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Advances and challenges of health care of the elderly population with chronic diseases in Primary Health Care

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Abstract *This paper analyzes the developments and challenges of healthcare for older adults, especially those with chronic diseases in primary care, in a study setting of a family clinic in the city of Rio de Janeiro. Data were produced through the development of techniques such as participant observation, a focal group with a Family Health Strategy (ESF) team, an interview with the family clinic manager, and interviews with seniors accompanied or not by relatives or caregivers. Worth highlighting is the shift of the biomedical healthcare model to the biopsychosocial model and its implications in elderly care, prevention and health promotion. Despite care advances, some difficulties were observed, especially regarding the access of the population to the service, pointing to the perpetuation of health care inequities. Concerning the elderly with chronic diseases, it is noted that the ESF team employs a set of both individual and group strategies, whose effects were identified in the statements of the older adults, family members and caregivers, who positively qualify the care received. We can conclude that the care process is influenced by a myriad of factors that appear as objects of questioning and intervention in primary care.*

Key words *Primary health care, Chronic diseases, The elderly, Family health strategy*

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Introduction

This study is part of a larger study entitled *Promotion and care for the elderly in Rio de Janeiro: a study of novel ways of producing health and reducing inequalities* carried out by the Jorge Careli Health and Violence Studies Department (CLAVES/ENSP/FIOCRUZ), which sought to identify innovative ways of approaching the health of the elderly with chronic diseases (diabetes, hypertension, depression) from an analysis of five elderly care services of excellence in the city of Rio de Janeiro. The Sergio Vieira de Mello Family Clinic (CFSVM), located in the district of Catumbi, was chosen as one of these sites because it allows the analysis of care for older adults with chronic diseases at the primary health care level and also because it has a Family and Community Medicine Residency Program in place, which is part of the Department of Comprehensive Family and Community Medicine of the State University of Rio de Janeiro (PRMFC/DMIF/UERJ).

According to data from the 2010 Census, people aged 65 or over represent 7.4% of the Brazilian population, indicating a significant enlargement of the top of the age pyramid[1]. In less than forty years, Brazil has gone from a typical mortality profile of a young population to a design characterized by complex and costlier diseases, typical of the more advanced age groups. Chronic Noncommunicable Diseases (NCDs) grow over the years and affect 75.5% of the elderly population (69.3% among men and 80.2% among women)[2], generating functional limitations and disabilities.

The aging process is also strongly influenced by the life history of seniors, their different ways of social insertion throughout life and exposure to vulnerability contexts[3]. The complex health demands of older adults require services to respond adequately to their needs not only for disease prevention and control, but also for the promotion of active and healthy aging, aiming at their greater autonomy and well-being.

Thus, the role of PHC stands out as the basis for a new model of care and organization of health systems, as a priority gateway capable of servicing all people and community families, who also actively participate in it[4,5]. PHC actions should lead to a comprehensive user care that can improve health conditions, quality of life and autonomy of individuals and the community[6]. The Family Health Strategy (ESF), in turn, is a reorientation of the PHC health care model that seeks to ensure comprehensive family-centered and community-based care[7].

The PHC has specific attributes such as first contact care, longitudinal, comprehensive and coordinated care[8], standing out in the scope of chronic disease prevention and care. According to Oliveira[9], there are still few studies that investigate the potential of PHC in elderly care, in the control of chronic conditions and in the provision of preventive services. However, existing studies indicate that it can provide better care management of chronic conditions, reduce unnecessary hospitalizations and trips to emergency rooms or emergency care units.

Despite the expanded PHC and ESF in the country in recent years, some challenges still persist. When analyzing the quality of PHC care provided to the older adults, Araújo[10] observed that points such as integrality, family orientation and accessibility are weak, indicating the need for improvements, mainly concerning the increased family focus, working hours of PHC facilities and in the development of actions beyond focusing on the most prevalent problems and diseases. Also, Silva[11] assessed the quality of care for the elderly with diabetes mellitus or hypertension in PHC in a health district of the city of Belo Horizonte, and identified a weakness of family health teams in the promotion of proactive, planned, coordinated care and people-centered actions, which are relevant strategies in the care of chronic diseases.

