Original Article

Hypertensive patients in primary health care: access, connection and care involved in spontaneous demands

Usuários hipertensos na atenção primária à saúde: acesso, vínculo e acolhimento à demanda espontânea

Usuarios hipertensivos en la atención primaria de salud: acceso, unión y acogimiento a la demanda espontánea

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ABSTRACT

Objective: To assess the impacts of inclusion of care for spontaneous demands in the treatment of hypertensive patients in primary health care.

Methods: Third generation qualitative assessment survey conducted with 16 workers in a Primary Care Health Unit (PHCU) of the city of Fortaleza, state of Ceara, in the period between July and September of 2015. To collect data, systematic field observation and semi-structured interviews were used, and the stages of thematic content analysis were adopted for data analysis.

Results: Participants revealed that access, connection and care are fundamental to the treatment of hypertension. However, they said that the introduction of free access for spontaneous demands compromised the flow of care in the hypertension programs.

Conclusion: A dichotomy between the practice of care recommended by health policies and the one existing in the reality of PHCUs was shown, causing evident losses to the care of hypertensive patients in primary care.

Keywords: Primary Health Care Hypertension. Care.

RESUMO

Objetivo: Avaliar os impactos da inserção do acolhimento à demanda espontânea no tratamento de usuários hipertensos na atenção primária de saúde.

Métodos: Pesquisa de avaliação de terceira geração qualitativa, realizada junto a 16 trabalhadores de uma Unidade de Atenção Primária de Saúde (UAPS) da cidade de Fortaleza-CE, no período entre julho e setembro de 2015. Para a coleta de dados, foram utilizadas observação sistemática de campo e entrevistas semiestruturadas e, para a análise, adotaram-se as etapas da análise de conteúdo temática.

Resultados: Os participantes revelaram que o acesso, vínculo e acolhimento são fundamentais para o tratamento da hipertensão, entretanto afirmaram que a introdução do livre acesso à demanda espontânea comprometeu o fluxo de atendimento dos programas de hipertensão.

Conclusão: Foi evidenciada uma dicotomia entre a prática do acolhimento preconizada pelas políticas de saúde e a existente na realidade da UAPS, acarretando prejuízo ao cuidado do hipertenso na atenção primária.

Palavras-chave: Atenção primária à saúde. Hipertensão. Acolhimento.

RESUMEN

Objetivo: Evaluar el impacto de la inclusión de acoger la demanda espontánea en el tratamiento de pacientes hipertensos en atención primaria de salud.

Método: Estudio de evaluación cualitativa de la tercera generación hecho con 16 trabajadores de una Unidad de Atención Primaria de la Salud (UAPS) de la ciudad de Fortaleza, en el período entre julio y septiembre de 2015. Para la recolección de datos, fueron utilizados observación de campo sistemática y entrevistas semiestructuradas, y en el análisis se adoptaron las etapas del análisis de contenido temático.

Resultados: Los participantes revelaron que el acceso, enlace y la recepción son fundamentales para el tratamiento de la hipertensión, sin embargo, dijeron que la introducción de libre acceso a la demanda espontánea en peligro el flujo de la atención de los programas de hipertensión.

Conclusión: Se demostró una dicotomía entre la práctica de acoger recomendado por las políticas de salud y existiendo en la realidad de la UAPS, causando daño a la atención de los pacientes hipertensos en atención primaria.

Palabras clave: Atención primaria de salud. Hipertensión. Acogimiento.

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INTRODUCTION

The Family Health Strategy (FHS) emerged 21 years ago as a new health intervention for the implementation of primary care, focusing on restructuring the health care model in force until then. In this sense, the FHS proposes to change the health care model, removing focus from the hospital model, evolving to closer attention of communities[1], with care and connection being key tools for confidence-building with the user.

As one of the structural axes of the Unified Health System (SUS), the primary care level is now living a special time where it is identified as a priority for the Brazilian Ministry of Health, and among its current challenges, those relating to access, connection and care should be highlighted[2].

In the case of chronic noncommunicable diseases, hypertension (HTN) especially stands out as the most prevalent disease worldwide, accounting for 13.5% of all deaths, which significantly increases cardiovascular risk, being a clinical multifactorial condition characterized by high and sustained blood pressure levels. In Brazil, the average prevalence is 32.5%, thus representing a serious public health problem[3-4].

