Healthcare pathways of the elderly in one health region in the Federal District, Brazil

Trajetórias assistenciais de idosos em uma região de saúde do Distrito Federal, Brasil

Ruth da Conceição Costa e Silva Sacco[1], Marcella Guimarães Assis[2], Raíssa Gomes Magalhães[1], Sílvia Maria Ferreira Guimarães[1], Patrícia Maria Fonseca Escalda[1]

DOI: 10.1590/0103-1104202012618I

ABSTRACT The aim was to identify the healthcare pathways of the elderly in one health region in the Federal District and their perceptions about these pathways. A qualitative study analyzed 14 healthcare pathways of elderly people, using tracer methodology. Interviews were conducted with the elderly and caregivers, processed by content analysis; and medical records were reviewed. Maps of the paths described were prepared by geoprocessing. It was found that the actual healthcare pathways taken by the elderly differ from what law would predict, and that the weaknesses detected were related to poor accessibility conditions, lack of professionals, lack of medicines, and the long waiting time for specialized health care. The expectations reported by the elderly involved humanization of care, emerging elements such as being well received by the personnel, the building of bonds, qualified listening, and a feeling of well-being after the medical consultation. Although the care model is still fragmented and far from ideal, users feel satisfied with the care provision and identify positive aspects in the health care process. However, the organization of work processes and the articulation between levels of health care need to be reviewed and adapted to the specificities of this life phase.

KEYWORDS Patient acceptance of health care. Health services for the aged. Health services accessibility. Delivery of health care. Health of the elderly.

RESUMO *O objetivo foi identificar as trajetórias assistenciais de idosos em uma região de saúde do Distrito Federal e suas percepções acerca desses percursos. Pesquisa qualitativa que analisou, com base na metodologia de caso traçador, 14 percursos assistenciais de idosos. Foram realizadas entrevistas com idosos e cuidadores, processadas por análise de conteúdo; e consulta a prontuários. Mapas das trajetórias descritas foram elaborados por geoprocessamento. Identificou-se que o percurso real feito pelos idosos difere do previsto na legislação, e que as fragilidades apontadas estiveram relacionadas à difícil acessibilidade, ao deficit de profissionais, à falta de medicamentos e ao tempo de espera para atendimento na atenção especializada. As potencialidades relatadas pelos idosos envolveram humanização no atendimento, tais como o bom acolhimento por parte da equipe, a construção de vínculos e escuta qualificada, e sensação de bem-estar após as consultas. Apesar de o modelo de atenção ainda ser fragmentado e estar distante da situação ideal, os usuários se sentem satisfeitos com os cuidados recebidos, evidenciando aspectos positivos no processo do cuidar em saúde. Entretanto, a organização de processos de trabalho e a articulação entre os níveis de atenção à saúde precisam ser revistas e adequadas às especificidades desse ciclo de vida.*

PALAVRAS-CHAVE *Aceitação pelo paciente de cuidados de saúde. Serviços de saúde para idosos. Acesso aos serviços de saúde. Assistência à saúde. Saúde do idoso.*

[1] Universidade de Brasília (UnB) – Brasília (DF), Brasil.
ruth.sacco1@gmail.com

[2] Universidade Federal de Minas Gerais (UFMG) – Belo Horizonte (MG), Brasil.

Introduction

The aging of the population reflects a demographic transition resulting from the decline in fertility and mortality rates[1] and represents a challenge in view of the need for the development of adequate health policies and care services for the elderly[2]. In Brazil, the estimated number of elderly (≥60 years old) for 2020 is 32 million, which means an increase of more than 200% as compared to year 2002, when they were 14 million[2]. In the Federal District (FD), following the national trend, the elderly population has increased by 7.7% in 2010 with a further increase by 10.5%, in 2018[3].

Even though the decline in mortality from infectious and communicable diseases contributed to increase life expectancy[4], there has been a rise in the prevalence of chronic and degenerative diseases affecting mostly the elderly. Such scenario points out the need for new strategies to promote healthy ageing[6], defined by the World Health Organization (WHO) as the process of developing and maintaining the functional ability that enables well-being in older age[7].

Therefore, the Universal Health System (UHS) has adapted itself to ensure qualified and efficient actions and services by means of a new organization structured in networks. The discussion about Integrated Health Services Delivery Networks (IHSDN) emerged with Resolution CD49.R22, adopted on October 02, 2009 by the Pan American Health Organization (Paho) to address the problem of health services fragmentation and hierarchy[8].

The IHSDN may be defined as follows:

> Integrated Health Service Delivery Networks (IHSDNs) are a group of organizations that provide, or arrange for the provision of, equitable and integrated health services to a defined population[8(11)].

The aim is developing Primary Health Care (PHC) as a basis of the healthcare system and providing services in a way that is aligned with the user needs and preferences, with accessibility, equity, efficiency and technical quality[8]. In Brazil, they are called Health Care Networks (HCN) and coordinated by the Primary Health Care (PHC), the first contact between users and the communication center with the Health Care Network (HCN)[1,9]. So the PHC strives to avoid the concentration of services and investments at the secondary and tertiary health care levels[10,11].

The Family Health Strategy (FHS) is a model of services suggested by the PHC, emphasizes the whole set of actions and places the individual at the focus as integrated family member[12], provides welcoming and qualified listening aimed at meeting the demands[13] and orients the user through his or her course of care within the HCN[14]. The analysis of this health care pathway makes it possible to identify vulnerabilities and potentialities in the HCN[15] and uncovers the perception by the users of the quality of the care services delivered[16].

Considering the ageing of the population and the specificities required by the new epidemiological profile, as well as the presuppositions of the HCN and the PHC, this study identified healthcare pathways of the elderly in need for health services in a Health Region in the Federal District.

