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Local health planning: care of the elderly versus Permanent Health Education

Planejamento local de saúde: atenção ao idoso versus Educação Permanente em Saúde

Planificación local de salud: atención al adulto mayor versus Educación Permanente en Salud

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Abstract

Objective: To analyze the Permanent Health Education proposals and health actions, in the context of the elderly, within local health plans.

Methods: A qualitative, exploratory, descriptive study, conducted by documentary analysis of 29 local health plans of Basic Health Units of a city in Paraná state, Brazil. The data were submitted to Similitude Analysis using IRaMuTeQ® software. The Freirean Praxis was used as theoretical-analytical reference.

Results: The similitude of the planned actions of Permanent Health Education in the care of the elderly underlined four central zones, composed of the words: prevention, group, Brazilian Family Health Support Center (FHSC), and age; the similitude of planned actions in the care of elderly centered on two central zones, formed by the words, group and the elderly.

Conclusion: The proposals were both focused on individual and collective care, but were not based on problematization and active aging, favoring curative actions to the detriment of the integral care of the elderly.

Resumo

Objetivos: Analisar as propostas de Educação Permanente em Saúde e as ações de saúde no contexto do idoso nos planos locais de saúde.

Métodos: Estudo qualitativo, exploratório-descritivo, realizado por análise documental de 29 planos locais de saúde de Unidades Básicas de Saúde de um município do estado do Paraná, Brasil. Os dados foram submetidos à Análise de Similitude utilizando o software IRaMuTeQ®. Utilizou-se como referencial teórico-analítico a Práxis Freiriana.

Resultados: A similitude das ações programadas de Educação Permanente em Saúde na atenção ao idoso destacou quatro zonas centrais, composta pelos vocábulos prevenção, grupo, NASF e idade, enquanto a similitude das ações programadas na atenção ao idoso originou duas zonas centrais, formadas pelas palavras grupo e idoso.

Conclusão: As propostas foram ambas centradas na atenção individual e coletiva, porém não foram pautadas na problematização e no envelhecimento ativo, privilegiando ações curativas em detrimento da integralidade da atenção ao idoso.

Resumen

Objetivos: Analizar las propuestas de Educación Permanente en Salud y las acciones de salud en el contexto del adulto mayor en los planes de salud locales.

Métodos: Estudio cualitativo, exploratorio-descritivo, realizado a través del análisis documental de 29 planes de salud locales de Unidades Básicas de Salud de un municipio del estado de Paraná, Brasil. Los datos se sometieron al análisis de similitud utilizando el software IRaMuTeQ®. Se usó como referencial teórico-analítico la Práxis Freiriana.

Resultados: La similitud de las acciones programadas de Educación Permanente en Salud en la atención al adulto mayor destacó cuatro zonas centrales, conformadas por los vocablos prevención, grupo, NASF (Núcleo de Apoyo a la Salud de la Familia) y edad, mientras que la similitud de las acciones programadas en la atención al adulto mayor originó dos zonas centrales, formadas por las palabras grupo y anciano.

Conclusión: Las propuestas se centraron en la atención individual y colectiva, pero no fueron tenidas en cuenta en la problematización y en el envejecimiento activo; se privilegiaron acciones curativas en detrimento de la integralidad de la atención al anciano.

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Introduction

The Permanent Health Education (PHE) is a structuring part of the National Education Policy and Development of the Brazilian Unified Health System (SUS), in effect since 2004, and considers daily health as an essential part of teaching and learning, and it articulates work and learning. The policy aims to promote the qualification and transformation of the work processes of health teams, in order to strengthen the development of care practices, and contribute to the consolidation of new health actions.⁽¹⁻⁶⁾

Considering the health context as the locus for the development of PHE actions, health care of the elderly emerges as a current and growing theme, as population aging is a current and progressive phenomenon in our country, which brings with it new demands for Primary Health Care (PHC), requiring that health professionals be qualified to support this population.⁽⁷⁾

However, caring for the elderly in PHC is still focused on chronic conditions, to the detriment of the integrality of health care,^(8,9) transforming one of the main objectives of PHC, which is to prevent diseases and promote health in active and healthy aging,⁽⁷⁾ which demonstrates the need for educational practices in this area.

