Comprehensive health care of the elderly in the Family Health Program: vision of health professionals

ATENÇÃO INTEGRAL NA SAÚDE DO IDOSO NO PROGRAMA SAÚDE DA FAMÍLIA: VISÃO DOS PROFISSIONAIS DE SAÚDE

ATENCIÓN INTEGRAL EN LA SALUD DEL ANCIANO EN EL PROGRAMA SALUD DE FAMILIA: VISIÓN DE LOS PROFESIONALES DE LA SALUD

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ABSTRACT

By the year 2025, Brazil will be the sixth country in the world with the largest elderly population. Public policies have the duty to help more people reach older ages with the best possible state of health. The objective of this study is to understand the perspective that health professionals have of comprehensive care and health needs. Subjects were seventeen health professionals who make up two teams of the Family Health Program (FHP) in the city of Santos. The subjects' statements were analyzed from the perspective of Social Representation, and using the theoretical framework of the Collective Subject Discourse. The analysis of the statements showed that the professionals are striving to meet the health needs of the elderly through actions of health prevention and promotion; however, their social and psychological needs are being met. The elderly need more integration and agility in the health system, since they have difficulties in terms of accessibility and movement in health services.

KEY WORDS

Aged.
Aging.
Health of the elderly.
The Family Health Program.
Primary health care.
Health services for the aged.
Patient care team.

RESUMO

O Brasil, até o ano de 2025, será o sexto país do mundo em número de idosos. É função das políticas públicas contribuir para que as pessoas alcancem idades avançadas com melhor saúde. O objetivo deste estudo foi conhecer o que pensam os profissionais sobre necessidades de saúde e atenção integral. Os sujeitos foram dezessete, que compõem duas equipes do Programa Saúde da Família, no Município de Santos. A abordagem foi qualitativa, os discursos foram analisados a partir da Representação Social, referencial teórico do Discurso do Sujeito Coletivo. A análise revelou que os profissionais se esforçam para atender as necessidades de saúde dos idosos através de ações de prevenção e promoção da saúde. No entanto, suas necessidades sociais e psicológicas não estão sendo atendidas. Concluímos que os idosos necessitam de maior integralidade e agilidade no sistema de saúde, porque possuem dificuldades no acesso e deslocamento nos serviços de saúde.

DESCRITORES

Idoso.
Envelhecimento.
Saúde do idoso.
Programa Saúde da Família.
Atenção primária à saúde.
Serviços de saúde para idosos.
Equipe de assistência ao paciente.

RESUMEN

Brasil, hasta el año de 2025 será el sexto país del mundo en cantidad de ancianos; es función de las políticas públicas contribuir para que las personas alcancen edades avanzadas con mejor salud. El objetivo de este estudio fue conocer qué piensan los profesionales sobre necesidades de salud y atención integral. Los sujetos fueron diecisiete, que integran dos equipos del Programa Salud de la Familia, en el Municipio de Santos (SP, Brasil). El abordaje fue cualitativo y los discursos fueron analizados a partir de la Representación Social, referencial teórico del Discurso del Sujeto Colectivo. El análisis reveló que los profesionales se esfuerzan para atender las necesidades de salud de los ancianos a través de acciones de prevención y promoción de la salud; sin embargo, sus necesidades sociales y psicológicas no están siendo atendidas. Se concluye en que los ancianos necesitan de mayor integralidad y agilidad en el sistema de salud porque tienen dificultades de acceso y desplazamiento en los servicios de salud.

DESCRIPTORES

Anciano.
Envejecimiento.
Salud del anciano.
Programa de Salud Familiar.
Atención primaria de salud.
Servicios de salud para ancianos.
Grupo de atención al paciente.

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INTRODUCTION

According to the World Health Organization (WHO) Brazil will have the sixth largest number of elderly people in the world by 2025. The population 60 years or older increased from 7.3 to 14.5 million between 1980 and 2000 and at the same time, life expectancy also increased in the country. The increased number of elderly people and life expectancy need to be followed with a view to improve and maintain quality of life because lack of information concerning the health of elderly people is considerable and their challenges are substantial, as well[1].

The rapid aging of the population in developing countries is accompanied by dramatic changes in the structure and role of families. Urbanization, migration of young people to cities in search of jobs, smaller families and more women in the formal job market mean there are less people available to care for the elderly[1].