Recognizing the centrality of the care of the elderly population with chronic diseases, we intend to identify the challenges and advances in the health care of this population at the PHC level through the understanding of the specifics of care for the seniors with chronic diseases in a service that needs to attend people of different age groups and health needs on equal terms.

Methods

A study was carried out at the Sergio Vieira de Mello Family Clinic (CFSVM) in the district of Catumbi, central region of the city of Rio de Janeiro. Highly socially unequal users are identified in its territory, ranging from extreme poverty and lack of infrastructure to others with a middle-class population. Living with violence is constant in this territory, a common setting of this city and other metropolises of the country.

The CFSVM covers six territories that also name the family health teams: Catumbi, Navarro, Apoteose, Coroa, Mineira, and Paula Mattos. With the exception of Catumbi, all other teams consist of resident doctors from the Family

Ciência & Saúde Coletiva, 24(4):1369-1380, 2019

and Community Medicine Residency Program (PRMFC/UERJ). Each team is equipped by a multidisciplinary body, consisting of community health workers (ACS), nursing technicians, nurses, family and community doctors, and PRMFC/UERJ resident physicians. We decided to perform the study with the Paula Mattos team because it is manned by the Program's residents and includes both low-income and higher-income families.

Fieldwork was carried out between January and April 2016 and included participant observation and individual interviews with the elderly with or without relatives or caregivers both in their visits to the clinic and in their homes. Also, an interview was conducted with the clinic manager and a focal group with professionals from the Paula Mattos Team. Two physicians of the PRMFC, one nurse and three ACS participated in the group. The interviewed team indicated the names of five senior women with chronic diseases who were invited to participate in the study.

The five elderly women interviewed were between 84 and 88 years of age, three were accompanied by a family member or caregiver who also participated in the interview. Their inclusion in the study sought to retrieve the statements of other stakeholders who, given the experience of providing care to the elderly with chronic diseases, contribute with perceptions about their health care. This approach is relevant because it expands the spectrum of the complex process of care and allows relatives/caregivers to be an interlocutor when the elderly have cognitive limitations.

The research project was submitted to the Ethics Committee of the Sérgio Arouca National School of Public Health (Fiocruz) and approved with Opinion Nº 1.010.360 and the reporting date of March 30, 2015.

The data collected were explored in the light of the content analysis technique, in the thematic modality[12] and under the systemic perspective that seeks to understand the world and its phenomena through the concept of complexity, that is, considering the dynamic and inter-relational potential of the systems and their transforming capacity, and the assumption that there is no reality to be discovered detached from the observer, but an intersubjective relationship that implies in the recognition of the subject that observes as an inseparable part of the observed system[13].

The analysis of interview data followed the following script[14]: a) transcription of interview recordings; b) exhaustive and comprehensive reading of the transcribed material in light of the initial assumptions; c) elaboration of analysis structures from the clustering of excerpts from the interviews in preliminary thematic axes; d) thematic recategorization following identification of the central ideas present in each of the axes; e) elaboration of comprehensive, interpretive and contextualized summaries of the problems pointed out from the theoretical precepts of the systemic vision. The main findings of the study are shown from the following central themes: (1) Advances, obstacles and challenges in health care and promotion of the quality of life of the elderly; (2) Care provided to seniors with chronic diseases; (3) Perception of the elderly, family members and caregivers about the follow-up provided by the CFSVM team.

Results and discussion

Advances, obstacles and challenges in health care and promotion of the quality of life of the elderly

Because it is one of the most vulnerable segments of the population, it is expected that primary health care services will be able to organize and provide services to the elderly, considering their specific demands and seeking to reduce health inequities.