Therefore, in order to achieve integrated health care for the elderly, the care in the PHC scenario must then be permeated by PHE, which represents an important strategy to promote increased access and comprehensive health care of the elderly.⁽⁷⁾

In order to drive the PHE practices and effectively transform health actions for the elderly, the integration of these subjects into health planning is essential. The municipal manager is responsible for ensuring PHE practices for all professionals, paying special attention to emerging issues, such as care for the elderly.⁽⁷⁾

In this direction, planning becomes effective in the municipal health plans and in the local health plans of the PHC. These are management tools of the Brazilian Basic Health Units (BHU), and are part of intersectoral policies based on the expanded conception of health, centered on the dynam-

ics of its social production, guaranteeing the right to health with a territorial basis approach. It is an instrument qualified for recognizing and evidencing local specificities that need to be considered in health planning, in order to integrate and qualify health actions,⁽¹⁰⁾ in addition to guide the care and educational practices in the context of health care for the elderly.⁽¹⁾

Finally, local health plans become initiatives that support and induce the PHE processes, supporting the provision of care, especially the care of the elderly. In this sense, the present research was anchored in the following guiding question: Is the PHE related to the actions for care of the elderly in the local health plans? So, the objective was to analyze the PHE proposals and the health actions in the context of the elderly in the local health plans.

Methods

This was a qualitative, exploratory, descriptive, analytical-interpretive research conducted from August to October of 2017, which used as a data source the local health plans of the BHUs of a city located in the Northwest region of the state of Paraná, Brazil.

Documentary analysis technique was used for this purpose, which consists of identifying, verifying, and analyzing the documents of local planning to identify the health practices in the care of the elderly that are permeated by the PHE. The local health plans are public documents, organized by the local management of the BHUs, with annual periodicity, and are primary sources, i.e., documents that have not yet received analytical treatment, and therefore were used for interpretation and analysis.⁽¹¹⁾

These documents were requested by e-mail and / or telephone of the managers of the 31 BHU of the referred municipality. There were 29 local plans, which were archived in virtual folders, because the material was sent in digital format. There was no response by two managers. With the documents in hand, the following questions were used to guide the analysis: What are the planned actions that guide care for the elderly? And what are the planned actions that involve PHE practices for health of the elderly?

For analysis of the 29 local health plans, the material was read in its entirety; for each guiding question, a text was drawn up with excerpts from the plans, which originate two *corpus*: one about the programmed actions that involved the actions of PHE for the healthcare of the elderly (*corpus* one); and another on the programmed actions that involved healthcare practices for the elderly (*corpus* two).

These *corpus* were submitted, separately, to lexicographic analysis using the *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* – IraMuTeQ® software,⁽¹²⁾ using the Similitude Analysis, which enabled the identification of the occurrences and the connection between the words present in each *corpus*. These were grouped in central zones and peripheral zones, facilitating the identification of the structures represented in the content from the local health plans, and generating two trees of similitude that were used for interpretative analysis. The theoretical and analytical framework used was the Freirian *Praxis*,⁽¹³⁾ with regard to the transformative potential of praxis in work and care processes.⁽¹⁾

This study respected all criteria established in the Standards for Reporting Qualitative Research (SRQR) instrument, as a support tool for reports of qualitative studies.

As a documentary analysis, which used documents of the municipal administration, this research obtained favorable opinion for its completion, under number 1,948,003/2017 (CAAE: 47111915.5.0000.0104), meeting all the ethical precepts guided by Resolution 466/2012 of the National Health Council.

