

The aged user's perception of Primary Health Care access and quality

A percepção do usuário idoso sobre o acesso e a qualidade da Atenção Primária à Saúde

Percepción del usuario mayor sobre el acceso y la calidad de la APS

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Abstract

Introduction: The aging of the Brazilian population already has repercussions on primary health care. **Objective:** Assess the perception of the elderly regarding access and quality of the Health System of Bambuí, Minas Gerais. **Methods:** This research uses a qualitative approach. The model of signs, meanings and actions was used to collect and analyze the data. Interviews were carried out at home, the choice of which was based on criteria to guarantee the heterogeneity of the participants. **Results:** The analysis was based on the emic perspective. The analysis revealed elements that make up the elderly user's perception about the implantation and consolidation of SUS and the local FHS in the category "PHC challenges in the perception of the elderly user". It was evident that, in the perception of the elderly, the public service has improved, but difficulties of access and the dissatisfaction of some with the quality of the service still remains. This leads to seek secondary care, urgency and private medicine. **Conclusions:** The findings point out that in the perception of the elderly, the implementation of the FHS was positive, however, primary health care can still be improved.

Keywords: Primary health care; Family health; Anthropology, Medical.

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Resumo

Introdução: O envelhecimento populacional brasileiro já repercute na Atenção Primária à Saúde. **Objetivo:** Avaliar a percepção dos idosos quanto ao acesso e à qualidade da atenção em Bambuí, Minas Gerais. **Métodos:** Esta pesquisa tem abordagem qualitativa. O modelo dos signos, significados e ações foi utilizado na coleta e análise dos dados. Foram realizadas entrevistas nos domicílios, cuja escolha baseou-se em critérios para garantir a heterogeneidade dos participantes. **Resultados:** A análise fundamentou-se na perspectiva êmica. Nela, emergiram elementos que compõem a percepção do usuário idoso acerca da implantação e da consolidação do Sistema Único de Saúde e da Estratégia Saúde da Família local na categoria — Desafios da Atenção Primária à Saúde na percepção do usuário idoso. Observou-se na percepção dos idosos, o serviço público evoluiu para melhor, porém ainda persistem dificuldades de acesso e a insatisfação de alguns com a qualidade do serviço, o que os leva à busca pela atenção secundária, pela urgência e pela medicina privada. **Conclusões:** Os achados demonstram que na percepção dos idosos a implantação da Estratégia Saúde da Família foi positiva, porém a atenção primária em saúde ainda pode ser melhorada.

Palavras-chave: Atenção primária à saúde; Saúde da família; Antropologia médica.

Resumen

Introducción: El envejecimiento de la población brasileña ya tiene repercusiones en la atención primaria de salud. **Objetivo:** Valorar la percepción de las personas mayores sobre el acceso y la calidad del Sistema de Salud de Bambuí, Minas Gerais. **Métodos:** esta investigación utiliza un enfoque cualitativo. Se utilizó el modelo de signos, significados y acciones para recolectar y analizar los datos. Las entrevistas se realizaron en el domicilio, cuya elección se basó en criterios para garantizar la heterogeneidad de los participantes. **Resultados:** El análisis se basó en la perspectiva emic. El análisis reveló elementos que configuran la percepción del usuario mayor sobre la implantación y consolidación del SUS y la ESF local en la categoría “Desafíos de la APS en la percepción del usuario mayor.” Se evidenció que, en la percepción de las personas mayores, el servicio público ha evolucionado para mejor, pero aún persiste dificultad de acceso y el descontento de algunos con la calidad del servicio. Esto hace que busquen atención secundaria, urgencia y medicina privada. **Conclusiones:** Los hallazgos señalan que en la percepción de los adultos mayores, la implementación de la ESF fue positiva, sin embargo, la atención primaria de salud aún se puede mejorar.

Palabras clave: Atención primaria de salud; Salud de la familia; Antropología médica.

