ATTRIBUTES OF PRIMARY HEALTH CARE FOR PEOPLE WITH CHRONIC CONDITIONS

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ABSTRACT: The presence and extent of Primary Health Care attributes from the perspective of patients with Systemic Arterial Hypertension and Diabetes Mellitus are evaluated. Current cross-sectional study was undertaken with 41 patients from health units qualified by Primary Care and Family Health teams, in a city in the state of São Paulo, Brazil. Data were collected by Primary Care Assessment Tool-Brazil. Descriptive analysis comprised rate ≥6.6 for the presence and extent of attributes. Analysis of essential and derived attributes revealed that, in all health units, the first contact access obtained the highest (9.1) and the lowest (3.3) scores for usage and accessibility, respectively. The attributes integrality (services available and provided), family and community guidance had low scores, ranging between 4.9 and 5.8. The Essential Score was 6.6. In the analysis of the units, the Family Health teams obtained higher scores than the Primary Care teams. Results detect differences in attributes in the organizational arrangements of primary care, which indicates the need for qualification of primary care, mainly by the Family Health Strategy, and the strengthening of attributes in professional practice.

KEY WORDS: Diabetes mellitus; Health evaluation; Hypertension; Primary health care; Quality of health care.

ATRIBUTOS DA ATENÇÃO PRIMÁRIA À SAÚDE NOS CUIDADOS ÀS PESSOAS COM CONDIÇÕES CRÔNICAS

RESUMO: Avaliar a presença e extensão dos atributos da Atenção Primária à Saúde na perspectiva das pessoas com Hipertensão Arterial Sistêmica e Diabetes Mellitus. Estudo com delineamento transversal, desenvolvido com 41 usuários de unidades de saúde habilitadas em equipes de Atenção Básica e de Saúde da Família, em um município do estado de São Paulo, Brasil. Os dados foram coletados por meio do instrumento *Primary Care Assessment Tool*-Brasil. Na análise descritiva, adotou-se valor ≥6,6 para presença e extensão dos atributos. Na análise dos atributos essenciais e derivados, em todas as unidades de saúde, o acesso de primeiro contato obteve o maior (9,1) e o menor escore (3,3) em termos de utilização e acessibilidade, respectivamente. Os atributos integralidade (serviços disponíveis e prestados), orientação familiar e comunitária alcançaram baixos escores, variando de 4,9 a 5,8. O Escore Essencial foi de 6,6. Na análise das unidades as equipes de Saúde da Família obtiveram escores superiores às equipes de Atenção Básica. Os resultados deste estudo evidenciam diferenças nos atributos nos arranjos organizacionais da atenção primária, o que indica a necessidade de qualificação da atenção primária, principalmente pela Estratégia de Saúde da Família, bem como de fortalecimento dos atributos na prática profissional.

PALAVRAS-CHAVE: Atenção primária à saúde; Avaliação em saúde; Diabetes mellitus; Hipertensão; Qualidade da assistência à saúde.

INTRODUCTION

Primary Health Care (PHC) is a model organization and reorientation of health services characterized by first contact of people with health services. PHC aims at solving the most frequent and less specialized health issues of the population[1-2] and deals with the promotion of health, prevention of disease, assistance and others, identifying health needs and coordination of Health Care Networks (HCNs) in services with medium and high complexities[2].

In the wake of current complex biopsychosocial requirements which health professionals have to cope with within PHCs, the model´s evaluation is one of the main mechanisms to respond to the needs for planning activities and services and for improving its performance[3]. Further, due to the uniqueness of each service and of people´s distinct conditions, the importance of research that may contribute towards the elaboratation of more centralized planning for the patients´ needs is underscored. The above includes the reformulation of teams´ work processes and the reorientation and better qualifications of managers to adequately attend to new demands[4].

Within the Brazilian scenario of different situations and complex demands, Non-Transmittable Chronic Diseases (NTCDs), particularly Systemic Arterial Hypertension (SAH) and Diabetes Mellitus (DM), are highlighted. Although the assistance of people with NTCD is not centered solely on PHC, the best opportunities are met at this level since the control and quality of life of people with NTCD are best attended to by integral and longitudinal care which is the PHS´s special task[3].

These health conditions are relevant and require care due to their high morbidity and mortality rates, indeed a true challenge for PHC[5]. Main difficulties lie in the incorporation of routine actions in health promotion and control of risk factors, since SAH and DM care is still centered on medical care and focused on severity instances within the ambulatory or hospital units[6]. Increase in the percentage of people that control these diseases at medium and long term for impacts on the reduction of morbimortality rates is another challenge. Consequently, PHC´s essential attributes – access,

longitudinality (continuity), integrality and coordination – are the most important factors in combating NTCDs[5].

