Institutionalization of care practices for chronic conditions and the management of assistance in Primary Health Care*

Institucionalização das práticas de atenção às condições crônicas e gestão do cuidado na Atenção Primária (resumo: p. 15)

Institucionalización de las prácticas de atención a las enfermedades crónicas y a la gestión del cuidado en la atención primaria (resumen: p. 15)

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The purpose of this study was to analyze the institutionalization of care practices for chronic conditions and the management of assistance in a primary care service. The socio-analytical line of Institutional Analysis was chosen as the theoretical-methodological framework. In this intervention research, participant observation, groups held with health teams and interviews conducted with the individuals responsible for developing research and evaluating the service were used as tools. The results show that the subject's resistance to change is an obstacle to the development and consolidation of the care practices for chronic conditions. In addition, there is not a collective responsibility of all the professionals, demonstrating the lack of planning and engagement of the team. Also worthy of note is the results-oriented management policy, which oppresses and discourages collective power and innovation.

Keywords: Institutional Analysis. Chronic disease. Work process. Primary Health Care.

Introduction

According to the World Health Organization, Chronic Conditions (CC) are responsible for 41 million deaths on an annual basis. Among the most frequent conditions, we find cardiovascular diseases (17.9 million), cancers (9 million), and diabetes mellitus (1.6 million). It is a global problem, as only 25% of the people with CC are assisted and only half of them, approximately, meet the desired clinical treatment goals. This result derives mainly from insufficient access to health care and from an inadequate handling of CC[1].

The direct and indirect costs of CC in Brazil have been increasing over the last five years. The increase has been more significant in the costs of medicines (88%), followed by those related to social security (66%) and morbidity (33%). These data are indirect indicators of the increase in the population living with CC. The number of social security benefits increased in the last five years proportionately to sick pays, and it is already possible to visualize a decrease in retirements due to CC. As a percentage of GDP, CC costs are stable, probably because of the lower number of years of life lost[2].

This situation challenges the services to search for a new model of care that leads to better results, as a large part of these diseases are Primary Care Sensitive Conditions (PCSC). In this context, a Primary Health Care (PHC) service composed of 12 Primary Care Units in the city of Porto Alegre, state of Rio Grande do Sul, has been developing, since 2011, managerial policies, changes in the work process, and a permanent educational process with the health teams to introduce the Chronic Care Model (CCM). The model proposes the use of new technologies in the provision of CC care, like collective and sequential consultations, supported self-care, motivational interviews, and stratification according to risks and vulnerabilities, among others[3].

The construction of this model was based on the assumption that a universal public system should incorporate different patterns of social determination of health, operating in five levels: the first is the level of health promotion, with intersectoral action on the intermediate determinants; the second is the level of CC prevention, with action on the proximal determinants, related to behaviors and lifestyles; the third and fourth levels act on CC stratified by risk and handled by CC management technologies; and the fifth level acts on high-complexity CC by means of the clinic management technology[4].

However, to introduce this model of care, transformation processes are necessary, that is, "subjects who, in the daily practices, transform the mode of producing health care, transforming themselves in the process"[5] (p. 402). In short, this means producing a new way of managing health care and new relations between workers and users[6].

Nowadays, the care practices for CC are seen as instituting forces that aim to modify the care practices, having the work and management processes as intervention foci. Thus, this study aimed to analyze the institutionalization of practices of CC assistance and care management in a PHC service in order to identify the instituted and instituting dynamics, as well as the "critical knots" that may be hindering or potentializing the work processes.

Theoretical-methodological path

We used the socio-analytical line of Institutional Analysis (IA) as the theoretical-methodological framework. This choice derives from the fact that social analysis aims to apprehend the social and organizational reality and transform institutions based on the discourses and practices of subjects[7,8]. IA has an articulated set of concepts, among which the most relevant are those of institution, implication and analyzer.

The concept of institution can be analyzed dialectically, consisting of three moments: the moment of the instituted, of the instituting and of institutionalization. According to Lourau[9], we can understand instituting as contestation - capacity for innovation. The instituted, in turn, is the established order, the values, modes of representation and organization considered normal from the ideological point of view. Finally, the moment of institutionalization is the result of the tension between the two previous moments, when institutional practices are updated in their continuous becoming[9].