Results

With regard to the programmed actions of PHE for the care of elderly, Figure 1 presents the semantic range of the most frequent words in *corpus* one. Four central zones were generated: prevention (n=59), age (n=50), group (n=39), and FHSC (n=32). Five peripheral zones that were linked to the central prevention zone were also identified (Figure 1).

The programmed actions of PHE for care of the elderly presented a focus on the actions per-

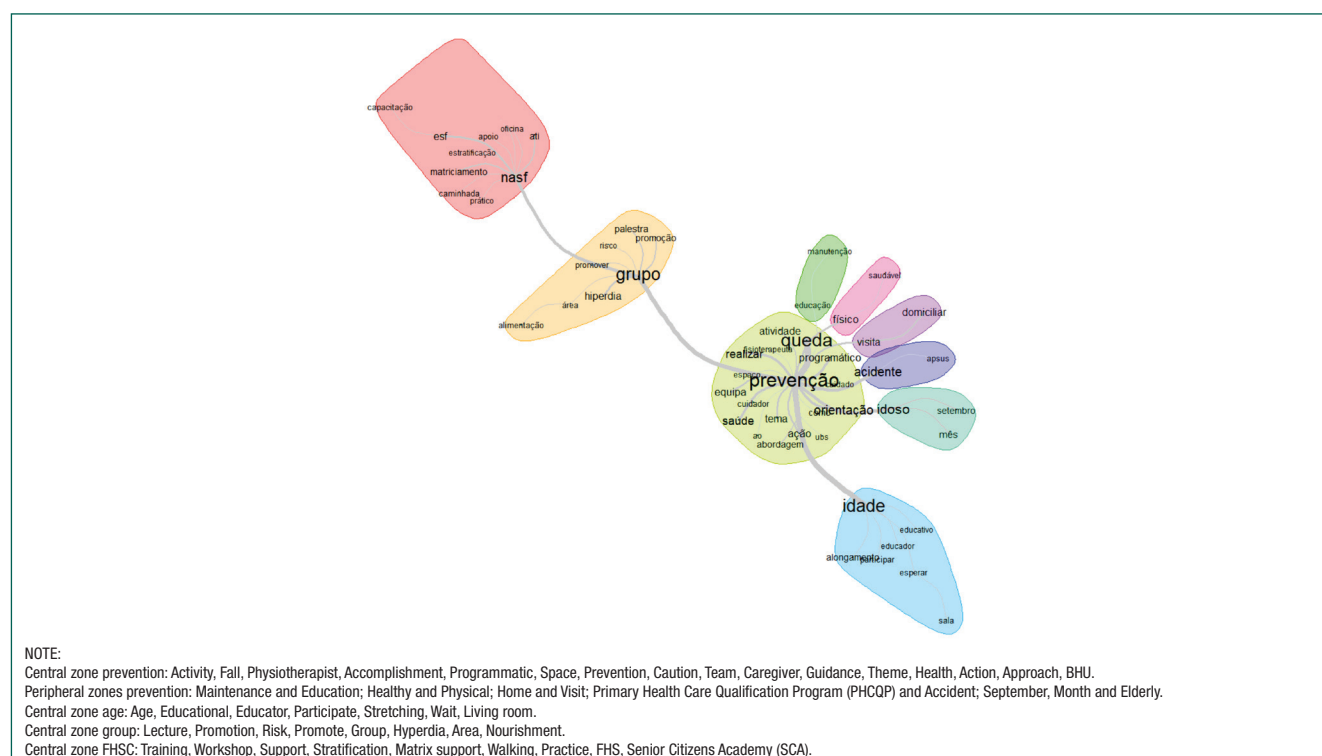


Figure 1. Similitude analysis: planned actions of Permanent Health Education in the care of the elderly