Care in ambulatory and hospital first care units focused on the acute conditions does not favor an adequate intervention in the control of arterial pressure and glycemic levels, smoking, sedentary lifestyle, weight control, care of feet and regular ophthalmological exams. The strengthening of PHC as a component of HCN is a mandatory to promote a proactive follow-up of people with critical conditions. Follow-up must be coordinated by PHC team and services of secondary and tertiary care of HCN so that, together and with equilibrium, they may act on health´s social determinants[6].

A review of national scientific productions that assessed PHC from the perspective of patients and health professionals shows that the most used tool was Primary Care Assessment Tool (PCATool) and that gaps still persist for the evaluation of the PHC health service by patients[7]. Further, there is a lack of research work in Brazil involving populations with SAH and DM concomitantly evaluated by PCATool.

However, current evaluation is relevant to analyze the PHC-guided quality of services since it provides users´ perception on this care model and on practices of individual and collective care and health administration[8]. So that the above mentioned gap may be minimized, current study evaluates the presence and extent of PHC attributes from the perspective of patients with SAH and DM.

METHODOLOGY

Transversal and descriptive research was undertaken in a municipality in the interior region of the state of São Paulo, Brazil, with a wide public network in PHC services and coordinates medium and high complexity health services. The district health center comprises a unit for theoretical and practical activities of a government-run university and coordinates 20 Primary Care Units, Family Health Units and Basic Health Units which have family health (FHT) and basic care (BHT) teams. Current researchers asked permission from the Municipal Health Secretary to undertake the survey and 14 health units (10 with FHTs and 4 with BHTs)

accepted to participate in current research. The units´ participation comprised identification of patients with SAH and DM and made available a room for interviews with participants.

Participants were adult/elderly users, males and females, diagnosed with SAH and DM. Inclusion criteria comprised: users of participating units; diagnosed with SAH or DM regardless of data of diagnosis; over 18 years old. Exclusion criteria were users with health conditions that impaired participation at the moment of research and three failed appointments. Research complied with requirements by Resolution 466/2012 of the National Health Council and was approved by the Committee for Ethics in Research of the Nursing School of Ribeirão Preto, n. CAAE: 89778718.5.0000.5393, approval n. 2.802.188.

SAH and DM patients listed in the units amounted to 4,531. Since current research is a pilot study which will foreground another research work with mixed method design, it was decided to recruit two or three users per health unit (minimum 28 and maximum 42). Lots were drawn on R Core Team (2018) 3.5.3, with randomized numbers stratified by gender and age bracket. Forty-one patients with SAH and DM participated, with only one refusal. Data were collected by a trained research team (two undergraduate female students, one female postgraduate student and the supervisor), between February and June 2019, by a questionnaire at the health units or at the home of the participants, according to the latter´s preference.

Likert (ordinal variable) Primary Care Assessment Tool (PCATool)[9], version for users, was employed to measure individually the care structure and process at the PHC. The tool was translated and validated for Brazil and denominated Primary Care Assessment Tool (PCATool-Brazil). Its available is free (public domain) in a handbook of the Ministry of Health[9]. In the literature, PCATool-Brazil is a valid and reliable tool to evaluate PHC quality, especially to verify the guidance degree in its principles[10]. All the tool´s components were used without any change in contents. It was taken into account that the quality of health care within the perspective of patients with SAH and DM depended on the presence and extent of PHC attributes.

Data were stored in the Microsoft Excel® database, employing double digitation to eliminate errors, and processed by IBM SPSS Statistics, 25. In the case of continuous variables on sociodemographic characteristics, central trend measurements (means and medians) and dispersion (standard deviation), and proportion for categorical variables were calculated. Items for such characterization were based on the 2010 demographic census of the IBGE and adapted for current analysis. Statistical analysis of PCATool-Brazil followed guidelines by manufacturer[9]. In other words, scores for each attribute were calculated by the simple arithmetic means of rates of responses to items of each attribute. Essential Score was measured by the sum of mean score of components that belong to essential attributes divided by the number of components. General Score was calculated by the mean of the sum of mean score of essential attributes added to the affiliation degree and to derived attributes and divided by total number of components.