INTRODUCTION

Family Health (FH), a strategy of the Unified Health System (*Sistema Único de Saúde – SUS*), is based on the constitutional principles of universality, equity, and comprehensiveness of health care. It aims to strengthen Primary Health Care (PHC) through community guidance for social participation, health promotion and surveillance, favoring the quality of life of individuals, families, and communities. FH teams are composed, at least, of a doctor, a nurse, a nursing assistant and/or technician and a community health agent (CHA).¹

Although the FHS has made it possible to expand user access to the SUS, there are still gaps that need to be improved to improve the quality and solvability of public health services.²

The aging of the Brazilian population already has repercussions on the SUS. According to the National Health Survey, the demand for health services by aged people for the treatment of illnesses or acute situations increased from 8 to 13%.³

In order for PHC to function effectively as the main user entrance to SUS, it must be able to solve most of the population's health problems and, for that, it is important that its four fundamental attributes are strengthened: attention at first contact; longitudinality; completeness; and coordination of care, which requires the recognition of users' needs by professionals and the follow-up of each case, in order to avoid unnecessary and iatrogenic care. This will enable comprehensive care.⁴

The Health Care Network (HCN) must have diagnostic and therapeutic support systems, pharmaceutical care, health information, logistical systems for the identification of users, clinical records, regulated access to health transport care and systems governance.⁵ In addition, services also need to respond to the sociodemographic and cultural contexts of the population assisted.¹

However, the situational diagnosis of community health from the perspective of health professionals is, in many cases, quite divergent from the needs and problems perceived by the population. The perception of professionals who usually guide health programs remains associated with biomedical knowledge, without considering the popular knowledge of the population. This has a network of cultural symbols that should be considered by the health service.^{6,7}

Despite the progress in the implementation and expansion of the FHS,⁸ there are still challenges to be improved to meet the needs, especially of this growing aged population; so that health care is of quality.

Thus, with a view to strengthening PHC, this article proposes to listen to aged SUS users about their perception of access and quality of the FHS in Bambuí (MG).

METHODS

This research uses a qualitative approach carried out in the municipality of Bambuí, located in the mid-west of the state of Minas Gerais. The city has an estimated population of 23,936 inhabitants,⁹ of which 85% live in its headquarters, with 91% of FH coverage in the urban area. Aged population represents 16% of the inhabitants, of which 80.7% depend exclusively on SUS and the others have private health insurance. Life expectancy is 70.2 years, and the main economic activities are agriculture and commerce.¹⁰ The micro-region of Bambuí is linked to the regional health department by the macro-region of Divinópolis. The local HCN⁵ has a FH team in each of the six Basic Health Units (*Unidades Básicas de Saúde* – UBS), a polyclinic, a team from the Family Health Support Center (*Núcleo de Apoio à Saúde da Família* – NASF) and two hospitals, one connected to the state and one to the municipal network.

The model of signs, meanings, and actions developed by Corin et al.¹¹ was used in the collection and analysis of data to allow the systematization of the context elements that participate in the construction of typical ways of thinking and acting of the research participants. According to Geertz,¹² mentor of the interpretive current in Anthropology, culture constitutes a universe of symbols and meanings that allows the subjects of a group to interpret their experiences and guide their actions.

From this current emerges a new conception of the relationship between individuals and culture. Anchored in this perspective, this model of analysis seeks to work with representations (ways of thinking) and behaviors (ways of acting) associated with specific health problems, with access to the conceptual logics privileged by a specific population. It seeks to understand and explain a given condition, as well as to identify the different elements of the context that intervene in the construction of behaviors concretely adopted by a population in the face of a given disease.⁶

To reconstruct the universe of representations and behaviors of the aged population in Bambuí, interviews were carried out in the participants' homes. To allow for greater heterogeneity in the group, selection criteria included: team territory, gender, age, and functional status. Only aged people without cognitive alterations that could impair the interviews were approached. The saturation criterion regulated the final size of the sample.¹³ The technique of semi-structured interviews was used, based on three guiding questions: how do you think your health is? What do you think of the health service you attend? For you, has the health service changed in recent years?

The interviews lasted an average of one hour, were recorded, and later transcribed. In the present work, interpretations were aimed at understanding the phenomena from the perspective of the aged people, in the desire to give voice to these interlocutors. This emic perspective configures an innovative

conceptual and methodological framework, in which the scientist's interpretation is built on the basis of the interviewees' perspective rather than the researcher's or the literature's view.⁶

After careful and repeated readings, significant units were identified. The coding of the interviews was performed and revised by the main researcher so that all the information obtained was grouped into analytical categories, with as little ambiguity as possible. Finally, correlations and associations between the different categories were examined.

In this way, the speeches were grouped into a comprehensive category, "challenges of PHC in the perception of the aged user", which allowed the emergence of thematic nuclei aligned in two great axes: the elements identified by the interviewees regarding PHC attributes and the repercussions in the actions of aged users, in case these attributes are not met.

