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PRINCIPLES OF PRIMARY HEALTH CARE TODAY: A REVIEW

PRINCÍPIOS DA ATENÇÃO PRIMÁRIA À SAÚDE NOS DIAS DE HOJE: UMA REVISÃO

PRINCIPIOS DE LA ATENCIÓN PRIMARIA DE SALUD HOY: UNA REVISIÓN

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ABSTRACT

Objective: To analyze the scientific knowledge produced in the literature on the principles of Primary Health Care (PHC). **Methodology:** Integrative review with sampling consisting of works found in the SCIELO publication bases, Virtual Health Library, in October 2019 by independent reviewers. Exclusion criteria: Duplicate work, PHC program reviews and reviews. Inclusion: works derived from research and original articles. **Results:** 565 studies were identified and 15 articles were included in the final sample that describe the essential attributes of primary care: first contact access, longitudinality, comprehensiveness and coordination and as derived attributes: community and family orientation. **Conclusion:** Challenges persist for the implementation and effectiveness of attributes in the health service. Thus, public policies that constantly reinforce and improve the health system are recommended.

Descriptors: Primary Health Care, Health Services, Health Assessment.

RESUMO

Objetivo: Analisar o conhecimento científico produzido na literatura sobre os princípios da Atenção Primária à Saúde (APS)**. Metodologia:** Revisão integrativa com amostragem constituída por trabalhos encontrados nas bases de publicação do SCIELO, Biblioteca virtual da saúde, em outubro 2019 por revisores independentes. Critérios de exclusão: Trabalhos duplicados, Análises de programas da APS e revisões. Inclusão: trabalhos derivados de pesquisas e artigos originais. **Resultados:** Foram identificados 565 estudos e incluídos 15 artigos na amostra final que descrevem os atributos essenciais da atenção primária: acesso de primeiro contato, longitudinalidade, integralidade e coordenação e como atributos derivados: orientação comunitária e familiar. **Conclusão:** Persistem os desafios para a implantação e efetivação dos atributos no serviço de saúde. Assim recomenda-se políticas públicas que constantemente reforcem e aperfeiçoem o sistema de saúde.

Descritores: Atenção Primária à Saúde, Serviços de Saúde, Avaliação em Saúde.

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RESUMEN

Objetivo: Analizar el conocimiento científico producido en la literatura sobre los principios de la Atención Primaria de Salud (APS). **Metodología:** Revisión integradora con muestreo conformado por trabajos encontrados en las bases de publicación SCIELO, Biblioteca Virtual en Salud, en octubre de 2019 por revisores independientes. Criterios de exclusión: Trabajo duplicado, revisiones y revisiones de programas de APS. Inclusión: trabajos derivados de investigaciones y artículos originales. **Resultados:** se identificaron 565 estudios y se incluyeron en la muestra final 15 artículos que describen los atributos esenciales de la atención primaria: acceso al primer contacto, longitudinalidad, integralidad y coordinación y como atributos derivados: orientación comunitaria y familiar**. Conclusión:** Persisten desafíos para la implementación y efectividad de los atributos en el servicio de salud. Por ello, se recomiendan políticas públicas que refuercen y mejoren constantemente el sistema de salud. **Descriptores:** Atención Primaria de Salud, Servicios de Salud, Evaluación de la Salud.

INTRODUCTION

Primary Health Care (PHC) had its idea described for the first time in 1920 in the Dawson Report. This report proposed a way of organizing national health systems and restructuring the health care model in England at different levels of complexity. Primary health centers should solve most of the population's health problems and also function as a gateway to the health system that would be linked to secondary health centers and teaching hospitals.[1]

The consolidation of PHC occurred through movements 2 after the 1960s and 1970s with the formulation of comprehensive and preventive medicine that proposed to be closer to the sociocultural environment of individuals and thus constitute a conducive environment for carrying out disease prevention . Since then, it has been presented as the most effective and assertive model of health care access to health, for having changed the curative, hospital and individual approach to a preventive, collective and democratic model. Unlike how it is sometimes described: a selective model focused on the poorest populations.[3]

From this perspective, the historical milestone of the APS occurred in 1979 at the Alma Ata conference. The World Health Assembly defined a social goal, known as “Health for all by the year 2000”, which triggered a series of actions that had repercussions on the ideology of primary care.