The great challenge is to implement policies that enable people to age and remain active, policies defined by a process of optimizing opportunities for health, participation and safety to improve the quality of life of people as they age[1].

Health policies concerning the elderly were initiated in the 1980s during the reformulation process of the Single Health System (SUS). From that point on, health care to the elderly was increased, however, with a work organization predominantly focused on individual medical care directed to chronic-degenerative diseases. This situation is related, on the one hand, to the increase of chronic diseases in the 1980s and on the other hand, to the way Brazil developed its promotion of the health of the elderly population[2].

To meet the growing demands of an aging population, the National Policy for the Elderly (NPE) was created based on the SUS regulation to ensure social rights to the elderly, enable their autonomy and reaffirm their right to health at all levels of health care[3-4].

In 2006 the National Health Policy for the Elderly (NHPE) was implemented and it defines primary care as the gateway for elderly people to have access to health care and is considered the place where they are referred to a network of specialized services of medium and high complexity. Immediately thereafter, the Primary Health National Policy was created and is characterized as developing a set of health actions at the individual and collective levels, which includes the promotion and protection of health, harm prevention, diagnosis, treatment, rehabilitation and maintenance of health. Primary health care should focus on the aging process and the health of elderly people through the development of teamwork-based participative and democratic managerial and health practices directed at populations of well-delimited territories, in which individuals assume responsibility for the population's health taking into account the dynamics of the territory[5-7].

In 1994, the Ministry of Health created the Family Health Program (FHP) with the objective to refocus the model of health care and give a new momentum to health services, to establish bonds with the community through humanization[8].

From this perspective, the Basic Health Unit (BHU) came to be called Family Health Unit (FHU) and its actions include identifying the health problems of individuals and families, proposing interventions to solve these problems, consolidating local strategic planning and specific actions in relation to groups with a higher risk of becoming sick and dying in addition to other strategies of an individual and collective nature[9].

The FHU functions according to some operational guidelines: limiting the clientele; integrality and priority; ensuring reference and counter-reference to higher levels of complexity, so that integral care is provided to individuals and families. A basic health team is composed of at least one family physician, one nurse, one nursing auxiliary, one dentist, one technician in oral hygiene, one dental assistant and four to six community health agents (CHA)[9-10].

Elderly people require flexibility from the health system because as a consequence of the aging process, they become less able to seek health services and go to different levels of care. For elderly people, especially the most needy, any difficulty becomes an *excuse* to break or interrupt the continuity of care to their health.

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Integrality and the health needs of the elderly

What does integrality mean? It is one of the basic SUS guidelines instituted by the Constitution of 1988. In fact, the constitutional text does not use the term *integrality*, rather it mentions *integral care, prioritizing preventive activities without harming social services*. However, the term 'integrality' is currently used to designate precisely this guideline[11].

The integrality principle corresponds to a critique of the dissociation between public health practices and social practices. Linking the two means firstly blurring the distinctions that have crystallized between the public health services and social services through two transformations. The first is related to vertical programs, that is, the fragmentation of activities in the unit and the second, the unification of patients' files within the units[11].

However, there is another meaning of integrality: government actions in the health field directed to certain populations in order to answer the health problems of these groups. We could say that this set of meanings of integral-

ity refers to government actions and health policies with a view to meet the health needs of the elderly population.

According to some authors, health needs (HN) can serve as a good script to evaluate the services, guide processes of managerial training and restructure the practices in the health services. These authors departed from the ideas proposed by Stotz concerning the utility of working with the taxonomy of HN as a script to evaluate and organize the services[12-13].

Stotz defends the idea that the descriptive and operational concepts adopted in a given taxonomy "need to be re-conceptualized in order to express the dialectic of the individual and the social". This was the intention of Cecílio and Matsumoto because they believe that the use of a given taxonomy of HN might have power to verify to what extent HN are being considered, heeded and met in the operationalization of health services. Health needs originate from a set of different theoretical contributions and different conceptions[12-13].

- Need for good living conditions (ideas worked by San Martin; Berlinguer and Castelhanos);

- Warranted access to all technologies that improve and prolong life (ideas worked by Bradashaw; Pineault; Nemer and Schraiber);

- Need for bonding with one professional or team (ideas worked by Campo and Merhy);

- Need for autonomy and self-care in the choice of how *to live life* (ideas worked by Merhy; Campos and Canguilhem).