To ensure anonymity, each interviewee was identified by gender, order of interview, marital status, and age. Four researchers participated in the analysis of the interviews.

This work is part of a larger project entitled "Anthropological approach to the dynamics of functionality in the elderly", approved by the Ethics Committee in research with human beings of the René Rachou Research Center (CPqRR), Protocol CEP No. 29/2009. All participants signed a consent form, in accordance with Resolution No. 196/1996 of the National Health Council.

RESULTS

The present study evidences the perception of 57 aged people, 27 men and 30 women, between 61 and 96 years of age, in relation to health services. All the aged subjects were registered in the six teams of the local FH. The researched group was characterized by low education, strong influence of the Catholic religion and rural origin. Most migrated from rural to urban areas seeking greater access to education and work for their children, greater proximity to the health service and better living conditions. As for marital status, 24 were married (mostly men), one lived in a stable union, seven were single, and 25 were widowed (higher number of women).

Respondents experienced the process of building the Brazilian public health system in the last 30 years. The analysis revealed elements that make up the aged user's perception of implementation and consolidation of SUS and the local FHS in the category "PHC challenges in the aged user's perception". Table 1 shows the elements identified by the interviewees in terms of PHC attributes and the repercussions on users' actions, in case of difficulty or non-satisfaction of these attributes. FH, the health model implemented in PHC, brought undeniable improvements.

Regarding the "gateway", when it comes to rural areas, access has improved, as "the health station" is now close to home. From the statements of the interviewees, it is clear that before SUS, there were no doctors in the "countryside", there was a geographical barrier, it was difficult to get access to the service and, even more, to the "medical" professional. Shimizu¹⁴ confirms these statements by proving that users residing in rural areas require special attention from public policies due to their inequities.

In some speeches, it is clear that the *first access* to the health system has improved, even rehabilitation is now present,³ but this issue is still not completely resolved in PHC. Therefore, some users justify the practice of seeking access at the hospital, through SUS, or by paying. The *integrality* attribute assumes that users can be referred by the FHS to secondary services located in other cities that make up the HCN of Bambuí.⁵ It also makes it difficult to link PHC as a first contact and, at the same time, reinforces the importance of investing in PHC as the main gateway to the system and the

coexistence of several gateways to SUS (PHC, hospital, and urgency). This outlines a scenario in which people access the system through what they consider to be easier, possible or more resolute. It is known that where FHS coverage is consolidated (compared to places where this coverage was lower), the probability of users citing the emergency room or hospital as a usual source of care decreased by 37%.¹⁵

As for the *integrality* attribute, the issue of the doctor “giving” medicine and the fact of “getting medicine through SUS” is highlighted, and going to the public system aims to “save” health expenses. However, some users have reported needing to buy them. It is noticed, in some interviews, the lack of supply of the basic pharmacy of the “health station” and, in other cases, the lack of correct prescription of medicines

Table 1. Attributes of Primary Health Care, before and after the introduction of the Family Health Strategy and repercussions on respondents' actions.

