Health, 2015, 7, 365-370
Published Online March 2015 in SciRes. http://www.scirp.org/journal/health
http://dx.doi.org/10.4236/health.2015.73041

Scientific Research Publishing

Assessment of Comprehensive Health Care of the Elderly in Primary Health Care

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Received 31 December 2014; accepted 10 March 2015; published 18 March 2015

Abstract

Objective: To assess comprehensive care in the elderly population, as well as the quality of care in Primary Health Care. Methods: This is an exploratory descriptive study with a quantitative approach, conducted from July to December 2012, in the city of Santa Cruz, Rio Grande do Norte, Brazil. A sample of 130 subjects chosen by drawn was calculated, and data collection was performed at their homes. Results: There were interviewed 130 people, 92 (70.8%) women and 38 men (29.2%), with a minimum age of 60 and maximum of 96 years, with a mean of 72.8, median of 72.0 and a standard deviation of 8.3. Regarding the quality of care ratings of the PHC team, 48.5% (n = 63) of respondents stated this to be good, while 32.3% (n = 42) rated this as fair. Conclusions: In this perspective, one of the most appreciated meanings that were given to comprehensive care by health care professionals refers to holistic knowledge of each patient, resulting in the non-fragmentation of care. Thus, it is noticed that comprehensiveness has some weaknesses that need to be corrected, which shows the need for education and training of professionals assigned to primary health care services.

Keywords

Comprehensive Health Care, Health Evaluation, Health of the Elderly, Primary Health Care, Professional Practice

How to cite this paper: de Andrade, F.B., do Ceu Clara Costa, I., dos Santos Ferreira, T.L., Silva, I.C.F.G.A., Araújo, Í.K.M., de Oliveira Pereira, D., de Assunção, J.R.G., dos Santos Dutra, J.I. and de Lima Cabral, A. (2015) Assessment of Comprehensive Health Care of the Elderly in Primary Health Care. *Health*, **7**, 365-370. http://dx.doi.org/10.4236/health.2015.73041

1. Introduction

Comprehensiveness has become a principle of the Unified Health System (SUS in Brazil) and a challenge to health professionals, considering that the work of multidisciplinary teams is essential to reach its goal, which shall prioritize the organization of the work process, plan and construct new knowledge, and modify the health care model, so as to provide the elderly people with comprehensive health care.

According to the 2010 census, Brazilian population today is made up of 190,755,799 million people, 51% women and 49% men [1]. According to the National Policy for the Elderly and the Elderly Statute, the number of elderly people aged 60 years or more is 20,590,599 million, which represents approximately 10.8% of the total population [2].

One of the biggest challenges of contemporary public health is population aging. A fact that had initially occurred in developed countries was recently showing to be more accented in developing countries. In Brazil, the number of elderly people (≥60 years old) increased from 3 million in 1960 to 7 million in 1975 and 14 million in 2002 (an increase of 500% in forty years), and it is estimated to reach 32 million in 2020 [3]. Therefore, according to the changes observed in the population pyramid, aging-related diseases are getting noticed in society at large, which implies an increasing demand for health services.

Elderly people's health and quality of life, when compared to other age groups, are influenced by several factors such as physical, psychological, social and cultural rights; so that when considering the elderly's health assessment and promotion, the knowledge of an entire health team shall be also considered since it is important for health professionals to work in multidisciplinary and multidimensional teams. Regarding the elderly care, it is necessary to estimate the maintenance of quality of life, so that the whole human aging process is considered always seeking for the possibilities of prevention, maintenance and rehabilitation of their health condition [4].

Thus, as the human aging process is inevitable, it is essential that the health care provided to the elderly people shall be increasingly directed to these age group particularities, allowing them to experience a higher quality period of life, considering that the higher risk of complications arise in this stage of life.

In order to meet the increasing demands of an aging population, a National Policy for the Elderly (NPE) was created based on UHS regulations, whose goal is to ensure the social rights of the elderly, create conditions to promote their autonomy, integration and effective participation in society [5].

Based on these perspectives, it is a function of health policies to provide aging people with the best possible health condition, which implies maintenance of their quality of life. Thus, in 2006 it was implemented a National Health Policy for the Elderly (NHPE) which defines the Primary Health Care (PHC) as an entry point to the elderly's health care and a reference to system of specialized health services of medium and high complexity [6].