When questioned about the elderly care actions, the professionals and manager interviewed listed a number of services such as scheduled and one-off visits, and general procedures such as blood collection and vaccination, which may also be done in home care, and oral health care actions that are not restricted to the elderly population.

Regarding the elderly healthcare actions, especially for seniors living with chronic diseases, the support of the Family Health Support Center (NASF) stands out. In the specific case of the CFSVM, the NASF team that supports family health teams is composed of a multidisciplinary team that includes a nutritionist, a physiotherapist, a physical educator, a psychologist and a social worker.

Elderly health promotion actions have also been identified as the "*Life Champions*" Group which takes place in partnership with the Social Assistance Reference Center (CRAS). It is a social group focused exclusively on the elderly, which discusses various topics of interest. The *Carioca Gym*, an activity directed to the entire population, but which receives a considerable number of elderly people, is part of a municipal govern-

ment program of Rio de Janeiro connected to the PHC facilities, and works with the perspective of promoting quality of life from physical activities. Furthermore, it also promotes external activities (walks and meetings at the users' residence). These initiatives have a significant impact on the social determinants of health and the prevention of chronic diseases[15].

The Carioca Gym and the Life Champions group are the main social arrangements in partnership with the clinic for the elderly, which provides benefits for physical and mental health. The engagement in gatherings and exchanges of experiences alleviates social isolation to which many older people are subjected, strengthening sociability and community social ties. Thus, a crucial component of PHC is put into practice, which is to promote social and cultural changes based on an expanded concept of health.

Because it is a population with important physical limitations, professionals and the manager believe that home visits (HV) are very relevant in elderly care, drawing the team closer to seniors, especially in cases that demand greater care or when the user cannot reach the service due to territorial limitations:

As we have this territorial feature with many slopes and stairs, for home visits, we use the criteria of being bedridden and being in a place that is difficult for the elderly to access the service. We first evaluate whether access is good for seniors or not (Professional).

The relatives and elderly interviewed also recognize the relevance of the HV:

Because she already has difficulty walking and she has to climb the stairs here at home. So for her to be taken care of at home is great, excellent. She did not have that kind of coverage, she actually never had (relative).

The relevance of HV to the elderly is also valuable due to the presence of professionals, because they are good listeners and provide words of comfort in difficult times.

Despite actions performed in the clinic that seek to ensure comprehensive care, some obstacles are posed by respondents. An initial difficulty lies precisely in the refusal of the SUS in general, and of ESF in particular, by a portion of the population, especially among the elderly with greater purchasing power. As highlighted earlier, the Paula Mattos team covers a territory with people with different socioeconomic characteristics.

In Brazil, the health reform has resulted in overcoming a hegemonic way of understanding the disease-centered and body partitioning health-disease process, moving towards an expanded concept of health, based on a biopsychosocial model. However, this requires breaking with a paradigm that encompasses a deep cultural change, not only among health professionals, but also among users of health services:

I think there is a difficulty with the adherence of patients who are accustomed to other systems. We see the patient as a whole, including the psychological part. We do not just measure the pressure or diabetes. We frequently visit the household to verify the situation, and many of them are visited only by the cardiologist or pulmonologist. For patients to understand our role and why they are no longer going to the cardiologist, I think it is also a challenge that we have in our clinic, the HV (professional).

This viewpoint can be explained, at least in part, by the historical notion of public health and health centers as disease control locations among the poor population, without the concern of comprehensive care to the individual[16]. The social acceptance of this new model therefore poses a challenge, insofar as it is still difficult for families to recognize the importance of team visit, even if the doctor is not present. The idea persists that the follow-up will not take place if the doctor is not there, although all other professionals are. In this regard, one of the elderly women interviewed emphatically questioned the doctor's spaced visits, even if receiving regular visits from the ACS and the nurse.