In Brazil, Since the emergence of School Health Centers in the 1920s to the present day, we have witnessed several attempts to organize PHC. The first experiences of community medicine in the 1970s, under the influence of the health reform movement and with the support of Universities, marked the beginning of the participation of municipalities in the development of PHC. Already in the early 1980s, with the process

of redemocratization in the country, the Integrated Health Actions (AIS) were proposed, followed by the Unified and Decentralized Health System (SUDS), until in 1988 the Unified Health System was established (SUS) with the new Constitution. In 1994, with a positive evaluation of the Community Health Agents Program (PACS), the Ministry of Health proposed the Family Health Program (PSF), which soon after came to be understood as a strategy for reorienting the care model.[4]

Since then Primary Care has had Family Health as a priority strategy for its organization in accordance with the precepts of the Unified Health System and is responsible for the health care of its users, becoming the main gateway to the system; offering individual and collective health actions and has been molding itself to the health situation of the Brazilian population that requires constant modulations to boost its development.[4]

Having said that, it is understood that the PHC is a solid health system whose function is to organize the health system in order to keep it efficient and its operation has adopted different political, economic, social and cultural outlines over these almost one hundred years.[5] This study aimed to analyze the scientific knowledge produced in the literature on the principles of Primary Health Care.

METHOD

The present work is an article constructed from a master's thesis entitled: "Challenges of primary care in supplementary health" presented to EMESCAM - Vitória, Espirito Santo. This is an integrative review of national and international literature on the concept of PHC. Because through this type of review it is possible to fill in the gaps of a given subject through multiple published studies.[6,7] The choice of review was due to the fact that this approach allows for the synthesis of knowledge and its applicability by different methods and practices[6] and answer the guiding question of the research: “What is the concept and/or attributes of Primary Care nowadays?”. From then on, the secondary study of the dissertation was deepened.

The study was elaborated based on the recommendations of Ganong[8], which suggests six phases of construction: 1) elaboration of the research question 2) search in the literature; 3) data collection 4) analysis of findings; 5) interpretation of results; 6) report of the integrative review. Works derived from research describing the characteristics and attributes of PHC, original articles, published in the following languages: English, Portuguese and Spanish between the five years from 2014 to 2019

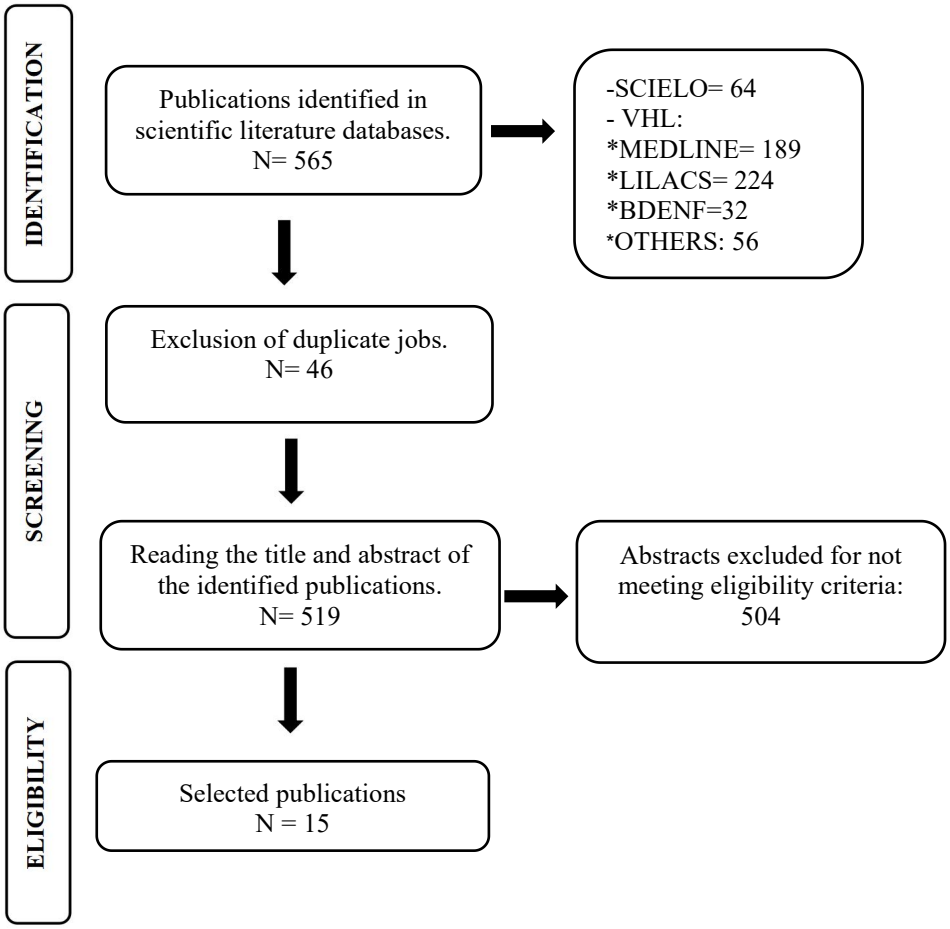
were excluded. Duplicate works that analyzed the PHC assessment instruments were excluded, scientific review works and those whose analysis focused on a PHC program.