Another concept is implication, which refers to the set of activities we perform and, in the case of academic activity, our epistemological field and the underlying social demands[10,11]. Barbier[12] defined the three dimensions of implication: affective-libidinal, existential and structural-professional. Therefore, we are moved all the time by our affective, ideological and professional choices concerning our research and/or intervention practice, the institutions to which we belong, our theoretical-methodological field, and the society in which we live[9].

The identification of analyzers is also a primordial task. Analyzers are the events that enable to perform the analysis, allowing the apprehension of the "invisible" institution[13]. Lourau[9] says "[...] it is the analyzer that performs the analysis" (p. 69). Thus, the analyzers can be constructed during the process or emerge in a spontaneous way. Based on their identification, it is possible to learn non-verbalized aspects about groups, organizations, and their functioning. The analyzers help to unravel what was hidden, to disorganize what was relatively organized, and to give a different meaning to facts that are already known[8].

The study was carried out in the Primary Care Units of a service that is guided by the values, principles and attributes of PHC. These Units act in geographically delimited territories or catchment areas with a total population of approximately 108,000 inhabitants, in the east and north zones of the city of Porto Alegre. The service has three main purposes: health care, professionals' education and production of knowledge/technologies in PHC, in the sphere of the Brazilian National Health System (SUS).

To carry out the intervention research, we contacted managers who coordinate the change process of the care model developed in the service. Four Primary Care Units were indicated that met the selection criterion of understanding and being familiarized with the use of care practices for CC.

Initially, participant observation was used as a tool to the interventions. The researcher observed the Units' workers, aiming to understand how the new health practices were performed. Then, four groups were held, one in each Unit, with the presence of one

observer. These groups reconstituted what had been analyzed during the observations and held new discussions on care practices for CC. They were important devices in the construction of a collective analysis of the practices and the experienced work process.

Finally, after the analysis of the groups, semi-structured interviews were conducted with three managers of the service.

During the study, the researcher also registered her field observations in a research diary. According to Lourau[13], the diary technique does not refer specifically to the research; rather, it refers to the research process. The author mentions that this device enables "[...] to learn about the daily experience in the field (not the 'how to do it' of the rules, but the 'how it was done' of practice) [...]" (p. 77).

To analyze the data produced through transcriptions, analyses and reflections that occurred in the groups, interviews and diary records, we identified repeated discourses that contributed to construct the understanding of the practices of CC assistance and care management of this service.

The requirements of Resolution no. 466/2014 of the National Health Council were met and each subject confirmed their participation by reading and signing a consent document. The study was approved by the Research Ethics Committee of Grupo Hospitalar under number 18090. To ensure confidentiality, the participants were identified by flower names.

The Construction and Discussion of Some Analyzers

Transformations demand time to consolidate and the same happens with the care practices for CC, whose performance has been difficult, as "every new discipline or new space of knowledge contradicts the instituted knowledge". Lourau[13] argues: "I believe it is easier to recognize and identify what is already known or instituted". As for what is "new", "strange", "unknown", we have always been able to isolate it as incoherent (and we continue to do this today)".

It is important to mention that the inclusion of new care practices for CC in this service has promoted important changes in the work processes of the teams and in the health outcomes: amplified access, evaluated through the increase in the coverage of hypertensive and diabetic individuals (68% and 67% respectively); improvement in the quality of care, evaluated through the clinical control of diseases (77% of the hypertensive and 59% of the diabetic patients present clinical stabilization) and by the reduction in hospitalizations for primary care sensitive conditions; and the fact that risk stratification have started to be widely performed (88% of the patients). Dental appointments have become part of the routine care for diabetic users (37% of these patients received dental exams), and the investigation of depression in patients with CC have also become routine[3,14].

However, nine years after CCM was instituted and despite all the advances mentioned above, we observed that the teams get involved in different degrees and times and that some of the proposed practices are no longer occurring, while in others there is little participation of users. It was possible to perceive this fact in the reports of professionals who mentioned difficulties in replacing the strongly instituted model with the CCM.

The analysis identified two main points with their analyzers, expressing the movement of tension existing in the instituted-instituting-institutionalization dynamics, which affects the work processes in the daily routine of the health units. Among the tensions that we found, we highlight individual performance of tasks x team engagement and productivity x new care proposals.