On the other hand, what poses itself as an obstacle is also understood by the team as the main advance in elderly healthcare because of the changes applied by the biopsychosocial model in the way care is provided. The relevance of care as a process also traversed by family and community contexts is recognized. Health problems are viewed from a systemic perspective that is not limited to the focus of diseases as prioritized by the traditional biomedical model. The expectation of the population regarding the model of care that is provided is pertinent because, as Almeida[17] points out, in general, the responsibility for the establishment of the link is incumbent upon the professional without considering that people have conceptions and strategies of search for care which do not necessarily traverse the ESF proposal.

Another obstacle mentioned by the team was access barriers caused by the geographic characteristics of the territory. Considering Family Clinics as a PHC priority gateway, accessibility, that is, the degree of ease or difficulty with which people obtain health care is essential. It is, there-

Ciência & Saúde Coletiva, 24(4):1369-1380, 2019

fore, the factor that mediates the relationship between demand and actual entry into the service[18]. The geography of the territory itself, consisting of slopes and paving of the parallelepiped together with the scarce supply of collective public transport, impose barriers of access to the full use of the service. The elderly population is the most affected because, in many cases, it already lives with travel problems and the team also has difficulties to perform HV:

Because there was already a means of transport before. We had the tram and a bus line. An absurd geographic isolation has taken place because we have no facilitators. Taxis are sometimes selective, because they do not want to go up or down. Sometimes we want to do a blood collection and it comes with all the material, but it is very difficult to access. Effective transportation would be very important (professional).

It is necessary to think about access broadly, also through actions on the local public transport system. The team believes that the existence of an institutional vehicle would mean a simple solution that would facilitate the travel of professionals in the territory, reducing distances and increasing the number of visits in the time available.

Another access barrier concerns violence in the territory. The team observes a greater number of faults in the visits during shooting, since users "*are also afraid to leave home*". This situation requires greater flexibility of the team in the scheduling of visits as a way to ensure user safety. The situation is still worrying when the team itself cannot reach the homes of families:

We had a very complicated situation with an elderly woman due to violence [...], *we were not able to perform a home visit, and the old woman died.* [...] *if we did not have this violence, we would have managed to handle it better, and that death could have been avoided* (professional).

Violence as an obstacle to the health care of the population has been fomenting important debates both regarding its impact on the functioning of health services and on the own production of new demands for the health sector, insofar as it has repercussions on the health of the population and professionals. Because it is focused on the family and the community, the ESF requires that professionals travel through the territory, leading them to be exposed to violent contexts[19].

More often than not, health facilities must shut down for safety reasons, leaving the population unattended. Vulnerability to violence in the workplace generates fear and anxiety, as well as feelings of helplessness and frustration, with consequences to the physical and mental health of professionals. Violence may also lead to the de-characterization of the ESF work, since it often limits the performance of health professionals within the health facilities, thus changing the nature of care[19].

The need to assist a population beyond the recommended level is shown as yet another limitation: an average of 3,000 users per family health team is recommended[5]; however, the team interviewed reported having to attend a larger number, which they named of "overpopulated" team. At the time of the study, there were 3,633 registered users at Paula Mattos. This discrepancy is a hurdle to elderly care, since there are priority follow-up groups, and care for the elderly may not be included there.

We have seniors, pregnant women, children, tuberculosis, and all this with minimum service time. So for you to attend, care, prevention, treat the disease, diagnosis is very hard with the time available. We sometimes have twenty minutes to do all this (professional).

Excessive demand and productivity pressure for the whole team can hinder or prevent comprehensive care. Community health workers (ACS) are especially overwhelmed by periodic visits to a larger number of families than they are able to monitor, compromising the quality of their work.

The role of ACS is especially relevant in situations where seniors do not receive the support of family members. In some cases, it is the only reference of elderly care, which requires constant attention. Care occurs through the bond established between them:

This is the difficulty of elderly living alone. Often, they only count on us, they depend on our visit, our follow-up. One patient went sick; she even has a family. I went there and she said, "You came right here? You are my family". And indeed we are! Her daughters all live abroad (professional).