Primary health care aims to provide the elderly people with humanized attention and mentoring, monitoring and domiciliary support, which are able to include family and caregivers, also considering local cultures, aging diversities and the reduction of architectural barriers in order to facilitate their access in accordance with the proposal of the Ministry of Health's Physical Structure Manual, issued in 2006. Given that it is essential in all stages of life to adopt interventions that provide supportive environments and promote healthy choices, since they will influence an active aging process [6].

An essential Primary Health Care's feature is the comprehensiveness perspective, which is independent of the actions' organization model. From this aspect, it is assumed that comprehensiveness can be understood as the coordination of health promotion, prevention and recovery, which are set to health care effectiveness through activities that are structured in the same space, with the composition of interpenetrate knowledge and actions, *i.e.*, technical knowledge and practices of the various professionals working directly in health care concur with each other [7].

In light of the existing difficulties for the implementation of comprehensiveness in primary health care services, it was realized the need to assess how comprehensive was the health care provided to the elderly in the city of Santa Cruz, state of Rio Grande do Norte, Brazil. Therefore, this study aims to assess comprehensive care in the elderly population, as well as the quality of care in Primary Health Care.

2. Methodology

This is an exploratory descriptive study with a quantitative approach, conducted from July to December 2012, in the city of Santa Cruz, located in the state of Rio Grande do Norte, Brazil. Since this is an assessment study and

there is no grievance investigation, a sample of 130 subjects.

This work is part of a research entitled Primary Health Care: an assessment study on the user's perspective. The subjects' inclusion criterion was being elder, having preserved cognitive ability, residing in the community enrolled in the drawn PHC unit and signing the term of free and informed consent.

The sample was not probabilistic and convenience, according to the criteria of inclusion and exclusion. The interviews were conducted by interviewers graduate students in nursing UFRN/FACISA, in the environment and booked individually, after explaining the research objectives, as well as reading and signing the Informed Consent Form (ICF) by the subjects, using the instrument Primary Care Assessment Tool (the PCATool).

Because it is a quantitative research, data were tabulated and statistically analyzed using the Statistical Package for Social Sciences SPSS, version 17.0. For data analysis, descriptive analyzes (absolute-relative frequencies, mean, median, standard deviation) and chi-square test were performed, considering a confidence interval (CI) of 95%.

This study has followed the recommendations contained in Resolution 466/2012 of the National Health Council, regarding research with human subjects. This project was approved by the Ethics and Research Committee (ERC) at the Federal University of Rio Grande do Norte (UFRN) under the approval number 152/2012.

3. Results

This study is a survey to assess the comprehensiveness of care provided to the elderly people. For this purpose, 130 people were interviewed, 92 (70.8%) women and 38 men (29.2%), with a minimum age of 60 and maximum of 96 years, with a mean of 72.8, median of 72.0 and standard deviation of 8.3. As monthly family income was obtained mean of R$ 740.1 and median of R$ 572.5. Regarding the time period in which the user had attended the health care service, 94.6% (n = 123) of the respondents stated they have attended it for over 12 months, *i.e.*, a positive aspect.

In **Table 1**, we observed the classification of quality of care ratings regarding the Primary Health Care team, from the perspective of the elderly user, that 48.5% (n = 63) claimed this to be good, while 32.3% (n = 42) rated this as fair, 6.9% (n = 09) poor and, finally, 6.2% (n = 08) as excellent and terrible.

Table 2 shows the users' responses regarding the need of Primary Health Care, and data show that 37.7% (n = 49) of the respondents stated they always have this need; while 23.8% (n = 31) sometimes and 23.1% (n = 30) often. Considering Health Services and professionals' liability regarding their health, 39.2% (n = 51) affirmed they sometimes consider this liability; 28.5% (n = 37) always; and 13.8% (n = 18) never. With regard to health professionals understanding of their needs, 40.8% (n = 53) reported they have always understood their needs,

Table 1. Quality of care ratings regarding the Primary Health Care team. Santa Cruz, RN, Brazil, 2013.

	Terrible	Poor	Fair	Good	Excellent	Total
Quality of care ratings	6.2% (n = 08)	6.9% (n = 09)	32.3% (n = 42)	48.5% (n = 63)	6.2% (n = 08)	100.0% (n = 130)

Table 2. Correlation between quality of care ratings and aspects of Primary Health Care. Santa Cruz, RN, Brazil, 2013.