This HN taxonomy has been presented to local and/or managerial teams in the processes of evaluating the services in the basic health service. It has served as a good instrument to enable reflection, sensitization of professionals, and has contributed to the definition of new strategies of organizing care[12-13].

We believe that the FHP enables the delivery of integral care to meet the health needs of elderly people but it is necessary for the team of health professionals to manifest a problem-solving capacity when responding to the health problems of this population.

OBJECTIVE

To analyze the understanding of health professionals concerning integral health and the health needs of elderly people from the Family Health Program (FHP) in Santos, SP, Brazil.

METHOD

The qualitative approach was chosen for this study to better understand, through reports, what the participants of this study think about integral health and the health needs of elderly people. The reports were analyzed from the perspective of Social Representation (SR), a theoretical framework of the Collective Subject Discourse (CSD) [14].

SR is defined as the representation of one subject standing in relation to other subjects, concerning an object. In this study the object refers to integral care and the health needs of elderly people. The elements of this content are concepts and images. The images are condensed into a set of meanings, a system of reference that permits one to interpret what happens and give meaning to facts. It is a mental activity of individuals and groups to relate facts, objects and situations that concern them[15].

However, the subjects understand and interpret the situations in which they are inserted differently and do not behave similarly in the face of the same matter because SR depends on individuals' knowledge and experiences. Therefore, groups develop representations that are defined for each of its members. These representations focus on social behaviors and on the organization of the group and can modify the very cognitive knowledge of its members[15].

SR is socially developed and shared knowledge concerning an object and, thus, contributes to the construction of reality, permeates individuals and guides their behavior, permitting them to interpret what happens in daily life. Hence, we as social subjects learn the facts of daily life, data from our environment, and information contained in it (common knowledge/perceptions)[15].

The SR of the study's participants concerning integral care and health needs will be essential for services to be reorganized and health professionals to meet the needs of elderly patients, implementing the prevention of diseases and promoting health.

This study was carried out in Santos, SP, Brazil with an estimated population of 418,316 inhabitants. According to the Brazilian Institute for Geography and Statistics (IBGE) the estimation of 2003 is that Santos figured among the cities in the region with the largest ratio of elderly people, equivalent to 15.5% (65,217) of the population; the national average is 8%. Hence, aware that the elderly population in Santos is very large, we intend to analyze integral care in relation to the needs of the elderly[16].

Santos is currently in a transitional phase of organization of its Primary Care services and so far 11 teams of the FHP have been implemented, *four* of which have a Family Health Unit (FHU) and the remaining care for the population in other units that deliver health services.

The 11 FHP teams are distributed in four areas: the continental area, hills, central/historical and the Northwest region. The *four* FHU are located in Caruara (continental area), Monte Serrat (hills), downtown (central/historical) and Vila Progresso (Northwest region).

Data collection was carried out in the central/historical area because there is a large concentration of elderly people in this area and it is located in the center of the city. The

FHU in this area includes the neighborhoods Centro and Vila Nova, therefore, two FHP teams.

In 2001, the City Health Department in Santos (CHD) created the Elderly Health Program where 4,500 elderly people were registered. Several other services are currently offered with a view to improve the quality of life of this population[17].

The study's participants were health professionals: two physicians, two dentists, two technicians in oral hygiene, two nursing auxiliaries, two nurses and seven CHAs who work in the FHU; and employees from the CHD identified by the letter *E* and the sequence of the interview.

The project was approved by the Research Ethics Committee at the University of São Paulo, College of Nursing (Process nº. 663/2007/CEP-EEUSP) and by the CDH; the participants signed free and informed consent forms complying with the requirements of the CNS/MS Resolution 196/96.

The reports of the study's participants were digitally recorded and they answered to three guiding questions on the following subjects: FHU services and professionals; meeting the elderly people's health needs•; and integral care in relation to elderly people's health needs.

Data collected in the interviews were transcribed and organized through Collective Subject Discourse according to the authors' recommendations[14] to identify the meanings conferred on integral care and the health needs of elderly people. Hence, the reports of the participants were organized with the use of methodological figures essential to the CSD proposal: key expression, central ideas and collective subject discourse[14].