There is also a concern of the team directed to the family dynamics of the elderly, which is a challenge. Professional statements suggest that interactions between members of different generations within the household or with whom the elderly have no affinity, either due to financial imposition or physical weakness, contribute to illness. However, one must consider that, in popular classes, the aggregation of different generations in the same household or geographic space is beyond financial issues as one would usually

think. It is a way of organizing the family that includes solidarity between generations.

In the family context, violence against the elderly, expressed as financial and economic abuse, emerges as a factor that brings some concern to the team:

They complain a lot when the person receives payment. They feel very oppressed and say, "I have no more money, so now I depend on so and so". Then, a very strong depression creeps in them (professional).

Such violence is described as the illegal or improper exploitation of the elderly or their unauthorized use of their financial and patrimonial resources. This nature of violence is mainly observed in the family environment and is often associated with physical and psychological ill-treatment[20].

The clinic manager argues that the main challenge of the ESF team is establishing a link with older adults. This bond is one of the principles that guides the National Primary Care Policy and is based on affective and trust relationships capable of generating therapeutic potential[5]. The manager states that building the link requires trust, respect and empathy between users and staff, as well as a service organization that can respond to their needs. Bonding is a determinant for care:

If you do not have a bond with people, they will not come, will not open the door for you and will not take the medication. Think of this... "I don't like my doctor, I don't like my nurse, my nurse prescribed me this treatment, is that right? Because I think she doesn't like me" (manager).

The manager views CFSVM as a place where older adults gain visibility and their grievances are treated as unique.

Elderly care and health promotion, as well as their obstacles and challenges, were scrutinized by the subjects of the study, providing a broad overview of the level of excellence of care developed in the PHC. The quality of the bond, the driving force that gathers subjects in a network, established between the Paula Mattos team and the elderly and caregivers interviewed causes a stir. The obstacles and challenges concern rather the social and structural issues of the City than the quality of the care provided by the said team to the studied CFSVM population.

Care for the elderly with chronic diseases

With regard to the situation of the elderly with chronic diseases, NASF performance is highlighted. Mutual consultation with NASF professionals has been emphasized as a strategy that helps staff handle more complex situations by qualifying customer service and assisting professionals in approaches and decision-making. It appears as a tool that enhances the integrality of care and, from the viewpoint of the team, reduces the number of referrals to secondary care.

The construction of the unique therapeutic project (PTS) is an important strategy adopted by the team, especially in situations of greater difficulty. Covenants and care planning are carried out jointly by the staff with NASF support, which allows the collective elaboration of care and comprehensive care. Team meetings are also seen by professionals as an important device for ongoing education and training.

The groups aimed at users with chronic diseases are employed as a strategy to increase the qualified supply and adherence of elderly users with health problems, although they are not intended exclusively for this public. Because of their educational character, the groups appear as health promotion devices. At the time of the study, the CFSVM counted with the following groups: "nutrition"; "hypertensive"; "people with mental disorders" ("*Roda Vida*"); "chronic pain" and prediction of the implementation of two more: "diabetics" and "meditation and relaxation" (Med SUS) contained in the National Policy on Integrative and Complementary Practices[21].

These groups function as a space for lifestyle change and interaction with other people who experience a similar situation:

Groups are motivational. Because it is cool for you to have people who are more or less sharing the same afflictions, have the same illnesses with different developments, and can exchange experiences. Even more so in patients who are more reluctant to follow certain guidance (professional).

The team recognizes in these groups the stimulus to reflect on the process of illness and the factors involved that tend to stimulate ways of self-care and lifestyle changes, which are crucial elements in the treatment of chronic diseases.

The team identifies the need for health surveillance closer to the elderly with chronic diseases. The manager recognizes the electronic medical record, a component of the clinical information system, as indispensable not only for registration, but also for the qualification of the follow-up of users, especially those with chronic diseases that demand greater regularity of care.

