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Comprehensiveness in primary health care

Integralidade na atenção primária à saúde

Integralidad en la atención primaria a la salud

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This is a reflective essay whose objective was to rescue the sense attributed to comprehensiveness in the practice of Primary Health Care in Brazil. The study covered a conceptual background and its application in health care. Comprehensiveness is a continuous challenge due to the complexity of its operationalization. It involves different actors and strategies of articulation in different scenarios that are configured in networks, be it in the assistance plan, in the management or in the construction of public policies.
Descriptors: Integrality in health; Primary health care; Health management; Public health.

Este é um ensaio reflexivo cujo objetivo foi resgatar o sentido atribuído à integralidade na prática da Atenção Primária à Saúde no Brasil. O estudo abrangeu um histórico conceitual e sua aplicação na assistência à saúde. A integralidade constitui um desafio contínuo devido à complexidade da sua operacionalização. Envolve diferentes atores e estratégias de articulação em diferentes cenários que se configuram em redes, seja no plano assistencial, na gestão ou na construção de políticas públicas.
Descritores: Integralidade em saúde; Atenção primária à saúde; Gestão em saúde; Saúde pública.

Este es un ensayo reflexivo cuyo objetivo fue rescatar el sentido atribuido a la integralidad en la práctica de la Atención Primaria a la Salud en Brasil. El estudio abarcó un histórico conceptual y su aplicación en la asistencia a la salud. La integralidad constituye un desafío continuo debido a la complejidad de su operacionalización. Implica diferentes actores y estrategias de articulación en diferentes escenarios que se configuran en redes, ya sea en el plano asistencial, en la gestión o en la construcción de políticas públicas.
Descriptores: Integralidad en salud; Atención primaria a la salud; Gestión de la salud; Salud pública.

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INTRODUCTION

Comprehensiveness is one of the principles and directives of the Unified Health System (SUS) instituted and guaranteed by the Federal Constitution of 1988, in article 198 and regulated in September 1990 by Law 8080/90. It was defined as "an articulated and continuous set of preventive and curative actions and services, individual and collective, required for each case at all levels of complexity of the system"[1].

The comprehensiveness adopted by the National Policy for Health Promotion (NPHP) in its third edition (2010, p.13) implies an even more complex conception:

> *"[...] articulation and syntony between health production strategies, in broadening the listening of workers and health services in relation to users, either individually and/or collectively, in order to shift care from the strict perspective of the their illness and symptoms for the embracement of their history, their living conditions and their health needs, respecting and taking their specificities and their potentialities into account in the construction of projects and organization of health work"[2].*

In its most recent version, the NPHP emphasizes that "comprehensiveness" refers to the care of a "universal citizen who resorts to equal care free from prejudice or privileges and that responds to the promotion, prevention, protection and recovery of health"[3].

A broader conception of national policies is perceived in the NPHP, in which comprehensiveness is also pointed out as a health promotion strategy. It aligns what is specific to what is potential in the construction of therapeutic projects, considering the autonomy and particularities of each human being. It is tied to a complexity of factors influenced by the social, economic, political and cultural contexts of the territory where people live and these, in turn, influence their choices and way of living[3].

The management of a health system integrated into networks favors the achievement of comprehensiveness and opens space for practices that include a multidisciplinary work with the participation of users and strengthening of bonds[4]. In this sense, comprehensiveness can broaden the traditional view regarding the scope of health promotion actions practiced in Basic Health Care (BHC), also called Primary Health Care (PHC)[5].

Assistance based on the principle of comprehensiveness and guided by interdisciplinary actions makes PHC the gateway for horizontal care, which must permeate all levels of care, seeking to meet the health needs of each individual.

Although there is no single meaning for comprehensiveness in health, a clear perception of its scope and potentiality becomes important to enable its application in the context of SUS. It is therefore assumed that comprehensiveness occurs when health professionals interact with users, seeking a common solution among individuals[6].

In the scope of PHC management, there are challenges to be overcome in order to implement comprehensiveness in the care practice based on an understanding of the human being in his complexity, in which all dimensions, both biopsychosocial and also spiritual, are taken into consideration. For this to occur effectively, managers should look at the individual who receives care in an integral way, considering him in all his needs, beyond the walls of health care centers.

It is important, therefore, to research strategies to consolidate the scientific development so as to strengthen comprehensive care[7].

The objective of this article was to rescue the sense attributed to the comprehensiveness in the practice of Primary Health Care in Brazil.

METHOD

This is a reflective essay in which we sought to understand how comprehensiveness has been implemented in Health Care in Brazil.

RESULTS

Twenty references covering two topics were used in this article of reflection, namely: conceptual history and Integrality in the management of Primary Health Care.