The survey of articles was carried out in October 2019 through the terms indexed by the Health Sciences Descriptor (DeCS): “Primary Health Care”, “Health Service”. The descriptors were combined with each other, according to the specificities of each database, using the rounding operators “AND” and “OR” in the publications databases: SCIELO, Virtual Health Library (BVS), BDENF (Database of Nursing), BBO (Brazilian Dentistry Bibliography), CVSP – Brazil (Virtual Fields in Public Health).

The studies were selected by two independent reviewers, according to previously established inclusion and exclusion criteria. First, the duplicated works were excluded and in the pre-analysis, the exploration of the material and treatment of the results obtained and interpretation were performed. In this stage, the organization of the information and the synthesis of the initial ideas were carried out and the main themes were highlighted in order to identify the possible categories through a table with the following items: title; authors; area of knowledge; method; country of publication; impact factor of the journal; year of publication; main objectives; main results and conclusion. For data extraction, an electronic form was created in Excell 2010 and organized in frames for better visualization of the results. Soon after, the material where the categories responsible for the composition of the themes were aggregated and classified was explored: First contact, Longitudinality, Coordination, Integrality and Family and Community Orientation.

565 publications were found, and after the selection process, 15 publications were selected. This process is demonstrated in the flowchart below, defined as figure 1.

Figure 1. Flowchart of the selection process of publications for integrative review.



RESULTS AND DISCUSSION

First contact access

This notion is explained as: The health service is a source of care for each new health problem or a new episode of the same health problem, except in urgent cases.[5] The studies pointed out that there are difficulties related to access and accessibility to services and the need to adjust between the needs of the population and the provision of PHC services, especially because the fragility of this attribute in health services is capable of compromising the other attributes.[9]

The participants attributed a bad evaluation to the accessibility item, but, regarding the use, a good score was obtained, which shows the effective interrelationship between provider and receiver of care, leading to user satisfaction.[9] In another study[10], this attribute received a low score in the evaluation of the male population studied in the municipality of Teresina, Piauí. The reasons were the opening hours of the units (business hours) in addition to there being no service at night, or on weekends. In addition, this study showed that more than 11% of this population felt a bond with the hospital, emergency room or emergency room. Even so, the study showed

that users recognize PHC as the main gateway to SUS health services.

Analogous to this, in another study[11], this attribute was evaluated as the worst. As in another[12], where the hours and days of operation of the units and the impossibility of telephone contact with them expressed the poor accessibility of users to the services. However, the first contact access regarding use was well evaluated by the participants.

