

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

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

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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 déficit 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.

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Introduction

The aging of the population reflects a demographic transition resulting from the decline in fertility and mortality rates¹ and represents a challenge in view of the need for the development of adequate health policies and care services for the elderly². 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 million². 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 2018³.

Even though the decline in mortality from infectious and communicable diseases contributed to increase life expectancy⁴, 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 ageing⁶, defined by the World Health Organization (WHO) as the process of developing and maintaining the functional ability that enables well-being in older age⁷.

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 hierarchy⁸.

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(m)}.

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 quality⁸. 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 member¹², provides welcoming and qualified listening aimed at meeting the demands¹³ and orients the user through his or her course of care within the HCN¹⁴. The analysis of this health care pathway makes it possible to identify vulnerabilities and potentialities in the HCN¹⁵ and uncovers the perception by the users of the quality of the care services delivered¹⁶.

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 methodology¹⁷. 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 basis¹⁸.

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 death²⁰. 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 visits²¹, 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/material²².

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.)

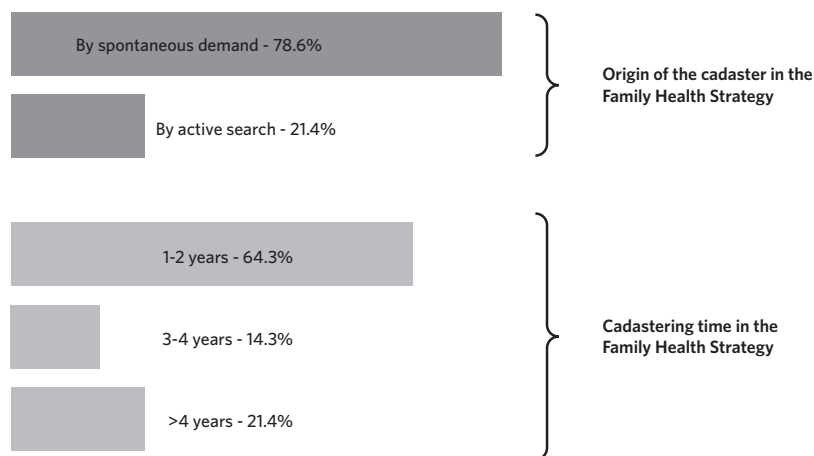
Variables	N	%
Civil status		
Married	2	14,3
Widowed	12	85,7
Household composition		
Lives with other person	12	85,7
Lives alone	2	14,3
Total Number of Elderly	14	100

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 mortality²⁴ –, 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 treatment²⁵.

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 professionals²⁶ (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 BHU²⁷. 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

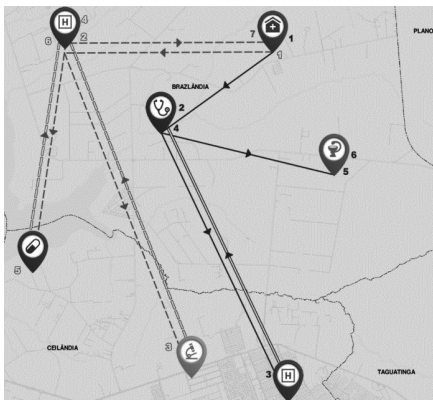
Healthcare pathways are paths chosen by individuals within the health network, and which may or may not lead to resolution and treatment¹⁵. Here, there is a counterpoint to the definition of a therapeutic path, which involves the search for health care by individuals, who, in quest of solutions to their 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*.

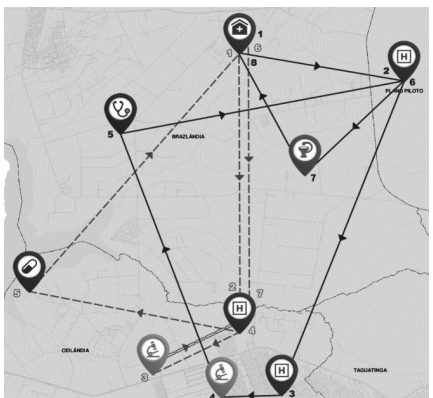
Figure 2. Healthcare pathways of the elderly in the Health Region West, Federal District, 2019

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

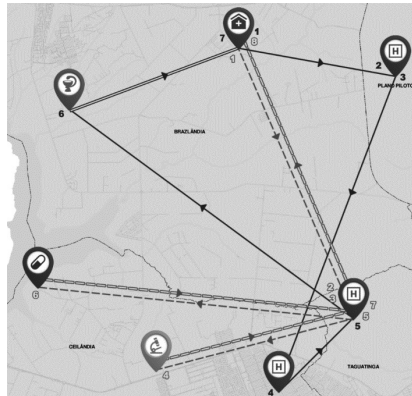
2.b UBS D, I1, 'persistent cough' complaint.



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)

Health Equipment

- General Hospitals
- Basic Health Units
- Doctor's Office
- Laboratory
- Ambulatory Pharmacy
- Pharmacy/Drugstore

Displacement

- Predicted flow
- Predicted return
- Actual flow
- Actual 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 tests³⁰.

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 comorbidities^{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 SC³⁴.

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 expensive³³.

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 RAS³⁶.

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 users²⁷. 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 principles³⁷⁻³⁹.

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, 11).

I don't know, they used to say: 'Madam, anything you need, you come to me'. They hug me. All 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, 14).

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 trust³⁶, 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 treatments⁴¹. 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 delivered³⁸. 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. Conill⁴⁵ 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 bodies⁴⁶. 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 care⁴⁷. 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 ages⁴⁸.

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 assistance⁴⁹. Elderly people are frequent users of health services and, for the most part, they need medication throughout their lives⁵⁰. 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 Paim⁵¹, 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 people⁹. 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, 11).

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, 13).

The speech of the elderly person 'UBS B, 11' 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 UHS⁵². 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 CHA²⁷.

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, 11).

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, 11).

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 actions⁵⁴. 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 density⁵⁵. Thus, the demand for SC exceeds the service provision, generating huge lines and causing the fragmentation of the elderly health care.

User 'UBS C, II' 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 costs⁵¹. 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. ■

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