DISCUSSION

Conceptual history

Integrity has been discussed since the 1970s, mainly after the beginning of the Psychiatric Reform Movement[8], which supported care in comprehensive health care networks. At that time, more than today, there was a reductionist concept of health that was geared toward specialization in medical practice.

What was not understood back then, and is better understood today is that academic studies did not discuss comprehensiveness as a single concept, but as an articulating set of different perspectives with the proposal of (re)inventing health in a more flexible, creative, view which reunites different sets of knowledge and modes of intervention[9]. From this perspective, seeing patients as integral beings, without disconnecting them from their social, family, spiritual, environmental, political and historical dimensions becomes a fundamental practice for the construction of comprehensiveness in the context of SUS.

The NPHP brings a discourse to expand knowledge, guarantee adjustments with SUS guidelines and consolidate health promotion actions in a holistic perspective. It advocates that as a doctrinal principle of SUS, comprehensiveness should permeate all health promotion actions, understanding that when health interventions are based on the recognition of the complexity, potentiality and singularity of individuals, as well as on collective good, more articulated and developed work processes will be created[3].

In order to achieve comprehensiveness in the SUS, changes in the work processes and instruments are needed, so that the goals and ideals of humanization, ethical legality and maximization of results may become a reality[10].

Comprehensiveness in the perspective of the Ministry of Health has the function of directing the operational actions of the SUS[3], but the concepts presented are complex, generic and lack a clear definition as to their application in the practice, in the different contexts of care, and especially in PHC. Although it is a principle, and as such, it should permeate all actions, comprehensiveness may not be fully implemented and, in this sense, be doomed to remain only in the theory.

The users of the system are complex beings. It is not possible to dissociate them from their multiple contexts and the system should not focus only on the illnesses that affect them. This dissociation has been practiced in the biomedical model that leads professionals towards the pathology and takes away their attention to patients, causing a distancing from the goal of comprehensiveness[11].

Fragmentation in interventions caused by the biomedical model does not only happen in primary care; it is still a predominant way of producing health in Brazil. This model is affected by the demands presented by users that have a set of needs that health workers must solve but who do not always do it in a comprehensive way[11].

The biomedical model has been institutionalized historically and is based on specialization, technology and protocols. It is considered the model of provision of care of PHC services in their specificities and it has worked partially and with low effectiveness. Although there has been a noticeable drop in mortality rates, pathologies that could be prevented such as hypertension, diabetes and pathologies related to mental health, among which depression stands out, are still predominant[12,13].

Many legal and institutional changes[14] have occurred since the approval of basic operational norms and institutionalization of SUS with the law 8.080/901 and subsequent editions of public policies aimed at its consolidation over the years.

With the regionalization of health services and the decentralization of the system, access to basic health care was expanded, strengthening the capacity of local government and autonomy in the field of health, and increasing the number of professionals with higher education. However, there are gaps in terms of inequalities related to the management of health services, as well as difficult

communication between the system and the services, compromising the health care of the population in a more comprehensive and expanded way[14].

The more financial resources are applied horizontally and systemically, the more results can be achieved, not only in terms of numbers, but mainly as regards quality of care[15].

Integrality in the management of Primary Health Care

PHC management, and more specifically the Family Health Strategy (FHS), should assure a comprehensive assistance to individuals in their family and social context. In this way, the goals of access to health proposed to their functioning would be met.

The concept of Comprehensiveness has gained strength for its implementation in the FHS. The political dimension has expanded primary care and increased the process of institutionalization of evaluation in the organization of health care. However, the challenges lie in the issues of scarce financial resources and in a process of professional training that is detached from the comprehensive care model that the PHC requires[15].

The principle of comprehensiveness covers three dimensions: health policies, the organization of health services, and health practices and the practices of health professionals[16].

Public health policies should invest more intensely in the improvement of health services, the implementation of processes, and the restructuring of policies, actions and services[15].

The organizational dimension shows the need to improve the interaction between levels of attention in the care process, considering the exchange of knowledge between health units. The dimension of care practices includes the relationship between caregiver and the individual, including promotion, prevention of risks and injuries, recovery and rehabilitation. The competencies to reach the ideal of comprehensiveness must be evaluated in the work process, aiming at better practices and tools that facilitate the assistance[16].

Regarding the organizational perspective, and in accordance with the concept of comprehensiveness, it must be ensured that individuals who depend on the health services have access to all the technological possibilities that their condition may require[4]. For this, financial, operational, technical and administrative management that also views patients as integral human beings become necessary.