This attribute obtained the highest score from the perspective of service users, which demonstrates that they have received some kind of attention. As for accessibility, it obtained a lower score. For the authors, welcoming is an essential part of this attribute in the health service, being a fundamental tool for the humanization of services. Good reception, resoluteness, integrality, listening to the individual, meeting their needs are fundamental elements in this process.[13]

Longitudinality

It is defined as the regular existence of a source of care exercised by health professionals and its use over time, that is, a long-term bond between users and health professionals. This attribute is associated with the possibility of a greater bond with the patient, better identification of health problems and with the satisfaction of these individuals.[14-15] This attribute may be associated with the reduction of hospitalizations, better preventive care, more adequate health care and reducing the use of health services.[5]

It is important to emphasize that the good evaluation of this attribute is ideal for successful therapy. In this variable it is possible to find a satisfactory score demarcated by more than one study.[9,11,12,16] In one of the studies it was identified that the health service or professional takes on a greater degree of responsibility for their care when children are treated in the same health service. They also state that for longitudinality to be effective and for health services to be oriented towards PHC, there must be a bond of affiliation between the family and the service, which involves good communication, knowledge about the clinical history of the child and about the family. The authors also reinforce that longitudinality in PHC services is an essential factor for the extension of other characteristic attributes of PHC.[9]

There is also an incidence of a high average score.[17,10] In one of the studies[12], the authors found a convergence in the values attributed to this attribute in the groups of interviewees, with values emitted by professionals being higher than those of users. It was then observed that there is continuity in the relationship between the user and the health service, with the

construction of bonds and accountability between professionals and users over time, permanently, following the effects of health interventions and other elements in users' lives.

However, we also found studies[13,15] that did not have a good assessment of this issue. When evaluating this attribute, the worst results were associated with questions, access to professionals by telephone, and information on the place of residence or work of each patient. The authors state that in Brazil there is no contact between the user and the health service via telephone contact and that the high turnover of health professionals weakens the bond and the longitudinality of care.

Integrality

Integrality is defined as the set of services available and provided by the APS to users. Among them are health promotion, disease prevention, rehabilitation and cure, in order to guarantee comprehensive care. [5]

This attribute is one of the most important for achieving PHC resolvability among the different health systems.[14] This means that primary care should solve up to 80% of the population's health problems, thus taking responsibility for the health conditions most common, as well as referral to other levels of health.

In the view of the nurses who participated in the study, this attribute received a negative evaluation, as in many situations professionals are limited to complying only with what is demarcated by the Government Programs and not in view of the need and local health.[16] The authors also cite that some professionals find it difficult to discuss topics such as “use of firearms”, advice “on the use of safety”, among others, because of sociocultural conditions.

For users of one of the surveys[16], the poor availability of some services such as “wart removal”, “splints”, advice and guidance contributes to this attribute not having a good evaluation, the offer of these services would reduce the user's demand for the urgency and emergency service and, in addition, would increase the user's satisfaction.

This attribute is present when activities are developed that meet the needs of the population and that comprehensiveness means cooperation and coordination between care service providers in order to develop an authentic health system13, but this is not happening in the Unified Health System. Therefore, it is important to discuss which services should really remain and which ones should be included in the PHC[15], since it is relevant to raise local demands and know all the

logistics of the Health Care Network and states that it should not be prioritized only compliance with specific programs, restricted to groups, leaving aside services that are important and necessary for registered users.[15]

Care coordination

Coordination of care is defined as the articulation of primary care with other levels of care, in a synchronized manner and focused on a common goal in health care.[13] Thus, coordination of care implies a form of continuity, whether by the same professional, or through the sharing of medical records, aiming at the search for comprehensive care for the user.[12]

Therefore, for coordination to be effective, PHC must fulfill three essential functions: organization of flows and counter-flows of users through the various areas of care, the responsibility for health and the monitoring of users at any level of health care in which they are and the resolution of most of the problems of the population within the health system9. It also emphasizes that it is up to the coordination of care the knowledge and the availability of information regarding health problems and services provided prior to the needs of this service to the user and that, even though this attribute is well compliance with this attribute needs to be improved and its challenges are improving the quality of information in medical records, the implementation of electronic medical records in all health services, the establishment of care networks to optimize access and use of other health resources in the network, ensuring communication mechanisms (referral and counter-referral).

In the attribute Coordination – Integration of Care, the referral to specialized services, from the point of view of the professional who refers, outlines the lack of a feedback that favors the continuity of care, and, from the point of view of the users, the interest of the primary care professional on the results and quality of care provided at other care levels.[12] The authors state that coordination requires both a means of transferring information, the structural component, and the recognition of this information, the procedural component. As for Coordination – Information System, the evaluation revealed that, although the professional makes the medical record available, users inform more frequently that they do not have the possibility to consult it.