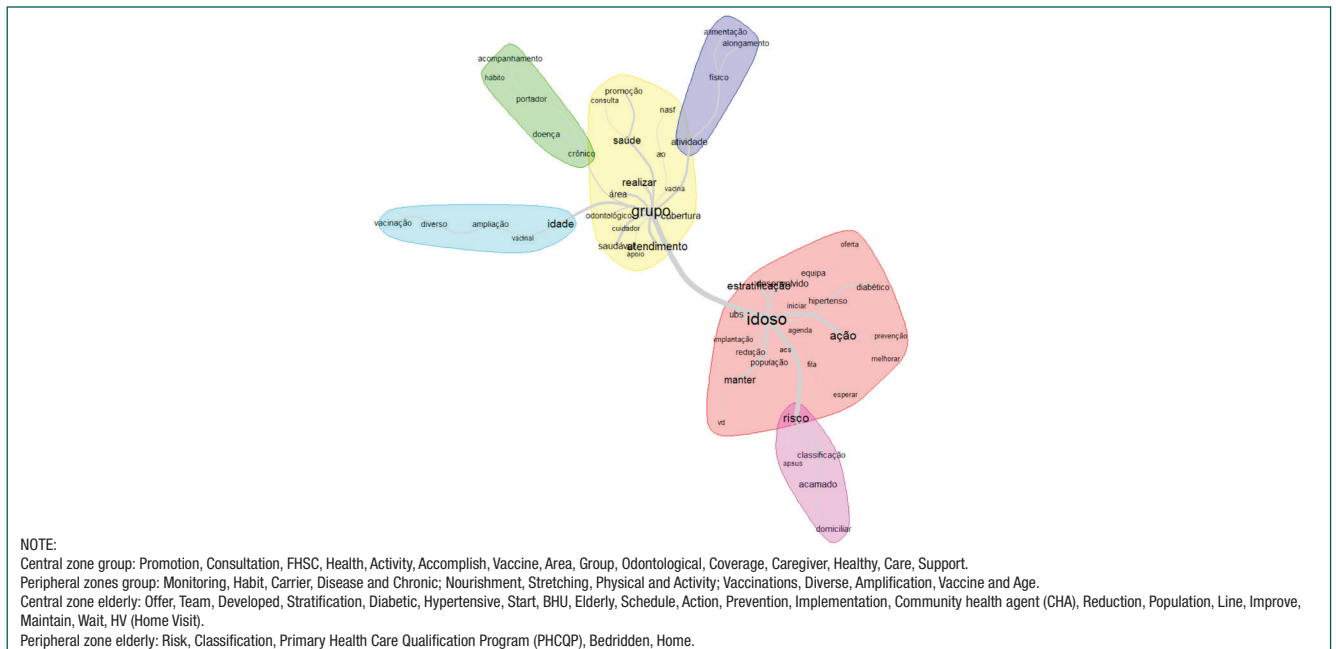


Figure 2. Analysis of similitude: planned health actions for the elderly

formed by the Brazilian Family Health Support Center (FHSC) professionals as promoters of educational activities, caring and case management, followed by the operating groups for development of PHE, which is focused on the prevention of diseases, and the maintenance and promotion of health. The actions of the PHE are also developed at the individual level, for the prevention of falls, by giving orientations to the elders and their caregivers, home visits (HV), and actions focused on conditions related to aging.

Regarding caring actions planned for the elderly, the most frequent words present in *corpus* two created two central zones, delineated by the words group (n=38) and elderly (n=31). One showed connection with three peripheral zones, and the other connected to one peripheral zone, respectively. These are presented below in figure 2.

The similitude analysis of figure 2 showed that the actions programmed for the care of the elderly are developed from two strategies of care, collectively during the operative groups, and focused on chronic conditions, with of health promotion and disease prevention activities. However, it also develops at the individual scope with focus on home services for bedridden elders and actions of control and monitoring of the health conditions of the elderly.