In the sense of professional practice, dialogue between managers, health professionals and users should be opened up so as to allow a better interaction, empathy, exchange of knowledge and social construction. This approach enhances the expected results, building and developing best care practices. These practices must be grounded on values, ethical precepts and theoretical foundations of health promotion, taking into account the beliefs and the scientific base on which their objectives are supported[4].

The academic training of professionals is focused on learning about diseases and not health in a comprehensive perspective[15]. There is an urge to change the hegemonic biomedical model, because it is necessary to consider the health of the population with all its social, economic and cultural complexity.

The active participation of the multidisciplinary team may or may not enhance the comprehensiveness, since there are two types of teams, one called "teaming group" in which the actions of the professionals are juxtaposed making interaction difficult, and another, the "integration team" in which professionals align the methods of care, interacting with each other to achieve better results[10]. The latter is focused on accomplishing the therapeutic plan as a team, enhancing communication and the best results that comprehensive care can provide, not underestimating the complexity of care and demonstrating the multidisciplinary health needs of each person assisted, and making the division of tasks more flexible.

Regarding the health care practice, when the focus is on health prevention,

promotion and education, the gains are notorious. Humanization, performance, multidisciplinary work focused on results, embracement, active search, and guidance to the community become evident[15].

The SUS is under construction, and it is noteworthy there are still roles to be defined that are related to the state and the union, as well as the lack of integration between the levels of care and actions of comprehensiveness and intersectoriality[14].

Among the challenges for comprehensiveness is the realization of work on a network of connections, with a need to move within each work process and interconnect health services[17].

In the field of mental health, creative innovations must be promoted in work practices, because for comprehensiveness to take place, managers, workers and users must have responsibility and create conditions for transdisciplinary dialogues[18].

The "Care Lines and Networks" model organized upon the FHS. They suggest this model as a way to overcome the fragmentation of health care and management, aiming at the construction or reconstruction of comprehensive care[19].

The effective implementation of comprehensiveness as the axis of the "Health Care Networks" model has encountered challenges that need to be overcome. However, the continuity and radicalization of the process of implementation of regional care networks seem to be a possible and promising direction[19].

The gradual disruption of the biomedical model must take place, broadening the look to the general needs of the population, their way of life or lifestyle. In this sense, all the dimensions of the human being must be considered, as well as the social determinants of the health and disease process. It is necessary to leave the idea of just "treating" and start thinking about promoting health care in its full breadth.

It is necessary to move towards a health process in which the technical knowledge and the peculiar issues of each population should serve as stimuli to promote health[20].

Comprehensiveness in Health Care is a difficult concept, but not impossible to be inserted into the care practice. It is necessary to understand the importance of integrality to the system, which can be defined as articulated care among the networks managed by professionals who are trained to comprehensively promote the health of individuals, families and communities in their biopsychosocial and spiritual aspects.

The FHS is the level of health care that can offer greater conditions to approach individuals in a comprehensive way, because the contact of the professionals with the patients is very frequent and allows a greater approximation with the reality. Community Health Agents (CHA) know the needs of the population very closely, are inserted in their context and experience the day to day difficulties of the community.

Not looking at health management in PHC from the point of view of comprehensiveness can be a mistake that would result in the persistence of a society impregnated with the most diverse chronic problems. Not forming an extended and intersectoral network that communicates well to solve problems is also another mistake. There is no way to carry out effective health actions without the participation of all actors involved in the search for comprehensive care.

After 27 years of SUS a lot has been built and none of the steps was easy, as well as the very establishment of the system was not easy. There is a horizon of perspectives and struggles to achieve comprehensiveness, but it is assumed that there are also strong possibilities for success.

CONCLUSION

It is necessary to change the course. It is evident that the practice of comprehensiveness is complex and challenging. As a principle and guideline of the SUS, comprehensiveness seeks a holistic, humanizing, respectful, caring, responsible and participative attitude that requires a degree of maturity and commitment from all the actors involved.

The sense attributed to

comprehensiveness in the PHC practice, rescued in this reflective essay, was that it depends on collective and participatory actions. It should be articulated in "Health Care Networks" to act on the social determinants that cause attrition in the population health.

Comprehensiveness must be operationalized in a multidisciplinary and intersectoral way, in harmony with the different health problems of each region of the country, taking the culture, the lifestyle, the belief and the social position of the assisted persons into account.

In this sense, the involvement of the government, health professionals and users of the system as a whole must be committed to putting into practice the principles that govern the SUS, to weave and strengthen links that move towards disease prevention and health promotion.

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CONTRIBUTIONS

Mônica de Fátima Freires da Silva, Eliél Martins da Silva and **Sarah Lidiane Santos da Silva Oliveira** participated in the research and conception of the study. **Gina Andrade Abdala** and **Maria Dyrce Dias Meira** contributed to the critical review.

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