Material and methods

The qualitative study identified healthcare pathways of the elderly using tracer methodology[17]. Semi structured interviews were conducted with the elderly and the caregivers, and medical records were reviewed to serve as tracer for the analysis of the health care processes and to obtain information about how they actually operate on a day-to-day basis[18].

The study has been conducted in the Health Region West (HRW) of the Federal District (FD), which includes two Administrative Regions (AR): Ceilândia and Brazlândia. The first one, with 432 927 inhabitants (7,24% are

elderly), is the most populated of the FD; the second region has 53.534 inhabitants (7,01% are elderly)[19]. The HRW was chosen in view of the high percentage of vulnerable elderly, at increased risk of functional decline and death[20]. Five Family Health teams (FHt) from four Health Basic Units (BHU), three from Ceilândia and one from Brazlândia, were selected based on the age structure of their respective coverage areas.

Following this technique, each team was asked to indicate three meaningful cases of the service profile: typical, 1 succeeded, 1 under tension, totaling 15 tracer cases. The inclusion criteria were residence in the HRW and aged ≥18 years (if interview conducted by a caregiver, in case of cognitive impairment of the elderly person). The exclusion criteria were individuals not found after three attempts of getting in touch at different times of the day and through different media.

The interview script was designed after some exploratory visits[21], including nine questions related to the reason for going to the UBS, the perception about the care experience, the path of an individual through his course of care, the present health conditions of the elderly and their relationship with the PHC. The information was recorded (voice recorder Sony ICD-PX240), transcribed and interpreted. A semantic analysis of the content was performed, from the categories of analysis that emerged from the information/material[22].

The interviews subsidized the creation of maps, through geoprocessing tools, for three healthcare paths, using the Geocentric Reference System for America (Sirgas)[23], and an infographic was designed to display them.

This survey was approved by the Ethics Committee under report numbers 2.202.975 (Brasília University) and 2.269.757 (FD Health Department). All participants signed the Free and Informed Consent Form.

Outcomes and discussion

In this study, one of the 15 cases indicated by the BHU was excluded because the attempts to contact were not returned. Thus, the healthcare pathways for 14 elderly people and their perceptions about health care in the FD were identified. The results showed that the course of care as foreseen by law, based on the norms and protocols of the FD Health Department, diverged from the one actually experienced by the elderly. However, despite the weaknesses they pointed out for the functioning of the HCN, all the respondents reported they were satisfied with the care provision and with their current health situation.

Most of the elderly were aged between 70 and 79 years old (42.9%), female (57.1%) and widowed (85.7%). *Table 1* shows sociodemographic features of these elderly people.

Table 1. Characterization of the elderly (tracer cases), from Basic Health Units (UBS) selected, Health Region West, Federal District, 2019

Variables	N	%
Age		
60-69 years old	3	21,4
70-79 years old	6	42,9
80-89 years old	5	35,7
Gender		
Male	6	42,9
Female	8	57,1

Table 1. (cont.)

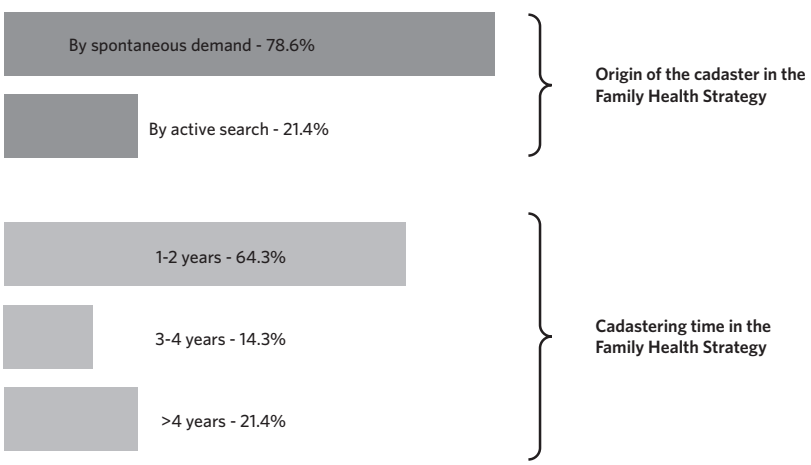
Variables	N	%
Civil status		
Married	2	14,3
Widowed	12	85,7
Household composition		
Lives with other person	12	85,7
Lives alone	2	14,3
Total Number of Elderly	**14**	**100**

Source: The authors, 2019.

Although most of them are widowers (85.7%) – which can have implications, as widowhood is related to more unfavorable health prognosis and early mortality[24] –, 92.9% of the elderly lived with a relative, which allows us to infer that they are individuals who count on a social support network, an important aspect when it comes to adhering to treatment[25].

Regarding the situation of registration in the FHS, it was found that it was mostly carried out on spontaneous request in situations of seeking treatment for disease, emphasizing that there is a flaw in the registration made by the BHU, caused by failure in the work organization process or deficit of professionals[26] *(figure 1)*.

Figure 1. Origin and cadaster time of the elderly (tracer cases) in the Family Health Strategy (FHS), selected Basic Health Unit (BHU), Health Region West, the federal District, 2019



Source: The authors, 2019.

In the FD, isolated experiences of the FHS have been carried out by some teams. However, only in 2017 this model of care was chosen as a structuring element of PHC, using the existing workforce in the BHU[27]. Thus, this panorama probably explains the short time span of the registers of the elderly in the FHS, most of them covering two years.