In another study[18], there is a sign that there is some difficulty for users to receive communication about the results of exams received by the services and that the services have medical records, but users cannot access them. The authors point out that the services are poorly organized to be user-

centric. For this dimension, it is pointed out that the main weakness is due to the failure in communication with other services in the care network due to problems in referral and counter-referral.[19]

Care coordination obtained a high evaluation score both in the integration of care and in the information system.[20] The authors reinforce the ability of the PHC, through the teams of the Family Health Strategy (ESF), to guarantee the continuity of care in the interior of the health care network and that the existence of a medical record with its information at all points in the network is essential for the coordination of health care and that, with population aging and the consequent increase in the prevalence of chronic diseases, make integration of the increasingly necessary information system.

Family and community guidance

Family orientation and so-called community orientation are considered derived attributes. Family guidance is understood as the importance of taking into account the family context, both with regard to its potential to contribute to care or, on the contrary, as its influence in the form of a threat to health. Community guidance consists of recognizing the health needs of the community through epidemiological data.[18]

The approach or not of PHC, in family orientation, reflects on the success or failure of patient care.[18] In addition, it is essential that PHC professionals develop action plans together with the population to face health problems and risks. In one of the surveys[13], this attribute was poorly evaluated. The authors point out that the lack of acceptance, respect, commitment, among others, are the main causes of user dissatisfaction.

When approaching family guidance, it was observed that health professionals still work with the traditional model of health education, in which the doctor and nurse are the holders of knowledge, while the population is passive and does not participate. the construction of his therapeutic project and his family's therapeutic project.[17] As for community guidance, it is important to highlight that social participation is an important tool to empower people about their rights in relation to the provision of health services.

The Family Guidance attribute obtained an average score below the established reference and reaffirms that the focus on the family is essential to guarantee quality care.[10] This attribute is consolidated when the achievement of Comprehensiveness provides a basis for considering patients within their

environments, when the assessment of needs considers the family context and its exposure to health threats and when the Coordination of care faces limited family resources. As for Community Orientation, the researchers also attributed a low score to this attribute. It is necessary that the primary care service knows the social context in which the user is inserted, this concerns the possibility of understanding their needs,

CONCLUSIONS

In view of this review, it is understood that the concept of PHC persists in the literature as proposed in the 20th century, since the characteristics and attributes are consolidated in the literature that currently evaluates its applicability. However, there are still difficulties in the effective operation and implementation of this sector. The studies show that although the PHC is the preferred gateway to the health system, there is difficulty in scheduling, delay in waiting for care and restricted operation in days and times, which consequently make it difficult to access other levels of health.

The weaknesses in carrying out the longitudinality and coordination of care and thus the formation of bonds between users and health professionals occur in part due to the turnover of professionals, and in part due to the lack of any other form of contact with health professionals, making weaken the bond formation.

It is important to highlight that the lack or non-existence of a physical structure may imply low quality of care, although adequate structure does not necessarily imply high quality, only pointing to potential for its existence, but this environment is essential to maintain comprehensive and expanded care. for carrying out health promotion and disease prevention. In addition, the PHC is responsible for or is the basis for carrying out the coordination of care where effective communication between the PHC services and specialized services is one of the needs for the coordination of care to be effective both between professionals and with the systems used to fulfill this attribute.

For users, there is still a lack of clarification and guidance on social risk factors and there is still a vertical relationship between health professionals and users. Health professionals still work with the traditional model of health education in which the doctor and nurse are the holders of knowledge while the population is passive and does not participate in the construction of their therapeutic project and their family's therapeutic project.

Some authors point to the need to structure teams to discuss health concepts

and treatments beyond the biological concept, through a multidisciplinary and cooperative approach that breaks with the curative biomedical model. will affect the fulfillment of the others. Therefore, it is necessary for this sector to be resolute in order to provide a link with the population and adjust services according to their needs.

Therefore, public policies are suggested that constantly reinforce and improve the Brazilian health system in order to provide qualified and effective health care, promotion and prevention. Thus, establishing adequate health conditions for the population and devising appropriate strategies for the best possible health care.

Finally, the limitations found in this review were: the time frame of 5 years and the absence of searches in other databases, which may have restricted the selection of articles and the deepening of the analysis.

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