the elderly with chronic illnesses in many ways, such as through the provision of continuous use

Figure 1. Flow chart built by the authors concerning the experience of the elderly who live in the community in relation to the primary health care. Botucatu, São Paulo. Brazil, 2011



of medication in the treatment of the illness and also through the work of the Family Health Team that conducts home visits, organizes meetings with the population, gives individual and collective advice, amongst other initiatives[14].

Most participants stated that they like the unit, the care and assistance provided by the Family Health Unit.

> *The care is good, is very good (E1).*
>
> *They have always provided good care (E2).*
>
> *Always well taken care of, I have nothing to complain about, I have to praise (E9).*

In addition to the positive opinions about the care provided in the unit, there were reports mentioning the home visit performed by the USF professionals.

The home visit shows to be an important tool in the care for the elderly's health which, in addition to the performance of health actions, permits the prevention of complications resulting from the chronic illness and which also becomes a strategy that benefits the bonding between the family and the healthcare team. The home visit is aimed at assessing the needs of the patients, their families and the environment they live in, to enable the healthcare team to establish a care plan focused on recovery and/or rehabilitation of the family members, taking into account the patients' needs and the availability of the service[15].

Among the various features of the Family Health Program, the proximity between the unit and the users and their families can be highlighted, since its basic principle is to meet the demand of the community the healthcare actions are directed at.

The intervention methods in areas of social exclusion should consider the perspective of integrality and the care as value and of the gift as a system of mediation of the practices. The discussion about what health means and about the organizational determinants or conditions of the users' well-being depends on how the corporate mobilizations on the one hand and the corporate and utilitarian interests on the other hand affect the organization of the public sphere and put the user in a central position[14,15].

The central position of the patient in the PSF can be observed, differently from a Primary Healthcare Unit, as per the statement:

> *I really liked the assistance provided here in the unit, they come here, are all nice people, and before, in order to do anything we had to go there, it was a sacrifice, sometimes there was nobody willing to take us there... (E6).*

The patients also acknowledge the medication given by the service:

> *It helps, doesn't it? The medication they give us, imagine if I had to buy them? With what? The help they give us, at the university, at the unit, is good, isn't it? (E8).*

It is possible to think that, although integral care is a basic principle of the Unified Health System, some reports indicate that, for the participants, the care provided is closer to a gift than to the right to health.

> *Here it is good, it is not bad... I don't have complaints about the rest, if I go to get medication, I get it, there are people who complain about it, but not me (E12).*

The idea of integrality as a principle should guide to listening, understanding and, from this, to meet the demands and needs of people, groups and communities. Based on this principle, and on acting in health, the services should offer promotion of health actions, prevention of risk factors, assistance to damages and rehabilitation according to the process dynamics health-illness, and these should be articulated and integrated in all organizational areas of the health system. Thus, the health institutions play a strategic role in absorbing the knowledge about new ways of acting and promoting integrality in the health field and represent a privileged locus of observation and analysis of the elements that constitute the institutional principle of integrality, either in relation to the therapeutic practices offered to people, or in relation to the health practices disseminated in the community[15].

> *Health here in Botucatu is ok, because what we see around, so many complaints, if you go to Unesp you are assisted, if you go to the unit, you are assisted, then I have nothing to complain about, there are people who still complain, but I don't know... (E10).*

Always well assisted, I have nothing to complain about, I have to praise (E9).

The elderly expressed that they like the care provided and show a perception of the minimum access in relation to their needs, focusing their perception on the operational sphere of the healthcare service.

Dissatisfaction

Reports are also heard, however, with explicit complaints concerning waiting periods for assistance.

Oh yes, so so, we can manage, it is ok. It is hard to get an appointment but there are a lot of people aren't there? (E3).

In Carreira and Rodrigues' research, it could be observed that the families report several difficulties in using the public healthcare service, and among them they point out to the problems of non-continuity of the programs conducted by the primary healthcare units, which occurs mainly due to the change of government, when some public healthcare policies are changed. These administrative changes usually cause discontinuation of the treatment of elderly people, who perform follow ups of their chronic condition and have to adapt to the new bureaucratic rules established by the healthcare services[16].