Implication of the professionals: conflict between individual performance of tasks and team engagement

Considering health work an institution, as it has pre-established norms and rules, professional implication is nothing more than the relationship that the professionals establish with health work. The professional has a relationship with the work to be developed. They may like it, dislike it, be indifferent to it (libidinal implication), believe in the care practices for CC they and their team perform, not believe that CCM is a good model (ideological implication), be backed by the management to develop their functions in a satisfactory way, succeed in developing the work that was agreed with the team (organizational implication). Therefore, they are always implicated, whether they want it or not[15].

The management of CC care requires a team that works together, as comprehensive care provides better health care outcomes. A study carried out in the city of Curitiba to identify the perception of users and health teams about innovations in CC care showed the importance of the participation and strengthening of the groups directly involved in the intervention process, by means of a reflective action that includes managers, local teams and users[16].

An experience of shared care in the SUS was conducted at the Laboratory for Innovation in CC Care in the city of Santo Antônio do Monte, state of Minas Gerais, having the integration of chronic care provision as one of the main strategies to minimize the burden of these conditions. This innovation laboratory employed CCM, risk stratification for CC, new health technologies, and multiprofessional and interdisciplinary work. The main results of the laboratory were satisfaction of health teams and users, improved glucose control in diabetic patients, and an increase of approximately 50% in the evaluation of the institution's capacity for CC care[17]. Yeoh et al[18]. carried out a systematic review and also found that patients were more satisfied with the implementation of the model in comparison to usual care.

In 2012, the service studied here followed up 89 children with asthma through sequential consultations, in which the individual shares their experiences with professionals from different areas and they divide the information given to the

individual[19]. The results were high adherence to the model, an increase in the family's knowledge of the disease and its handling, and greater comprehensiveness of care. In addition, the disease remained controlled in a higher number of children, which meant a significant reduction of trips to the emergency room and of hospitalizations for asthma[20]. Despite the positive impact of this model, it was developed during three years only. It was not in force at the moment of the research, as the professional reported:

> We've had sequential consultations, but they require many modifications. I think it's hard to maintain them, however good the results are and although we see improvements in indexes, adherence and other things related to care. To us it is something outside our usual routine, we organize an activity and it is not part of the routine [...] and the team has changed a lot, people have retired, new people have arrived, and this kind of broke our continuity, but we performed sequential consultations during three years, after this period it kind of ended up being demobilized. (Nurse Rose)

In this sense, we can state that the professionals are stuck in the segment of reproduction, in the desire to "do the same", denoting a crystallized and hardened organization plan that tends to perpetuate itself, precisely through the strength and conservation of the instituted. Salci et al.[21] evaluated the health care delivered by PHC professionals to people with diabetes mellitus in the CCM perspective and found a similar situation. The professionals did not engage in the assistance and in the systematized follow-up for the prevention and reduction of chronic complications of diabetes; moreover, the educational activities were either partially performed or were not performed altogether.

Another relevant issue is that the care practices for CC do not happen based on collective thinking; they occur because of the individual desire of some professionals, as the discourse of nurse Lotus shows:

> And there's the issue of desire. Some people in our team are very motivated to perform the innovative practices of health promotion and others aren't, so it ends up depending on an individual desire, instead of an understanding that belongs to the whole team. (Nurse Lotus)

A study carried out by Heidemann et al.[22] in the cities of Florianópolis and Toronto also found little engagement and articulation of the team, as well as lack of organization to conduct groups and other health promotion activities. Raupp[23] carried out a study in small cities of the state of Rio Grande do Sul and also pointed out, as a worrying factor, the small number of prevention or health promotion actions, even in the cases of users who already had complications deriving from CC.

Another aspect that we found is the dedication put into the care practices for CC, which takes up a large part of the time and requires planning, making the professionals feel that "there is one more thing to do". Many times, they mentioned they are overburdened, which hinders their engagement in some of these innovative proposals. Nurse Lotus explains it in the following way:

> The practices, the groups, don't happen only at the moment of the encounter. There is a preparation, a pre-organization of knowledge, the organization of the process, of the methodology, we have to think about how it will happen [...] There are people who, because of the work and of the overload, don't get involved, sometimes because they're overburdened. (Nurse Lotus)

The time allocated to the development of care practices for CC can indicate a part of the organizational dimension of professional implication. It is possible to state this when we verify, by means of the discourse, the way in which time has been used by the health professional in the performance of their functions. The discourse above, collected in a group, shows what is instituted and present in the daily routine of the health professionals in general: lack of time to perform the innovative practices.