In this context, the Primary Health Care (PHC) has the important assignment of being the preferred gateway to the health care system, recognizing the set of needs and positively impacting the health status of the population[5]. Therefore, HTN has shown to be a great challenge for the primary network as it is a condition where biological and sociocultural determinants coexist, and in order for an approach to be effective, the active participation of individuals, their families and the community is required, which results in a noticeable contribution to access, connection and care in these cases[6].

In this sense, it is necessary to understand that the resoluteness of care for hypertensive patients is not only in the use of medicine and the institution of regulatory measures, but in consideration of the person as a whole[7]. These actions must be provided in association with the care of spontaneous demands and qualified listening, especially in emergency care, involving actions that should be undertaken in all health care units, including the primary care services[8]. The actions must articulate the PHC teams and the population, enabling the establishment of a connection, which characterizes the continuity of care, legitimizing this level as a priority and preferred gateway to the care networks of SUS health care, and ensuring continuity of care to hypertensive patients.

However, over 20 years after the implementation of SUS and despite advances related mainly to the expansion of services within the basic health network, access to health services remains a challenge[9]. In the city of Fortaleza, state of Ceara, free access and care for spontaneous demands began to be implemented in 2013, with a series of changes in the dynamics of health units. Since then, the units operate during new shifts (12 hours of daily care) with a team that is available exclusively to meet the the free demand, in which the nurse is allocated in a room next to the reception to welcome users seeking assistance, performs risk assessment and determines the need for medical care, according to the principle of equity, regardless of the users' relationship with the family health teams.

In this context, it is believed that by allowing free access of spontaneous demands to PHC, especially in the case of hypertension, a disease that requires ongoing treatment, the effectiveness of care and the connection with users may be compromised, as users turn to primary care units targeting timely care, confronting the control of acute cases of illness with health promotion strategies for chronic diseases proposed in this level of care.

Although scientific literature indicates the importance of access and care in health [4,7-9], it was noticeable that few productions discuss the impact of their institution in the care of people with hypertension in primary care. Thus, it becomes essential to understand the factors that influence the use of primary care in the treatment of hypertension, identifying satisfaction with the care provided to hypertensive patients and the results in disease control.

From this problem came the following guiding question: *What are the impacts of the inclusion of care for spontaneous demands in the treatment of hypertensive patients in primary health care.*

Also based on the national need to work with research focused on the reality of primary care in order to obtain knowledge about programs for this level of health assistance, and the trend established by the programs of the Ministry of Health that seek to reveal the reality of assistance, this study aimed to evaluate the impact of the inclusion of care for spontaneous demands with risk rating in the treatment of hypertensive patients in primary health assistance.

METHOD

This is a third generation evaluation research with a qualitative approach, which is characterized by judgment, where the evaluator performs the function of describing and measuring, plus establishing the merits of the program evaluated, based on external references[10]. This type of research affirms the need to take into account the partici-

pation and perceptions of those involved, considering the relationship as a fundamental part of the actions[11].

In this case, it will help determine whether the insertion of care for spontaneous demands with risk rating has reached the objectives to meet population health needs in accordance with the principle of equity, ensuring health care, regardless of the arrival order, providing the relevant decisions in the context of primary care.

This research was carried out from the development of a master's thesis[12], and its data collection was completed in a Primary Care Health Unit (PHCU) of the city of Fortaleza, state of Ceara, in the period between July and September 2015.

The city of Fortaleza is administratively divided into seven Regional Secretariats (RSs), which have an executive role regarding sectoral policies, which pivotally define their priorities, setting specific goals for each population group. Thus, research was conducted in a PHCUs belonging to RS IV, in which the State University of Ceará (UECE) is inserted[13].

Health workers participated in the research selected by convenience from their hours of availability to meet the researcher, which are embedded in the inclusion criteria (those who had an employment relationship with the PHCU and directly assisted hypertensive patients for more than six months) and exclusion (those absent from service for vacation or leave).

The first stage of data collection, started from systematic field observation in order to recognize the drive and understand the reality of assistance given to hypertensive users. It was maintained throughout the entire period of study development and happened in a structured, open and non-participative manner[14].

Semi-structured interviews were carried out with the participants in order to learn their opinions regarding access, connection and care for users with hypertension in primary care[15]. Thus, the interview guide was composed of five questions with approaches related to hypertensive service flow within the PHCU, access, bond and care for these users in the primary care network.