	Never	Rarely	Sometimes	Often	Always	p-value
Need of primary health care	6.9% (n = 09)	8.5% (n = 11)	23.8% (n = 31)	23.1% (n = 30)	37.7% (n = 49)	0.057
Health Services and professionals' liability regarding their health	13.8% (n = 18)	11.5% (n = 15)	39.2% (n = 51)	6.9% (n = 09)	28.5% (n = 37)	0.005
Understanding of their needs	5.4% (n = 07)	6.2% (n = 08)	35.4% (n = 46)	12.3% (n = 16)	40.8% (n = 53)	0.000
Health professionals' care to the users' speech	6.2% (n = 08)	3.8% (n = 05)	33.1% (n = 43)	13.1% (n = 17)	43.8% (n = 57)	0.001
Health professionals' knowledge on the user's history of life	30.0% (n = 39)	8.5% (n = 11)	33.8% (n = 44)	9.2% (n = 12)	18.5% (n = 24)	0.000
Home visits proposed by health professionals	48.5% (n = 63)	13.1% (n = 17)	34.6% (n = 45)	2.3% (n = 03)	1.5% (n = 02)	0.121

35.4% (n = 46) sometimes and 12.3% (n = 16) often. Regarding the health professionals' care to the users' speech, 43.8% (n = 57) reported they have always cared by them, while 33.1% (n = 43) said sometimes and 13.1% (n = 17) often. In reference to the health professionals' knowledge on the patient's history of life, 33.8% (n = 44) stated they sometimes know about it, while 30.0% (n = 39) said they never know, and 18.5% (n = 24) always. Regarding the home visits proposed and conducted by health professionals, 48.5% (n = 63) claimed they never do it, while 34.6% (n = 45) said they sometimes do and 13.1% (n = 17) said they rarely do it. With respect to the period of time that the user had attended the health service, 94.6% (n = 123) reported attending for over a year, while 2.3% (n = 3) reported attending between one and four months, and 2.3% (n = 3) between nine and twelve months. Concerning the professionals' knowledge about the users' financial reality, 49.2% (n = 64) claimed they have never shown this knowledge; while 27.7% (n = 36) sometimes, and 13.1% (n = 17) rarely. And finally, as to the health professionals' orientation understanding by users during consultations, 42.3% (n = 55) reported they always understand it; 42.3% (n = 55) sometimes and 8.5% (n = 11) often.

The chi-square test was performed in order to compare the correlation between quality of care ratings and aspects of Primary Health Care. In all tests, it was considered as statistically significant the probability lower to 0.05 ($p < 0.05$).

Among the correlated data, only those relating to the need for primary health care and home visits proposed by health professionals were insignificant, as they obtained chi-square test $p > 0.05$ and, respectively, $p = 0.057$ and $p = 0.121$.

4. Discussions

From the analysis of the users' answers in **Table 2**, it was noticed that the majority affirmed that only sometimes health professionals who take care of them in health services are responsible for their health, but that those professionals always understand their needs and, sometimes, they know about their histories of life.

Thus, the formation of bonds between patients and professionals at health services happens through good communication, trust, and by considering the problems reported by the patient and its biopsychosocial aspects [8]. Thus, listening to the patient is a way to guarantee comprehensive care, as it considers several factors in the human being's context, such as demographic characteristics, cultural, social and economic values and also the family condition.

In this perspective, one of the most appreciated meanings that were given to comprehensive care by health care professionals refers to holistic knowledge of each patient, resulting in the non-fragmentation of care. From there, it is necessary to recognize the political, cultural, psychological and socioeconomic aspects that are categorical of health, in order to suggest a comprehensive model of health care.

However, users participating on the survey have also stated that health professionals never know about their financial reality, such a statement that makes the responses become contradictory, since they had said before that health professionals understand their needs. Therefore, health professionals should be informed about the users' financial conditions, since this fact may negatively influence the conduct established by the professional.

Most respondents said they have attended a health service facility close to their homes for more than one year. This statement shows that in most cases the primary health care unit is set as the most common reference in the attempt to meet the needs of the population, leading us to suggest a greater supply and availability of this source of care, which must be harmonized with the health needs of the local population [8].