Scores were then transformed into a $0 - 10$ scale, following handbook[9], for better visualization of results. In the 1 - 4 Likert scale, scores ≥ 3 indicate adequate extent of each attribute (responses 3 or 4). In transformation, formula comprised: obtained score $- 1$ (minimum rate) $\div$ 4 (maximum rate) $- 1$ (minimum rate) x 10. Consequently, ≥ 6.6 featured a high PHC score and indicated adequate extent for each attribute when transformation occurred ([3-1] x 10 $\div$ [4-1] $= 6.6$), following the tool´s validity analysis[11].

RESULTS

The sociodemographic characteristics of the 41 people with SAH and DM interviewed revealed mean age 61 ± 9.8 years and mean schooling 7.3 years. Table 1 shows other sociodemographic characteristics.

Table 1. Sociodemographic characteristics of users with SAH and DM of health units of the western district. Ribeirão Preto SP Brazil, 2019. (n = 41)

(Continua)

Characteristics/ Category	N	%
Gender		
Female	25	61.00%
Male	16	39.00%
Age		
30 - 49 years	06	14.63%
50 - 69 years	29	70.74%
70 - 89 years	06	14.63%
Self-declared skin color		
White	27	65.85%
Brown	12	29.27%
Black	02	4.88%
Marital status		
Married	22	53.67%
Widow/widower	08	19.50%
Single	05	12.20%
Judicially separated	04	9.75%
Divorced	02	4.88%
Schooling (years)		
2 – 4 years	15	36.60%
5 – 8 years	13	31.70%
9 - 12 years	08	19.50%
13 - 15 years	04	9.75%
No schooling	01	2.45%
Job		
retired	25	61.00%
housewife	08	19.50%
unemployed	04	9.75%
Formal and informal labor	04	9.75%
Family income		
2 minimum wages	14	34.15%
3 minimum wages	12	29.27%
1 minimum wage	08	19.50%
4 minimum wages	06	14.63%
Did not inform	01	2.45%
Number of people living on total income		
1	03	7.31%
2	15	36.60%

(Conclusão)

Characteristics/ Category	N	%
3	13	31.70%
More than 4	10	24.39%
Head of family		
Interviewee	23	56.09%
Partner	12	29.27%
Interviewee + partner	02	4.88%
Mother	01	2.45%
Other person	03	7.31%
Residence		
Owns house	34	82.94%
Rents house	04	9.75%
On loan	03	7.31%
Religion		
Catholic	21	51.23%
Evangelic Christian	11	26.83%
Spiritist	06	14.63%
Jehovah´s Witness, Umbanda and Mormon	03	7.31%.

Table 2 demonstrates scores for attributes and Essential and General Scores of PHC for all units (FHT+BHT) and, separately, for units with FHT and those with BHT. Access to first contact had the highest (9.1) and the lowest (3.3) scores for all units respectively for usage and accessibility. Further, three essential attributes, two derived and General Score, had low extension degrees. Filiation degree, four essential attributes and Essential Score were high for PHC and revealed robust presence and adequate extent of each attribute. Analysis of units with FHT, in all attributes, even those with low scores, showed that teams had scores higher than BHT ones, namely, access to first contact (usage); longitudinality and coordination (information systems)

Table 2. Scores of attributes and general and essential scores of Primary Health Care of Health Units of the Western District. Ribeirão Preto SP Brazil, 2019. (n = 41)

Attributes of Primary Health Care	FHT+BHT (n=41)	FHT* (n=30)	BHT † (n=11)
Affiliation degree	7.3	8.1	5.1
Access to first contact (usage)	9.1	9.2	8.9
Access to first contact (accessibility)	3.3	3.6	2.4
Longitudinality	7.8	8.0	7.3
Coordination (integration of cares)	6.7	6.9	5.5
Coordination (information system)	7.5	7.7	7.2
Integrality (available services)	5.7	5.6	6.2
Integrality (services given)	4.9	5.1	4.5
Family guidance	5.8	6.5	3.9
Community guidance	5.5	6.5	2.5
Essential score	6.6	6.8	5.9
General score	6.4	6.7	5.4

* FHT: Family Health Team; † BHT: Basic Care team.

DISCUSSION

Through an analysis of all units (FHT and BHT), current study showed that Essential Score (6.6), following the experience of users´ with SAH and DM, tended towards PHC. Results corroborate study[12] on PHC evaluation but undertaken with a population of children´s care givers. It also identified the minimum rate for Essential Score. It should be highlighted that the rate of Essential Score of units (FHT and BHT) are related to the Essential Score of units with FHT (6.8) since this rate in BHT proved to have a low trend towards PHC (5.9). The above is due to high FHT scores in the attributes Access to First Contact (usage), Longitudinality and Coordination (systems of information). Consequently, units with FHT have better conditions to implement PHC principles since the model performs activities based on territory, identifying and intervening on the population´s life and health conditions under analysis[13].

