Assistance model for patients with asthma in primary care

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Summary

To create a program structured for the control and prevention towards asthma worsening, it is necessary to settle down actions of regionalization, planning and management. Currently, the Ministerial orders allow each municipality district to cope their needs with local initiatives, based on the search of the health indicators with University partnerships. Taking into account this context, it is feasible the implantation of an effective model through organized demand of attendance flow and physical structure, besides the withdrawal of medications and professional training. To describe the modus operandi situation currently in the Primary Health Care Units regarding these patients' reception, diagnosis, and follow-up, as well as the current situation according to the professional profile and sector. To introduce an assistance model for reception, of these patients in these primary care units. This is a bibliographical review based on the specialized literature such as scientific papers selected through the search on the SciELO and Bireme databases, from Medline and Lilacs data sources. A Committee was set up by members from the Health and Service , the Medical School, and scientific societies for discussion and planning.

Keywords: Asthma; public health; health primary care; health promotion.

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Introduction

Asthma is a genetic disease of chronic inflammatory nature characterized by hyperresponsiveness of the inferior airways and variable limitation to aerial flow, mediated by environmental exposure. The classification of asthma seriousness is based on a frequency analysis and on the intensity of symptoms, besides an evaluation of lung function and the need for a bronchodilator[1-3].

The high pyschosocial and economical cost and the impact of asthma on the population have led scientific and governmental entities to perform actions to control and care for this disease sufferers. However, the lack of standardization of the concept and of the diagnostic and therapeutic criteria have made it difficult an optimization in treatment[4,5]. Every health care system has two main aims: the first one is to use consensual knowledge so that a maximum level of optimization in the population health and the handling of each disease are achieved. The second one is to generate a system which promotes the gathering of subgroups and their access to these services[6,7]. Thus, the purpose of this study is to present a critical survey, which is specific to asthma, the way the public health system works, besides proposing a basis for an ideal assistance model, based on literature and on evidence.

Epidemiologic impact

Bronchial asthma is one of the most prevalent chronic diseases, with an estimate of 0.7 to 18.4%. Presently, there are around 300 million asthma sufferers in the world, and Brazil is eighth within this context, with an average prevalence of 15 to 20%, according to a multicenter study. Concentration of the population in precarious dwellings determine the similarity in the prevalence of asthma in Brazil in relation to developed countries, whose main cause is industrialization[6,8-12].

Each year around 350,000 people are admitted to hospitals in Brazil due to asthma, which constitutes the fourth cause of hospitalization under the Brazilian public health system (*Sistema Único de Saúde - SUS)* (2.3% of the total number), and it is the third cause of hospitalization among children and young adults. In the 1970's and 1980's, there was an increase in the number of deaths due to asthma, in the occurrence of severe cases and in exacerbations of the disease involving tertiary care such as emergency units and hospitals[8,9,13,14]. There are records of an increase in the number of hospital admissions between 1993 and 1999 and there are indications that asthma prevalence is rising all over the world, including Brazil, since there is an aggravation of the causes and a growing number of scientific publications with epidemiologic studies[15-19].

Objectives

1. To discuss the modus operandi present situation of Primary Health Care Units for collecting, diagnosing and following-up asthma patients, as well as the present situation regarding their professional and sectorial profile.

2. To present an assistance model for collecting, diagnosing and following-up asthma patients in primary health care.

Methods

Linked to Faculdade de Medicina de São José do Rio Preto, this study attempted to discuss the protocol based on the *IV Consenso de Asma*, on the Global Strategic Report for the Management and Prevention of Asthma, updated in December, 2009, and on the guidelines based on evidence for the management and prevention of asthma at the Health and Hygiene Department from São José do Rio Preto. It is about a bibliographic review based on specialized literature, by means of consultation to scientific articles selected through SciELO and Bireme's databases, from Medline and Lilacs sources. A committee was formed for discussion and planning by members representing the Health and Hygiene Department from São José do Rio Preto, from Faculdade de Medicina de São José do Rio Preto, from *Associação Brasileira de Asmáticos (ABRA*), from *Sociedade Paulista de Pneumologia e Tisiologia (SPPT)* and from *Sociedade Brasileira de Pneumologia e Tisiologia (SBPT)*.

Discussion

Even being an allergic disease of chronic characteristics, asthma is seen, especially in the public sphere, just as a seasonal disease. In spite of the existence of funding for the acquisition of control drugs, there has not been the creation of local asthma handling policies by means of programmed, specific and coordinated activities [6,20-23].

Ministerial decrees allow each municipality to deal with its priorities by means of local initiatives and pose an example and model. Therefore, it is up to universities and scientific societies to stimulate the implementation of specific programs for continued care for asthma in the primary sector, based on basic and feasible concepts adopted by the Ministry of Health. The establishment of primary care foresees regionalized priorities through strategic areas based on local needs. Each prioritization has epidemiologic studies as its allies[20,24].

It is the duty of the City Health Departments to program actions of Basic Care starting from their territorial base, preferably inserting the Family Health strategy by emphasizing care flow, ensuring a reference and counter reference scheme, and the resources which make such actions feasible, including dispensing medication nationally accepted or contemplating asthma among the

diseases which are specific to receive access to a special medication dispensing scheme. Besides programmatic actions, the system must elaborate monitoring methodologies and evaluation of basic care in the municipal sphere, along with the feeding of national databases[6,24-27]. The elaboration of an organized programmatic actions' methodology can meet territorial characteristics of the population, just like the development of mechanisms for the qualification of human resources enables the attention of needs found[20,28,29].