Interviews were conducted until the objective of the study was answered, and adopted a sample of 16 participants for this purpose. Among them are doctors, nurses, dentists, pharmacists, nursing staff, oral health technicians, laboratory technicians, community health workers and receptionists.

In order to contextualize and analyze the manifested content, the survey adopted thematic content analysis[16]. The data were stored in audio files, transcribed and analyzed as shown in the Figure 1.

The study was approved by the Ethics Committee of UECE under opinion No. 1.068.382, and during its development, the ethical and legal requirements of Resolution No. 466, of December 12, 2012 of the National Health Council[17] were followed. All participants were informed of the objectives, rationale and relevance of the study, and were then asked to sign the Free and Informed Consent Form safeguarding the option to participate or not in the research, anonymity and the option to withdrawal at any time. In order to keep their anonymity, participants were identified throughout the study by the letter "P" followed by numbers from 1 to 16 that were randomly distributed.

RESULTS AND DISCUSSION

Based on the adoption of hypertension as a multifactorial chronic disease requiring treatment strategies for its prevention and control of complications, there was

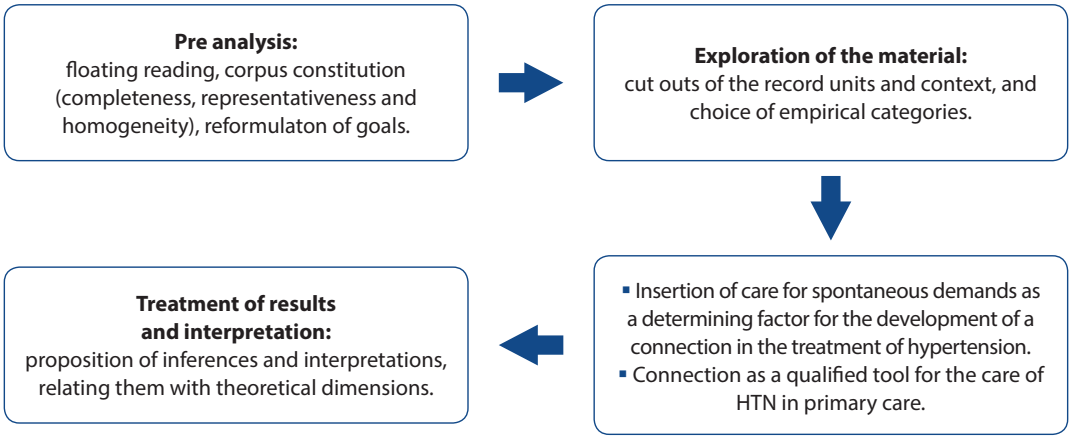

Figure 1 – Flow adopted for the content analysis

Source: Prepared by the author, based on the thematic content analysis [11].

the need for these users to be assisted with care and connection. For the development of the empirical categories described below, it was remembered that the FHS should have its attention focused beyond the patient user, especially in the hypertension control program, involving the family, the environment and the community, with the multidisciplinary team working beyond healing practices and providing universal, equitable and comprehensive care.

Insertion of care for spontaneous demands as a determining factor for the development of a connection in the treatment of hypertension

The insertion of care for spontaneous demands of hypertensive patients was perceived as crucial to the development of a connection. It was noticed that hypertensive crises are frequent, denouncing the non-adherence to hypertension programs and divestment of the user from the service. It has been found that users seek the PHCUs in times of disease "acuteness" (crises), in exchange for elective consultations to control blood pressure and risk factors.

Addressing the flow of care, after inserting care for spontaneous demands, respondents were asked about changes in the care of hypertensive patients within the PHCU, in order to understand how the process occurs within care in assistance. The following statements were highlighted:

> *This current management model with basic health units opened from 7am to 7pm is interesting in theory, giving the impression that there really is functionality. The basic health unit is open from 7 to 7 [7 am to 7pm], but is it really providing services? And follow ups? What we see are many hypertensive patients in suffering (P14).*

> *Now, doctors devote much time to SD [spontaneous demand], causing the number of consultations for hypertension and diabetes to be in the range of 16 [users] a week, which is very little. It is impossible to calculate a percentage average regarding hypertensive patients (P4).*

In the meantime, it is emphasized that the PHCUs work through new hours (12 hours of daily care), with a team available exclusively to meet the demand, in which the multidisciplinary team is structured so that the nurse performs risk rating and determines the need for medical care, regardless of the users' relationship with the family health teams. This fact makes it easy to search for assistance in times of crisis instead of waiting for elective consultations.