Analysis of all units (FHT+BHT) revealed that the General Score rate was close to (6.4), even though it did not reach the intersection line. This result may be due to the fact that calculation has included the affiliation degree and the essential attributes and derivates. Consequently, the essential attributes Access to first contact (accessibility) and Integrality (available and given services) and derivates, such as family and community guidance, contributed towards a decrease in rates, due to low scores

It should be highlighted that General Score in units with FHT tended towards PHC and a low guidance degree in units with BHT. Results are similar to those in studies which evaluated PHC, even though they were undertaken in different scenarios and with different populations. In fact, they also identified low General Score[14] and differences in organizational arrangements of primary care, demonstrating better improvements in units with FHT[15-16].

Affiliation degree in the analysis of all units (FHT+BHT) revealed the attribute´s presence and extent (7.3), with a higher score for units with FHT and low guidance to BHT. Affiliation degree identifies the health service or the health professional proper for the care[9]. Studies using PCATool evidenced that units with FHT had a high affiliation degree through a mark identified by users as reference service[16-17].

The attribute Access to primary contact, within the dimension usage, defines whether the service is the first site sought by a patient to cope with a health issue or whether he needs forwarding to a specialist[9]. It also refers

to processes established to attend to patients[14]. Attribute had presence and extent, regardless of the service modality of PHC (FHT or BHT), and demonstrated that free service may be a factor that favors the dimension usage[14,18]. Further, Access to primary contact for patients with SAH and DM may contribute towards the decrease in morbidity and mortality, hospitalization indexes and unnecessary forwarding to specialists. The latter are also factors that contribute towards the health system since they favor the efficient use of resources[14,19].

In the dimension Accessibility, the attribute Access to primary contact, within the analysis of all units (FHT or BHT), had a low guidance degree (3.3). The attribute evaluates the capacity of the service to attend patients in each and every health problem or episode of the same problem (instances of severity), excepting emergencies and urgencies[9]. Low degree may be related to the services´ geographic and organizational barriers, such as work schedule of units and the difficulty of patients to timetable visits and waiting time[20-21].

In the case of the perception of people with chronic conditions on access to primary health services, impediments comprised deficiencies related to disease, such as limited mobility, chronic pain, weariness, fragility, structural obstacles, such as the unavailability of services outside working hours[22]. These perceptions may jeopardize patients´ health. In fact, when they are aware of access barriers to health services, health care may be postponed. It may be dangerous not only at the individual level but it may burden the family, the community and the entire health system[1]. Consequently, the presence and extent in primary contact access is an asset for true health needs and better life style[19].

Longitudinality had a high score in the analysis of all units (FHT+BHT) and in the two modalities of PHC service. It is an attribute characterized by regular and consistent care by the health team through the establishment of interpersonal bond between patients and professionals[1]. However, in practice it is only effective when there is an adequate supply of services and professionals in the health unit, since these factors favor the strengthening of the bond[14-23]. The attribute´s evaluation takes into consideration the social aspects of territories in which health services are inserted and the

manner issues are related to work precariousness since they interfere in the relationships and bonds with PHC´s patients[23].

The attribute Coordination, within the dimension Integration of care, also has presence and extent within the joint analysis of the units (FHT or BHT) and in FHT. However, the expected score was not reached in BHT (5.5). The attribute is the capacity of guaranteeing the continuation of care through service integration that responds to health needs at different sites of the care network. One should highlight that continuity may significantly impact the health community since it raises its capacity to solve health problems with bearable costs in the wake of current socioeconomic, demographic and epidemiological situation[1]. Consequently, low score in BHT may be due to the care model which gives priority to the fragmentation of care and, therefore, causes a disarticulated care within PHC. Care of chronic conditions care must be directed by practices of coordination to integrate assistance levels[24].

Within the dimension systems of information, the attribute Coordination was directed towards PHC in the two service modalities, FHT and BHT. Coordination materializes by the adequate conversation between professionals and also by information technology systems, or rather, those that favor the continuity of assistance[20,25]. A better and more effective communication between generalist and specialist professionals should be established to warrant integral care and widen the health service supply. Further, the patient in HCN should be directed by qualified reference and counter-reference, always seeking the bond and care continuity[26]. Consequently, the municipality under analysis has a system of digitalized cards to interlink the municipal network in health care which facilitates the flow of information between professionals and service.