In the SR presented through the CSD, individuals of the collectivity that generates the representation *cease to be individuals to be transmuted, dissolved and incorporated in one or several collective discourses that express them and to the representation itself*[14].

The collectivity represented in the CSD comprises a *discursive collectivity* because the produced discourse corresponds to an aggregation of discourse that *does not gather equal parts but pieces of different discourses. Believed to be intercompatible and thus possibly aggregated, these allow composing a single discursive whole*. Hence, its content is composed of what is said by an individual and of what his/her *collective partner* complements, since according to its sociological assumption, CSD is a symbolic expression of the field to which both belong to and the position they occupy in it[14].

The steps until the synthesis of CSD included: reading the set of reports collected during interviews several times; reading the answers to each question, highlighting the selected key expressions; identifying the central ideas of each answer; analyzing all the key-expressions and central ideas and grouping those similar into homogeneous sets, which would be a synthesis of the central ideas of each report[14].

RESULTS AND DISCUSSION

The interviews were carried out with health professionals of the central/historical FHU, the content of which were grouped into three categories: FHU health services and professionals; meeting elderly people's health needs; integral health in relation to elderly people's health needs.

The FHU health services and professionals

This category refers to the way the health services of the central/historical FHU are organized to care for the elderly population and discuss the actions of health professionals in the FHP.

> [...] So, it's a program that came to improve the life of the elderly... Here in the FHP we collect...implement the TB program, in which we, nursing auxiliaries, always go to their homes and we even bother them, because if we don't go in the morning, we go in the afternoon, or whenever we go to them... we go, medicate them, go to their homes, sometimes we go only to check their blood pressure and they say they can't manage to get to the unit [...](E1).

The family health team is a unit that produces health services in the FHP. Each member performs a set of actions separately, though always seeking to link with the actions performed by the other work agents. The teams should seek integrality of actions and not only reproduce a biomedical care model in their work process[18].

The FHP develops social actions, diagnostics and prevention of diseases. The health professionals discuss these actions and seek to meet the health needs of elderly people in an integral way.

> [...]the care delivered to elderly people here in Santos... we're still trying to construct it, it passes through the issue of prevention, the care delivered in the FHP both by the physicians and the health team and now we're working on the issue of promoting physical and psychological activities... some teams already do communitarian therapy with the elderly... because the elderly people stay away and don't live together with the community... so our intention in the FHP is to take this person out of home so he can participate in free activities... they like to dance... we already took them to do Taichi, the objective is to include elderly people in cooperative games, stretching exercises, because then we include the issue of them relating with others, socialization, so they know each other and...don't stress on the disease [...] (E10).

We see in this report the concern of professionals to welcome and assist elderly patients. Studies[12] indicate that health services intend to enlarge the individuals' autonomy. For this goal to be achieved, one has to understand that *the disease or risk to become sick might demand from institutions support in the long term* and for the *construction of his/her autonomy* , the healed patient depends on a combination of techniques of individual support (medication, clinical care, access to information, physical rehabilitation,

reference in case of crises), with other sociocultural techniques (socialization, ability to work, relationships with others, living in a world of conflicts and disputes). Therefore, desinstitutionalization and demedicalization have to be reconsidered[12].

Additionally, according to these authors Canguilhem's ideas reflect that *healing someone would be to always fight for enlarging the individual's level of autonomy* with the objective to enlarge the individuals' autonomy to improve their understanding of their own body, disease, relationships with their social environment and consequently their ability to institute standards that enlarge their possibilities of survival and quality of life[12].

Elderly people do not always have the expectation that health actions will improve their quality of life, or enable them to cope with problems they face in their daily life. They expect to become smarter so that they can solve part of their suffering and overcome part of their obstacles themselves. Elderly people are becoming increasingly autonomous, especially when their family members and health professionals do not support them.

Meeting elderly people's health needs

The following reports show that health professionals have made efforts to meet the health needs of elderly patients in the FHU.

> [...] I guess that we have met their needs as best as we can because we still have many problems and a lot of things still lack. There are many tenements here where these elderly people live by themselves, they don't have someone to take care of them, they don't know how to read, to write, they take medication wrongly, and, we can't go every time, the whole time... they'd need someone to care for them. We take notes for them on a small piece of paper so they can take the medication, but it is hard. They have medication for high blood pressure, diabetes, they have follow-up... The physician goes there, we go there, sometimes just to check blood pressure, those who can't leave the house, but being there all the time is difficult [...] (E6).