So, despite of the fact that assuring the quality of primary health care is presently one of the Unified Health System (SUS in Brazil) great challenges, the results on the accessibility to primary health care services aforementioned demonstrate the understanding of the primary health care services as the most popular reference, or even the only option to meet the health needs of the population.

Still in accordance with **Table 2**, the respondents ensured that health professionals at health services have always provided them with care in which they could talk about their problems. Thus, it is noticed that the host proposal is seen as one that seeks to shift the focus of health care from a physician-centered perspective to a health care provided by a multidisciplinary team that aims at solving the problems presented by the user, which can be seen as a form of continuity of care, also establishing a bond between health professionals and the community.

From there, you realize that in other studies the host proposal shall be assisted in the same way: to ensure that the host shall involve all health professionals in different areas, considering that the disease causes the patient's

weakness, fear and suffering. Based on this, individuals will need care from a multidisciplinary team to intervene and ensure their quality of life and thus solving the problems presented by them [9].

Regarding the health team monitoring ratings related to their health, the majority of respondents rated the monitoring quality as good. Based on the health team monitoring ratings related to the elderly people's health, it is noticeable that this causality can be explained by the fact of primary health care being understood as a space that shall address the most common problems of the community and provide health promotion, preventive, curative and rehabilitative services able to raise health and the well-being of the population to its maximum, which implies an effective primary health care service and, therefore, monitoring the quality of population's health.

However, in some studies it can be observed that health professionals, despite of the fact of being in a team, act singly and leave aside the information and knowledge exchange with the users on the real difficulties of the community, so that they can, as a team, think about strategies in order to face the problems that are in fact lived deeply by the population [10].

So that this provided health care may present an expected result, it is important that health professionals can establish a good communication with users, whereby they are able to transmit the essential guidelines and recommendations for the positive outcome of the interventions outlined. But the opinion of respondents resulted in a tie, in which some state to always understand the guidelines and recommendations of the health professionals during consultations while others state to understand them only sometimes. At this point, it is apparent that the continuity of care might be compromised from a failure in communication between health professionals and users.

A qualified listening, the bond and liability are essential conditions so that health care can be effectively performed. And yet the biological model seems to be reproduced, which is a fact that disregards the need for implementation of a health surveillance model and emphasizes health promotion [10].

In the results, it was noticed that when asked about spontaneous home visits by health professionals, the majority of respondents had stated that health professionals were never available to make those visits, which shows the fragility in the process of active search and community orientation.

Despite being an old procedure, home visits provide innovative results, as they allow knowing the users' reality, as well as their families'. It is one of the most appropriate tools in providing health care for the individual, family and community, and shall be performed rationally, with defined objectives and guided by the principles of efficiency, so that strengthens user-therapy-professional bonds and eases hospital expenses [11].

In this context, the home visit or home care becomes an important tool for the operationalization of elderly care in various social contexts, as it emerges as an appropriate care model to solve, or minimize, the elderly health problems in a holistic perspective, given that from their personal and social relations it is possible to establish the factors that influence their health, illness and recovery, besides providing a humane care.

The most common meaning attributed to the active search is to seek for the individuals. Changing the active search direction, which was once a common term to epidemiological surveillance operated in a symptomatic model, began to enter the users' realm and to establish a therapeutic bond in order to be part of their culture and thus become a control strategy as it shall meet the health needs in addition to meeting the demand [12].

The community orientation is related to the health professional's knowledge about the community needs, since it is based on the records and direct contact with the community, besides their relationship with them, that shall make planning and actions to become more effective [13].

The health care team must seek to understand the elder in his/her various dimensions, to observe them as single individuals, and to include the familiar and social context with which they continuously interact. So that it is possible to effectively operationalize a plan of care that meets the particularities of each elder. It is noticed that comprehensiveness is not applied in its entirety concept by health professionals working at the health services attended by respondents, since those professionals do not consider the context linked to the users' history of life and their financial, cultural and psychological aspects, as well as their families' and society's; they only take into consideration the doctor-patient biological factor.

Due to the need for a comprehensive care provided to the elderly people and the goal of improving their quality of life, it is necessary to modify the health professionals' performance from the various areas of knowledge which comprise the health field. Therefore, it is necessary to implement comprehensiveness in the professional practice, from the provision of a wider range of possible health services in primary care, allied to the practice of health promotion and prevention.

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