It has been found through the speeches that the inclusion of care for spontaneous demands has not been well accepted by health workers, for, according to them, urgent cases and emergency cases overlap with scheduled appointments that focus on prevention and health promotion in hypertension, compromising the connection with the users belonging to the area of expertise of its teams.

> *Before, we had two shifts just for the care of hypertension and diabetes. Now, we only have one shift, with about 250 hypertensive patients, outside the coverage area (P11).*

It was noticeable that in the PHCU investigated, stimulating free access and care for spontaneous demands was against what is advocated by the MH which seeks, with these measures, to legitimate primary care as a priority and preferred gateway to SUS, ensuring assistance continuity for hypertension patients. According to the statements in this health unit, the care for spontaneous demands is compromising the connection with hypertensive patients attended by the health team.

> *We have a PHCU close to use and, therefore, many cases are referred here because of the SD [spontaneous demand], which is for emergency care [...] it serves not only the demand of the neighborhood, but also all the other neighborhoods (P16).*

> *What we are finding is that hypertensive patients are not using the scheduled demand, frequently coming forward as spontaneous demands, since it is easier, considering that there is no need to scheduled an appointment, and they are met upon arrival, each receiving medication, which they consider is enough (P1).*

However, there another larger problem arises, which is the non-adherence to treatment plans, bringing the "convenience" of hypertensive patients to primary care, discontinuing the monitoring of users with chronic disease that requires continuous supervision, control and prevention of sudden crises, characteristic of the clinical condition of hypertension.

> *What happens today is that hypertensive patient is not always met by the doctor or nurse of his staff, meaning that a certain emergency was created in basic care, where every day there is a rotation of physicians, who are in a room that is called SD, which meet a demand for people who are not even from the neighborhood (P10).*

In this context, the prospects of linking users to the territory of each PHCU are to be desired, considering that this emergency service, overlapping the follow-up of health assistance regarding chronic disease in systematically promoting and preventing complications of the disease, which enables the patient to disregard the treatment plan.

People often do not come to the appointments and when they "feel sick", and end up coming here and are met by any other professional, meaning they are not monitored (P10).

Hypertensives end up using SD to receive care because they aren't able to schedule appointments, with no ties to any doctor, because each time they come, they see a different professional (P12).

The complaint that users have limited access to this consultation provides investigative discussion about the issues and situations that have led users with high blood pressure to opt for service in spontaneous demand.

The existence of a dichotomy between those practices that have been implemented in various scenarios was noticed from the speeches. It signals deficiency with respect to the change of the hegemonic model, since it has been insufficient to change the way of thinking and performing everyday actions at various levels.

In addition, the reception of complaints and specific behaviors related to acute situations of illness favors the low solvability, with health problems being resolved in a fragmented and focused way, contributing to the user constantly returning for service for not having his health demand actually welcomed.

In comparison with the experiences reported by workers of the health unit, care should emerge as a tool capable of promoting the connection between the health unit and user, allowing the stimulus to self-care, better understanding of the disease and co-responsibility in the therapy proposed[18]. Corroborating that although it assists in universal access, it strengthens the multidisciplinary and intersectoral work, qualifying health care, humanizing the practices and stimulating prejudice combat actions.

In this perspective, care should be understood as a relationship that can develop and strengthen affection, contributing to the therapeutic process between users, workers and managers of the health system.

It is also important to note that in the context of the service, the care for free demands was identified as the moment when the user is welcomed, which happens in a physical environment isolated from the daily care of health teams within the PHCU, unlike the dimension of welcoming and caring as a pillar fundamental for the construction of the new PHC model, involving much more than just receiving the user, but also giving that user attention by listening and identifying individual needs.

In this sense, it is emphasized that care is based on social inclusion, respect and promotes bonding through dialog. Nonetheless, reducing care to exclusive practices of risk classification without the guarantee of listening makes the practice performed at the gateway just one more step to be followed by the user in his flow in the unit.

Thus, care should not be associated solely with the moment users are checked in at the clinic reception, it is a change in the work process, in order to meet all those who seek it, and should focus on understanding the accountability of workers for users, the qualified listening of the user's complaint, the operative care assurance and coordination with other services for continuity of care, when needed.