It is necessary to bear in mind that, although the changes currently desired and imprinted on the health work processes qualify the organization and provision of services, they bring new demands to the workers, as they shake the traditional forms of their functions, roles, responsibilities, performance and, mainly, the form of interaction with peers and users[24]. Therefore, the professionals feel overburdened by an almost infinite demand. Thus, the new (the innovative practices) causes an initial feeling of resistance, "I will not do it, I will not get involved". That is, although the proposal is innovative, its concretization is crossed by this field of contrary forces, as IA reminds us. Both forces, the revolutionary force of the instituting and the conservative force of the instituted, integrate the researched reality in a conflicting way.

We also noticed that, for some professionals, this new care model seems to be external to them, with little or no interlocution with their concrete reality. One of the nurses explained it in the following way:

> The issue of these innovative practices is really very beautiful on paper, but we don't have space and not all the professionals are here on the same day. So, I think it's beautiful, it'd be good if we could do it here, but in light of our reality, you see it's something I wouldn't say impossible, but difficult. This structure of the CCM is difficult, it's a very big change. (Nurse Rose)

It is worth remembering that, in the organizational culture of the health area, the units' workers are frequently distant from the outline of practices that meet users' needs and are compatible with local conditions. When the workers do not participate in this construction, there may be resistance, mainly to new work practices.

As for the PHC service analyzed here, it also has difficulties in reformulating the form of assistance expected in the model of care for people with CC, as it is still structured and organized to meet its own priorities, performing the practices according to what is more adequate to the professionals' work. We believe that the persistence in this established form of functioning prevents user participation, as they are obliged to comply with the service's offers and hours, and their own availability is not taken into account. During a group, the community agent Lily comments that users have difficulties in participating in some of the practices because they are offered during regular business hours, which is complicated for people who work. In this case, it is not the Primary Care Unit that adapts to the users' time; it is the opposite that happens.

> At our Health Unit, these practices happen when people are working, so this is also a limiting factor, because we offer them when people can't come. (Community agent Lily)

However, we found some professionals who believe that the new modalities of assistance are important and that, with planning and engagement, they can be introduced. That is, according to one of the basic principles of IA, the highly positive implication of the subjects involved is fundamental to build and institutionalize the care practices for CC. In this sense, the smoking cessation groups and the group targeted at healthy eating, called *Saúde no Prato* (Health on a Plate), can be considered instituted in the assistance practice of the Primary Care Units of this service.

The Health on a Plate Project, created by Nutrition and Dentistry professionals, guides people on adequate eating habits through collective consultations. In 2012, it was awarded the prize "Highlight in Health" by the Municipal Health Council of Porto Alegre, in the category Health Innovation. The Smoking Group also uses the method of collective consultation, as well as motivational approaches to smoking cessation. The goal of this service is that each unit conducts three smoking groups per year. Data from this service indicate that 36% of the smokers participate in the groups offered by the Units and have an index of 48% of tobacco cessation[14].

In one of the units, the groups started in 2011 and 12 groups were conducted, in which 109 people participated. Of this total, 46 had stopped smoking by the fourth encounter, which represents 42.2% of cessation[25].

To Esmeraldo[26], the construction of health care models is an unfinished, dynamic and permanent process, in consonance with the particularities of each reality. Each service can construct "its own model" based on each territory and its specificities. The author also recommends that the models be grounded on concrete realities, on their specificities - or else, it is not possible to consolidate them.

The changes in management and in the work processes of the teams that participated in this study were grounded on the CCM proposed by Mendes[27]. However, although this model was adapted to be applied to the SUS, it is important to reflect that "there is no recipe" for the transition from a model targeted at acute conditions to a model that provides care for CC. Therefore, the transition must have unique characteristics in order to guarantee the particularity of care, considering the context of each local health system. According to Salci[21], for the CCM to become a reality in the primary care network and be effective, it is fundamental that changes occur in many spheres of the care model, including a more specific preparation, as well as changes in the structure of health care.

A new model of care, targeted at dealing with CC and aiming to promote changes in the *micropolitics* of the health work process is always complex and lies in a setting of dispute between instituted forces. Micropolitics refers to the effects of subjectivation, a set of phenomena and practices capable of altering concepts, perceptions and ways of thinking[28].