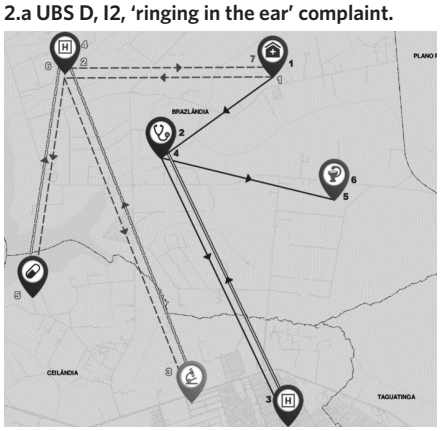
The healthcare pathways of the elderly

Healthcare pathways are paths chosen by individuals within the health network, and which may or may not lead to resolution and treatment[15]. Here, there is a counterpoint to the definition of a therapeutic path, which involves the search for health care by individuals, who, in quest of solutions to their problems, exceed health services, and their analysis considers socio-cultural aspects, which influence the individual pathways[28,29]. In this study, we chose to trace the route as care pathways, in view of the need to identify flows between levels of care.

The elderly participants had comorbidities, such as: diabetes mellitus, systemic arterial hypertension, loss of vision limiting the performance in Activities of Daily Living (ADL), dementia, joint pain, pulmonary fibrosis, neoplasms and infectious diseases of compulsory notification, which probably made them go through public and/or private health services. Geoprocessing maps were prepared for only three of the 14 cases analyzed, since the lack of medical records, the memory bias and the absence of documents provided by the elderly and/or their families impaired the identification and confirmation of addresses of the health services accessed. The actual pathways were superimposed on those predicted, as suggested in the regulations governing HCN in the DF, and the result is shown in *figure 2*.

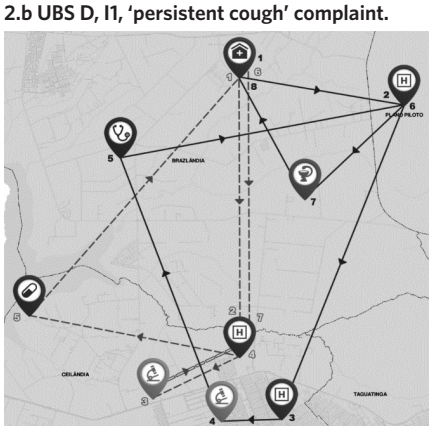
Figure 2. Healthcare pathways of the elderly in the Health Region West, Federal District, 2019

2.a UBS D, I2, 'ringing in the ear' complaint.



Actual	Expected
1 Basic Health Unit Nº 5 Brazlândia	1 Basic Health Unit Nº 5 Brazlândia
2 Private otolaryngologist	2 Regional Hospital Brazlândia
3 Hospital das Clínicas	3 Ceilândia Laboratory
4 Private otolaryngologist (Return)	4 Regional Hospital Brazlândia
5 Private drugstore (Consultation)	5 Ceilândia Outpatient (Ambulatory) Pharmacy
6 Private drugstore (Purchase)	6 Regional Hospital Brazlândia
	7 Basic Health Unit Nº 5 Brazlândia

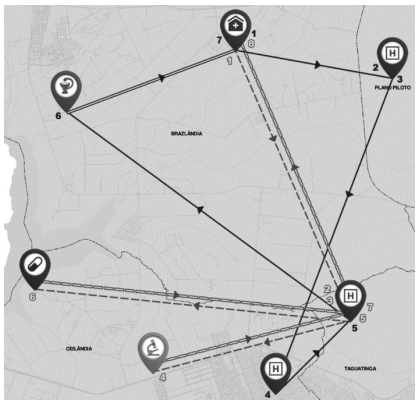
2.b UBS D, I1, 'persistent cough' complaint.



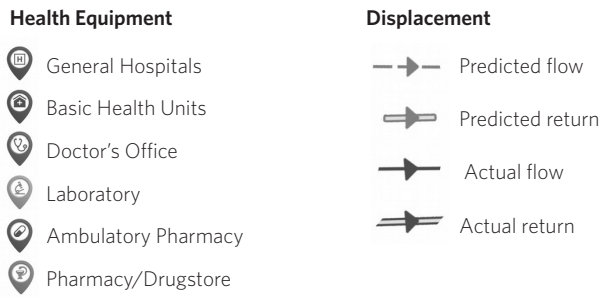
Actual	Expected
1 Basic Health Unit Nº 5 Brazlândia	1 Basic Health Unit Nº 5 Brazlândia
2 Hospital de Base	2 Regional Hospital Ceilândia
3 Hospital das Clínicas	3 Ceilândia Laboratory
4 Private laboratory	4 Regional Hospital Ceilândia
5 Private cardiologic exams	5 Ceilândia Outpatient (Ambulatory) Pharmacy
6 Hospital de Base	6 Basic Health Unit Nº 5 Brazlândia
7 Private drugstore (Purchase)	7 Regional Hospital Ceilândia
8 Basic Health Unit Nº 5 Brazlândia	

Figure 2. (cont.)

2.c UBS D, I2, diagnosis 'prostate cancer'



Actual	Expected
1 Basic Health Unit Nº 5 Brazlândia	1 Basic Health Unit Nº 5 Brazlândia
2 Hospital de Base (Consultation)	2 Regional Hospital Taguatinga (Consultation)
3 Hospital de Base (Exams)	3 Regional Hospital Taguatinga (Exams)
4 Hospital Anchieta (Radiotherapy)	4 Ceilândia Laboratory (Exams)
5 Regional Hospital Taguatinga (Follow up)	5 Regional Hospital Taguatinga (Radiotherapy)
Private drugstore (Purchase)	6 Ceilândia Outpatient (Ambulatory) Pharmacy
Basic Health Unit Nº 5 Brazlândia	7 Regional Hospital Taguatinga (Return)
	8 Basic Health Unit Nº 5 Brazlândia (Return)



Source: The authors, 2019.

Note: Doctor's office, laboratory and pharmacy/drugstore correspond to private health equipment.