Connection as a qualified tool for the care of HTN in primary care

Respondents expressed the employee/user connection as key to control and qualified treatment of hypertension. The practice of caring, as recommended in primary assistance, can facilitate the creation and strengthening of connections, as users begin to feel welcomed by the service and the workers begin to truly know the history of the user within their community.

It should be highlight that the characterization of a connection as a complicit relationship between users and workers, established at the moment of reception and known as a starting point for building trust between those involved in blood pressure control. It is considered that, in order to establish a bond, empathy and respect are essential, and the elements that denote the formation of the bond are based on mutual recognition between service and community, because a bond can not be established without an individual, without the free expression of the user through speech, judgment and desire.

It was noticed that interdisciplinary actions of co-responsibility among health workers and the population proved fundamental to the interviewees – because according to them, they provide bonds to be construed – in the production of qualified care and health promotion in hypertension.

The hypertensive program should be the basis of care (P16).

[Quality] is keeping your patient from the beginning, having a medical record that is always available in order to be able to access the complete history of the patient (P10).

The actual monitoring of hypertensive patients as it was before, in the Family Health Strategy, because doctors and health workers knew the patients and monitored them. Today, this is quite outdated (P14).

It was also found that health workers consider the employee/user connection as key to control and qualified treatment of hypertension. The construction of the connection must, through speech, be based on the building of bonds between workers and users through access, humanization, co-responsibility, dialog, respect and trust. From the construction of the connection and trust arise satisfaction and user safety.

It also highlights the importance of workers with a more sensitive profile to understand the real needs of the population, produce attention able to generate social satisfaction and technical excellence, in a resolute manner for users[19].

The connection allows trust to be built and the stimulation of self-care, promoting the understanding of the disease and the development of therapeutic strategies by users. Along with care, connection is another light technology associated with humanization, which does not exist without the users being recognized in the condition of individuals, increasing the effectiveness of health actions and encouraging user participation during care.

Especially in the case of hypertension, the bond constitutes an effective tool in the democratization of care practices, favoring negotiation between workers and users, making them autonomous subjects in the treatment, allowing the construction of co-responsible treatment plans, preventing comorbidities associated with HTN and promoting health.

Thus, the relationship established, the exchange of experiences, care and qualified listening may act as elements that enhance the quality of care, promote the safety of care and promote user satisfaction[20].

Connection happens through the relationship between the health worker and user, focusing on a practice centered on the individual. Thus, workers must seek to perform their tasks in a multidisciplinary way, considering the racial, cultural, religious and social factors present, involving caregivers and family in the development of community strategies that seek to control chronic diseases.

Focusing on the user with hypertension, connection constitutes an effective tool in the democratization of care practices, favoring negotiation between workers and users, making them autonomous subjects in the treatment, allowing the construction of co-responsible treatment plans, preventing comorbidities associated with HTN and promoting health.

FINAL CONSIDERATIONS

This field research has identified that there is a dichotomy in the studied PHCU between the practice of accepting free demands, as recommended in Primary Care Books, and the other policies promoted by the Ministry of Health, and the assistance provided in the reality of attention to hypertensive patients .

Being hypertension a chronic disease with high prevalence rates, requiring continuous treatment, the fact that care is perceived as a specific practice that associated with risk classification proved to be a binding factor for the creation of connections between health workers and users, causing losses to the care of hypertensive patients in primary care.

Regarding the manifestation of health workers, they demonstrated knowledge of the importance that access, connection and care have in the treatment of hypertension, as well as the co-responsibility for the process of care. However, they report that the introduction of free access for spontaneous demand compromised flow service users in the care of HTN programs. On the other hand, users need to be addressed with the provision of a health service to ensure universal, equitable, comprehensive and decisive care, with quality.

As the research limitation, it is believed that conducting similar studies in other UAPs from other SRs of Fortaleza is necessary to be able to assess the problems in the various existing realities and then compare them in a more comprehensive study. The knowledge here seized arouses the interest in expanding this research to seek solutions to improve the care and promotion of qualified and effective care.

The results of this study will provide a return to the health service in search of co-responsibility strategies among workers and managers responsible for the care of hypertensive patients, to share the difficulties faced in seeking to resolve the gaps left by connecting the host to the spontaneous demand in search of qualified care access and connection, and control of the disease and its risk factors.

The establishment of communications between public administration and universities in search of information sharing in order to provide feedback to the community of the benefits of scientific research is also essential.

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