Access		The perception of lack of access strengthens the hospital-centered model and physician-centered care
Before	<p>(...) there was a man who treated the people there, in his neighborhood [referring to the rural area]. But he wasn't a trained doctor, no. He was a charlatan (H45, 92 years old, widowed).</p> <p>At first, it was very difficult. It was all too difficult! Today, I remember my mother when she got sick, many years ago, we had to take her to the doctor in the countryside (...). There was no road (H11, 69 years old, married).</p>	<p>“I go to the doctor here, Dr. X. The day after tomorrow I'm going there [to the hospital]. Then it's Dr. Y, another time it's Dr. Z. I go to the health center from time to time (...) I prefer it to the hospital because there is more access there” (M4, Widower, 81 years old).</p> <p>“I pay (at the hospital), 10 reais, for the prescription. And also for controlled medicines, (the doctor) doesn't give the prescription. (...) [Do you have any difficulties getting it through the SUS?] Ah, yes. (...) It is preferable to pay. It makes it a lot easier” (M4, Widow, 81 years old).</p>
After	<p>It was just the hospital here. Now they have some health stations like this in the neighborhoods, it's closer for us to go... (H20, 69 years old, single).</p>	
Integrality		The perception of non-satisfaction of this attribute exposes the limits of professionals and services
Before	<p>“Yeah, it's better, a little! It was just the hospital here. (...)” (M 20, single, 74 years old).</p> <p>“I think it has improved (...) because there are a lot of resources now, there are many doctors, good doctors (...) and the doctors here are all very attentive, they are too good. Good, like, really good. (...) People come from far away from other cities to consult here because it is difficult out there (...). There were no such things here. Getting a person out was a hell of a problem. Now there is a car to take patients. It goes here, goes there and you don't have to pay anything. Before, there was nothing” (M19, Widow, 83 years old).</p>	<p>“These clinics are lacking doctors. [Why?] (...) the doctors at the health center seem not to be enough, they are not specialized” (H11, Married, 69 years old).</p> <p>[...] now there's still a lot of things missing, for instance, if you have to do a mammogram, we have to go out because they don't do it here. Sometimes some other different exam you need to do... (M37, 68 years old, married).</p>
After	<p>“(...) the problem here is that good doctors usually don't stay here. This is a problem, but I don't know why either. I don't know if it's politics... (...). There are these old doctors here, so they... I don't know if they kick the others out or what (...). That's what we wanted, good doctors, and equipment. 'Cause sometimes the doctor is good, but he doesn't have adequate equipment. There would have to be more assistance here to avoid migration to X, to Y. (...) I think doctors, they have to study a lot, do recycling (M 38, single, 69 years old).</p> <p>I did physical therapy, in the arm, they took care of me very well. He (referring to the mayor) is creating a center to treat people who have depression. (...) these times I have been attended to, I have been well cared for (M 38, single, 69 years old).</p>	

Continue...

Table 1. Continuation.

Longitudinality	The perception of insufficient longitudinal follow-up leads the user to seek in the private system the care they could have in the public service.
<p><i>Before</i> I feel you, there was no such thing as a health station when I moved here, there was nothing. It was in 1979. [Referring to what it was like to consult at that time]. [...] We... would paid, before we would paid. At that time, I don't think there was SUS, no, there wasn't, right? [...] it's from 88 on (H40, 71 years old, married).</p> <p>[...] It improved a lot, you see. Very good! We get medicines, I get these blood pressure medicines at the health center. Anything we need urgently, sometimes we can't go to the hospital, then we go to the health center. Well, it got a little better (M37, 68 years old, married).</p> <p><i>After</i> There is a post in the neighborhood. [...] Vaccine [...] [referring to the services you use at the UBS] if people feel sick, they rush there [...] It's a very good environment... the vaccines, the medicines they distribute [...] There is, there is an agent, a health agent. She always comes. There are times when it's once a month, but there are more. If there is any change in care, or vaccine, they let us know. They come and find out if we haven't been hospitalized, if we haven't had something more serious, the physical care... works... with this health center. There was an improvement (M10, 72 years old, married).</p>	<p><i>There is a doctor who is known, so I have that confidence to talk to him. (...) [referring to the fact that the doctor also works at the clinic]. I've already consulted with him at the health center, about four times... but I'll tell you the truth, that I think he is... I don't know if the others think too. The consultations he made through SUS, paying for the prescription, I think those are more forwarded (H7, 84 years old, married).</i></p> <p><i>"Now what's bothering me is that I got a bruise on my leg. (...) Yesterday my niece still came to make a bandage for me, because those people at the health center are very busy and don't come. Then she is doing the dressing herself. (...) If it wasn't for my niece I would have to do it myself. They ain't coming, no. They stay there, they go everywhere, but here?... there's one that used to pass by almost every day, now it's gone, it hasn't been here anymore, a bit tangled up. [And you go there?] No, I can't handle it. If it's not by car, I can't handle it, no. From there to here there is a lot of climbing" (M 27, Single, 80 years old).</i></p>
Care Coordination	The perception of lack of coordination leaves it up to the user to define a parallel care network.
<p><i>Before</i> (...) You didn't have doctors to do tests... (...) [referring to how care happened before SUS] they would come to the doctor by horse: look, so-and-so is like this and like that, with fever, with a headache, then they would take and prescribe the medicine. Many even died because they took medicine, and the medicine was bad for them (M35, 93 years old, widow).</p> <p><i>After</i> "They say it is FHP. Oh no, when you need it, the girl brings it (And do you think that before you had the FHP, and now that you have it, has anything changed?) Look, it has changed, because sometimes the girls come and measure my blood pressure. Then the pressure is measured, then, sometimes, the girl brings the doctor here. All you have to do is make an appointment and he comes, takes care of us properly, is very polite, treats us well, does not mistreat us (M13, 67 years old, widow).</p>	<p><i>"it's out there. Here, no. (...) when I see something simpler, I look for it here. Now, when I see that it is more serious, then I go there" (H6, married, 62 years old).</i></p> <p><i>I'm going to a doctor in Formiga, my son takes me by car. I go there every three months. One hundred and eighty reais. It's Parkinson's. I deal with a neurologist in Formiga. He told me: "Oh, Ms. M., there is no cure, but there is improvement. If you take the pills correctly and all the medicines I'm prescribing, you'll get better. In fact, I'm getting better, it relieves a lot [...]. I have diabetes... it's a lot (laughs) (M51, 69 years old, widow).</i></p>