Discussion

In this context, the programmed actions of PHE regarding care for the elderly, and the planned actions in the health of the elderly, were not developed in consonance; although both were focused on individual and collective care, the planned actions of care for the elderly did not include FHSC actions in team education, caring, parenting, and case management, reducing FHSC's role only to support operative groups with FHS teams.^(14,15)

When designing PHE and health care without the same guiding principle of contextual problematization- which is the FHSC function – the PHE is not assumed to be on the job training of the professional,^(1,2,5,16) as the real work materialized by the planning of actions in care for the elderly did not list any action of the FHSC in that regard. Given this fact, local health plans dichotomize education and care, distancing the ideals of the PHE.

Knowing that what is recommended in the actions programmed for the elderly has a real possibility of being integrated through the PHE,⁽¹⁾ it is not possible to develop the actions planned for the care of the elderly without incorporating the FHSC teams, especially because one of the priority roles of the FHSC is technical and pedagogical support in

order to address the culture of care fragmentation and the lack of accountability for care.^(14,15)

The FHSC enhances collective reflection and contributes to meaningful learning through PHE, allowing professionals to review the work processes and develop the critical awareness needed to achieve transformations in knowledge and skill^{13,17)} in the care of the elderly. By ignoring the FHSC's role in the work process, its potential educator is also omitted, which may obstruct *praxis* as an inducer of the transformation of reality.^(2,5,13)

In the PHE, in which work is an educational foundation and transformer of the reality, the professional is the protagonist of the desired transformations in his/her concrete practice.^(1,5,18,19) Through the problematization of practices, and seeking alternatives for transformation, the PHE is present, as it stimulates action-reflection-action and enables proposals for viable solutions to the lived reality. From this perspective, problematizing means "thinking about practice", presupposing breaking with the individual logic to think as a team,⁽⁶⁾ suggesting the FHSC's performance in this context, in order to impact on care as a committed, qualified and critical-reflexive action, thus, the *praxis*.^(3,13)

However, the local health plans showed that the PHE is reduced in the care of the elderly, to the prevention of falls in older age, with this being the most relevant theme in the PHE that permeated the health programs in the care of the elderly, and limited in activities developed during the month of September, in which the federal management suggests that actions for the elderly population be intensified because it is the considered the month of the elderly.

There is a shortage of PHE activities that qualify the contextualized care for the elderly in PHC, since other influencers of active and healthy aging are neglected; but when they exist, they are sparse and clack of continuity²⁰⁾ mischaracterizing thinking and action in practice.

The programmed actions of the PHE in care for the elderly are minimized to trainings and workshops, many of them in the form of lectures, maintaining a linear logic of learning, poorly contextualized with the concrete reality, which does

not respect professionals as individuals capable of reflecting and transforming practice from their knowledge.⁽²¹⁾ In this context, the Brazilian "Primary Health Care Qualification Program - PHCQP", a state management program whose objective was to organize the actions and services in PHC, was accomplished through workshops; one of them defined strategies to classify the elderly population in the FHS territory.⁽²²⁾

Although based on active methodology, that does not present a mechanism for forwarding information, but rather, the development of knowledge,⁽²⁾ ignored the different contexts but focused on the definition of guidelines for identification of conditions of the elderly,⁽²²⁾ but not the organization of health care for the elderly in a problematized manner, which would establish the PHE.⁽¹⁶⁾ Therefore, it was a professional qualification activity, although it had a great influence on thinking about the work process which would be necessary to prevent accidents of the elderly, from the perspective of care.

It should be noted that not every training implies a process of PHE, because it does not directly involve the real transformation of health practices, although all training aims at improving the performance of professionals that is undeniably necessary to implement *praxis*.⁽¹⁾ Therefore, professional qualification can be understood as one that enables access to new knowledge and skills so that, in a timely manner, the critical integration into the concrete reality, based on daily reflection, is able to associate knowledge and actions and move toward transformation of practices.^(13,23)

In this context, although PHE originates in daily work, the adequate preparation of the professional is necessary, as it is the source of knowledge that reveals the *praxis*.^(1,24) From this perspective, the problematization of practice is only possible through knowledge. The PHE and training, therefore, can not be dissociated, and the latter should not be dismembered with ideas of transformation, under the threat of activism.^(3,13) In this sense, and in both cases, there must be movements toward critical reflection of form that leads to education that thinks not only about work but worldwide production,⁽²⁾ stimulating professionals to seek new positions for better health care.⁽⁵⁾