Figure 2.a represents the path of a 78-year-old woman whose complaint was ringing in the ears. She went to the BHU in her neighborhood, where a medical imaging procedure was prescribed. In view of the delay in care by a specialist in the HCN/UHS, she sought a private otolaryngology clinic. *Figures 2.b and 2.c* refer to two different paths of the same 89-year-old, who sought BHU due to persistent cough (*figure 2.b*), having been referred to Specialized Care (SC) to have imaging tests for suspected tuberculosis. In addition, years ago, he had been diagnosed with prostate cancer and had his first access through BHU, as shown in *figure 2.c*.

In the three presented pathways, it becomes evident that the BHU of the coverage area was the first access for the cases and made the reception and forwarding to the SC. However, from that point on, the flow did not occur as expected, because in two of the three cases (*figures 2.b and 2.c*), the elderly accessed the private network, for consultation with a specialist and for complementary tests, to avoid waiting lines at UHS This finding corroborates the study by Raupp et al.[29], which points out this fragility as present throughout the country. In the DF, it was only in 2018 that the Health Regulatory Complex (CRDF) was implemented, with PHC as the organizer of access, which could explain the difficulty for the elderly to schedule medical consultations and specialized tests[30].

Comparing the actual course of care with the predicted one, it was observed that none of the cases followed the expected treatment path, which is indicative of poor integration between the points of care and flaws in the

technologies available in the health system, generating fragmentation of care and a longer and more expensive path for the elderly[12,31], in addition to making them more likely to develop other comorbities[32,33]. The longitudinal monitoring carried out within the health service, especially by the PHC, confirms the efficiency of the BHU and the user's satisfaction with the care provision. Conversely, these care paths show weaknesses in the functioning of referral and counter-referral flows, thus hindering access to SC[34].

The results showed that, although the path of the elderly started in the public network, there were steps taken the private network, regardless of the complexity of the cases, as referrals made to the SC also had flows diverted to services paid for by the users themselves (*figure 2.a*). It was highlighted that in the situation of greater complexity (treatment of prostate cancer, *figure 2.c*), in which the actual course of care was outside the health region of the elderly's residence, the health equipment used was mostly from HCN/UHS, that is, the network itself indicated alternative care paths for timely and free treatment of the neoplasm, although through a longer course of care and outside the HRW.

Spedo et al.[35], in a similar study conducted in São Paulo (SP), stated that the most complicated bottleneck was in services of medium complexity, especially due to managerial failures related to the lack of political prioritization, despite the existence of mechanisms, such as the regulatory complex and the computerization of the operations. These authors pointed out that there must be a logic of feedback between PHC and medium complexity, because access to SC is necessary for PHC to be more effective in solving health problems, and, in contrast, if PHC has a poor level of effectiveness, referrals to SC will increase. In the FD, the analyzed pathways did not occur as expected, showing a real fragmented flow resulting from weaknesses in the logistical systems involving the FD/HRC, a situation that hinders access to specialized levels and comprehensive care, making the elderly's journey longer and financially expensive[33].

Perception of the elderly about health care for the elderly in PHC

The perspective of users and their satisfaction with the care in addition to the analysis of the paths taken in search of health care must be considered as strategies for the evaluation of the care provision, so that the gap between the theory and the reality of SUS does not prevent the realization of RAS[36].

The content analysis of the interviews with the elderly allowed us to identify four different analysis categories, all correlated to SUS principles and/or guidelines and PHC (*chart 1*).

Chart 1. Categories of analysis identified, and features observed in these categories

Category of Analysis	Thematic Axes Involved
Humanization in service	Reception, bonding, qualified listening, and well-being
Organization of work processes	Access to the Basic Health Unit
Organizational resources	Human resources (deficit and sufficiency)
	Material resources and infrastructure (deficit and sufficiency)
Service in specialized attention	Waiting list and communication between levels of care

Source: The authors, 2019.

The users' perceptions were related to both strengths and weaknesses in the path of care, in the Federal District (DF), and the main ones are shown in *figure 3*.

Figure 3. Weaknesses and potentialities through the course of care for the elderly, Health Region West, Federal District, 2019

Source: The authors, 2019.

HUMANIZATION IN CARE SERVICE

In user-centered practices, it is necessary to develop skills for adequate reception and establishment of a bond between staff, professionals and users[27]. Thus, user welcoming should be seen as a powerful device and operational guideline for the health system, being useful for the identification of demands, the construction of a professional-user bond and comprehensive care, in compliance with PHC principles[37-39].

In this study, welcoming and qualified listening were identified as potential, and the reports were associated with quality and the feeling of well-being after the visits, as shown below:

> *They talk to us, explain everything with the greatest patience, with the greatest affection, do you understand? This, for me, is very important, I am a person like that [...] I stay like this, look, it could be... I like that little thing, that friendship, pure friendship.* (UBS C, I1).

> *I don't know, they used to say: 'Madam, anything you need, you come to me'. They hug me. Al these girls hug me like this, like hugging a mother* [referring to the nurses]. *I keep going there. It is always the same people that welcome me. I have always been well taken care there. Even when I go there just to get a medical prescription, I am so well received.* (UBS A, I4).

It was noted that the satisfaction of the elderly was causally related to welcoming and bonding, thus demonstrating their importance for the continuity of care and highlighting them as potentialities of PHC. A similar result was identified by Uchoa et al.[40] and by Vello et al.[1], who highlighted welcoming and bonding as the most satisfactory dimensions of care for users.

Bond building presupposes the relationships of affection and trust[36], and the ties

between those involved are strengthened when socializing becomes frequent, contributing to the effectiveness of the treatment, and avoiding unnecessary consultations and hospitalizations, as users adhere better to the proposed treatments[41]. These relational technologies are especially important for the elderly who, for the most part, have chronic non-communicable diseases, depend on drug treatment, and need continued health care.