The National Policy for Permanent Health Education (PNEPS) operates in the micropolitics of the work process. Lemos[29] explains that, according to the logic of PNEPS, it is in the creation of a new subjectivity that problematization can contribute to educate workers to assume an ethical-political commitment and become capable of acting critically in the micro-spaces of health, which is essential to institutional change.

Although the Permanent Education proposal of PNEPS is already consolidated, we notice that it has a lot to contribute to the reflections we are proposing here. Hearing what the professionals have to say and valuing the ways in which they perform the care practices for CC can be a path, as well as investigating these experiences as a way of tracking the power of each one of them.

Management policies: tension between productivity x new care proposals

Elements that signal a results-oriented management policy emerged from the discourses. Such policy oppresses the collectives and discourages them from transforming the practices. The analysis of the professionals' reports showed that demanding productivity does not adjust to the reality of the new model of care. In addition, the quantitative logic of production of consultations prevents the participation of the entire team, either due to lack of time or because they are not available to perform the practices.

> There is a culture that really demands a lot in terms of productivity of consultations and demands a lot in terms of goals, sometimes even in a way that is, how can I put this...? A little dissociated from this change in the model of care. (Nurse Lotus)

The demand for indicators and number of consultations bureaucratizes assistance and does not always correspond to quality in the services. Furthermore, these difficulties experienced by the teams can be explained by lack of dialog between health professionals and managers about the implementation of these practices in the Units. This can be seen in the report of the psychologist Strelitzia.

> We receive contradictory messages from the institution. At the same time that they say, Wow, renovation is great, they say that the productivity of consultations cannot decrease, and if it does, we will have to justify [...] The management doesn't understand that we are a PHC service and that, in fact, our indicator isn't only productivity and number of consultations. Our managers are not prepared to talk about what it means to produce health. (Psychologist Strelitzia)

The teams' action targeted at meeting the demand for consultations also shows that the policy of care for people with CC is only partially fulfilled. Similar situations have been found in other studies carried out in PHC, showing that this situation happens repeatedly in different places. A study conducted by Heidemann *et al*.[22] also found that the professionals' work process focuses on the productivity of care. The managers demand that the population be assisted by means of individual consultations, and the articulation between the health promotion practices and the social determinants of health is rarely performed, which causes an imbalance in these health activities.

Galavote *et al*.[30], in their study about work management in the Family Health Strategy, also identified elements that signal a results-oriented management based on discipline and control of the workers' practices, grounded on orders and acts that regulate work. Such work is said to be prescribed, dead, instituted, work that deprives the worker of their autonomy and inventiveness, that is, of the instituting.

We asked the managers to explain to us this results-oriented management policy mentioned by the teams. One of the interviewees stated that the excessive demand reported by the workers could be due to the education/experience of the professionals, maintaining the teams immersed in health care and leaving in the background some aspects of the innovations in care for people with CC.

> The changes proposed by the service are clear, but they are clear only to the people that coordinate it, sometimes it doesn't reach the teams, it doesn't reach all the professionals, some have difficulty understanding it because of their education, their experience. For example, many of them are administrative employees, so it's hard for them to internalize these innovations, these changes in the work process that the service proposes to do. So, I think these contradictions really exist. (Interviewee Begonia)

Donnangelo[31] argues that, in fact, the professionals usually complain about the rules imposed by the management, which the author calls external interferences. Changes take time. Acquired habits are not quickly abandoned. For this change to occur, there must be a (de)construction of the instituted knowledge; people must be open to new ideas and experiences, abandoning rigid conceptions. Although a new model of care has been instituted and implemented, the time for changes in the workers' behavior to occur is different from the time in which the changes are instituted.

In this sense, stimulating co-management processes would be an interesting alternative. In PHC, it is necessary that the management be closer to the services, that workers and managers analyze their implications, co-managing the CC care practices. Through participatory management, it is possible to promote improvements like the democratization of planning and decision-making, in the perspective and view of the subjects who are directly involved, which will enable that health production meets the needs of the population and of the workers[32].

The study conducted by Penedo, Gonçalo and Queluz[33] shows that shared management favors the work process and strengthens the relations between leader and workers. When everyone can express their opinions and have the opportunity of discussing together to form consensuses collectively, workers can overcome their difficulties and find the best solution to the group, even when there are divergent opinions.