In the health field, as in any other dimension of social life, there is an interweaving of social relations between individuals that compose a social network. In general, a social network can be defined as a web of interactions between subjects involved in concrete actions. The level of connectivity of a network determines the factors that unite its members and permit a better and greater exchange of reciprocity and network stability[19].

Hence, the issue that health teams have to face is that of facilitating the actions of support networks and encouraging the development of other networks based on coping with health problems. For that, these networks have to be mapped through listening and observing webs that are not always evident but which certainly can indicate the way to construct a perspective and attitude capable of understanding and respecting another[19].

> [...]Talking about Family Health Program of this unit in the central/historical region, we see that it is not very easy because we see the need of other professionals... The team is very small, there's a nurse, the physician, the nursing auxiliary and the community agent who brings the problem to the nurse and which we discuss within the team... but, it depends on other professionals... I guess that the team should have a social worker and a psychologist... I feel the need for a social worker with me 24 hours a day because the majority of the problems in this region, 100% of it is social... is the elderly person abandoned by the son who used to give garbage for her to eat. We'd need to find a place for this lady to live and would need a social worker... and a psychologist to care for the affected psychological condition of this elderly lady [...] (E15).

As observed in the participants' reports, the elderly person who lives in the central region of the city needs more social support. Visits to the households permit health workers to know the context in which these people live, who do not seek for the services because they are debilitated and broken by disease. Their living conditions are very poor; they are abandoned by their families and usually do not have appropriate food. They mainly need the support of health professionals who work in the FHP and other professionals such as social workers and psychologists.

> [...] No, I still think that we're starting the program, we're still trying to deliver a more humanized care, more global, with a different view of social medicine and this would demand a certain change of culture both of professionals who are involved with a cultural change and also of patients and individuals who are being cared for. I guess that the program has a very beautiful philosophy, of welcoming, but we still face difficulties like these I mentioned such as the cultural, of the individual or professional who wants to solve problems immediately and we also have difficulties in other areas. It's not only in the health field. We have difficulties with the social field in the region where I am, leisure activities, psychological conditions, living conditions, which impedes the program from developing everything it could [...] (E11).

The FHP enables this social network, when all, professionals and elderly people, become involved to solve everyday problems. For that, is necessary to know some of the functions of the social support network. Among them there are the social campaign; emotional support; cognitive guidance and counseling; social regulation; material help and help form the services; and access to new contacts. By social campaign we mean group activities; emotional support represents support, loyalty, sympathy and solidarity; cognitive guidance means sharing and/or clarifying information and knowledge, exposing models of behavior; social regulation includes disapproval of antisocial behavior; material help and help from services refer to aid provided to solve an economic or health problem, etc; and finally, access to new contacts implies enlarging the network[19].

Understanding the family, its social space and not only the individual, is the basic core to this approach; delivering integral, continuous, quality care with problem-solv-

ing capacity; developing strategies to intervene in risk factors and humanize practices; encouraging the establishment of bonds, commitment and responsibility between health professionals and the community; encouraging people to acknowledge that health is a citizen's right and organizing the community for an effective social control, are the FHP commitments[18].

To deal with elderly people one has to understand that old age is not a disease but rather a stage of life for people 60 years old or older. The great majority of these people are in good physical conditions, though as they age, they become more prone to debilitation and need help for self-care. Promoting the health of elderly people should take into account good mental, physical and social functioning and also the prevention of illnesses and impairment[18].

Integral care in relation to elderly people' health needs

Braga works with the notion that establishing bonds with the patient and family is the responsibility of a team in which *bonding with the patient/family should not exclusively occur with a single professional, but with the team*[18].

> [...] The care delivered in the FHU in the dentistry field should be simpler, approaching the elderly person in a clear way so they understand the explanations about the procedures, always looking at the patient as a whole, health promotion, and not only their mouth, usually the dentist only looks at the teeth or mouth, but in our case, if it works... we have to look at hem a whole. If we note some problem, medication is not being taking, we talk to the team, with the physician, so he can go to the person's house or the person has to come to the unit so we can educate the elderly person, because one is not only looking at the patient's mouth [...] (E8).