ORGANIZATION OF WORK PROCESSES

The elderly reported their difficulty in accessing the BHU, which demonstrated the poor organization of work processes. One of the major attributes of PHC is accessibility, defined with the provision of services by HCN, because access is mandatory for health care to be delivered[38]. Access and accessibility have close meanings, since they are related to the capacity, not only to produce and offer services, but also to make them responsive to the health needs of the population. Here we used the concept of accessibility, which includes both the geographic dimension (distance, time and cost of transportation) and the socio-organizational dimension (ability to meet demands adequately and timely)[42].

Regarding accessibility, the elderly reported important weaknesses in PHC:

> *[...] that can change a little... What I think, like this, when having a medical consultation. Because we go too early to get an appointment. Sometimes I leave at 5:30 am to wait there in the line. Even being an elderly. We go to the line outside. So cold! Even with the FHS, you still have to wait in a long line.* (UBS C, I1).

> *It's bad for us here to go to the health center. These are the conditions; we don't have a car... You see, I'm still going to the health center today. Now, I can take it. But then how will it be when I cannot take it anymore?* (UBS D, I2).

According to Franco et al.[43], the PHC restructuring took place with the implementation of the ESF to ensure the organization of the work process and service to all users who seek the unit, with no need for number slips and lines at dawn. However, the speech of the user 'UBS C, I1' demonstrates that, even 25 years after the implementation of the FHS in Brazil, and considering that two years have passed since the adoption of the FHS in the FD, some BHU still work in the traditional way, forcing users to wait in long lines to be served.

The distance from the service location reported by the user 'UBS D, I2' demonstrates the adverse reality of the recommendation made by Silva et al.[44], who affirm that the proximity of the service location is one of the fundamental aspects in PHC, which must offer services in a planned way and considering the geographical location of the BHU, which in turn must be strategically close to the population's homes to improve accessibility, especially for elderly people.

Home visits by health personnel have the effect of providing satisfaction to the elderly, because of the direct contact with users. Conill[45] identified in his survey that visits were assessed as positive by respondents. In the present study, the elderly showed a greater sense of well-being and satisfaction when home visits were part of their prescribed care and claimed a higher frequency of this type of service.

> *I love the girls. One day, they arrived here at my place, my blood pressure went up with so much joy. Can you believe it? Because they came here to visit me, give me attention, know about my health. They came to take care of me.* (UBS C, I1).

> *If they came more often, at least once a month* [referring to the frequency of home visits]... *That would be good... I mean, I know that's not what you do, but at least a little bit of conversation with us. Then, I would feel happy. He used to say: 'I'll be back on Tuesday'. Then, you waited anxiously, and he didn't come* [referring to a nurse who

scheduled the home visit but didn't show up]. (UBS C, I2).

Efforts were also noted to prioritize care for the elderly, perhaps to comply with the Elderly Statute (EI), which ensures them this right in public and private bodies[46]. The records of some users show situations in which access was facilitated:

They gave him priority due to his age [a family member referring to the elderly user], *the situation of being an elderly person who has no close relative. So, many times, I saw that the employees already knew about the case, they already followed, even because of the way he was, debilitated, demented, already. The reception was different.* (UBS A, I1).

Every time I go, I don't come back without having been taken care. Whatever, having an appointment or not. Someone finds a way and I can have my medical consultation. The people here already know me and always manage to help me. The elderly enters first. (UBS C, I1).

A study with multidisciplinary teams in São Paulo identified a positive change in the behavior of those involved in caring for the elderly after the publication of the IS and found, above all, greater respect in care[47]. In Salgueiro, in the inland area of the state of Pernambuco, elderly people interviewed about their satisfaction with the care provision at the PHC, reported that their expectations were met whenever they sought the service (82.3%). However, regarding the priority, 38.5% stated that there is no differentiation, emphasizing that, in some PHC, the course of care of the elderly followed the same criteria as that of users of other ages[48].

PHC ORGANIZATIONAL RESOURCES

The lack of medicines and medical materials for users demonstrates the fragility of the free UHS principle, which should not generate financial costs for the elderly, and must guarantee pharmaceutical assistance[49]. Elderly people are frequent users of health services and, for the most part, they need medication throughout their lives[50]. Thus, this unavailability affected the lives of elderly users.

It's because I take too much medicine, right? Sometimes we don't find it, we need to buy out of pocket. I do it often. When I don't have it, I have to purchase and pay for it. Sometimes I borrow money to buy medicine. (UBS D, I2).

Then, whenever there is, I take it. The hard part is the blood glucose tape. The government is not sending it. I still have a box there. I brought it from there, but now they do not have it anymore. (UBS D, I2).

First time he came here he promised me he would get me one of those portable [elderly woman with cystic fibrosis, referring to a portable oxygen cylinder the FHt nurse had promised her during a home visit]. *No answer. No information. I know it is a hell of a run, it is boiling, down there, isn't it?* (UBS B, I2).

Adding to this, the deficient infrastructure was also pointed out by a user as a hindrance to the resolution of problems.

All is uncared for [referring to the management by the city government] *because you go to the hospital there, this is a shame. You go to that Health Care Unit, oh, my God, what a neglect!* (UBS A, I3).

For Paim[51], the negative aspects of the consolidation of the UHS include medication and pharmaceutical assistance policies, and incipient infrastructure. For him, this may be the result of limited investments in the public health sector in Brazil, which are reflected in difficulties in maintaining services and expanding infrastructure.

In addition to the lack of medicines and supplies, the elderly perceived a lack of health professionals. The eSF must include at least

one family doctor or general practitioner, one nurse, one nursing assistant and one Community Health Agent (CHA) for every 750 people[9]. However, this number of professionals is often insufficient due to the large coverage area and the high demand. In addition to the disruption of work processes, this may result in loss of quality of the services provided, in addition to causing professional overload, as shown below:

> *The doctor is all alone, there is so much work for him. There should be at least three doctors, you know. Because it is too much work for him! The poor one, he goes here, he goes there. No one who could handle all those patients he serves.* (UBS B, I1).