Finally, it is important to notice that management does not refer only to the organization of the work process; there is also the problem of political-administrative discontinuity. This phenomenon can be defined by the interruption of initiatives, projects and programs, radical changes in priorities, and the shelving of plans, always according to a political bias, disregarding considerations about possible qualities or merits whose actions are discontinued. As a consequence of managers coming and going, institutional memory and knowledge are lost and working teams are discouraged[34].

Due to this, the permanent education and qualification of the manager, both in the field of technique and in that of politics, are fundamental to the acquisition of knowledge and skills that overcome the discontinuity that has been characterizing health policy management. To Paim[35], qualification, not only of professionals who are directly involved in the assistance, but also of managers, is one of the critical points of the management of public health services.

Final remarks

The institutionalization of the care practices for CC demands a reorganization of the work processes. The inclusion of the analysis of implications was relevant in the studied context, as it enabled us to understand institutional belonging and to obtain an expanded view of the professionals' work processes within the institutionalization of the CCM.

Concerning the implication of the professionals, we observed conflicts between individual performance of tasks and collective engagement. Stuck in the organization plan of individualism, most professionals insist in a dominant and curative type of assistance. Few professionals had disposition or implication with the care practices for CC, which shows lack of planning and integration among team members.

As for the management policy, a tension between the demanded goals was revealed, based on productivity and incorporation of the new proposals. The work rhythm and the pressure to meet deadlines were considered critical factors and showed that the managers focus on results, which has hindered the construction of the new care alternatives.

When public health policies are understood in a scenario of projects in dispute within the society, the perception of the obstacles mentioned by workers must be analyzed in light of facts that influence the implementation process of this policy. After all, the individuals included in the implementation process of the care practices for CC - managers, workers and users – are in this scenario.

It is important to clarify that this research did not aim to judge anyone, nor to blame the teams or the managers for the difficulties found in the Units. In fact, it analyzed the "tensions" present there that can help managers, coordinators and teams to reflect on the care practices for CC and their implications in work processes. Furthermore, this research can inspire similar analyses in other places that can be experiencing situations that are analogous to that of the service we studied.

Authors' contribution

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Conflict of interest

The authors have no conflict of interest to declare.

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Este estudo teve por objetivo analisar a institucionalização das práticas de atenção às condições crônicas e da gestão do cuidado em um serviço de Atenção Primária. A Análise Institucional, na vertente socioanalítica, consistiu no referencial teórico-metodológico escolhido. Foram utilizadas como ferramentas a observação participante, a realização de grupos com as equipes de Saúde e entrevistas com os responsáveis pelo desenvolvimento de pesquisas e avaliação do serviço. Os resultados mostraram que a resistência do sujeito à mudança implica obstáculo para o desenvolvimento e a consolidação das práticas de atenção às condições crônicas. Além disso, não há uma responsabilidade coletiva dos profissionais, demonstrando a falta de planejamento e engajamento da equipe. Destaca-se, também, uma política de gestão por resultados que oprime e desestimula a potência dos coletivos e a criação de novas alternativas diante dos impasses vivenciados.

Palavras-chave: Análise Institucional. Doença crônica. Processo de trabalho. Atenção Primária à Saúde.

El objetivo de este estudio es analizar la institucionalización de las prácticas de atención a las enfermedades crónicas y de la gestión del cuidado en un servicio de atención primaria. El análisis institucional, en la vertiente socioanalítica, constituyó el referencial teórico-metodológico elegido. Como herramientas se utilizaron la observación participante, la realización de grupos con los equipos de salud y entrevistas con los responsables por el desarrollo de investigaciones y evaluación del servicio. Los resultados mostraron que la resistencia del sujeto al cambio implica un obstáculo para el desarrollo y la consolidación de las prácticas de atención a las enfermedades crónicas. Además, no hay una responsabilidad colectiva de todos los profesionales, demostrando la falta de planificación y compromiso del equipo. También se destaca una política de gestión por resultados que oprime y desincentiva la potencia de los colectivos y la creación de nuevas alternativas ante los impases vividos.

Palabras clave: Análisis institucional. Enfermedad crónica. Proceso de trabajo. Atención Primaria de la Salud.