Integrality is a PHC attribute that comprises bio-psycho-social activities of the health-disease process through promotion, prevention, cure/rehabilitation and care within the different levels of complexity[14]. Current study showed low scores for the attribute in available and given services. The former comprises experiences of patients on health services, regardless of having or not having received them, and the latter identifies themes

from different sites which have been approached with the patient at any time[9].

Results suggest that the patients´ life context may not be included in care activities, and thus corroborate studies in which these attributes receive low scores[14,17,20,25]. The weakness of such attributes suggests to health professionals the idea of seeing the patients as social and political agents, articulated to the society in which they are inserted so that they may prepare care plans that attend to the true needs of people, with care centered on individuals and not on the disease[19]. Further, the attribute Integrality favors the effectiveness of attributes derived from family and community guidance, which also have a low degree of orientation for PHC. Consequently, the promotion of integrality contributes towards health promotion activities for the supply of appropriate care and true needs of the population and for the prevention of SAH and DM complications, with an improvement in life quality[27].

Health services with attributes family and community orientation favor a more qualified care to patients and collaborate towards an improvement in health indexes. In fact, care in family orientation is centered on the agent and family and on the integral knowledge of their health problems. Community orientation acknowledges the needs of the community´s health and the importance of its relationship with patients and families for the planning and joint evaluation of services, inverting the hegemonic care logic centered on the physician[1,9,14]. The materialization of family and community orientation occurs when integrality is put into practice since it considers the agents in their contexts and evaluates the needs which must be met to promote integral care within the family and community milieu and also health determinants[28]. The presence of cultural orientation is associated with an increase in the patients´ satisfaction and their collaboration with self-care[29]. This is highly relevant for SAH and DM patients since it impacts chronic conditions and eventual complications.

Therefore, the evaluation of PHC attributes provides discussion on health practices, serves as a tool for guidance to health policies and progress in the local health system. It also identifies the capacities and weaknesses of assistance given to the population and serves as a reference for professionals, managers and researchers[14].

The limitations of current study are: (1) A single tool was used to analyze the phenomenon of PHC attributes even though, besides PCATool, the European Task Force on Patient Evaluation of General Practice Care (EUROPEP) is also an instrument employed in Brazil to assess PHC[8], coupled to the National Program for the Improvement of Access and the Quality of Basic Care (PMAQ)[30]. (2) Current study was conducted within a single district of the city and therefore only an intersection of the situation has been obtained; it may be widened towards a broader diagnosis of the municipality. (3) Current study was evaluated from the point of view of patients and did not include other agents, such as health professionals and managers. (4) The study´s design portraits conditions within a determined point in time.

CONCLUSION

Current study evidences that, within the context of all health units evaluated (FHT + BHT) and within the perception of patients with SAH and DM, the attributes Access to first contact (accessibility), Integrality (available and given services), Family and Community Orientation and General score had low rates for PHC. Current evaluation indicates further studies which may identify, within the process of team work, how these attributes function in practice and, thus, seek ways to overcome weaknesses that provide attributes with low scores. It is also highly important that health professionals may discuss their job to problematize these data and reflect on professional practice and the political and social contexts.

Current analysis also evidenced that the presence and extent of PHC attributes, even those with low scores, are higher in units with FHT when compared with those with BHT. Only three attributes with BHT had an orientation towards PHC: Access to first contact (usage), Longitudinality and Coordination (systems of information). The above result evidences differences in attributes in the wake of organizational arrangements of primary care and make it an indication of the need of PHC qualification in Brazil, especially through the

strengthening of health units with FHT. Since the municipality has low FHT coverage, evidence becomes particularly important for the health district under analysis and for the city.

Further, the evaluation of each PHC attribute underscores the complexity of PHC qualification in Brazil and problematize its weaknesses in the present context of public policies within primary care, poor funding, management of health services, working processes and regional inequalities of municipalities. Discussing the manner PHC is evaluated contributes towards the broadening of nurses´ roles and favoring the development and the good functioning of health systems. Current study made possible a better structure for further research work which will comprise an analysis of the joint method and amplify knowledge on patients´ perceptions on PHC. It will provide a better understanding on the manner weaknesses and capacities of attributes interfere in the care of people with SAH and DM. Further research will be undertaken to evaluate PHV through different methods, tools and social agents for a better analysis of the phenomenon.

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