> *Only what I told you about that thing, isn't it?* [about the health care professionals that miss work very often], *they do not show up in some months. I don't know, it is only because they get a doctor's note, but it is because the team is also reduced.* (UBS A, I3).

The speech of the elderly person 'UBS B, I1' illustrates health awareness, as the user understands that there is a deficit of professionals and recognizes that they are overloaded. The recognition of the population and their participation in the organization, management and control of health actions and services play a major role in improving public policies, due to the importance of the division of responsibilities between users and UHS[52]. The pressure exerted on the team shows the disorganization of the care provision and points out the need for strategies and skills to deal with aging.

Considering the reform of the PHC (*Converte* APS), through which the FHS became mandatory in all BHU in the FD, the low adherence on the part of physicians was highlighted, which could explain the situation reported above. Physicians who chose not to remain in PHC were relocated to other levels of health care. This prompted actions to maintain minimal health care for the population, such as the creation of the position of nurse specialist in family and community health and the carrying out of public exams for hiring nurses and doctors specialized in family and community medicine. However, the deficit of CHA is an even greater bottleneck: three thousand professionals are necessary, and only a minimum is available for the training of the teams, totaling one thousand CHA[27].

HEALTH CARE IN THE SC

The operation of the SC within the UHS goes without the organization in HCN, which responds for the accomplishment of the principle of integral care, to avoid fragmenting the health care delivery at different levels of complexity[30,53].

When asked whether they had already sought health care from other services and how their experience had been after their consultation in BHU, the elderly reported negative experiences with being referred to specialized levels of medium and high complexity.

> *Then she asked me to get a test, but nobody calls, no doctor, no one calls. Hospitals do not call, do they? And I cannot afford it now. It is too much money. Not with all the expenses I have.* (UBS D, I1).

> *Then I had all my tests with private labs, because to get them through the public health care service* [silence, as meaning 'I would still be waiting for a long, long time']... *For two years things went like this: I had one test, and when I went get the other one the first one had already expired; and when I went back to the doctor for a medical consultation I had to start all over again* [making reference to the sluggishness to have tests done through the SUS]. (UBS C, I1).

Survey indicates lack of communication between the levels of care as responsible for further fragmenting the health care process and compromising the integrity of the actions[54]. The elderly is referred to other levels of care when the PHC does not provide the

care required, as when tests are necessary that require greater technological density[55]. Thus, the demand for SC exceeds the service provision, generating huge lines and causing the fragmentation of the elderly health care.

User 'UBS C, I1' reports difficulty to get a test and to return for a new consultation with the doctor. This uncovers a problem with provision of appropriate access, as well as a failure in communication between different points of care, thus imposing on the elderly a longer treatment path, with higher social costs[51]. Furthermore, the financial costs of the SC are increased as the user needs to take new tests for not having been able to schedule a follow-up consultation in due time.

Final considerations

The pathway of an elderly through his course of care is still quite different from what is stipulated by the law, and accessibility barriers cause difficulties that hinder the provision of appropriate access and the solution of care related problems. It became evident that even though the model of health care is still fragmented and far from an ideal situation where all PHC features are present, the users are satisfied with the care provided and identify humanizing attitudes and solidarity building in the health care practices.

Vulnerable points include the lack of materials and medicines, infrastructure and human resources, difficulties to access the care services and failures in the communication among levels of care/departments.

The BHU has a great potential that is perceived by the users. However, the organization of related processes and their articulation with the other levels of health care need to be revised and revamped to meet the specificities of this life cycle.

Collaborators

Sacco RCCS (0000-0001-6131-0852)* contributed substantially in designing, planning, analyzing, data interpretation and writing of the article. Magalhães RG (0000-0001-7851-7227)* contributed in analysis, data interpretation and writing of the article. Assis MG (0000-0003-1636-555X)*, Guimarães SMF (0000-0002-2097-2355)* and Escalda PMF (0000-0003-0021-1193)* contributed in critical review and final approval of the content. ■

*Orcid (Open Researcher and Contributor ID).

References

1. Vello LS, Popim RC, Carazzai EM, et al. Saúde do Idoso: percepções relacionadas ao atendimento. Esc. Anna Nery. Rio de Janeiro. 2014; 18(2):330-335.

2. Closs VE, Schwanke CHA. A evolução do índice de envelhecimento no Brasil, nas suas regiões e unidades federativas no período de 1970 a 2010. Rev. Bras. Geriatr. Gerontol. 2012; 15(3);443-58.

3. Companhia de Desenvolvimento e Planejamento de Brasília. Pesquisa Distrital por Amostra de Domicílios. Ceilândia e Brazlândia. 2018. Brasília, DF: Secretaria de Estado de Planejamento e Orçamento do Distrito Federal; 2018.

4. Meireles VC, Matsuda LM, Coimbra JAH, et al. Características dos idosos em área de abrangência do Programa Saúde da Família na região noroeste do Paraná: contribuições para a gestão do cuidado em enfermagem. Saúde Soc. São Paulo. 2007; 16(1):69-80.

5. Schmidt MI, Ducan BB, Silva GA, et al. Doenças crônicas não transmissíveis no Brasil: cargas e desafios atuais. The Lancet. 2011; 9:61-74.

6. Gonçalves LHT, Alvarez AM, Sena ELS, et al. Perfil da família cuidadora de idosos doente/fragilizado do contexto sociocultural de Florianópolis, SC. Texto Contexto Enferm. 2006; 15(4):570-77.

7. Organização Mundial de Saúde. Relatório Mundial do Envelhecimento e Saúde. Genebra: Organização Mundial de Saúde; 2015.