Primary care units must involve a bigger proportion of patients who receive continued attention than first timers, and the description of primary care unit is related to prevention, which involves several attributes of real reach to the population, such as: accessibility, integrality, coordination, continuity, responsibility, and longitudinality[24]. The capacity of a basic health system depends on adequate facilities, input, and staff qualification which, by means of collecting, diagnosing and following-up is able to meet the needs of Health Promotion, in search of results in the Universality sphere[30].

The local planning of each referenced unit for mild and moderate asthma control actions must follow a master plan, ensuring health integrality and spontaneous demand. Some other effective instruments for implementing a priority program is the active search and the notification of aggravations in order to have a statistic control of all the territorial demand which includes from intermittent asthma identified in active search to exacerbations identified in secondary and tertiary care of the health system[28,31].

To promote the conceptual alignment of physical structure in health units in an outpatient clinic basis, considering the peculiarities of primary care services and their organization requires a study of local specificities. This proposal will rationalize the use of the units space by contributing to make them more humanized, with flows and physical determinants which generate more satisfaction to their users. Some parameters must be used to characterize a unit and, therefore, quantify its needs, which are defined by the Ministry of Health in three aspects, which is the UNIT itself, constituted by a set of physically grouped environments where related activities are performed, besides the PHYSICAL UNIT, which comprises a set of related and support environments pertaining to a functional unit and, finally, the FUNCTIONAL UNIT, composed of a set of activities and subactivities pertaining to the same attribution[32-34].

The physical structure depends on the activity-compartment binomial, which comprises organized demand in a certain environment. Therefore, to generate a necessary dimension of a health unit, data such as epidemiologic profile, number of inhabitants, existing health units, service range coverage, existing demand, restrained demand, and population growth must be analyzed based on the qualification of human resources in consultations and post consultations. Both the project and the "Technical Manual for the National Registry of Health Facilities", version 2/2006 (*Manual Técnico de Cadastro Nacional de Estabelecimentos da Saúde, versão 2/2006)* which will serve as a guide to the architectural project. It must be defined simultaneously with the human resources and equipment project, both elaborated by the Ministry of Health[18,35,36].

Planning an Asthma Program (AP) starts with the correct identification and relevance of the disease within the community to be cared for, adapting it to the social context of the municipality where it will be implemented. It must be formed by a multidisciplinary team involving network professionals, a technical team and representatives of Scientific Institutions and a University. An AP planning and implementation process necessarily goes through awareness and information of managers and health teams involved. With this purpose, specific strategies must be formulated, such as programs for capacitating multipliers at the *UBSs* and within the community, addressing scientific update, besides information on epidemiologic and statistic data and successful experiences in other municipalities[20,23].

Care for asthma patients must be universal and address the latest consensus among experts, whose aim is to control symptoms, avoid chronic limitation to the aerial flow, allow normal work, school and leisure activities, preserve lung function, avoid crises, emergency calls and hospitalizations, reduce the use of a bronchodilator for relief, minimize adverse effects of medication and, finally, avoid death[37].

Asthma has been treated with the traditional dichotomization of the airways smooth muscles (bronchodilators) and the suppression of airways inflammation (corticoids). Thus, current consensual recommendations suggest asthma treatment in its totality, that is, rapid relief and long term control. According to consensus, patients must have rapid relief medication available as needed, considering the bordering parameter of the occurrence of night awakenings two days a week or even twice a month. This situation must be considered as one of the indicators for the unmanageability of the disease[9,21,38-40].

To enable the recommended treatment, municipal resources include specific budget allocations which are guaranteed by Ministry Decrees in the Federal Sphere and agreed upon between State and Municipality, according to the resources polarization structure from the municipal authorizing officer who adheres to decentralization[41]. The public network does not possess a specific program of care for bronchial asthma, as is the case with

hypertension and diabetes. Therefore, intermittent mild asthma sufferers are excluded from a longitudinal follow-up, or they are treated with a brochodilator for relieving symptoms, without effectively treating the inflammatory and obstructive process. Those who suffer form persistent or moderate mild asthma are mistakenly referred to specialties outpatient clinics for high cost treatment[3].

Each drug chosen acts as an essential element for the effectiveness of the health care process. However, the right to have access to a drug, warranted by *SUS,* is not enough for the materialization of the optimization of the health-disease process[26]. In the formulation of pharmaceutical assistance policies, drugs are an important input but, at the same time, they are an important risk factor when inappropriately used. Within this context, the scope of public management is to ensure clarity in the use of a drug and, mainly, to provide a safe and efficient prescription, based on protocols which establish diagnostic criteria for each disease, a treatment recommended with the drugs available in their respective correct doses, control mechanisms, follow-up, results verification, prescription rationalization, and supplying of these drugs[42,43].

Conclusion

In Public Health, the search for Health Indicators brings together concepts and principles which generate the promotion of activities by means of needs reading, with a current highlight to those inherent to bronchial asthma. Therefore, this revision allows us to reach the following conclusions:

1. There is a limitation for the management of asthma in the public health sector which, according to the care flow based on the aggravations and non-functional physical space, contributes to the standardization of seasonal care and the prevalence of aggravations. Although there are assistance and dissemination of consensus for the management of asthma in the public health sector, it is still not possible to reach, in a satisfactory way, the compromising and knowledge of professionals about the disease and the proposal of the Ministry of Health for basic care. It is necessary to implement a continuing education program aiming at a health system characterized by great professional mobility.
2. An assistance model which coordinates care flow with the participation of a health team and a specific dynamics of drug dispensing which values decentralization, besides an adequate physical-environmental adequacy to facilitate collecting, diagnosis and follow-up of an asthma patient in primary care can determine a profile for the promotion of Health for the *UBSs*.

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