Integrality is not a concept, though it does have many meanings, among which we found: physicians refuse to reduce patients to a biological system; seek to acknowledge patients' needs in addition to their explicit demands; medical schools and health services should not have fragmented and reductionist attitudes. Integrality is understood as a connected and continuous set of actions and preventive, healing, individual and collective services at the system's different levels of complexity. Its principles correspond to a critique of dissociation between public health practices (preventive) and social practices[11].

> [...] The elderly person has priority in all means taken... is intensively working at preventive actions and mental health... not that they are psychiatric-dependent... by having psychologists... a project to provide them leisure activities... at least I miss that a lot here... more social interaction with young people, it's good for them, to feel loved by young people, exchange of energy...all this... in this sense, health is all this... not only dedication or only disease [...] (E7).

Health needs in primary care have become a social complex that involves appropriate technology and should propose referrals within the care system (reference and counter-reference system). The services should be organized to largely encompass the health needs of the population they care for and should promote globalized care[11].

> [...] Caring for elderly people should largely and clinically comprehend all senses, and when we work in the peripheral area of the city it's important that a very consolidated network exists, not only to welcome them, but with a Social Service extremely active so we can truly deliver integral care. It is really difficult without the Social Service, the elderly people are abandoned not only by their families but also by the community itself... the way they are currently living... many of them have dementia... this is increasing and worsening the quality of life of the elderly [...] (E2).

The health of the elderly people and integrality face challenges such as the establishment of bonds between elderly people and workers (welcoming); access to health services; supply of technological options to cope with health problems; broadly meeting health priorities; understanding the health needs related to aging through interaction with the elderly[18].

> [...] we're very advanced in this issue of aging diseases here on the hill. Here, the elderly person, because of the topography of our area, we try to visit them at their houses, so we save them the work of going to the unit, then we take care of high blood pressure, diabetes, collect exams, but… I guess we haven't met all the health needs of elderly people… because their needs include other issues, include the need of feeling useful, productive, to collaborate with society in some way and what these elderly people don't have and we can't give them, we even had ideas, to construct a place where the elderly people could interact and socialize, so they could develop some aptitudes, a program where they'd• feel more useful, productive, but it hasn't been implemented yet, and this is only one aspect, but by this example I mean that we haven't met all the health needs of the elderly people [...] (E5).

The Family Health Strategy (FHS) implemented new practices, among them the change of the object's role in health: the family in its household; recovering actions of prevention and promotion; human resources are priority: education, qualification and remuneration; and the establishment of new professional bonds in the services[11].

FINAL CONSIDERATIONS

The elderly who live in the central region of Santos and are cared for in the central//historical FHU present poor living conditions and have difficulties searching for health services due to the region's topographic characteristics that hinder their access and also due to diseases.

The interviewed health professionals know of the FHP but feel insecure because the program was implemented in the region not long ago and through household visits they have made efforts to deliver integral care and meet the needs of elderly people.

The study's participants have difficulties dealing with social and psychological problems because the services do

not have a multiprofessional team available, such as social workers, psychologists, physiotherapist and nutritionist. Hence, there is no structured social support network to care for the elderly.

The lack of coordination between the different health and social resources directed at elderly people is one of the elements that contributes to the elderly's dependency. The fragmentation of health and social needs make elderly people dependent on the supply of services and care. Moreover, this lack of global care means that resources are passed to others but none is truly effective in meeting people's needs.

Therefore, health professionals should enable elderly people to become independent and become active in their aging process, and should organize care taking into account the resources necessary to meet the health needs of elderly people and their families in a flexible way.

Household visits emerge in the current time as a basic activity that has to be carried out through Primary Health Care to meet the health needs of elderly people. The proposal of this service is to develop the abilities of health professionals in relation to the cure and prevention of diseases and health promotion, delivering integral, opportune, continuous and quality health care.

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ANNEX 1

Script with guiding questions to collect data from health professionals from the FHU

1. A health service directed to elderly people should meet all their health needs. In your opinion, how should care be delivered to the elderly?

2. Have the actions implemented in the FHP met all the health needs of elderly people? Why?

3. In your opinion, has the SUS promoted changes in the care delivered to the elderly people? Which changes?

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