8. Organización Panamericana de la Salud. Redes Integradas de Servicios de Salud: Conceptos, Opciones de Política y Hoja de Ruta para su Implementación en las Américas. Serie: La Renovación de la Atención Primaria de Salud en las Américas. Washington, D.C. nº 4. 2010.

9. Brasil. Secretaria de Estado de Saúde do Distrito Federal. Portaria nº 77, de 14 de fevereiro de 2017. Publicada no Diário Oficial do Distrito Federal nº 33, seções I, II e III de 15 de fevereiro de 2017. Estabelece a Política de Atenção Primária à Saúde do DF. 15 fev 2017. [acesso em 2020 jul 14]. Disponível em: http://saude.df.gov.br/wp-conteudo/uploads/2018/04/Portaria-SES_DF-n%C2%BA-77-2017-Esstabelece--a-Pol%C3%ADtica-de-Aten%C3%A7%C3%A3o--Prim%C3%A1ria-%C3%A0-Sa%C3%BAde-do-Distrito-Federal.pdf.

10. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Saúde do Idoso. [acesso em 2019 set 1]. Disponível em: http:www.portal.saude.gov.br.

11. Lima-Costa MF, Matos DL, Camargos VP, et al. Tendências em dez anos das condições de saúde de idosos brasileiros: evidências da Pesquisa Nacional por Amostra de Domicílios (1998, 2003, 2008). Ciênc. Saúde Colet. 2011; 16(9):3689-3696.

12. Brasil. Ministério da Saúde. Política Nacional da Atenção Básica. 2017. [acesso em 2020 jul 14]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html.

13. Tesser CD, Neto PP, Campos GW. Acolhimento e desmedicalização social: um desafio para as equipes de saúde da família. Ciênc. Saúde Colet. 2010; 15(3):3515-624.

14. Brasil. Ministério da Saúde. Portaria nº 4279, de 30 de dezembro de 2010. Estabelece diretrizes para a Rede de Atenção à Saúde. Diário Oficial da União. 30 Dez 2010. [acesso em 2020 jul 10]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2010/prt4279_30_12_2010.html.

15. Gerhardt TE, Pinheiro R, Ruiz ENF, et al. Itinerários Terapêuticos e suas múltiplas dimensões desafios para a prática da integralidade e do cuidado como valor. In: Pinheiro R, Mattos RA. Razões Públicas para a integralidade em saúde: o cuidado como valor. 2. ed. Rio de Janeiro: UERJ-ABRASCO; 2009. p. 279-300.

16. Cabral ALLV, Martinez-Hemaez A, Andrade EIG, et

al. Itinerários terapêuticos: o estado da arte da produção científica no Brasil. Ciênc. Saúde Colet. 2011; 16(11):4422-4442.

17. Kessner DM, Kalk CE, Singer J. Assessing health quality – the case for tracers. N. Engl. J. Med. 1973; 288(4):189-94.

18. Feuerwerker LCM, Merhy EE. Como temos armado e efetivado nossos estudos, que fundamentalmente investigam políticas e práticas sociais de gestão e de saúde? In: Mattos RA, Baptista TWF, organizadores. Caminhos para análise das políticas de saúde. Porto Alegre: Rede UNIDA, 2015, p. 439-460.

19. Companhia de Desenvolvimento e Planejamento de Brasília. Pesquisa Distrital por Amostra de Domicílios (PDAD): Microdados Ceilândia e Brazlândia. Brasília, DF: CODEPLAN; 2018.

20. Oliveira MLC, Amâncio TG, organizadoras. Situações de saúde, vida e morte da população idosa residente no Distrito Federal. Curitiba: CRV; 2016.

21. Gondim SMG. Grupos focais como técnica de investigação qualitativa: desafios metodológicos. Paidéia. 2003; 12(24):149-161.

22. Bardin L. Análise de conteúdo. São Paulo: 70. ed.; 2016.

23. Fundação Instituto Brasileiro de Geografia e Estatística. Sistema de Referência Geocêntrico para as Américas (SIRGAS). Rio de Janeiro: IBGE; 2000.

24. Fernandes BL, Borgato MHA. Viuvez e a Saúde dos Idosos: uma Revisão Integrativa. Revista Kairós. Gerontologia. São Paulo. 2016; 19(3):187-204.

25. Aquino GA, Cruz DT, Silvério MS, et al. Fatores associados à adesão ao tratamento farmacológico em idosos que utilizam medicamento anti-hipertensivo. Rev. Bras. Geriatr. Gerontol. Rio de Janeiro. 2017; 20(1):116-127.

26. Merhy EE. A perda da dimensão cuidadora na produção de saúde: uma discussão do modelo assistencial e da intervenção no seu modo de trabalhar a assistência. In: Campos CR, organizador. Sistema Único de Saúde em Belo Horizonte: reescrevendo o público. São Paulo: Xamã; 1998. p. 103-20.

27. Fonseca HLP. A reforma de saúde de Brasília, Brasil. Ciênc. Saúde Colet. 2019; 24(6):1981-1990.

28. Glote CRM, Gerhardt TE. Itinerários terapêuticos: integralidade no cuidado, avaliação e formação em saúde. As trajetórias assistenciais revelando à rede de atenção à saúde dos portadores de doenças cardiovasculares. In: Pinheiro R, Mattos RA. Razões Públicas para a integralidade em saúde: o cuidado como valor. 2. ed. Rio de Janeiro: UERJ-ABRASCO; 2016.

29. Raupp LM, Dhein G, Medeiros CRG, et al. Doenças crônicas e trajetórias assistenciais: avaliação do sistema de saúde de pequenos municípios. Physis. 2015; 25(2).

30. Batista SR, Vilarins GCM, Lima MG, et al. O Complexo Regulador em Saúde do Distrito Federal, Brasil, e o desafio da integração entre os níveis assistenciais. Ciênc. Saúde Colet. Distrito Federal. 2019; 24(6):27.