In the team, the ACS plays a strategic role in the health surveillance of the elderly, since they

Ciência & Saúde Coletiva, 24(4):1369-1380, 2019

can signal to other team members the need for more specific interventions. As to the home care of the bedridden elderly, the manager points out:

Now [the HV] of bedridden is excellent. On average they [the ACS] make two to three visits a month. Now let's assume they go there and see that they are not well, they take them to a team, also because nurse and doctor have to visit these patients once a month (Manager).

A major concern of the team refers to the difficulty of adherence to treatment by elderly people with chronic diseases. The lack of knowledge about the implications of these problems, especially in cases involving silent diseases, challenges the team:

When people hurt themselves, such as cutting the foot, they see it. But when they have diabetes and do not feel anything and do not even know it, it's hard for you to tell them that they are going to take medicines at specific times. Our great challenge is showing that they are silent, but serious diseases. And the issue of medication... The importance of medication when they do not have any symptoms, because many are only aware when they are using insulin (professional).

The process of illness is experienced in a singular way and the awareness of the illness is very much linked to pain or physical disability. The clear communication between users, family and professionals about the short- and long-term implications of chronic diseases is fundamental in understanding the situation[22]. It is known that the success of the treatment is linked to the active participation and involvement of the user in this process. Adherence to treatment does not depend only on professional prescriptions, but on user's recognition of their health situation and the relationship with their habits[15].

Regarding the manager, as important as respecting the user's right to deny the visit to the ACS or to refuse any specific treatment is investigating the factors behind that refusal. The relationship between gender and health care is one of those factors that draws the attention of the team, requiring sensitization efforts. The manager notes that men are less likely to attend the service, showing that men and women are influenced by distinct cultural elements that lead them to develop opposite behavioral patterns concerning self-healthcare. Men's low demand for health services is influenced by a hegemonic model of masculinity, in which the concepts of virility, strength and invulnerability prevail[23].

Besides gender issues is the stigma surrounding some diseases, which is a barrier to adherence to treatment. This is the case of depression, which, in the popular classes, is often seen as a "sickness of the rich" and not as a legitimate health problem. Thus, a major challenge for the team is to tear down these cultural barriers that hinder care:

And a patient hardly accepts depression, even at a slight level. It is more difficult to work with elderly patients because they sometimes have difficulty understanding why this is happening. They come from a generation that often deemed depression as a 'fuss' or something to do with those who have financial condition, and they have nothing to do with it. A young patient coming from another generation will adhere much easier than an elderly patient (professional).

Both professionals and the manager of the facility refer to the difficulty of having some families in the treatment of the elderly with chronic diseases, which contributes to an irregular treatment from the team's viewpoint. In cases where it is difficult to involve the family in the care, the manager affirms that it is necessary to invest more in the construction of a trust bond between the family and the team. Another point worth emphasizing is conflicts over care both in contexts in which seniors do not want to feel dependent on their relatives and in which family members are forced to care for their elderly against their will and motivation.

The professionals report having difficulty dealing with the conflicts that occur within the family environment of older adults with chronic diseases. The embarrassment felt by the team in these situations requires an exercise of deconstructing the traditional concepts of care within the family. Minayo[20] clarifies that in Brazil and in the world, the family is a privileged locus of housing and care for the elderly. However, the skills to care for, protect and respect the elderly is not something natural, but a co-construction throughout the family life cycle. The justification that the family is the only structure responsible for the elderly is easily broken when one observes family dynamics marked by conflicts resulting from diverse situations, such as the abandonment and incompatibility of personality, values and life styles among the young and the older ones[22].

The multiple demands of elderly people with chronic diseases often require intersectoral attention to their health. The team cited partnerships with the Open University of the Elderly (UNATI-UERJ), CRAS, Health Coordinator of the planning sector (CAP) and Home Care for the Elderly (PADI) program. However, the diffi-

culty of articulation with the care network is still pointed out as one of the main challenges in the consolidation of global care to the elderly:

I think we still have little talk with CRAS and with the other devices that we can obtain in case of any problem. Facilitating and narrowing this relationship would be utterly crucial. I think this is still a weakness (professional).