supplied by SUS and/or the lack of filling in forms for access to special medicines provided by the State or Union. Pharmaceutical Care (PC) should go beyond “medicines” and consider all its dimensions in the organization of services: geographic, economic, functional, availability (existence of services in adequate quantities to the needs of users) and communicational (dialogue in relations of care).¹⁶

As for the assistance received at home by the FH team, there were reports of progress brought about by the FH implementation; however, users with mobility difficulties or access to the “health station” for various reasons, who should be candidates for home visits — a fundamental tool in this new model — were not included in this service.¹⁷

Some aged people, realizing that their cases seem more complex and feeling insecure or dissatisfied with the care provided in the FHS, on their own initiative, reported looking for a specialized service and/or private practices to, paradoxically, and often, consult. professionals who could serve them through SUS. They feel that the paid consultation would be more “oriented”. This practice contributes to inequity in access to health services, since only those with better financial conditions have the resources to access the private system.¹⁸

Thus, the attributes *longitudinality* and *coordination of care* are still fragile in the perception of the interviewees. Added to this, the biomedical model that is perceived in the culture of the population, especially the aged, according to which only doctors could solve health problems, has not yet been overcome.¹⁹ In the perception of users, professionals are not “specialized”, they would need to be “recycled” and also “they do not have adequate equipment”.

The issue of turnover and lack of doctors in PHC is quite complex. In addition to the very small offer of adequate training such as medical residency in Family and Community Medicine and specialist doctors in Brazil, many are subject to precarious work contracts and, in large centers, where there are more specialized professionals, health care providers hire them to work in the private sector.²¹

All these weaknesses may be aggravated by the insufficient number and high turnover of physicians, the unpreparedness of these professionals to work in PHC and/or the lack of adequate diagnostic support. It would be up to the FH to oppose this still hegemonic logic and strengthen the work in a multidisciplinary team.^{22,23} To this end, it is necessary to modify the logic of individual consultations and incorporate health promotion, prevention, and recovery (rehabilitation) into the daily life of practices.²⁴ In order to strengthen the bond between users and health professionals, access to information must be expanded and participatory strategies in collective activities, health promotion, health education and socialization must be strengthened.⁴ And, for aged people with chronic conditions, it is necessary to guarantee access to health promotion, especially for those in the process of frailty or with some functional disability.²⁵

These results demonstrate that, despite the improvement in the first contact, doubts are still perceived as to the effectiveness of the other three PHC attributes. Inequality in access exposes a context in which the majority of aged people in Brazil cannot afford to pay for private health plans or doctors. According to data from the National Health Agency (*Agência Nacional de Saúde – ANS*), only 13% of health plan users are aged.²⁶ The current austerity policies of the federal government, applied to social security, will make this situation even worse.²⁷

In the absence of institutional resources, aged people seek support in the community and families. However, the very transformation and redefinition of the functions and values of the modern family should increasingly lead to the establishment of stricter boundaries between family and community and demand the transfer of functions, once concentrated on the family, to public policies.²⁸

FINAL CONSIDERATIONS

The findings reveal that, in the perception of the aged, the implementation of the FHS was positive, but health care still needed to be improved. Faced with the reality of aging, SUS will be increasingly challenged to deal with issues that go beyond the biomedical view and affect the population's living and health conditions and the need for care. This will demand the action of the FHS in a coordinated, longitudinal, integral, but also intersectoral way.

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CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

ACDO: Conceptualization, Data Curation, Formal Analysis, Writing – original draft. KCG: Conceptualization, Data Curation, Formal Analysis, Writing – Review & Editing. WJS: Conceptualization, Data Curation, Formal Analysis, Writing – Review & Editing. JOAF: Conceptualization, Data Curation, Formal Analysis, Writing – Review & Editing.

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