In this study, there were also reports of people missing the past, when there were Primary Healthcare Units:

In Ielo's time, there was more assistance, we got a Diabetes appointment every 3 to 4 months, not anymore (E13).

The participant heard mentioned the previous administration and part of the previous experience to appreciate the care provided in the current unit. One of the aspects related to the integrality pointed out by Mattos is the issue concerning the importance of the management of healthcare policies in the cities. That is, what are the responses provided by the administrators to the needs of the population, which is directly related to the organization of the services.

The networks of collaborating mediators are systemic sets involving users, healthcare agents and specialized professionals in the units (mainly doctors and nurses), who are responsible for the civic, humanitarian, cultural, political, administrative and legal movements in the transition from a centralized care model to a decentralized participatory model that is reorganizing the local public sphere[17].

On the other hand, the active aging policy proposed by the World Health Organization (WHO, 2005) has also discussed elderly health issues, emphasizing that aging well is part of a collective construction and should be facilitated by public policies and by opportunities for healthcare access in the course of life[17].

Although there is a policy to benefit the elderly, it can also be noted that the financial and economic abuses do not occur only within the families, but they are also present in the state relation, omitting rights, in the delays of benefit payments, in the retirement payment and others. They are also victims of larceny, taking advantage of the physical vulnerability in bank agencies, shops, streets, ATMs[18].

The integrality becomes a relevant attribute to be taken into account in the assessment of the quality of care, services and healthcare systems, generally those directed to a policy of primary care[15].

In order to conduct a practice in accordance with integrality, it is necessary to effectively perform team work, since the graduation process of healthcare professionals. It is necessary to establish training strategies that support dialogue, exchange, transdisciplinarity between the different formal and non-formal types of knowledge that contribute to the individual and collective health promotion initiatives[15,16].

Based on the reports, it can be seen that there is satisfaction with the Family Health Unit, with the team, but there are also people comparing this new strategy with the strategy used in the old primary healthcare units.

But as regards integrality, the changes have not been so evident. They happen here and there, but have not yet achieved the expected generalization or visibility. For this exact reason, it might be convenient to dedicate more attention to examining these experiences, the majority being local, which turn the practices into the direction of the integrality. There is the need to recognize them, to analyze the conditions that made their rise possible, to reflect about the potential and the limits of their dissemination, to analyze the experiences that are based on the integrality as an important subject of research[17].

The integrality proposes the expansion and development of care in the healthcare professionals and is not only defined as a basic guideline of the Unified Health System (SUS). This means that the integrality "shall be daily constructed". In the day-to-day of the ESF teams, the integrality is present in the micro processes of health work, in the duties of each professional who adopts a caring and compromised position with the users, their care and the cure, while establishing bond, conducts and equitable priorities to care for them in relation to their needs. The integral approach of patients/families in the ESF is supported by the teamwork of the various professionals who are part of the interdisciplinary teams[16,17]. A report of the World Bank released in 2011 about aging in Brazil[18] points out the several challenges to be faced in our country so that there are structural and educational conditions to provide integral care to elderly people. It suggests that the appropriateness of healthcare services to the demand is urgent and that the educational institutions follow up the process of demographic change and have the appropriate resources

for the new reality presented. This is the only way to adapt and fully assist elderly people in their demands. This research, although undertaken in a restricted place, showed the need for the healthcare professionals to educate themselves in relation to the senile aging process and plan strategies of integral care in their units from the elderly's point of view.

FINAL CONSIDERATIONS

This research was aimed at understanding how the elderly identify and perceive the care provided at the Family Health Unit.

The statements of the participants show the duality in the perception of the care provided, with positive and negative aspects. The home visit, the distribution of medication and the care in the unit are elected as positive and the waiting periods and delay in getting an appointment as negative. They reveal to be unaware of the right to health and have demands for individualized care actions. Although they sometimes need complex health care, they do not demand care in an integrated service. It is considered that there could be a level of integrality in the actions of a well-articulated team, but that complete healthcare integrality can only be achieved in an integrated service.

The need for awareness and social action in relation to aging is evident and the importance of the training organizations to ensure the education of future professionals focused on healthcare based on a cooperation network among the various professionals can be highlighted.