Besides the disarticulation of the network, excessive bureaucracy and the lack of a well-defined flow chart, the team understands that strategic devices are missing so that the elderly can be accommodated in all their complexity. This is the case, for example, of the lack of temporary shelters, in quantity and quality, for the elderly in situations of vulnerability.

Intersectoriality is a fundamental element in the realization of comprehensive care, since it articulates different bodies from a common goal: the improved quality of life of the population. All sectors must work together so that each individual can be worked on as a whole[24].

Besides the formal support represented by health and social assistance institutions, the team identifies neighbors as key elements in the health care of the elderly, insofar as they play the role of informants and partners not only in health but also in the daily tasks of the elderly. Neighbors can prevent accidents, help them out with household chores, and relay information to the family health team if they notice anything different. Neighbors play a key role in situations where the elderly have no family support. The team brings two examples:

We have two emblematic cases of elderly people, one from each [resident] *doctor, where the caregiver is a mechanic of a workshop with no degree of kinship, but is a person who assume the responsibility. The other is neighbors who have been close to the elderly woman for many years, despite the fact that they do not have intimate contact, and they also assumed the responsibility for the care.* (professional)

The elderly, family members and caregivers also emphasized the importance of the bonds of friendship established with neighbors as a mechanism of social interaction and protection, which is a relevant point, since many elderly people tend to feel alone and isolated. Studies show that the nurturing of friendships and relationships works as a fundamental protective factor, especially concerning the development of depression and self-destructive behaviors[25].

Assistance for the elderly with chronic diseases is permeated by various options of care actions, but still with anemic interaction among the components of the care network for this population. The process of sickness brings some difficulties of understanding its severity by the elderly, which will demand a closer approximation of the family. However, the work with this root institution by the ESF is incipient, since to be in the place of caregiver, the family also must be taken care of in its interfamily relational difficulties and relationships between relatives and seniors. This is because the chronic diseases of the elderly can be mitigated in a loving and welcoming family context.

Perception of the elderly, family members and caregivers about the follow-up received by the CFSVM team

Of the five elderly women interviewed, four had impaired walking ability, one of them was bedridden due to advanced arthrosis and Alzheimer's disease. Thus, the home visits were highlighted by the elderly, family members and caregivers as of utmost relevance to meet their needs, a perception also shared by the team.

The team's regular visits were recognized as something that improves the well-being of the elderly, as one respondent points out: "*The presence, a word of comfort for us. All this helps, right?*" (elderly). This statement proves the role of bonding and acceptance in the production of care. In some interviews, the statements of the elderly women evidenced their solitude and isolation. The absence of close relatives and even the feeling of displacement when living among family members reveal some of the challenges of the elderly, which are aspects to be considered by the family health teams. In spite of the relevance of the bonding, reception, and humanization of care for the control of chronic diseases in the elderly, Penha et al.[26] found that some PHC professionals do not recognize them as relevant and favor approaches that employ material and tangible resources.

In general, the elderly, family members and caregivers interviewed identify the changes in the health care model and experience positive and close attention. They also show surprise at the type of follow-up offered by the family clinic that differs from what they were accustomed to:

I'm surprised, because people come here, we receive follow-up, she [the elderly] *is also having follow-up, which she never had, to have a doctor coming here to visit. You even have blood test at home. In case of any problem, we take her there and received care that same day* (relative).

Ciência & Saúde Coletiva, 24(4):1369-1380, 2019

The users know the professionals by name, which denotes an important sign of the bond established between user and staff. When asked about the quality of the care received, the respondents highly praised the service and were very satisfied. However, although they observe advances in the service model, they recognize that this is not a reality that affects the entire elderly population of the country.