31. Brasil. Ministério da Saúde. Portaria nº 4.279, de 30 de dezembro de 2010. Estabelece diretrizes para a organização da rede de atenção à saúde no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União. 30 Dez 2010. seção I, página 89.

32. Brasil. Ministério da Saúde. Portaria nº 2048/GM, de 05 de novembro de 2002. Diário Oficial União. 2002 Nov 5. [acesso em 2020 jul 10]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2002/prt2048_05_11_2002.html.

33. Alves MLF, Guedes HM, Martins JCA, et al. Rede de referência e contrarreferência para o atendimento de urgências em um município do interior de Minas Gerais – Brasil. Rev. Med. Minas Gerais. 2015; 25(4):469-475.

34. Cunha EM, Giovanella L. Longitudinalidade/conti-

nuidade do cuidado: identificando dimensões e variáveis para a avaliação da Atenção Primária no contexto do sistema público de saúde brasileiro. Ciênc. Saúde Colet. 2011; 16(1):1029-1042.

35. Spedo SM, Pinto NRS, Tanaka OY. O difícil acesso a serviços de média complexidade do SUS: o caso da cidade de São Paulo, Brasil. Physis. Rio de Janeiro. 2010; 20(3):953-972.

36. Uchimura KY, Bosi MLM. Qualidade e subjetividade na avaliação de programas e serviços em saúde. Cad. Saúde Pública. Rio de Janeiro. 2002; 18(6):1561-1569.

37. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília, DF: Organização das Nações Unidas para a Educação, a Ciência e a Cultura; Ministério da Saúde; 2002.

38. Fagundes S. Apresentação. In: Ortiz JN, Bordignon MO, Gralha RS, et al. Acolhimento em Porto Alegre: um SUS de todos para todos. Porto Alegre: Prefeitura Municipal de Porto Alegre; 2004. p. 11-2.

39. Souza ECF, Vilar RLA, Rocha NSPD, et al. Acesso e acolhimento na atenção básica: uma análise da percepção dos usuários e profissionais de saúde. Cad. Saúde Pública, Rio de Janeiro. 2008; 24(l):100-110.

40. Uchoa AC, Souza EL, Spinelli AFS, et al. Avaliação da satisfação do usuário do Programa de Saúde da Família na zona rural de dois pequenos municípios do Rio Grande do Norte. Physis, Rio de Janeiro. 2011; 21(3):1061-1076.

41. França AJ, Andrade FA, Araújo TM, et al. Relação intraequipe e produção de vínculos em uma Unidade de Saúde da Família. EFDeportes. 2014; 18(190).

42. Donabedian A. An introduction to quality assurance in health care. New York: Oxford University, 2003.

43. Franco TB, Bueno WS, Merhy EE. O acolhimento e os processos de trabalho em saúde: o caso de Betim, Minas Gerais, Brasil. Cad. Saúde Pública. 1999; 15(2):345-53.

44. Silva KL, Sena RR, Seixas CT, et al. Desafios da política, da gestão e da assistência para a promoção da saúde no cotidiano dos serviços. REME – Rev. Min. Enferm. 2012; 16(2):178-187.

45. Conill EM. Políticas de atenção primária e reformas sanitárias: discutindo a avaliação a partir da análise do Programa saúde da Família em Florianópolis, Santa Catarina, Brasil, 1994-2000. Cad. Saúde Pública. 2002; 18(1):191-202.

46. Brasil. Lei nº 10.741, de 01 de outubro de 2003. Dispõe sobre o Estatuto do Idoso e dá outras providências. Diário Oficial da União. 1 Out 2003 [acesso em 2020 jul 10]. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/2003/l10.741.htm.

47. Martins MS, Massarollo MCKB. Mudanças na assistência ao idoso após promulgação do estatuto do idoso segundo profissionais de um hospital geriátrico. Rev. Esc. Enferm. USP 2008; 42(1):26-33.

48. Parente AS, Mesquita FOS, Oliveira MR. Satisfação dos idosos atendidos pela estratégia de saúde da família em um município do interior de Pernambuco. Rev. Adm. Saúde. 2017; 17(68).

49. Viacava F, Oliveira RAD, Carvalho CC, et al. SUS: oferta, acesso e utilização de serviços de saúde nos últimos 30 anos. Ciênc. Saúde Colet. Rio de Janeiro. 2018; 23(6):1751-1762.

50. Brasil. Ministério da Saúde. Política Nacional de Medicamentos. Aprovada pela Portaria nº 3.916, de 01 de outubro de 1998. Brasília: 1998. [acesso em 2020 jul 14]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/1998/prt3916_30_10_1998.html.

51. Paim JS. Sistema Único de Saúde (SUS) aos 30 anos. Ciênc. Saúde Colet. 2018; 23(6):1723-1728.

52. Arakawa AM, Simone ALH, Magali LC, et al. Percepção dos usuários do sus: expectativa e satisfação do atendimento na Estratégia de Saúde da Família. Rev. CEFAC. 2012; 14(6):1108-1114.

53. Arruda C, Lopes SGR, Koerich MHAL, et al. Redes de atenção à saúde sob a luz da teoria da complexidade. Esc. Anna Nery. 2015; 19(1):169-173.

54. Gouveia GC, Souza WV, Luna CF, et al. Satisfação dos usuários do sistema de saúde brasileiro: fatores associados e diferenças regionais. Rev. Bras. Epidemiol. 2009; 12(3):281-96.

55. Santos CTB, Andrade OLM, Silva MJ, et al. Percurso do idoso em redes de atenção à saúde: um elo a ser construído. Physis. 2016; 26(1):45-62.

Received on 12/19/2019
Approved on 06/08/2020
Conflict of interests: non-existent
Financial support: Fundação de Apoio à Pesquisa do Distrito Federal (FAP/DF). Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (Capes), Código de Financiamento 001