Based on the above, as a challenge for society, it can be said that it is our responsibility, as healthcare professionals, to view the elderly beyond their limitations and as a citizen with the right to integral care in the various levels of complexity.

Despite its limitations due to being descriptive and covering a restricted population, this study points out the healthcare professionals' need to be aware of the senile aging process and plan integrated care strategies in their units. In addition, it serves as a warning to the administrators and to the State about the urgent need to organize the care services concerning the elderly people living in the community, suiting the service supply to the demand presented by the currently increasing number of elderly people and those who will have various degrees of care needs.

REFERENCES

1. Valadares FC, Souza ER. Violência contra a pessoa idosa: análise de aspectos da atenção de saúde mental em cinco capitais brasileiras. Cienc. saude colet. 2010;15(6):2763-74.
2. Silvestre, J. A. & Costa Neto, M. M. Abordagem do idoso em programas de saúde da família. Cad. Saude Publica. 2003 mai/jun;19(3):839-47.
3. Venturi I, Rosado LEFP, Cotta RMM, Rosado GP, Doimo LA, Tinoco ALA, et al. Identificação da área de influência do serviço de atenção básica do sistema público de saúde à população idosa, município de Viçosa-MG. Cienc. saude colet. 2008;13(4):1293-304.
4. Tanaka OY, Ribeiro EL. Ações de saúde mental na atenção básica: caminho para ampliação da integralidade da atenção. Cienc. saude colet. 2009;14(2):477-86.
5. Mattioni FC, Budó MLD, Schimith MD. O exercício da integralidade em uma equipe da Estratégia Saúde da Família: Saberes e Práticas. Texto & contexto enferm. 2011 abr/jun;20(2):263-71.
6. Araújo MAS, Barbosa MA. Relação profissional de saúde/idoso. Esc Anna Nery. 2010;14(4):819-24.
7. Franco TB, Magalhaes HMJr. Integralidade na assistência à saúde: a organização das linhas de cuidado. O Trabalho em Saúde: olhando e experienciando o SUS no cotidiano. 2ª edição; São Paulo: HUCITEC; 2004.
8. Motta, L.B. & Aguiar, A.C. Novas competências profissionais em saúde e o envelhecimento populacional brasileiro: integralidade, interdisciplinaridade e intersetorialidade. Cienc. saude colet. 2007;12(2):363-72.
9. Machado, M.F.A.S. et al. Integralidade, formação de saúde, educação em saúde e as propostas do SUS - uma revisão conceitual. Cienc. saude colet. 2007;12(2):335-42.
10. Mattos RA. A integralidade na prática (ou sobre a prática da integralidade). Cad. Saude Publica. 2004 set/out;20(5):1411-6.
11. Minayo, MCS. O desafio do conhecimento, pesquisa qualitativa em saúde. 11ª ed. São Paulo: Hucitec; 2008.
12. Bardin, L. Análise de conteúdo. Lisboa (POR): Edições 70; 2008.
13. Silva HS, Lima AMM, Galhardoni R. Successful aging and health vulnerability: approaches and perspectives. Interface: Comunicacao, Saude, Educacao. 2010;14(35):867-77
14. Carreira L, Rodrigues RAP. Dificuldades dos familiares de idosos portadores de doenças crônicas no acesso à Unidade Básica de Saúde. Rev. bras. enferm. 2010 nov/dez;63(6):939-9.
15. Silva BK, Bezerra AFB, Tanaka OY. Direito à saúde e integralidade: uma discussão sobre os desafios e caminhos para sua efetivação. Interface: Comunicacao, Saude, Educacao. 2012;16(40):249-59.
16. Conill EM. Avaliação da integralidade: conferindo sentido para os pactos na programação de metas dos sistemas municipais de saúde. Cad. Saude Publica. 2003 set/out;20(5):1417-23.
17. Viegas SMF, Penna CMM. A construção da integralidade no trabalho cotidiano da equipe saúde da família. Esc Anna Nery. 2013 jan/mar;17(1):133-41.
18. Banco Mundial. Banco Internacional para a Reconstrução e o Desenvolvimento. Envelhecendo em um Brasil mais velho: implicações do envelhecimento populacional para o crescimento econômico, a redução da pobreza, as finanças públicas e a prestação de serviços. Washington (USA): Banco Mundial; 2011.