One criticism of the elderly concerns the referral to the specialized care that is a weak point in comprehensive healthcare for seniors with chronic diseases. The respondents showed anguish and dissatisfaction with the long waiting time for a visit. Regarding chronic diseases, specialized care should be complementary and integrated to basic care in order to overcome the fragmented and decontextualized performance of traditional care models[15].

In fact, there is still a deep inequality in the Brazilian setting in the health care of the elderly, making the users interviewed feel privileged in a scenario of multiple needs. The team admits that while the country has been working to reduce these inequalities through the construction of a universal health system, access to education, leisure and means of transport still occurs selectively affecting, above all, the poorest population.

The shift from the biomedical care model to the biopsychosocial care in PHC brought recognition and gratitude by the interviewed users who began to receive comprehensive, longitudinal and regular health care from the ACS, physicians and nurses of the ESF.

Conclusions

From the respondents' statements, this study shows advances in health care for the elderly with chronic diseases in PHC. The professionals and manager of the family clinic analyzed are sensitive to the situation of the elderly, especially the elderly with chronic diseases who require different and regular care strategies.

It is speculated that the alignment of professionals' statements and practices with what has been advocated by public health policies is, at least in part, due to the greater incentive in recent years to the qualification of health professionals as one of the lines for the strengthening of PHC. Thus, we highlight the presence of family and community medicine resident physicians in the ESF team interviewed who, based on a training that is concerned with the individual-family-community triad, that is, with a complex and contextual aspects of health issues, can operate care guided by the concept of integrality within the biopsychosocial paradigm. Besides team meetings, resident physicians are accompanied by preceptors who encourage reflection on the practice and qualification of on-site performance of residents. Studies show that PHC is more effective when it counts with the presence of specialized physicians, in this case, the Family and Community Physician[27].

Despite advances, some barriers persist, affecting seniors' full access to health care, limiting the quality of care, protection and health promotion for this population. Care for users with chronic diseases must occur comprehensively[15], which is only possible if articulated in a network. The disarticulation of intra- and intersectoral networks, pointed as a weakness in this study, is a challenge to be overcome. Difficulty in access, limited team performance due to the lack of human and material resources and the difficulties of ESF teams in addressing the specifics of family dynamics and even with the elderly themselves compromise the resolution of care.

Tensions between the families of the elderly and the team suggest the need to strengthen the support network for the elderly and the qualification of the professionals so that they can have a more comprehensive attitude towards family-related issues. Families face many challenges in the care of older adults, which can generate physical, emotional wear and great overload of tasks in their daily life.

The CSVM has already had a group geared to caregivers of the elderly, relative or contracted caregiver. This institutional support is relevant, above all, in the care of the elderly with physical and mental limitations, which is the status of most of the elderly who were interviewed. In a study carried out with relatives responsible for the care of elderly people with dementia, Caldas[28] observed that these caregivers demand objective and subjective support, because they require reliable services to accompany the elderly relative and they themselves need adequate spaces for reception, since they feel exhausted and weakened by the intense workload to which they are subjected in daily treatment with the elderly.

This group was remembered by the caregiver of one of the elderly women interviewed as a moment of learning and exchange of experience, which is essential when the caregiver does not have previous knowledge for the task.

Dependence, stress and family isolation are risk factors for violence, maltreatment and intra-

family neglect with the elderly[29], thus the importance of greater support for the elderly and their relatives.

Regarding the limitations of the study, it should be noted that the interviews with the elderly and their relatives/caregivers reached a specific population: senior women over 80 years old with multiple comorbidities. The team indicated the users who demanded regular monitoring. Thus, it was not possible to listen to the elderly, for example, who attended the health promotion groups, where the study lacked the perception of these users about the care received.

The study reveals a complex universe in which the care process is influenced by a myriad of both macro and micro factors that are configured as objects of questioning and intervention in primary care, since they affect the quality of life of the elderly.

Collaborations

M Schenker and DH Costa equally participated in the concept, design, drafting and final revision of the paper.

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