In a manner that is more in line with these PHE ideals, teaching and learning are incorporated into the daily practice of care for the elderly in PHC, in the real context in which they occur, configuring PHE in the context of home care: during the home visits. Practice, as a source of knowledge, problematizes the doing and enables professionals to develop new knowledge and practices from their reflections,^{1,2,5,13,23)} as care for the elderly is expected in the local health plans analyzed in the present study.

Regarding this aspect, it is important to promote the community health agent for conducting and scheduling home visits, which in turn contribute by enabling the exchange of knowledge among the professionals involved, who, by problematizing the reality experienced, find strategies that potentiate the care for the elderly, recreating their own practice and enabling action-reflection-action.^(13,25)

The same occurs in the operative groups and educational activities in the waiting room, which are also a *locus* of the PHE, as a structure of interaction between the different health professionals, including the FHS and FHSC teams, allowing the horizontal dialogue that permeates *praxis*,⁽¹³⁾ enhancing professional learning, avoiding the fragmentation of knowledge, and optimizing the spaces of care and health.^(1,5) In a permanent dialectical movement, these moments constitute processes of construction and deconstruction of knowledge and actions, becoming, through the PHE, strategic resources for work management and also for health education.⁽⁵⁾

According to the plans analyzed, a scarcity was observed both in the actions programmed for the PHE and those for the elderly in the city where the study was conducted; unfortunately, this was an usual situation in the PHC services.⁽²⁶⁾ The existing actions were not planned in order to address the integrality of the elder's health,^(8,9) predominating the biomedical care model that favors curative actions, such as home care of the bed-bound elder and control of his chronic conditions, through the Brazilian *System of Registration and Monitoring of Hypertensive and/or Diabetics Patients*, popularly known as HYPERDIA, regardless of the global evaluation of the elderly proposed as health care for the elderly and aging from the Ministry of Health.⁽⁷⁾

The hegemonic models are distant from the PHE, and do not use health planning as a management tool,⁽²⁷⁾ but have a great influence on the practices and organization of PHC,^(17,27,28) as identified in this research.

As a result, the elderly person seems to be seen by local planners as the disease they have. For this reason, the actions programmed for this population are reportedly for follow-up and control of chronic patients, associating the elder with disease, and reducing the range of care actions. The lack of issues related to healthy aging in the local plans makes it difficult to implement an elderly health policy that contemplates senescence,⁽²⁰⁾ although, some health promoting activities were evident in the analytical material, such as healthy habits of physical exercise and healthy nutrition.

Therefore, it is necessary that health professionals participate effectively and with autonomy in the planning process and implementation of the planned actions for which PHE must be present,⁽⁷⁾ in order to guarantee the integrality of health care for the elderly, which is essential to overcome the limits of traditional health practices, qualifying the service and care provided.^(2,19)

Limitations of this study include the lack of comparison of the planned actions of health in the care for the elderly with what, in fact, is executed in practice. New studies to complement these findings must be conducted, as well as those in other contexts and scenarios, to strengthen the knowledge about PHE and care for the elderly in PHC.

Conclusion

The programmed actions of PHE and the care for the elderly are focused on individual and collective caring, but they ignore the role of the FHSC as a facilitator of *praxis*, which may prevent the transformation of knowledge and actions. In addition, the planned health actions for care of the elderly were not based on problematization or on healthy and active aging, but favored curative actions aimed at chronic conditions, at the detriment of integral care for the elderly, also limiting learning through practice.

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Collaborations

Nogueira IS, Labegalini CMG, Carreira L and Baldissera VDA contributed to the study design, analysis, data interpretation, critical analysis of the intellectual content, and final approval of the version to be published.

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